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Quarterly circulation approximately 213,000 to all RNs, LPNs, and Student Nurses in Ohio.

Screening and Intervening with Suicidal Patients – Help for the Non-Psychiatric Nurse

Author: Angie Chesser, PhD, RN, CNS, BC

INDEPENDENT STUDY

This independent study has been developed for nurses to enhance understanding of how to screen and intervene with the suicidal patient. 1.14 contact hours will be awarded for successful completion of this independent study. (Expires 12/2012).

The author and planning committee members have declared no conflict of interest. There is no commercial support or sponsorship for this independent study. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. Describe personal issues that can impact nurses caring for suicidal patients.
2. Recognize risk factors for suicide.
3. Identify how non-psychiatric nurses can screen and respond to suicidal patients.

Suicide Impacts Us All:

Suicide leaves a lasting legacy of loss and pain in our society. Like a pebble thrown in a pond, its impact circles outward touching multiple lives in painfully indelible ways. Suicide is a major public health problem in America and worldwide. Each day in America a person dies by suicide every 16 minutes and more than 33,000 persons die by suicide each year. Of the persons who die by suicide each year, 90% had a diagnosable mental illness at the time of their death.[1]

Nurses, because of their contact with patients across multiple settings, have a crucial role to play in suicide prevention and intervention. Nurses interact daily with patients and their significant others experiencing health issues leading to loss and psychological pain. While suicidal thoughts and behaviors are often associated primarily with psychiatric patients and settings, in fact, many patients were found to have visited their primary care physician within three weeks prior to committing suicide.[2] They expressed a variety of physical symptomatology often without definitive findings. Yet, they rarely directly shared suicidal thoughts or plans. While this finding can be anxiety provoking for caregivers, it also provides an enormous opportunity for intervening and preventing suicide. Nurses interacting with patients and significant others in multiple care settings across the entire life span from youth to old age can have a crucial role to play in reaching out to suicidal patients and saving many lives.

Before nurses can reach out to potentially suicidal patients in a caring and effective way, it is important for them to do some self-reflection. This self-reflection can be protective to the nurse as working with suicidal patients can be a stressful personal challenge with potential physical and emotional impacts.[3] Self-reflection also assists a nurse in examining beliefs and attitudes which can decrease their ability to reach out, assess and intervene with suicidal patients.

Nurses can have personal beliefs, attitudes and emotional responses to suicidal patients which stem from many possible sources: upbringing, religious beliefs, social and/or cultural issues and the impact of suicide in their personal lives. It is crucial for nurses to identify and deal with their own issues regarding suicide because failure to do so can affect their ability to therapeutically assess and intervene with suicidal patients.[4]

See Figure I for some self-reflection questions nurses can answer which may help identify potential personal issues that can hinder work with suicidal patients. Nurses can seek help with these issues through personal counseling and/or seeking clinical supervision when working with suicidal patients.

FIGURE I
Self Reflection about Suicidality

Questions to ask yourself:

1) Do I believe suicidal patients are sinful, weak or shameful?
2) Do suicidal patients arouse high anxiety in me–perhaps making me minimize warning signs or avoid caring for them?
3) Do suicidal patients elicit anger in me?
4) Do I feel the need to rescue suicidal patients?
5) Have I experienced intense guilt or rejection after a patient's suicide or attempt?
6) Do I have personal experience with a family member, friend or co-worker or patient committing suicide? Could my reactions to this event be impacting my care of suicidal patients now?
7) If I have a diagnosed mental illness, does working with suicidal patients worsen my symptoms?

If you have concerns about working with suicidal patients, please:

1) Speak with your supervisor.
2) Seek personal counseling if needed.

Next, nurses live in a society which stigmatizes suicide and mental illness. Stigma prejudice and bias against the mentally ill and those struggling with suicidal thoughts and behaviors make it more difficult for patients to share their pain and seek help. The media and the way it portrays suicide impacts the way we see suicide and persons who attempt or commit suicide. Research on media portrayals of suicide shows an increase in suicide when the number of stories increases, a suicide death is repeatedly reported, put on the front page or leads to evening news, and/or the reporting is very dramatic.[5, 6] Media portrayals of suicide may also reinforce misinformation or myths about suicide by suggesting that suicide often happens totally unexpectedly to otherwise healthy people or by romanticizing/idealizing suicide as a heroic choice.[7]

Suicide myths abound in our society. Nurses can play a key suicide prevention role by knowing about these myths and dispelling them through their work with patients, significant others, community educational opportunities and in their clinical practice. Here are some common suicide myths:

1) Myth: Asking a person about suicidal thoughts/behaviors may prompt them to commit suicide.
   Fact: Talking about suicide in an empathetic manner can decrease the likelihood of suicide. Directly asking about suicidal thoughts and behaviors can lower a person's sense of isolation and increase their sense that they are cared about and help is available.

2) Myth: Suicide happens without warning.
   Fact: While some rare suicides occur without warning, most suicidal persons give verbal and non-verbal warnings of their distress and pain. Unfortunately, these communications may be missed or unheeded.

3) Myth: Suicide happens only to specific groups of people (certain gender, race, age, socioeconomic status, religion, cultural group, etc.).
   Fact: Suicidal thoughts and behaviors can affect anyone.

Screening and Intervening continued on page 11

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Editor's Notes

CE4Nurses
Online Continuing Education for Nurses, By Nurses

All independent studies published in the *Ohio Nurse* are free to ONA members but now they can be completed online through our newly redesigned CE4Nurses website. Non-members can also complete the studies published in this issue online for $12.00 per study. See page 5 for more details. Non-members: think about joining ONA! See page 3 for a membership application and five reasons for joining the only professional organization in Ohio for registered nurses.

ONA OHIO NURSES ASSOCIATION
Ohio Nurses Association

Get your copy of Legal Regulations and Professional Standards for Ohio Nurses

The third edition of *Legal Regulations & Professional Standards for Ohio Nurses* is available for purchase from the Ohio Nurses Foundation. Much has changed in the health care environment since the initial publication of this resource ten years ago and this new, updated edition will enable students and registered nurses alike to become more familiar with the law, rule, and professional standards that define nursing practice.

This resource is available as an Adobe© PDF available via email for $18.00. To order your copy, please visit www.ohnurses.org > Practice > Legal Regulations Guide. Please allow seven to ten business days for delivery.

OHIO NURSE

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Employer _____ US Citizen? (__)Yes (__)No

RN License Number _____ License State _____ Basic School of Nursing _____ Grad. Mo/Yr (basic program) _____

SELECT MEMBERSHIP CATEGORY **See page 4 for membership rates**

Full Rate
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(__) Not employed
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(__) Full-time student (please provide documentation)
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SELECT PAYMENT PLAN *$25.00 fee for returned checks*

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AUTHORIZATION to provide monthly electronic payments to Ohio Nurses Association (ONA): This is to authorize ONA to withdraw monthly dues payments on or after the 15th day of each month from my checking account designated by the enclosed check for the first month's payment. I understand this amount includes a monthly service fee of 33 cents. ONA is authorized to change the amount by giving the undersigned thirty (30) days notice. The undersigned may cancel this authorization upon receipt by ONA of written notification of termination twenty (20) days prior to the deduction date as designated above. ONA will charge a $15.00 fee for any returned drafts.

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(__) Annual Payment Plan– Enclose check payable for annual amount to ONA.

To pay with a credit card, you must fill out the online membership application at www.ohnurses.org >join.

Mail to: ONA Dues Processing Department, P.O. Box 14845, Columbus, Ohio 43214-0845

One dollar ($1.00) per month of your dues goes to an account set up to support ONA's political efforts. You may choose at anytime to opt out of this dues designation. Opting out does not reduce the dues amount. If you are interested in opting out, please contact the Director of Health Policy at 614/237-5414.

ONA Dues are not deductible as a charitable contribution for federal income tax, but can be partially deductible as a business expense. A percent of the dues not deductible is calculated each year based on the amount spent lobbying. When preparing your taxes, contact ONA for the percentage that is deductible in the year you make this payment.

TO BE COMPLETED BY ONA: Date_____ District_____ Mtype_____ Emp_____ Chk#_____ Amount _____

What Can ONA Do For Me?

The Ohio Nurses Association does a lot for the nursing profession as a whole, but what does ONA do for its members?

DISCOUNTED PRODUCTS AND SERVICES Members take advantage of a wide array of discounts on products and services, including professional liability insurance, home and auto insurance, hotels, rental cars etc.

WORKPLACE ADVOCACY ONA provides members access to a wide range of resources to help them make a real difference in the workplace, regardless of work setting. ONA provides members with resources to create healthy and safe work environments in all health care settings by providing tools to help nurses navigate workplace challenges, optimize patient outcomes and maximize career benefits.

EDUCATION Whether you've just begun your nursing career or are seeking to enhance or maintain your current practice, ONA offers numerous resources to guide you. For example, the Ohio Nurses Foundation awards nine scholarships annually with preference to ONA members. Members also save up to $120 on certification through ANCC, and can earn contact hours for free through the independent studies in the *Ohio Nurse* or online discounted rate, among many other educational opportunities.

NURSING PRACTICE ONA staff includes experts in nursing practice and policy that serve our members by interpreting the complexities of the Nurse Practice Act and addressing practice issues with a focus of ethical, legal and professional standards on a case-by-case basis.

LEGISLATIVE ADVOCACY ONA gives members a direct link to the legislators that make decisions that affect nursing practice. Members can become Legislative Liaisons for their district, join the Health Policy Council and participate in the legislative process in many other ways through their ONA membership.

These are just a few of the benefits nurses receive as ONA members. Dues range from $34–$47 a month and we offer reduced dues rates to new graduates, unemployed and retired nurses. Fill out and return the ONA Membership Application or go to www.ohnurses.org > Join/Renew to start taking advantage of what ONA has to offer.

Staff Nurses–Register Now!

The Safe Staffing Summit is *the* opportunity for nurses to learn about the Safe Staffing Law in Ohio

The Ohio Nurses Association and the Ohio Nurses Foundation are still on the road presenting the Safe Staffing Summit. We'll be in Columbus on March 23, Cincinnati on March 30 and Akron on April 6.

About the Summit

Ohio law requires that hospitals implement RN Safe Staffing Plans to ensure appropriate staffing levels are maintained at all times. By law, nurses must have representation on nursing care committees that are tasked with assessing and developing RN staffing plans. As advocates for quality patient care, nurses need to embrace the opportunity to collaborate with other hospital leaders and participate on these staffing committees.

The focus of the Safe Staffing Summit is to educate nurses about the law and how to effectively participate on hospital staffing committees. The Summit will begin with a two-hour continuing education program provided by the Ohio Nurses Foundation. The Ohio Nurses Association will conclude the program with a question and answer session about the safe staffing law and other issues participants bring forth. The Summit will be brought to five areas of the state in the attempt to educate as many nurses as possible. Look for a location near you!

To Register

Go to www.safestaffingsummit.wordpress.com for dates, times, locations and registration. The summit is free to ONA members and $25 for non-members.

The Safe Staffing Law CE

Objectives:
1. Describe the nurse staffing law in Ohio.
2. Discuss the staff nurse's role in the implementation of the law.

Presented by the Ohio Nurses Foundation.

2.0 Contact Hours

Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Tell us Your Story!

We loved hearing your stories and we want to hear more. Nurses make decisions, take actions and deliver care in ways that demonstrate leadership all the time. Think of a time when you felt especially proud of the role you played in a situation that affected the outcome for a patient, a student, a colleague, or a community. Submissions should be insightful, encouraging, or inspirational. We are looking for stories that have a strong beginning, middle and end and are ideally no longer than 500 words.

Terms and Conditions: All stories must be true. Names of patients, clients, colleagues, students and facilities must be changed to protect their identity. Please include your contact information; name, address, phone number and email address. There is no monetary prize if your story is selected for print and you retain all rights. Please send your story to Shannon Richmond at srichmond@ohnurses.org.

Ohio Nurses Association Membership Assessments and Dues Rates

Check below to determine your district. ONA Bylaws state that you must live or work in your district. Indicate choice if you live in one district and work in another

RATES EFFECTIVE 01/01/2011

Membership assessments and dues include American Nurses Association, Ohio Nurses Association and district fees.

Non-Union Members	Full Rate		75% Reduce Rate		50% Reduce Rate		25% Special Rate	
District Name & Number	**Monthly**	**Yearly**	**Monthly**	**Yearly**	**Monthly**	**Yearly**	**Monthly**	**Yearly**
01 Ashtabula County: Ashtabula **18 Knox-Licking:** Knox, Licking	34.96	415.61	26.31	311.71	17.65	207.81	8.99	103.90
03 District Three: Columbiana, Mahoning, Trumbull	46.92	559.05	35.27	419.29	23.62	279.53	11.98	139.76
05 Mohican: Ashland, Crawford, Marion, Morrow, Richland	35.38	420.61	26.62	315.46	17.86	210.31	9.09	105.15
07 Erie-Huron: Erie, Huron **15 Southern Ohio:** Adams, Athens, Gallia, Highland, Hocking, Jackson, Lawrence, Meigs, Pike, Ross, Scioto, Vinton **17 East Central:** Harrison, Jefferson, Tuscarawas **19 Lake County:** Lake **22 Wayne-Holmes-Medina:** Holmes, Medina, Wayne **24 Lorain County:** Lorain	34.55	410.61	25.99	307.96	17.44	205.31	8.88	102.65
08 Southwestern Ohio: Brown, Clermont, Clinton, Hamilton, Warren	36.21	430.61	27.24	322.96	18.27	215.31	9.30	107.65
10 District Ten: Butler, Champaign, Clark, Darke, Greene, Mercer, Miami, Montgomery, Preble, Shelby	38.09	453.11	28.65	339.83	19.21	226.56	9.77	113.29
12 Mid-Ohio: Delaware, Fairfield, Fayette, Franklin, Logan, Madison, Pickaway, Union	37.88	450.61	28.49	337.96	19.11	225.31	9.72	112.65
13 West Central Ohio: Allen, Auglaize, Hancock, Hardin, Paulding	34.80	413.61	26.18	310.21	17.56	206.81	8.95	103.40
16 Greater Cleveland: Cuyahoga, Geauga	39.05	464.61	29.37	348.46	19.69	232.31	10.01	116.15
28 Muskingum Valley: Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry	34.21	406.61	25.74	304.96	17.27	203.31	8.80	101.65
33 Stark Carroll: Carroll, Stark	38.26	455.11	28.77	341.33	19.29	227.56	9.81	113.78
34 Summit and Portage: Portage, Summit	38.55	458.61	28.99	343.96	19.44	229.31	9.88	114.65
35 Northwest Ohio: Defiance, Fulton, Henry, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood	37.46	445.61	28.18	334.21	18.90	222.81	9.61	111.40
37 Washington County & Eastern Valley: Belmont, Monroe, Washington	33.71	400.61	25.37	300.46	17.02	200.31	8.68	100.15

Registration Form:
Please check the appropriate Post Tests

Complete your post-test online! Go to www.ohnurses.org and click on CE4Nurses *See page 5 for details.*
Select the studies you are taking:

__ Balancing the Demands in Your Life Through Humor

__ Professional Boundaries and Sexual Misconduct

__ Screening and Intervening with Suicidal Patients

Name: _____

Address: _____
Street City State Zip

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ADDITIONAL INDEPENDENT STUDIES:
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Independent Study Instructions

To help Ohio's nurses meet their obligation to stay current in their practice, three independent studies are published in each issue of the *Ohio Nurse*.

Instructions to Complete Online

1. Go to www.ohnurses.org and click on the CE4Nurses logo
2. Click on "Ohio Nurse March Issue"
3. Click on each study you want to take and add it to your cart. (ONA members will see a price of $0.00 after they are logged in).
4. Complete the check-out process.
5. Go to the CE4Nurses Exam Manager either from your confirmation email or the CE4Nurses site.
6. Log in and click on View New Courses. Click on the study you want to complete, and follow the instructions provided in CE4Nurses Exam Manager.
7. Please read the independent study carefully.
8. Complete the post-test and evaluation form for each study.

Post-test

The post-test will be scored immediately. If a score of 70 percent or better is achieved, you will be able to print a certificate. If a score of 70 percent is not achieved, you may take the test a second time. We recommend that the independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be made available immediately for printing.

Instructions to Complete By Mail

1. Please read the independent study carefully.
2. Complete the post-test and evaluation form for each study.
3. Fill out the registration form indicating which studies you have completed, and return originals or copies of the registration form, post test, evaluation and payment (if applicable) to:
   Ohio Nurses Foundation
   4000 East Main Street, Columbus, OH 43213

Post-test

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

References will be sent with the certificate.

Questions

Contact Sandy Swearingen at 614-448-1030 (sswearingen@ohnurses.org), or Zandra Ohri, MA, MS, RN, Director, Continuing Education at 614-448-1027 (zohri@ohnurses.org).

Disclaimer: The information in the studies published in this issue is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

The authors and planning committee members of these studies have declared no conflict of interest.

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Balancing the Demands in Your Life Through Humor

Author: Deborah A. Hague, MS, RN

This independent study has been developed for nurses who wish to learn more about balancing the demands in their lives through humor. 0.84 contacts hour will be awarded. (Expires 6/2012).

The author and planning committee members have declared no conflict of interest. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

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The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. List three physiologic responses of the body to mirthful laughter.
2. Identify three reasons why we should use humor in the workplace.
3. Describe three functions humor serves in our lives.
4. Examine four humor strategies nurses can use to counter-balance the multitude of demands in our lives.

INTRODUCTION

Someone once said: "She who laughs, lasts!" In today's world, nurses find themselves constantly under pressure. We pressure ourselves to be good nurses, good mothers or fathers, good sisters or brothers, good sons or daughters. We find our lives sometimes become a big blur as we try to juggle all of our responsibilities. Finally, the day comes when we crash and burn. Our bodies simply force us to do what our minds and hearts won't–stop for a little rest. We can, however, prevent this "crash and burn" syndrome by simply adding a little laughter to our lives.

PHYSIOLOGY OF LAUGHTER

Most of us have not given a moment's thought to why laughter makes us feel good. Fortunately, there are many researchers out there who believe that laughter does have a positive physiologic effect on the body and they are actively pursuing the proof.

What we do know so far is that mirthful laughter (that is, the belly slapping kind!) has some very good effects on us. First, when we laugh we speed up our heart rate. Assuming we have a relatively healthy heart, this increases our cardiac output and sends more blood into our circulation. Our tissues then become highly oxygenated and we feel energetic and ready to go.

Laughter also increases our metabolic rate. Yes, when we participate in hearty laughter we burn calories! Although no substitution for a good diet, it is a great way to get rid of that extra piece of candy we sneak once in awhile.

Some researchers believe laughter is a wonderful way to cope with pain. Laughter is an effective distraction mechanism which can be used in conjunction with medication administration. This technique may increase the length of time a patient can stay on a lower dose of pain medication.

One of the best physiologic effects of laughter is that it diminishes skeletal muscle tension. When we "crack up" we use a lot of our muscles, especially our respiratory muscles. What has been shown is that the harder we laugh, the greater the compensatory relaxation. Take a minute to think about the last time you really laughed. Didn't you feel so relaxed when you stopped laughing that you could hardly stand up? That is compensatory relaxation at its peak.

One of the most exciting findings is that cortisol levels are decreased with mirthful laughter. When we are under stress we produce cortisol which is then secreted by our adrenal glands. In high levels, it is thought that cortisol can suppress our immune responses. If you think about it, it makes sense. When do we usually get sick–when we are most stressed? Mirthful laughter has been found to decrease cortisol levels by as much as 50 percent!

This is just a small sampling of what researchers have found regarding the positive impact humor can have on our health. One thing is certain: laughter should not be ignored as a way to improve our health and well-being while trying to balance our lives.

WHY WE SHOULD LAUGH AT WORK

Working in the healthcare arena today is very stressful. The environment has gotten so complex that we find ourselves having to run just to keep up with the advances

Balancing the Demands continued on page 6

NURSES TRUSTED to CARE

Balancing the Demands continued from page 5

and changes we face. It's easy to come "unglued" when we are trying to move patients through the system as efficiently as possible without giving them the impression of "rushing." So how can the use of humor and laughter make this easier for us and our patients?

Humor is a great way to illustrate points. As nurses we spend a tremendous amount of time teaching patients about their diseases, treatments, and side effects. There is a pervading opinion by educational psychologists that when humor is used during teaching, retention of the material rises. As we look back at our own education, who were the teachers we remember as the best?

The teachers with a sense of humor and who made learning fun are those from whom we learned the most. By incorporating humor into our patient teaching, we also make it enjoyable and less boring for ourselves.

Laughter also improves communication with our co-workers. We often can say things in jest, which effectively make our point, but are without the negative impact of direct confrontation. In other words, humor can be a great way to disagree without being disagreeable. If tension does exist, humor and laughter can easily break up that tension for the moment. We can then concentrate on our work, feeling less distracted by the conflict.

Humor also promotes creativity. From the moment we are born, we are socialized about when it is appropriate to use humor, where it should and should not be used and what kind of humor is acceptable in our society. In an environment where humor is promoted, we are given permission to put aside these rules and are challenged to be creative and use humor in a productive way. There are also those who believe that when we participate in humorous behavior we use both sides of our brains, not just our dominant side. Naturally, whole brain use expands our thinking capacity and thus, our ability to creatively problem-solve. This can be very good for us as we try to develop better ways of coping with our demanding lives.

HUMOR ROADBLOCKS

With all of these things in mind, what keeps us from using humor more in our lives? Some of us believe that it is unprofessional to laugh and have a good time at work. Again, somewhere along the line we have been "trained" to think that laughter at work is inappropriate. After all, nursing is a serious business! This belief could not be farther from the truth. Humor has been found to improve morale and increase productivity at work. The use of humor also makes us seem more "human" to our patients, helping them through the anxiety a visit to the physician brings.

Another roadblock may be that we feel we are just not funny. That may be true, since our early upbringing plays a big role in our use of humor as an adult. We may find that we never learned to look at the funny side of things. However, we can change that. With a little bit of effort on our part, we can become humor appreciators. That is, we can commit to the laughter prescription–a minimum of ten laughs per day. We can get these in many different ways: by reading the funny pages in the newspaper, sharing a joke with a friend, posting a cartoon on the refrigerator, or reading a humorous book. The nice thing about this commitment is that it is fun! You will find that making sure that humor is in your life everyday will soon be something you do not have to work at–it just happens.

We, as nurses, are naturally kind and considerate people. We like helping people. That is the reason many of us went into the profession. Because of this innate sense of consideration, we frequently will not use humor with patients and colleagues because we are afraid we might hurt someone's feelings. There are, fortunately, two rules of thumb we can use to be sure we do not do this. The first is the cardinal rule of humor: the best joke is the joke that is on you! When we laugh at ourselves, we give those around us permission to do the same thing. Our laughter is not offensive or hurtful to anyone else. It is the kind of laughter that builds bonds with people.

The second rule we should always have in mind when using humor with others is called the ATT principle. It is simply that the humor that we use is appropriate, timely and tasteful. Remember that we all have different senses of humor and what may be funny to you may not be funny for your fellow worker. So get to know your patients and colleagues. That way you can be sure that your humor use does not offend or hurt anyone's feelings.

HUMOR FUNCTIONS

Humor serves many functions in our lives. We use humor to distract attention from fearful stimuli. How many times have you joked with your patient just as you are about to do or assist with an uncomfortable procedure? Many physician offices recognize how anxiety producing just getting on the scale can be for some patients. They help diminish this threat by posting funny cartoons over the scale. The patients find themselves looking forward to the newest cartoon rather than dreading what the scale might read.

We also use humor to relieve stress. Many of us find that just watching a comedy on television or going to a funny movie can provide the needed relief to the stress our lives produce. We need to plan these types of activities as part of our commitment to creating a better balance in our lives.

Humor helps us socially too. Victor Borge once said: "Humor is the shortest distance between two people." When we laugh with people it helps to form a bond which is difficult to break. We develop a sense of comfort with other people with whom we laugh and that use of humor helps to maintain that relationship. If we were to look at personal ads (of course, for research purposes only!), we would find that most people are searching for a person who, among other things, must have a sense of humor. We all want to feel comfortable around other people and the use of humor makes that happen.

HUMOR TECHNIQUES TO BALANCE OUR LIVES

The question now is what can we do to add humor to our lives so that we can better balance the stressors of multiple demands? Let's take a look at some things we can do to lighten our workload and our personal lives.

WORKPLACE ALERT

The first thing we can do is recognize that there is humor all around us in our work environments. We often ignore it under the pretense of being too busy. We must not let this happen. When a patient or co-worker says something humorous, make an effort to remember it and share it with others so that they can enjoy it too. Start a list of daffy definitions like: barium–what you do when CPR fails. These can be a great source of fun and spur a tremendous amount of creativity. Designate every Friday as joke day, asking patients to tell you their favorite joke or telling yours' to them. Post humorous signs throughout the office like: In God we trust, everyone else must document.

POSITIVE PARTIES

Have a positive party. A positive party is funded by negative people. This technique works well in both the work and home setting. What you do is create a positive pot-any container will do. Every time someone is caught saying something negative, he or she has to put a dollar in the positive pot. At the end of a month you then have a party funded by all the negative people.

This humor strategy is particularly effective because so many of us do not realize just how negative we have become. The positive pot serves as a humorous, non-threatening reminder and soon we find ourselves laughing more and complaining less.

HUMOR TEAMS

Create a humor team in your office. This team assumes the responsibility to incorporate some humorous activity into the workplace on a regular basis. For example, one office had a TV and VCR that they used frequently for patient education. They decided that they would have humor lunches once a month during which someone would bring in a tape of their favorite comedy show or movie. During luncheon humor day, the TV and VCR would be used to support the staff rather than the patients. Another suggestion is to start a joke network with other office staff. Every Monday (so as to start the week off with a laugh), call another office or two and trade jokes. Or even better, fax or email a joke to several offices. These jokes can then be shared with all your co-workers and patients.

PUN FUN

Another way to break up stress is to have some pun fun. We often can elicit laughter through puns and word plays. Career chuckles are great pun fun. Through word play we can poke fun at other professions. For example, begin by saying "If I weren't a nurse, I would have been" adding some word plays like "a mother, but who was I kidding?"

HUMOROUS COMEBACKS

Perfecting the art of humorous comebacks is also a good way to balance our lives. Humorous comebacks are used to deal with verbal aggressions or incongruous statements. For example, there's a story in the humor circles about a man running to catch a bus pulling away from the curb. He jumps on and sits in the only empty seat, which happens to be next to an attractive, young woman. In an attempt to start up a conversation, he turns to her and says: "T-G-I-F." Not wanting to appear too eager, she spells back to him: "S-H-*-T." His dejected look quickly forces her to interpret that for him: "sorry, honey, it's Thursday!" They both then broke into laughter.

REWARD HUMOR

It is important that we reward those people around us who are willing to take the risk to use humor. We need to give them some positive feedback about their efforts. A wonderful example of rewarding humor is the "joker of the week" medal. On Friday the staff decides who should get the week's award for the funniest joke or event.

One office gave the medal to a nurse who humorously stated, one day in the midst of chaos, that "the difference between this office and the Titanic, is the Titanic had a band!" Of course, everyone laughed, including the patients. The stress and tension of being busy was broken through her use of humor.

WATCH FOR HUMOR IN THE ENVIRONMENT

There is humor all around us but most of the time we ignore it. Our lives are in high gear and we fail to take a moment to really look around us. When you drive to work, take a minute to read some of the bumper stickers that people have placed on their cars. A favorite of many women is, "Sometimes I wake up grouchy, other times I let him sleep!" Or "Life is like a diaper: short and loaded!"

We can usually find humor wherever we look. The next time you are in the grocery store, stop for a minute to read the bulletin board. Some of the hand-written signs that people post can be very funny. People tend to write them as they speak, rather than in a grammatically correct manner. We know what they are trying to say, but what they really wrote is a whole different matter. For example, someone once posted a sign that said "Dog for sale. Eats anything. Especially fond of children." We know what thoughts the writer was trying to convey, but by the way he wrote it, it tends to be interpreted in a humorous way.

CREATE POLICY SPOOFS

There are so many regulations in health care today that our organizations get overwhelmed with the necessary policies and procedures. Policy spoofs are great opportunities to poke fun at the bureaucracy. Send them to each other or to other offices or hospitals. Have a contest to see who can create the most bizarre policy. One policy parody discussed the new sick leave policy and how it was now unacceptable to be off sick when you were dying–after all, who would orient your replacement if you were not there! Another described the new restroom policy stating that timed paper roll retractors would be installed so that no one spent more than three minutes in the restroom. This activity becomes a great stress reliever when you feel overwhelmed by the rigidity of the rules and regulations in healthcare.

HANG OUT WITH PEOPLE WHO LAUGH

The best technique for balancing the demand in our lives is to ensure that we make time for relaxation. Seek out and become friends with people who make you laugh. Chances are good that they will help you participate in more humorous activities than you ever thought you would or could! If you have boring friends, educate them about the positive power of humor. Take the time to show them you care by sharing laughter with them. The more you utilize humor the more you will find others who do the same.

CONCLUSION

Someone once said: "We do not stop laughing because we are old, we grow old because we stop laughing." Humor is an effective strategy for balancing the demands in our lives. When we learn to see the funny side of every situation, we have taken the first step in gaining control. The use of humor in our lives is a skill. Like every other skill, it takes planning and practice. Take the time now to put yourself first. Giggle, grin, laugh, and grow!

Nursing 2015: Just Culture

"A Just Culture Toolkit" is now online at http://nursing2015.wordpress.com/blue-team-documents/just-culture-tool-kit-building. The Blue Team of Nursing 2015 Initiative compiled the toolkit to educate nurses about the concept of "Just Culture," recently adopted by the Ohio Board of Nursing.

The Toolkit includes definitions, position statements by AORN and ANA on Just Culture, case studies in implementing a Just Culture, videos, presentations, scenarios with a decision tree, speakers' bureau, annotated bibliography, and resources for health care executives.

Workplace Violence

The Blue Team's next project is Workplace Violence in Health Care Settings. The next meeting is March 31, 2011 10:00 a.m.–2:00 p.m. at the Ohio Nurses Association Headquarters. Jeff Beers, RN, MA, Clinical Risk Manager at University Hospitals Case Medical Center will present an Algorithm for Intervention to Prevent Escalation When Dealing with Challenging Situations and the Critical Incident Management Team: Peer to Peer Support.

Please RSVP to Kathleen Morris at kmorris@ohnurses.org if you would like to attend the meeting. Lunch is catered and offered at $10.00 or one can bring their lunch. Please call Michele Valentino with any questions about the Blue Team at 330-354-1449.

Join the Blue Team

The mission of the Blue Team is focus on the practice culture of nursing and any issues pertaining to that. The Blue Team is actively recruiting new members to this dynamic group that is so very pertinent to the essence of the future of nursing. All Ohio nurses are encouraged to attend any of the upcoming meetings of the Blue Team in 2011. They are Mar. 31st, July 29th, Sept. 11, from 10 till 2 PM at ONA, 4000 East Main St., Columbus, OH 43213.

The Blue Team is moving ahead with great projects that affect nurses in their practice today and in the future. We would love to have you join us. If you are interested, please email Kathleen Morris at Kmorris@ohnurses.org. Members do not have to belong to ONA to join the Nursing 2015 Initiative. The group is made up of representatives of staff nurses, nurse executives and a representative of the Ohio Hospital Association.

Balancing the Demands continued on page 7

POST TEST AND EVALUATION – BALANCING THE DEMANDS IN YOUR LIFE THROUGH HUMOR

Complete your post-test online! Go to www.ohnurses.org and click on CE4Nurses *See page 5 for details.*

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

NAME _____SCORE

1. One physiologic response of the body to mirthful laughter is
   a. rapid eye movement
   b. increased heart rate
   c. improved GI motility
   d. decreased metabolism

2. The educational psychologists believe that the use of humor during teaching results in
   a. better retention of the material
   b. the ability to give more information
   c. improved understanding of the material
   d. the learner not taking things seriously

3. The use of humor improves creativity because it
   a. makes us laugh in situations that are not funny
   b. forces us to use both sides of our brain
   c. helps us to be funny people
   d. improves our writing skills

4. One of the major reasons that nurses do not use more humor in the workplace is because
   a. we were never taught how to tell good jokes
   b. nursing is a serious business
   c. we think laughter is unprofessional
   d. patients don't like it

5. The cardinal rule of humor is
   a. never tell a joke about money or politics
   b. the best joke is the joke about yourself
   c. if you think it is funny, so will everyone else
   d. know your audience

6. The social function of humor helps us to
   a. be more romantic
   b. laugh more easily in crowds
   c. form and maintain relationships
   d. tell humorous stories better

7. Instituting a workplace alert means that
   a. patients should beware of laughter
   b. physicians must learn to tell jokes
   c. laughter is not allowed at work
   d. nurses should tune into the humor around them

8. The function of a humor team is to
   a. make sure no one laughs inappropriately
   b. be sure there is a regular dose of humor in the office
   c. put on a show for patients
   d. represent the office at social functions

9. Humorous comebacks
   a. defuse verbal aggression
   b. explain away bad jokes
   c. interpret ethnic slurs
   d. create tense situations

10. The best humor technique for balancing the demands in our lives is to
    a. always have a good joke handy
    b. keep a humor diary
    c. create a cartoon corner
    d. hang out with people who laugh

Evaluation

1. Were the following objectives met?

   a. List three physiologic responses of the body to mirthful laughter. ___ Yes ___No

   b. Identify three reasons why we should use humor in the workplace. ___ Yes ___No

   c. Describe three functions humor serves in our lives. ___ Yes ___No

   d. Examine four humor strategies nurses can use to counter-balance the multitude of demands in our lives. ___ Yes ___No

2. Was this independent study an effective method of learning? ___ Yes ___No

   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____

4. What other topics would you like to see addressed in an independent study?

SEND WITH REGISTRATION FORM ON PAGE 4

A New CE4Nurses!

CE4Nurses has been the premier destination for Ohio nurses to get quality continuing education at affordable prices–and the Ohio Nurses Foundation is making it even easier for nurses to get the contact hours they need to maintain their license and stay at the forefront of their practice.

With over 50 courses to choose, RNs can easily earn contact hours toward license renewal at their convenience.

The new CE4Nurses will let nurses:

- Purchase as many studies as they want at one time
- Store the studies they've purchased to complete at their convenience
- Save answers in the middle of a test and come back to it later
- Flag questions that are skipped and go back to them later
- Review all answers before submitting the test
- Re-take the test up to two additional times if needed
- Print a certificate upon passing the study
- See all studies taken at CE4Nurses and print certificates any time
- Complete the 3 studies published in the *Ohio Nurse* online (and free for Ohio Nurses Association members)

By earning contact hours through CE4Nurses, nurses are guaranteed that their one-hour requirement of Category A meets the guidelines set forth by the Ohio Board of Nursing so long as they take one of the CATA Studies.

Get Started

To get started, go to www.ohnurses.org and click on the CE4Nurses logo. Browse the course listing and add the studies you want to purchase to your cart. Complete the checkout, and then you will receive a confirmation email that gives you instructions on how to complete your studies in the CE4Nurses Exam Manager. What are you waiting for? Try the new CE4Nurses today!

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Professional Boundaries and Sexual Misconduct

Author: Jan Lanier, RN, JD

This independent study has been developed for nurses who wish to learn more about professional boundaries and sexual misconduct relative to nursing practice. **This study meets the OBN requirement for 1 contact hour in law and rules (Nurse Practice Act)** governing nursing practice in Ohio required for renewal of an Ohio nursing license. 1.1 contact hours will be awarded for successful completion of this independent study. (Expires 11/2012). Copyright © 2002, 2004, 2006, 2008, 2010 Ohio Nurses Foundation

The author and planning committee members have declared no conflict of interest. There is no commercial support or sponsorship for this independent study. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Objectives:

1. Define the terms related to professional boundary issues.
2. Discuss the various categories of offenders.
3. Identify what a nurse should do if a boundary crossing or violation has occurred.

Have you ever shared your personal problems with a patient (or client)? Given a patient a gift? Complained to a patient about a co-worker? Socialized with a patient outside of your professional capacity? Accepted a gift of more than minimal value from a patient or family member?[1] If you answered yes to any of these questions you may have crossed a professional boundary. Crossing a professional boundary is a violation of the Ohio Nurse Practice Act and the rules adopted by the Ohio Board of Nursing. While most nurses recognize that engaging in sexual misconduct with a patient is wrong both legally and ethically–what actually constitutes that "misconduct" is often difficult to define. For example, many nurses ask, "Isn't it all right to date a former patient?" The relationship between boundary crossings and sexual misconduct is often poorly understood. Many nurses fail to recognize the inappropriateness of boundary crossings, believing that only sexual misconduct violates ethical or legal standards.

Maintaining professional boundaries and avoiding inappropriate sexual involvement can pose dilemmas for nurses who frequently find themselves sharing in their patient's most intimate life events. The very essence of nursing can be a "slippery slope" for many well-intentioned but naive, uninformed nurses. Patients trust that nurses will work in the patients' best interest. When a nurse engages in a sexual relationship with a patient, or otherwise crosses a professional boundary, that trust is violated.[2] The purpose of this independent study is to make nurses more aware of and sensitive to the importance of maintaining a professional nurse/patient relationship and to identify some of the negative consequences that can occur, both for the nurse and for the patient, when these boundaries are crossed.

The Ohio Board of Nursing has reported an increase in the number of complaints it has received alleging sexual misconduct or boundary violations by its licensees. This increase is likely the result of the changing face of the health care delivery system. Nursing care that heretofore would have been provided in an acute care setting now is being provided in patients' homes or community settings. Such settings are less public and less supervised than the traditional hospital or nursing home. Working with patients where they live often results in less formality and a loosening of the restraint that typically characterized the nurse/patient relationship in an acute care environment. In addition, advances in health care have increased the life expectancy of patients with chronic conditions, thereby allowing nurses to develop sustained relationships with patients and their families. Such relationships often lead to a blurring of the lines between caring professional and personal friend. Regardless of the setting or the length of time a nurse provides care to the same patient, the professionalism of the nurse/patient relationship must be maintained.

Sexual Misconduct: What is it?

Sexual misconduct is about power. It is an extreme abuse of the nurse/patient relationship. It is exploitation. It is about impairment and irresponsibility.[3] Engaging in sexual activity with a patient, as well as conduct that could reasonably be interpreted as sexual, is explicitly recognized as a violation of acceptable standards of safe nursing practice in Ohio. (Rule 4723-4-06 (M) Ohio Administrative Code [OAC].) Behavior, including verbal behavior, which is sexually demeaning, harassing, or seductive is considered sexual misconduct by the Board of Nursing. Under Ohio law, a patient is always presumed incapable of giving free, full, or informed consent to these behaviors. (Rule 4723-4-06 OAC). In other words, the rules of the Ohio Board of Nursing clearly make the nurse responsible for assuring that sexual misconduct does not occur even with a seemingly willing patient. "If the client consents, even if the client initiated the sexual contact, it is still considered sexual misconduct because it is an exploitation of the nurse/patient relationship."[4]

The impact of sexual misconduct varies and can be complicated by the trauma of a failed personal relationship. Should sexual involvement cease, a patient's response may range from a sense of exploitation to embarrassment, humiliation, and ultimately severe depression.[5] None of these reactions is conducive to the health and well-being of the patient, which ought to be the underlying goal of all nursing interventions.

What about dating a "former" patient?

Personal relationships that begin after the nurse is no longer caring for the patient pose significant questions. The Ontario College of Nursing has published guidelines that state, "nurses may initiate or engage in a relationship with a patient if it is anticipated that the patient will not require future care from the nurse. However, if the nature of the nurse/patient relationship was psychotherapeutic, the nurse may not engage in a romantic or sexual relationship for one-year post-termination, and then only if, in the nurse's judgment, the relationship would not have a negative impact on the client's well-being."[6] The American Nurses Association (ANA) Code of Ethics does not specifically address post-termination relationships but refers instead to private ethics. ANA has been encouraged to address this complex issue in the future.[7] The rules of the Board of Nursing are also silent on this matter. In the absence of clear standards regarding post-termination relationships, in dealing with a case involving a post-termination situation, the Board of Nursing members would likely look to standards developed by other entities or professions to determine if the nurse's conduct violated the laws and rules regulating professional practice. They would consider the type of nursing care provided and the length and nature of that care to determine whether sexual misconduct occurred. Regardless of when a personal relationship is established with a former patient, the nurse/patient role must not be resumed should future health care needs arise.

A case study

Nurse A is an independent home care provider for a pediatric patient. During the time that she is providing care to the patient, the nurse becomes sexually involved with the patient's father. The nurse permits the father to take sexually oriented photographs of her, and she engages in sexual activity with the father in the basement of the patient's home. The nurse also becomes aware of marital problems being experienced by the patient's parents. The patient's mother discovers the photographs and a videotape of the sexual activity between the nurse and the father.

Although the sexual misconduct did not involve the nurse's patient per se, the Board of Nursing found that her actions violated standards of safe care because the term "patient" includes not only the recipient of nursing care but also groups or communities. Although the nurse's actions did not overtly compromise the direct nursing care provided to the patient, the impact of her actions on the family unit (community) was extremely harmful and ultimately not in the best interest of the nurse's pediatric patient. The nurse's license was indefinitely suspended.[8] While sexual misconduct represents an extreme violation of the nurse/patient relationship, boundary crossings or violations can be equally devastating for both the patient and the nurse. Because boundary crossings are more subtle, they often go unnoticed and misunderstood. Nurses frequently believe they are helping their patients by becoming more friend than professional nurse. This is never acceptable behavior.

What are professional boundaries and why are they important?

Simply put, "professional boundaries" are the limits to how a (nurse) acts with a patient."[9] These boundaries are not visible. Nonetheless they define the types of behaviors that are most likely to enable nurses to effectively meet the health care needs of their patients and their patients' families. The concept that there are "limits" to acceptable nursing behaviors within the nurse/patient relationship and the reason for those limits form the framework for an understanding of the intricacies of professional boundaries. "Anything goes" cannot be the watchword to guide nursing behavior. Certain actions are not acceptable when a nurse is caring for a patient. Limits exist to help assure that a vulnerable patient is not exploited in any way even by a well-meaning nurse. Professional boundaries are defined as the "space between the nurse's power and the patient's vulnerability. The power comes from the professional position of the nurse and the nurse's access to private knowledge about the patient. Nurses' professional position affords them control over life-sustaining therapies and complex equipment through which they exert subtle but tremendous influence over their patients' behaviors. This power, which is an essential element in the nurse/patient relationship, enables the nurse to positively influence the patient's health status. However, if the extent of that power is not limited through the establishment of appropriate professional boundaries, the patient is subjected to

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unacceptable risks that could ultimately affect the patient's physical and emotional health."[10]

The difficulty in defining and maintaining professional boundaries has long been recognized within the nursing profession. "Professional nursing is emotionally complicated. It requires an ability to be meaningfully related to a patient and family yet separate enough to distinguish one's own feelings and needs."[11] The innate care-taking style that is a hallmark of the nursing profession increases nurses' susceptibility to being caught up into intense relationships. Further, boundaries and professionalism may be defined differently by members of the same staff.[12] Casual conversation for some may be excessive personal disclosure for others. "Joking and camaraderie may be seen as contributing to a pleasant atmosphere in some circumstances but may lead to boundary crossings in others, particularly if the jovial atmosphere is not counterbalanced by a solid understanding of professionalism."[13]

Boundary Crossings v. Boundary Violations

While some boundary crossings (accepting small gifts, sharing personal information, inviting a patient home) may seem innocuous, such incursions outside of the so-called "zone of helpfulness" can lead to more serious boundary violations. The likelihood of a boundary violation increases when the nurse assumes an additional role in the life of a patient, i.e., friend or cohort rather than professional caregiver.

Case study

A nurse is providing care to an elderly nursing home resident. The resident's family lives out-of-state and is not able to celebrate holidays or special occasions with her. The nurse begins to invite the resident home for the holidays, and the resident soon begins to count on these outings and looks forward to them. The nurse unexpectedly decides to leave employment at the long-term care facility and the social interactions with the resident suddenly cease. The resident does not understand what happened to her "friend" and feels a sense of personal rejection and desertion. What began as a well-meaning attempt to provide a positive experience for the resident ultimately had negative consequences for her.

Avoiding boundary violations does not mean nurses must sacrifice their helpful natures. Instead, helpfulness must be consciously centered along a continuum of professional behavior. The "zone of helpfulness" is located in the center of the continuum and is the zone in which the majority of patient interactions should take place. On either side of the center of the continuum are under-involvement or over-involvement.[14] When a nurse is under-involved with patients, distancing, disinterest, and neglect occur.

Conversely, when there is over-involvement, the risk of boundary crossings, boundary violations, and possibly sexual misconduct increases. There are no definite lines separating the zone of helpfulness from the ends of the continuum, instead it is a gradual transition or melding.[15] Nurses must be wary, however, when their interactions with patients border on the edges of the zone of helpfulness. Often it is not the action itself but the motive behind the action that determines whether a boundary has been violated. The complexity of maintaining professional boundaries is demonstrated in the following case study.

Case study

"A nurse gives a young female patient a compact disc featuring a favorite pop singer. The music is intended to provide a welcome distraction during strenuous rehabilitation exercises. Conversely, a nurse gives the same patient the same gift, but does it secretly, indicating that the gift reflects how special the patient is to the nurse. One nurse has a therapeutic motive for the gift while the other is trying to be friends."[16]

The second nurse in the above scenario crossed a professional boundary with the patient while the first nurse did not. The difference is the motivation behind the gift and the way in which the gift was presented. "When providing special privileges to a patient, one must always consider the motive behind the action. Was it done openly as encouragement or as a reward for efforts to comply with a care regimen; or was it done to gain approval and acceptance from the patient?"[17]

Experts have identified five stages of boundary infringement.[18] They are:

Stage I Inadvertent crossings where a nurse fails to set limits with a patient.
Stage II Attending to the patient in special ways.
Stage III Providing special favors under the guise of secrecy. The patient becomes significantly enmeshed with the nurse.
Stage IV Overt exploitation, active involvement of the patient, and the exchange of gifts.
Stage V Justifying and permitting extreme forms of misconduct accompanied by reliance on a rationalized delusional system.

The danger in stages I and II is the tendency to move to the other stages.

What does the law say about maintaining professional boundaries?

Ohio law authorizes the Board of Nursing to take disciplinary action when a nurse fails to establish and maintain professional boundaries with a patient. (Section 4723.28 (B)(31) Ohio Revised Code ORC). Nurses also risk disciplinary action if they obtain or attempt to obtain money or anything of value by intentional misrepresentation or material deception in the course of practice. (Section 4723.28 (B)(13) ORC). Rules of the Board further define expectations with respect to boundary violations.

* Nurses are not to misappropriate a patient's property or engage in behavior to seek or obtain personal gain at the patient's expense.
* Nurses are not to engage in behavior that constitutes inappropriate involvement in a patient's personal relationships.
* Nurses are not to engage in any behavior that could reasonably be interpreted as inappropriate involvement.

(Rule 4723-4-06 Ohio Administrative Code)

Case studies

A nurse has been caring for an elderly patient for several months. Recently the patient has given the nurse gifts that appear to be family heirlooms. Is this a violation of the Nurse Practice Act?

Many times grateful patients want to give gifts to their nurses. The law prohibits obtaining or attempting to obtain anything of value by intentional misrepresentation or material deception in the course of practice. Most gifts are not obtained by deception, so in deciding whether to accept a gift, one must first determine whether the agency policy permits gifts to be accepted. If so, the nurse must analyze the motives behind the gift. Often the decision about whether to accept a gift becomes an ethical rather than a legal dilemma. Gifts that are highly personal, overly sentimental, or represent a large investment of the patient's time, energy, or money should be graciously and sensitively declined. Gifts from psychotic, delusional, or delirious patients must be declined.[19]

A nurse had been providing care to an elderly patient for many months. One day, the nurse happens to mention that she is having serious financial problems. The patient offers to loan the nurse $5000. At first the nurse refuses but reconsiders as her financial situation worsens. The nurse agrees to repay the money on a set schedule. Initially, payments are made as promised, but once again financial problems arise that prevent the nurse from making payments. The patient's family members, upon learning of the arrangement, report the nurse to the Board of Nursing. Did this nurse violate the Nurse Practice Act?

While the money was not obtained by deception or misrepresentation, nonetheless a significant boundary violation occurred. The nurse received personal gain at the patient's expense. The nurse inappropriately shared her own personal problems with the patient–a boundary crossing. Subsequently, a boundary violation resulted when the nurse accepted a loan from the patient. The loan arrangement significantly altered the nurse/patient relationship and potentially jeopardized the ability of the nurse to care for the patient on a strictly professional level. Boundary violations do not just happen. Often there are signals that indicate a nurse is at risk for crossing the line between appropriate and inappropriate behavior.

Danger Signals in Nurse/Patient Relationships[20]

- You are spending a disproportionate amount of time with a patient.
- You are with a patient when off duty.
- The patient remains awake to see you when you are on the night shift or dresses in a particular fashion prior to your arrival on duty.
- You feel you are the only one who understands the patient; other staff are jealous of your relationship with the patient.
- You tend to keep secrets with the patient.
- You tend to report only negative or positive aspects of the patient's behavior.
- You "swap" patient assignments.
- You are guarded and defensive when someone questions your interaction or relationship with the patient.
- Your patient talks freely and spontaneously with you, and may even engage in conversation with sexual overtones. Patient remains silent and defensive with other staff or may avoid them altogether.
- Your style of dress for work has changed since you started working with the patient.
- You receive visits, cards, letters, e-mails, or phone calls from the patient after discharge.
- You tend not to accept that the patient is a patient.
- You view the patient as "your" patient in a possessive way.
- You choose sides with the patient against wife, husband, or children.
- You answer the patient¹s personal questions of you in a vague manner or you give your patient "double messages."
- You respond to a request for medications, passes, and the like differently for different patients.
- The patient continues to turn to you because "other staff members are all too busy."
- You tend to think that you are immune from fostering a non-therapeutic relationship.

Summary

Nurses often need help understanding how to effectively balance professionalism with effective care-giving. In other words, how does the nurse stay within the "zone of helpfulness?" Administrators and managers as well as nursing colleagues can help nurses with this difficult matter by being sensitive to the challenges and alert to signs of boundary crossings. Asking someone to be professional is too subjective.[21] "Employers should develop policies and guidelines for their own institutional circumstances that define a caring professional relationship and discourage inappropriate personal friendships with patients. To be effective these policies should reflect the types of care relationships that are commonplace in the particular setting."[22] Awareness is the key to avoiding crossing the professional boundary. "Being cognizant of one's own feelings and behaviors and observant of the behaviors of other nurses are important steps in finding the middle ground on the professional continuum. Nurses must also be clear about their own needs and the needs of their patients. They need to separate the personal from the professional."[23] Patients need professional health care from a nurse, not personal friendship.

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20. Disciplinary Guidelines; pg 26
21. Crampton; pg 594
22. Ibid.
23. Ibid.

POST TEST AND EVALUATION – Professional Boundaries and Sexual Misconduct

Complete your post-test online! Go to www.ohnurses.org and click on CE4Nurses *See page 5 for details.*

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

NAME _____SCORE_____

Please mark true or false to the following statements:

_____ 1. Professional sexual misconduct is a breach of trust.
_____ 2. It's okay to talk about one's personal problems or tell off-color jokes to a patient.
_____ 3. Professional sexual misconduct involves power and putting the patient's needs first.
_____ 4. It is always okay to accept gifts from a patient.
_____ 5. It is always okay for a nurse to interfere with a patient's personal relationships when in the nurse's judgment the relationships may hinder the patient¹s recovery.
_____ 6. Giving a patient a gift is okay if the gift is kept a secret so as not to make other patients feel bad.
_____ 7. The Ohio Board of Nursing has stated that a nurse may date a former patient if the nurse/patient relationship ended at least one year prior to the date.
_____ 8. Only if a nurse engages in sexual misconduct with a patient has the nurse crossed the line into unacceptable professional behavior.
_____ 9. While professional sexual misconduct may be wrong, the nurse can be excused if the conduct was initiated by the patient.
_____ 10. The incidence of boundary violations is increasing because nurses are more likely to provide care in less formal settings and over prolonged periods of time.
_____ 11. Sexual misconduct only refers to actual sexual contact, intercourse, or rape.
_____ 12. Any time a nurse could use knowledge of a patient to meet the nurse's needs a red flag should be raised by the power imbalance.
_____ 13. Boundaries are the limits that allow for a safe connection with the patient based on the patient's needs.
_____ 14. Joking and camaraderie may contribute to a pleasant work environment but could also lead to boundary crossings if not balanced by an understanding of professionalism.
_____ 15. There are no limits to acceptable nursing behavior. Regardless of the situation, nurses simply need to pay attention to their intuition to determine how to best relate to a patient.

Select the one correct answer

16. If a nurse feels sexually attracted to a patient, the nurse should:
    a. Discuss the feelings with a colleague
    b. Tell the patient
    c. Act on those feelings

17. If a patient demonstrates interest in developing a sexual relationship with the nurse, the nurse should:
    a. Encourage the patient
    b. Feel sexually attractive
    c. Transfer the patient's care to another nurse

18. Which of the following is (are) a danger signal(s) regarding nurse/patient relationships:
    a. Stopping to see the patient on your day off
    b. Swapping assignments so you can take care of this patient
    c. Feeling that you are the only one who truly understands the patient
    d. All of the above
    e. None of the above

19. You have identified that a particular nurse colleague seems to be attracted to a patient. You should:
    a. Ignore the situation
    b. Alert the patient to the attraction
    c. Discuss the matter with your roommate
    d. Suggest to the nurse that she think carefully about her involvement with the patient and consider alerting the nurse manager if the problematic behavior continues.

20. A nurse risks disciplinary action by the Board of Nursing for failure to establish and maintain professional boundaries if the nurse:
    a. Uses a patient's credit card with the patient's permission
    b. Begins to see the patient socially while continuing to provide nursing care
    c. Accepts a diamond bracelet from a grateful patient
    d. All of the above
    e. b and c only

Match the stages of boundary infringement with the definitions:

21. _____Stage I	a. Nurse takes care of the patient in special ways
22. _____Stage II	b. Rationalized delusional system, secret meetings, sexual misconduct
23. _____Stage III	c. Inadvertent crossings where nurse fails to set limits with the client
24. _____Stage IV	d. Nurse provides secrecy for special favors
25. _____Stage V	e Exchange of gifts, overt exploitation

Evaluation

1. Were the following objectives met?
    a. Define the terms related to professional boundary issues. ___ Yes ___No
    b. Discuss the various categories of offenders. ___ Yes ___No
    c. Identify what a nurse should do if a boundary crossing or violation has occurred. ___ Yes ___No
2. Was this independent study an effective method of learning? ___ Yes ___No

    If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____
4. What other topics would you like to see addressed in an independent study?

SEND WITH REGISTRATION FORM ON PAGE 4

Screening and Intervening continued from page 1

4) Myth: People who talk about suicide don't do it.
Fact: Since many persons who have committed suicide are found to have tried verbally or non-verbally to signal their distress and it went unrecognized or unheeded, this is untrue.

5) Myth: People who talk about or make a suicide attempt are just seeking attention.
Fact: Suicide talk and/or behaviors are a communication of pain and distress and always must be taken seriously. Persons seeking help by making a suicide attempt are at risk for dying by mistake. Whenever a person expresses suicidality, this must be assessed and appropriate clinical interventions applied.

6) Myth: A person who attempts suicide will not try it again.
Fact: Since many persons who ultimately commit suicide have attempted suicide previously at least once, this is untrue. A history of prior suicide attempts increases a person's risk for suicide.

7) Myth: Persons who attempt suicide are intent on dying.
Fact: This is untrue. Ambivalence about living or dying is common. The attempt may be a way to communicate feeling overwhelmed or hopeless.

8) Myth: When a depressed person's mood rises, the risk for suicide always lessens.
Fact: This can be untrue. Through medication and/or counseling, a depressed person's energy level can rise yet feelings of hopelessness can still be present. The person may have been ruminating on how to commit suicide and now has energy to complete the act. Also when a depressed person decides on suicide as the best strategy to end their pain, their sense of relief can be seen as a lessening of their depression.

Information on Suicide Risk Factors

Suicide, fortunately, is a well researched topic so information about suicidality and risk factors are available. Nurses need to be aware of multiple risk factors which correlate with serious suicide attempts and completed suicides. This knowledge is crucial as it provides the foundation nurses can use to heighten their awareness of suicide risk factors, assess and intervene with individual patients and provide education on this challenging public health issue. It is also important to understand that these categories of risk factors, while discussed individually, can combine and overlap in an individual patient raising or lowering their potential lethality.

Risk Factors:

1) Sex: Men commit suicide more often than women. In the United States (2004) suicide was the 8th cause of death for men but the 16th for women.[8] Yet women attempt suicide more often than men.[9]
2) Age: Generally suicide rates increase with age but alarmingly there has been an increase in suicide among adolescents and young adults.[10] Geriatric suicide is common with persons over 65 having the highest suicide rate.
3) Ethnicity: In the United States the highest suicide rates occur in the white population.
4) Religion: In the United States Protestants have higher suicide rates than Catholics or Jews.
5) Geography: In the United States western states have the highest suicide rates. Suicide rates are also higher in rural versus urban areas.
6) Season: Suicide rates are highest in the spring.
7) Marital Status: Married persons are less suicidal than single, divorced or widowed individuals.
8) Mental Illness: Living with certain mental illnesses can increase a person's lifetime risk for suicide. Since mentally ill persons seek treatment for physical health problems, it is important for nurses working in non-psychiatric settings to be aware of the higher risk for suicide in patients diagnosed with mental illness. Even more important is the suicide risk to patients who have an undiagnosed/untreated mental illness or a patient with a mental illness who has stopped treatment.

Mental Illnesses with high potential for suicide are:

Depression and Manic Depression carries a very high risk of suicide attempts and completed suicide. Depressed individuals experience feelings of lack of enjoyment in living, hopelessness and a helpless feeling that things will not improve for them no matter what they or others try to do. They often withdraw from others lessening their social support. Manic depression increases a person's suicidal risk both in the depressive phase of the illness and also in the psychosis of mania where their ability to make safe decisions is impaired. Bipolar patients experiencing a mixed episode (experiencing both mania and depression) are at especially high risk.

Schizophrenia can cause patients to become depressed as they realize the impact of this illness on the quality of their lives in comparison to others. They may have symptoms such as paranoia that lead to isolation, withdrawal and an inability to seek out treatment. They may also experience common hallucinations as voices telling them they are evil, worthless or to kill themselves or others.

Anxiety Disorders can lead to miserable symptoms of unrelenting anxiety, panic and dread which are inexplicable to both the patient and others. Anxiety disorders can lead to depression, withdrawal from others and feelings the disorder is taking over their lives in a totally incapacitating manner. Suicidal patients who are also experiencing anxiety/agitation are at high risk of attempting suicide as a way to end the unrelenting pain.

Post-traumatic Stress Disorder can increase suicidality whether it originates in early childhood trauma or devastating events occurring in adulthood. Survivors of trauma may experience alternating feelings of hyper vigilance, flash backs of the events, nightmares and emotional numbing. Many trauma survivors wrestle with feelings of being forever emotionally and physically damaged and guilt surrounding their actions during the traumatic events leading them to attempt or commit suicide.

Substance Use and Abuse is very highly correlated with suicidal attempts and completion. Intoxication, withdrawal and chronic usage of drugs and alcohol can contribute to a loss of judgment, inhibition and a life characterized by crisis and loss of economic and social supports. Substance use and mental illness are a combination which substantially increases a person's risk of death by suicide.

Dementia and Delirium have symptoms involving loss of memory, disorientation, hallucinations and delusions. This can lead to poor judgment, an inability to keep oneself safe and, in some persons, a sense of despair about their declining mental capacity leading to suicide.

Personality Disorder

Borderline Personality Disorder patients can be at risk for suicide. These patients have ingrained inflexible patterns of thinking, feeling and behaving which serve them poorly when faced with a crisis. These patients fear separation from others while driving others away by alternately clinging to them and then rejecting them. Some borderline patients may engage in self harm behaviors (often cutting or burning themselves). The patient experiences emotional numbing and experiences relief emotionally after the self harm. While they may not intend to die, these behaviors can be miscalculated and lethal.

Genetics

While no single suicide gene has been identified, genetics is being studied in relation to mental illnesses and suicidality. Genes related to serotonin have been studied in patients with histories of making a second suicide attempt shortly after a first attempt.[11] Since genetics are increasingly being identified as playing a role in mental illness, it has been found that a person with a family history of suicide is at higher risk of suicide. Thus asking about mental illness in the family and if any family members attempted or committed suicide should be a routine part of any suicide assessment. Suicidal patients who have family histories of mental illness and suicide are at higher suicide risk.

Medications

Increasingly research has linked the use of psychiatric and non-psychiatric medications to depression and/or suicidal behaviors in some patients. Recently the FDA has issued warnings on antidepressant and anticonvulsant medications and the pain medication Tramadol.[12, 13, 14] Although there has been controversy about these findings and warnings, as we learn more about the effects of psychiatric and non-psychiatric drugs on depression and suicide, it will be necessary for advanced practice nurses and physicians to become increasingly alert when prescribing medications for any condition. If a medication has been linked with depression and/or suicide, the patient should be advised to report any changes in mood or suicidal thoughts or behaviors to the prescriber immediately. Also when doing a suicide screening asking about both prescribed medications for all conditions and any non-prescribed drugs and alcohol use can be helpful.

Suicidal Characteristics

Suicidal patients often display or have certain characteristics which a nurse should be aware of as they can increase a patient's risk of suicide and/or homicide.

Emotional Characteristics:

1) They feel hopeless, helpless or trapped. They may feel that nothing they or others can do will help their current situation. They may have had major life changes they perceive as negative.
2) They express no enjoyment or reason for living. They may have changes in sleep, eating or activity patterns.
3) They feel a sense of loss (romantic, economic, personal, reputation), anger, shame or humiliation about their situation.
4) They feel isolated from others.
5) They feel others would be better off without them.
6) They may be suspicious about the motives of others and/or feel the need for revenge against others.
7) They may feel suicide is an honorable or noble solution to a personal problem.
8) They feel agitated and/or anxious and can't seem to find any relief from this painful state.
9) They may be attending to and/or feel they cannot resist what voices are telling them to do.
10) They feel they cannot maintain their safety or the safety of others. If they have a plan to harm themselves and have access to guns or other weapons, this is very dangerous.
11) They feel impacted by the suicide or death of others– want to rejoin the lost person or feel life isn't worth living without them.
12) They may feel overwhelmed by serious acute or chronic physical illness. Having chronic and/or increasing physical pain increases the suicidal risk. Dementia or delirium can increase risk due to hopelessness and lack of contact with reality.

Behavioral Characteristics:

1) They may be withdrawing from others.
2) They may be displaying signs of preparing for death: saying good-bye to others, giving away possessions, making a will unexpectedly, writing suicide notes.
3) Behaving in uncharacteristic, impulsive, dangerous or violent ways.
4) Talking to others in ways that suggests they may not be around, available or alive for future events or interactions.
5) Purchasing, collecting or having access to items which could be used to kill themselves (gun, knives, car, hoarding medications, hanging items, etc.)
6) Visiting medical caregivers without a sense of relief from symptoms.

Substance Abuse Mental Health History Characteristics:

1) Patients may have begun or increased drug/alcohol usage. Patients may have a history of substance abuse. Patients who are currently intoxicated, using regularly or withdrawing from substances are at high risk of suicide.
2) Patients displaying symptoms of diagnosed or undiagnosed mental illness can be at high risk. Symptoms of anxiety, depression, and psychosis are especially concerning. Many patients with diagnosed mental illness stop treatment and relapse which can put them at high risk of suicide.
3) Patients who have a family history of mental illness and especially those who have had suicide in their family history are at high risk.
4) If the patient has made previous suicide attempts, this increases the risk for suicide.
5) If the patient has been recently discharged from an in-patient mental health treatment facility, he may be at higher risk.

How non-psychiatric nurses can reach out, screen for suicidality and respond to suicidal patients.

Since suicidal thoughts and behaviors are not uncommon, non-psychiatric nurses may encounter suicidal patients across multiple health care settings (out-patient, home health, schools, nursing homes, residential treatment settings, prisons, hospitals, etc.)

A recent NSDUH Report found that in 2008 an estimated 8.3 million adults 18 years old and over had serious suicidal thoughts, 2.3 million made a suicide plan and 1.1 million attempted suicide.[15] Since it is likely that non-psychiatric nurses will encounter suicidal patients while giving care across the health care continuum, it is important that they understand their crucial role in being able to reach out, screen potentially suicidal patients, respond to them therapeutically and safely get them to specialized psychiatric care. Non-psychiatric nurses are not expected to do specialized diagnostic mental health interviews to assess the level of lethality a suicidal patient presents and then plan for the level of treatment the patient requires. Doing an in depth suicide assessment is a complex specialized process involving a patient's past and current mental/physical health; their suicide risk factors and protective factors and deciding what level of treatment a patient requires. Non-psychiatric nurses do play an important role in this process though by having a high index of suspicion regarding suicidality, by knowing and understanding suicide risk factors and characteristics and doing a suicide screening interview. Non-psychiatric nurses can provide the critical linkage needed to get suicidal patients to the specialized care they need to literally save their lives.

The non-psychiatric nurses who work in Joint Commission accredited hospital settings will have policies, procedures and protocols in place to screen, manage and refer suicidal patients. Joint Commission requires patients be screened for suicidality at admission, if any suicidal behaviors or ideation occur during hospitalization or any change in a patient's condition might increase their risk of suicidality. If a patient is at risk for suicide, policies and procedures should be in place addressing the need for 1:1 or increased levels of patient supervision, intense monitoring of the safety of

Screening and Intervening continued on page 12

Ohio Nurses Association Announces an Educational Partnership with Chamberlain College of Nursing

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*Chamberlain College of Nursing is accredited by The Higher Learning Commission of the North Central Association www.ncahlc.org, one of the six regional agencies that accredit US colleges and universities at the institutional level. Courses at the Jacksonville campus are approved by the Higher Learning Commission (HCL). Inclusion of the Jacksonville campus for degree-granting authority within the accreditation relationship will be reviewed through an October, 2009 site visit from the HLC. The associate and bachelor of science in nursing degree programs at the Columbus and St. Louis campuses are accredited by the National League for Nursing Accrediting Commission (NLNAC). The bachelor of science in nursing degree program at the Addison, Columbus, Phoenix and St. Louis campuses is accredited by the Commission on Collegiate Nursing Education (CCNE). Accreditation provides assurance to the public and to prospective students that standards of quality have been met. Program availability varies by location.

2011 CE Events

Everything You Ever Wanted to Know About Completing an Individual Activity CE Application

ONA Headquarters, Columbus
May 17, 2011 • 9:00 am–12:00 pm
August 10, 2011 • 9:00 am–12:00 pm
This session is your opportunity to get your questions answered about the CE criteria and rules as well as learn how to complete Individual Activity Application Forms.
No Contact Hours awarded. • Fee: $30.00
Register Online at www.ohnurses.org > Events.

Becoming An Approved Provider

ONA Headquarters, Columbus
10:00 am–2:30 pm
March 16, 2011 • July 13, 2011 • October 5, 2011
FEE: $65.00 per person

Provider Update

April 5 Event (OCLC Conference Center, Dublin)
April 15 Event (ONA Headquarters, Columbus)
April 18 Event (Detroit, Michigan)

FEE: $80.00/person

Sixth Annual CE and Staff Development Educators Conference

OCLC Conference Center in Dublin
(6565 Kilgour Place, Dublin, Ohio 43017; 614-764-6000)
April 6, 2011

FEE: $90.00/person

Medical Heritage Tea

April 28, 2011
Reception 4:00 pm • Program: 4:30 pm
Location–OSU Ross Heart Auditorium, Columbus, OH
FEE: Free

Back to the Future–Our Systems and Our Practice (Retired Nurses)

June 7-8, 2011 • ONA Headquarters, Columbus, Ohio

ONA Convention

October 14-16, 2011
Columbus, Ohio

Screening and Intervening continued from page 11

the patient's environment, communication of patient risk to all caregivers, education and information on managing a suicide crisis given to patients/families at discharge, and how to document patient suicide precautions. All nurses working in hospital settings should be aware of and follow the policies in place designed to keep suicidal patients safe when they are not in psychiatric treatment settings. The Joint Commission places such a heavy emphasis on the safety of suicidal patients in hospital settings because patient suicides remain the second most commonly reported sentinel event.[16]

For non-psychiatric nurses working in settings other than hospitals, it is important to check whether the agency has policies and procedures in place to screen and manage potentially suicidal patients. If the agency has policies/procedures, be familiar with and follow them. If no policies are in place, nurses can raise the issue of suicidal patient screening and safety in their care setting. Since non-psychiatric nurses may not encounter suicidal patients routinely, it can help to have a protocol and a screening tool available to use prior to encountering the suicidal patient (See Figure 2 at the end of the study). The screening tool can help organize the information needed to do a suicide screening and help the nurse focus on responding therapeutically to the patient. It can also be helpful in providing important clinical information to clinicians the patient is being referred to and/or the police in a crisis.

Nurses may come into contact with potentially suicidal patients in a multitude of ways. The nurse may be interacting with a patient about a totally unrelated health concern and as they talk the nurse becomes aware the patient is communicating risk factors or characteristics that warrant a suicide screening.

Also the nurse might be reviewing a patient's history and recognize it contains information that in the context of the patient's current clinical context warrants a suicide screening. A patient's family or others may approach the nurse expressing concerns. However information is conveyed to the nurse about a patient's risk of suicide, it is an opportunity to interact with the patient in a caring manner and perhaps save the patient's life.

It is important to sit down and convey you are not in a hurry when you begin a screening interview. Patients may convey suicidal ideation directly (life just doesn't seem worth living this way) or indirectly (my children are coming and I'll give them all my treasured items). Generally it helps to start a screening interaction with open ended questions about how the patient is feeling emotionally related to their health and other issues going on in their lives. Sometimes just having the nurse express genuine concern about their life and feelings will prompt the patient to share their pain and any suicidal thoughts, behavior or plans. If the patient just shares problems, concerns or pain but no suicidality, it is still very important to address this issue directly. One strategy to use is to say, "Sometimes when a person is experiencing these

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kinds of problems, they may feel life isn't worth living or have thoughts about hurting themselves. Are you feeling this way or having thoughts about harming yourself?" If the patient shares any suicidal thoughts or behaviors or seems in any way ambivalent about their desire to live or keep themselves safe, you should do a suicide and homicide screening.

If the patient is suicidal, it is important to convey a calm, caring and non-judgmental attitude. The nurse can convey that while things appear hopeless right now, the patient will be kept safe and help is available and can be accessed. Once a patient endorses suicidal thoughts, behaviors and/or plans, it is critical not to leave the patient alone until they are safely in the care of mental health professionals. Tragically, nurses and other caregivers have used "no suicide contracts" which are not evidence based[17] or allowed patients to leave a care setting promising to call a therapist, go to an ED, etc. The patient then suicides because they have the means and opportunity to complete the act. Since suicide can be planned or impulse driven, the safest plan is to protect the patient from the opportunity and means to suicide until they are thoroughly assessed and in the correct level of mental health treatment. The patient's family and significant others will often need education and support in understanding the serious risk to their loved one. Perhaps the patient has threatened before but not acted or the significant others are having trouble believing the patient will actually harm themselves. Families will often promise to watch the patient. This plan is unsafe because families cannot provide the environmental safety or 24/7 observation a patient requires. This is an opportunity to dispel suicide myths and provide education and support to others who care about the patient.

Conclusion

Non-psychiatric nurses have an important role to play in all health care settings in suicide prevention screening and referral. They also can educate and support families, significant others, and the community about suicidal risk factors and prevention. Although this may not be a routine part of their daily practice, by having an awareness of suicidal risk factors and taking action to respond to and screen potentially suicidal patients and getting them safely referred to mental health professionals, non-psychiatric nurses can be a vital link in the chain of our national suicide prevention efforts. Hopefully as more non-psychiatric nurses take on this challenge, countless lives can be impacted positively by preventing the tragic loss of suicide and its devastating effects on those who are left behind.

Footnotes

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FIGURE 2

Suicide Screening Tool for Non-Psychiatric Settings

Patient's name: _____

Street Address: _____

City, State & Zip Code: _____

Home phone: _____ Work phone:_____

If patient is a minor, Guardian's name: _____

Guardian's Street Address: _____

Guardian's City, State & Zip Code: _____

Guardian's Home phone: _____ Guardian's Work phone: _____

Information from: _____ patient family/significant other _____ friends/coworkers
_____ medical records/colleagues _____ school personnel
_____ law enforcement/ems

Sex _____ Male _____ Female
Age _____
Status _____ married _____ single _____ divorced _____ widowed _____ lives alone
List of prescribed/non prescribed drugs patient taking: _____
_____

Current Life Situation:

Patient/Others Report

____ loss
____ major life change
____ feeling hopeless/helpless
____ poor social support
____ conflict/estrangement from family/friends
____ feeling anxious/agitated
____ impacted by suicide/death of other
____ overwhelmed by acute or chronic illness or pain
____ seeking medical care without symptom relief
____ feeling under acute or chronic unrelenting stress
____ feeling worthless and/or humiliated
____ patient is currently using drugs/alcohol

Suicidality:

Patient/Others Report

____ Patient has thoughts of harming themselves or that life isn't worth living anymore
____ Patient displays behaviors related to self harm or preparing to die
____ Patient has a plan for how to kill themselves
____ (a) plan is specific/potentially lethal
____ (b) patient has access to means to carry plan out:____ gun, ____ meds, ____ car, ____ jumping, _____ hanging, ____ other:_____
____ (c) plan linked to specific time or event
____ (d) self harm in the recent past

If Patient is expressing suicidality, assess for homicide:

Homicidality: Patient/Others Report

____ Patient has thoughts of harming a specific person or group of persons:
Victim's name: _____
Victim's Street Address: _____
Victim's City, State & Zip Code: _____
Victim's Home phone: _____ Victim's Work phone: _____
____ Patient blames others or seeks revenge for current situation
____ Person has mental health symptoms which contribute to wish to harm others
_____ (a) Patient is anxious and/or agitated
_____ (b) Depression–believes others better off dead
_____ (c) Paranoia–believes others will hurt them so must protect self/others
_____ (d) Command hallucinations to kill others
____ Patient believes if they can't have a relationship with another person no one else should either (romantic, custody disputes, etc.)
____ Patient has substance abuse history, is intoxicated or currently using
____ Patient has history of domestic violence and/or violence against persons
____ Patient has a plan to harm/kill another
____ Patient has access to guns or other weapons

Mental Health (substance use and/or abuse)

Patient/Others Report

____ Patient is currently displaying symptoms of mental illness (depression, mania, psychosis, anxiety, organic brain disease)
____ Patient has a diagnosed mental illness.
Get name and number for any mental health treators.
____ Patient has history of substance abuse and/or is currently intoxicated, using or withdrawing from substances.
____ Patient has a family history of mental illness or suicide
____ Patient has a history of past suicide attempts

DISPOSITION: Patient safety maintained by:
____ 1) 1:1 observation and environmental scrutiny for harmful/lethal objects until
____ 2) Patient seen by _____ and safely transported to _____ mental health professional, _____ physician, _____ local crisis center _____ emergency room

If patient expressing suicidality and/or homicidality refuses help and/or elopes prior to referral–
If suicidal only contact patient's psychiatrist, physician or psychologist and have them fill out An Application for Emergency Admission so the police can be contacted to find and transport the patient to a crisis center or ED for evaluation.
If unable to contact above professionals, contact local police.
If homicidal contact the police, give them the assessment information and as much information on the potential victim(s) as you have. The police will then work to contact and protect the victim(s) and locate the patient so they can be taken for further evaluation. Always notify the police if you have knowledge that a patient has access to guns or other weapons.

Screening tool developed by Angie Chesser, Ph.D., RN, CNS, BC
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Screening and Intervening continued on page 14

POST TEST AND EVALUATION–Screening and Intervening with Suicidal Patients–Help for the Non-Psychiatric Nurse

Complete your post-test online! Go to www.ohnurses.org and click on CE4Nurses *See page 5 for details.*

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

NAME _____SCORE_____

Please circle one answer.

1. Women commit suicide at a higher rate than men.
   a. True
   b. False

2. Asking a patient about suicide can be dangerous.
   a. True
   b. False

3. Suicide has increased among adolescents and young adults.
   a. True
   b. False

4. Suicide is higher in urban vs. rural areas.
   a. True
   b. False

5. Substance abuse can increase a patient's risk for suicide.
   a. True
   b. False

6. Medications do not impact a patient's risk for suicide.
   a. True
   b. False

7. Patients who are suicidal may be homicidal also.
   a. True
   b. False

8. Nurses should examine their own beliefs about suicide.
   a. True
   b. False

9. The media does not impact suicidal behaviors.
   a. True
   b. False

10. Ninety percent of patients who die by suicide have a diagnosable mental health illness when they die.
    a. True
    b. False

11. If a homicidal patient leaves your care center, call the police.
    a. True
    b. False

12. When a suicidal patient's mood rises, the risk for suicide can actually be higher. Which statement about this is untrue?
    a. Medications can increase a patient's energy level. before their feelings of hopelessness decrease.
    b. The patient is trying to trick caregivers.
    c. When settling on suicide as a solution, their relief can be seen as a decrease in their depression.

13. Suicidal patients may display all of these emotional characteristics except:
    a. They may express wanting to rejoin a loved one who has died.
    b. They may feel others would be better off without them.
    c. They may express a sense of connection and support from those important to them.
    d. They may express anxiety and agitation.

14. Which factors can increase suicide risk in a person diagnosed with schizophrenia?
    a. Common hallucinations
    b. Confusion and disassociation
    c. Depression about their quality of life
    d. Paranoia
    e. Guilt surrounding their actions in a prior event
       1. a, b, c
       2. c, d, e
       3. a, c, d
       4. b, c, e

15. Which behavioral characteristics may suggest a patient is considering suicide?
    a. Taking a sudden vacation
    b. Visiting their physician or APN with no relief from symptoms.
    c. Withdrawing from friends and family
    d. Talking with others about not being around for future events
    e. Asking for family mementos or treasure items
       1. a, c, e
       2. b, c, d
       3. b, d, e
       4. a, b, d

16. Which characteristics increase the risk for suicide?
    a. Family history of suicide
    b. Current heavy use of drugs and/or alcohol
    c. Recently stopping mental health treatment
    d. Making a previous suicide attempt
       1. b, c, d
       2. a, c, d
       3. a, b, d
       4. All of the above

17. Homicidal patients may report which of the following characteristics?
    a. Having a history of domestic violence
    b. If I can't have the relationship, no one else should either
    c. Wanting to make amends to an injured party
    d. Having access to guns or other weapons
    e. Tries to blame others for current crisis
       1. a, b, d, e
       2. b, c, d, e
       3. a, b, c, d
       4. All of the above

18. Ways non-psychiatric nurses can reach out to suicidal patients:
    a. Find out if your agency has a P/P to screen and refer suicidal patients.
    b. Convey you have time and interest in talking with suicidal patients.
    c. Do not leave patients alone if they express suicidality.
    d. Convey to significant others how serious suicidal thoughts, behaviors and plans can be.
       1. a, b, d
       2. b, c, d
       3. a, b, c
       4. All of the above

19. What is the best approach to discussing potential suicidality with a patient who shares pain but no suicidal thoughts?
    a. After experiencing all this pain you must be thinking about suicide.
    b. Do you have a suicide plan?
    c. Sometimes when a person experiences this kind of problem, they may feel life isn't worth living or think about harming themselves. Are you feeling this way or having thoughts of self harm?
    d. How would killing yourself solve your problems?

20. If a patient who expresses suicidality refuses help and leaves your care setting, which steps should you take?
    a. Attempt to call their psychiatrist, psychologist or family MD for An Application for Emergency Admission to be completed.
    b. Hope the patient reconsiders and gets help.
    c. Call the patient's family and tell them to watch the patient carefully.
    d. If you cannot reach the patient's psychiatrist, psychologist or physician, call the police.
       1. a and c
       2. b and c
       3. a and d
       4. None of the above

Evaluation

1. Were the following objectives met?
   a. Describe personal issues that can impact nurses caring for suicidal patients. ___Yes ___No
   b. Recognize risks factors for suicide. ___Yes ___No
   c. Identify how non-psychiatric nurses can screen and respond to suicidal patients. ___Yes ___No
2. Was this independent study an effective method of learning? ___Yes ___No

   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____
4. What other topics would you like to see addressed in an independent study?

SEND WITH REGISTRATION FORM ON PAGE 4

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Editorial: Senate Bill 5 Affects All Registered Nurses

by Gingy Harshey-Meade,
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Chief Executive Officer, Ohio Nurses Foundation

The very hallmarks of the nursing profession are under attack and the Ohio Nurses Association needs your help. The ability of registered nurses to provide high standards of patient care and ensure patient safety are at risk and the implications for RNs are truly frightening. The recent introduction of Senate Bill 5, under the guise of labor reform, **removes the voice of nurses in decisions about patient care and workplace conditions** and it is a clear threat to patient safety.

Senate Bill 5 eliminates collective bargaining in the public sector. Wait. Don't stop reading just because you aren't part of a collective bargaining unit. Senate Bill 5 may not affect you today, tomorrow or next week, but Senate Bill 5 **will** impact you at some point in your career. Senate Bill 5 hurts **all registered nurses**. The legislation takes power away from nurses and places it solely in the hands of health facility management. Patients lose their strongest advocates and nurses lose their ability to address patient and workplace safety issues. Bottom line: **Senate Bill 5 is bad for nurses and bad for patients.**

Ohio's current collective bargaining law impacts you even if you aren't part of a union and never plan to be. The ability of nurses to bargain collectively–even if in only one facility in an area–sends out a ripple effect which benefits all nurses in that geographic market. Existing collective bargaining agreements often influence the workplace environment, patient care policies, compensation and facility support for nurses at the surrounding health care facilities. As facilities compete to attract the best nurses, the collective bargaining agreements at another facility help set the proverbial bar they must meet to ensure nurses are treated fairly and patients receive the best nursing care possible to achieve a positive health care outcome.

Through its labor arm, the Ohio Nurses Association bargains on behalf of its collective bargaining members for issues that directly impact patient care, many of which would be difficult to address otherwise. These agreements go beyond wages and compensation and focus on issues which **protect patients and the nurses who provide their care.** Regardless of the issues included in the contracts, collective bargaining provides a process that is time and cost-effective for all parties while protecting patients and nurses.

Some examples of these workplace issues are:

- Safe nurse staffing,
- Safe patient handling,
- Medication errors/adverse event prevention, and
- Maintenance of a safe environment for patient care.

Senate Bill 5 makes it all but impossible for nurses to use their collective strength to affect change–the very change you know could mean the difference between life and death. The Ohio Nurses Association has never been an organization driven by fear or prone to exaggeration but ask any nurse to name their greatest fear. It's losing a patient. That nurse will tell you that they are afraid a patient will die as a result of unsafe staffing levels or fatigue and exhaustion because of mandatory overtime and inadequate rest breaks, or the many other workplace conditions that lead to compromised care.

The threat to all registered nurses and their patients is real and it is now. Lawmakers expect to move this legislation quickly and it clearly is on the fast-track. We need your help to defeat Senate Bill 5 TODAY. Lawmakers need to hear from their constituents. We need you to get involved in our ***Safe Nurses, Safe Patients*** campaign to defeat Senate Bill 5.

As nurses, we need to stand up for ourselves and our patients. Visit the Ohio Nurses Association's website for more information about how Senate Bill 5 affects registered nurses and the action you can take to help defeat the legislation. As this article is written, the bill is being deliberated in the Ohio Senate. Because the legislation is on the fast-track the status changes very quickly. We recommend you go to www.ohnurses.org for the most up-to-date information, events and action you can take. We urge you to use the link on our Website to identify your legislators and contact them. Tell them to vote NON on Senate Bill 5.