MAssachusetts Report on Nursing

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Vol. 9 No. 1

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March 2011

Save the Date!

April 29-30, 2011
Living Legends in Nursing &
Annual Awards Banquet
Annual Spring Convention

2011 Living Legends and Excellence in Nursing Awards Dinner
Friday, April 29, 2011 ~ 6:00 pm - 9:30 pm
At the beautiful Dedham Hilton
MARN celebrates the BEST in Nursing in Massachusetts and MARN's successes for the past 10 years!
Cocktail Reception ~ 6:00 pm – 7:00 pm
Dinner and Awards Ceremony ~ 7:00 pm – 9:30 pm

10th Annual Spring Convention

Innovations in Health Care – Vulnerable Populations

PTSD

Elder Care

Pediatric Care

Saturday, April 30, 2011

MARN Business meeting

Keynote
Karen Daley. PhD, MS, MPH, RN, FAA
President of the American Nurses Association

Second Keynote
Barbara Blakeney, RN, MS
Past President of the American Nurses Association

Clio's Corner: MARCH 2001—The Birth of MARN The Birth of Health Care Reform: MARCH 2010

Mary Ellen Doona

On Tuesday March 23, 2010, American Nurses Association President Rebecca Patton sat in the front row in the East Room of the White House. Beside her were health care consumers. Behind them sat Caroline Kennedy, the niece of the late Massachusetts Senator Edward M. Kennedy, for whom health care reform was the cause of his life. Nearly 300 people filled the rest of the room. ANA's prominence as President Barrack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) signified Obama's recognition of nurses' long and valiant efforts for health care reform. Raising the quality of health care had been ANA's mission since its beginning in 1896. Throughout the process from bill to law, Obama referred to nurses as the "beating heart of the health care system."

The signing ceremony had special significance for Massachusetts' nurses. Only ten years before, the Labor Relations Cabinet of the Massachusetts Nurses Association (MNA) started proceedings to end MNA's 98-year affiliation with the ANA. Throughout the spring, summer and fall of 2000, pro-ANA members spoke at Town Hall Meetings throughout the State, on the pages of *The Massachusetts Nurse,* in response to the Hot Line questions on MNA's web site and in mailings to the membership.

Pro-ANA supporters argued that ANA represented nurses in all their diversity including staff positions, advanced practice, management, education, research, the military, health care policy, and as attorneys. ANA's united voice spoke for nurses, patient care, educational preparation, just wages, ethical practice and a safe nurse-patient milieu. Sadly the year 2000 saw the deaths of nurses who believed in ANA: Minnie Cohen who had served MNA as its president from 1967-1969; Mary Anne Garrigan, founder of the History of Nursing Archives at Boston University; Eileen Callahan Hodgman of the Beth Israel Hospital; and, Mary E. Macdonald of academia and the Massachusetts General Hospital. The pro-ANA nurses campaigned valiantly and argued eloquently, but on March 24, 2001 at Mechanics Hall in Worcester, Massachusetts two-thirds of members present voted to end their affiliation with ANA to become a labor organization for staff nurses.

Pro-ANA members were sad and anguished over the vote. Distraught as they were that relationships with colleagues had ended they focused on continuing their relationship with ANA. As Eleanor Vanetzian said, "Unity with the ANA was in the best interest of the public [we] served… and the best potential to represent all nurses and recipients of nursing care." When William Galvin signed the document on March 23, 2001 MARN was incorporated and the Massachusetts Association of Registered Nurses (MARN) became the constituent member of ANA.

Barbara Blakeney recalls, "We wasted no time… to build a new, vibrant organization." David Keepnews emphasizes, "MARN welcomes *all* nurses." MARN's first days were "energizing and exciting," Peggy Blum remembers, knowing at that point, "We were on our way!"

The Birth of MARN continued on page 5

2011 Awards for Nursing Excellence and Scholarships

Living Legends in Massachusetts Nursing
Phyllis Moore, DNSc, PMH, CNS, BC
Muriel A. Poulin, RN, BS, MS, D.Ed

Award for Excellence Nursing Research
Diane Feeney Mahoney,
PhD, RN, ARNP, BC, FAAN

Award for Excellence in Education
Susan Kelly-Weeder, PhD, RN, FNP-BC

Excellence in Nursing Practice
Neah Kim Ling, MSN, FNP, APRN

Mary A. Manning Mentoring Award
Marion Winfrey, RN, EdD
Erin Lamoureux, RN, MS

Ruth Lang Fitzgerald Memorial Scholarship
Sharon Lee Gifford, BS, RN

Loyal Service Award
Myra F. Cacace, GNP/ADM-BC, CDE

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MARN 2011 Annual Convention
All convention participants are welcome to contribute posters that will be displayed near the exhibitors and available for all who attend to see.

For Poster Guidelines and Submission Form Go to www.MARNonline.org by *April 4, 2011*

10th Annual Spring Convention

Innovations in Health Care – Vulnerable Populations

Saturday, April 30, 2011

Registration Information

Please include check or money order made out to MARN for the exact amount or you may choose to register and pay by credit card *online* at www.MARNonline.org.

Return registration form and check to:
MARN, PO Box 285, Milton, MA 02186.
Registrations MUST BE postmarked no later than *April 4, 2011.*

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- ❑ $75 MARN Members
- ❑ $85 Non-MARN Members

- ❑ $90 Convention Only 4/30/11
- ❑ $165 Awards Dinner 4/29/11 *and* Convention 4/30/11

Non-Members
- ❑ $125 Convention Only 4/30/11
- ❑ $210 Awards Dinner 4/29/11 *and* Convention 4/30/11

MaSNA Convention Only 4/30/11
- ❑ $50 MaSNA Members
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Checks returned for insufficient funds will be subject to an administrative fee.

Sponsor a Nursing Student or New Graduate Nurse for the 2011 MARN Spring Convention

Sponsor a nursing student or a new graduate to attend the 2011 MARN Spring Convention. Your sponsorship will provide the opportunity for novice future nurses to hear nurse experts; attend a special forum with MASNA students and network with nurses who share their passion for the profession.

See conference registration form on this page for more details.

The names of all sponsors will be listed in the MARN Newsletter.

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Policy for Accepting Announcements for the Newsletter

MARN encourages organizations and educational institutions to submit announcements about continuing education opportunities and upcoming events that are of interest to nurses.
Please note: The announcement can not exceed 75 words.
Fees must be included with submissions.
The Fee Schedule is as follows:
MARN Approved Providers/Sponsors—$25
Non MARN Approved Providers/Sponsors—$50
Payment can be mailed to MARN, PO Box 285, Milton, MA 02186. Please include a copy of the announcement and contact information (name, address, telephone, Email) with the check. Please email copy to www.MARNonline.org.
For more information, contact info@MARNonline.org.

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2011 MARN Living Legends in Massachusetts Nursing

Phyllis Moore, DNSc, PMH, CNS, BC

by Judy Beal, DNSc, RN

Dr. Phyllis Moore has made many significant contributions to the profession of nursing at state, national, and international levels. As a nurse educator and academic leader at Boston University, Yale University and Simmons College she has shaped the professional identity of thousands of young nursing students. A skilled clinician, educator, and mentor she has had a special way with students from diverse backgrounds, and always recognized their special talents and potential for future contributions, and understood their academic struggles.

Dr. Moore received her BSN from the University of Michigan, her MS in Adult Psychiatric Nursing and her Doctorate in Nursing Science from Boston University. When she retired from the chair position that she held for 12 years from Simmons College in 1985, the department named an award in her honor for an undergraduate student who has made significant contributions to enhancing and embracing diversity while in the program. This award is given at the pinning ceremony every May. In her academic leadership roles, Dr. Moore successfully wrote for and received many competitive national grants for graduate student traineeships, educational training, program project grants, and research. As a dean and academic administrator, she mentored many young faculty members, positively influencing the professional lives and careers of more than 50 young faculty members.

Dr. Moore has always been and continues to be the pent-ultimate nurse leader. She has been actively involved in numerous leadership roles in ANA, NLN, NEON, MNA, ENRS, MARN, and Sigma Theta Tau since the early 1960's. From 1985-1987 she was the President of the Massachusetts Nurses Association (MNA) and immediately following that, became President of the Massachusetts Nurses Foundation.

Prior to assuming these prestigious leadership roles, she served on or led more than 10 MNA committees and served as an ANA delegate from 1985-1995. A champion of diversity initiatives, she chaired the MNA Diversity Committee and now serves on the advisory board of the Simmons College Dotson Bridge and Mentoring Program for ALANA nursing students at academic risk. She has received numerous awards including those from Boston University, the New England Regional Black Nurses Association, MNA, and Sigma Theta Tau.

Dr. Moore has inspired hundreds of other nurses—faculty, colleagues, clinicians, students, and aspiring nurses. By her example and her dedication to the advancement of others, she has blazed trails for so many of us…from Massachusetts to Israel! She is one of the most dedicated professionals I have had the honor to work with. I don't think that Phyllis will ever really retire…she loves learning and contributing too much. And we as a profession in Massachusetts are better because of her and her work. She is most worthy to be named as a Living Nursing Legend in Massachusetts and the world!

Muriel Poulin, RN, BS, MS, D.Ed

by Susan LaRocco

Dr. Muriel Poulin has made contributions to nursing on a state, national and international level for more than 50 years. After her graduation from Massachusetts General Hospital School of Nursing in 1946, she continued her education at the Catholic University of American (BS), the University of Colorado (MS) and Teachers College, Columbia University (EdD). As a professor and chairperson of the nursing administration program at Boston University from 1972 to 1988, she educated and influenced nursing leaders in Massachusetts and around the world. After leaving Boston University, she became a visiting professor in Barcelona and later a Fulbright Scholar in the same university. While at Boston University, Dr. Poulin was awarded the Metcalf Award for Excellence in Teaching.

One of Dr. Poulin's most significant contributions to nursing was co-authoring *Magnet Hospitals: Attraction and Retention of Professional Nurses,* published by the American Nurses Association. This study is the basis for the Magnet Hospital Recognition Program that demonstrates the significance of nursing in the hospital.

Dr. Poulin was one of the founders of the American Academy of Nursing. She has always been active in professional organizations, including serving as an officer and on the boards of directors. These include the American Nurses Foundation, Massachusetts Nurses Association and the American Journal of Nursing Company. Her list of publications is extensive. She is worthy of the title Living Nursing Legend in Massachusetts!

Featured Articles: The Quest for a Healthier Workplace

President's Message: Violence in the Health Care Setting

by Anne Manton
PhD, APRN, PMHNP-BC, FAEN, FAAN

Anne Manton

A recent study by the Emergency Nurses Association (ENA) revealed some startling facts. Did you know that every week in the United States between 8 and 13 percent of emergency nurses are victims of physical violence, and of those, 15 percent sustained physical injury from the assault? In addition, more than half the nurses surveyed reported having experienced physical or verbal abuse at work in the past seven days (Emergency Nurses Association, press release 9/28/10).

While these facts are astounding, even more alarming is that in cases where nurses sustained physical injury, no action was taken against the perpetrator in almost half (44.9%) of the incidents. And who are the perpetrators of the abuse? According to the study, in nearly all incidents of physical and verbal abuse patients and their relatives were the perpetrators.

In June of 2010, The Joint Commission addressed the subject of increasing violence in health care institutions, specifically focusing on assaults and criminal events in a Sentinel Event Alert. While noting a steady increase in the numbers of assaults, rapes, and homicides in the past three years, the alert also identified contributing factors. In descending order of their significance, these include:

- Leadership—problems in the areas of policy and procedure development and implementation
- Education Deficit—inadequate staff education and competency assessment processes.
- Assessment—flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment
- Communication failures—both among staff and with patients and family
- Physical environment—deficiencies in general safety of the environment and security procedures and practices
- Care planning, information management, and patient education.

Both the Sentinel Event Alert and the ENA recommend that health care facilities adopt a zero-tolerance policy and mandate staff to report any real or perceived threats. In the ENA study, hospitals with a zero-tolerance policy had an 8.4 percent violence rate while hospitals with no policy regarding violence had an 18.1 percent physical violence rate. According to ENA Immediate Past-President Diane Gurney MS, RN, CEN (a MARN member), "These data underscore what nurses know first-hand; hospitals that have policies in place to respond to violence and to prevent it are safer for the health professionals who work in them and the patients who seek treatment in them."

In Massachusetts we are fortunate because in July 2010 Governor Patrick signed HB 1696 an 'Act Relative to Assault and Battery on Health Care Providers' into law. According to Senator Richard Moore, "This bill … will lead to corrective action being taken against those who would harm a nurse on the job, and it will communicate to the public and to the medical community the severity of the problem."

The new law is a step in the right direction, but there is more work to be done. As nurses we need to think in terms of prevention strategies, identification of high risk areas, increased staff education as to how to manage situations and prevent escalation, and the development of institutional policies and procedures.

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Enough is Enough
Nurse on Nurse Bullying is Alive and Well in 2011

R. Gino Chisari, RN, MSN

Nurse-on-nurse bullying is broadly defined as any type of repetitive episode in which a nurse suffers verbal or emotional abuse, physical threats, humiliation, intimidation, or other behaviors by a fellow nurse—*usually done in public*—that interferes with a nurse successfully carrying out one's job performance. Others terms you will see in the literature or hear about that also describe nurse-on-nurse bullying are, vindictive, cruel, malicious or some humiliating attempt to emotionally undermine a colleague. Unfortunately, nurse-on-nurse bullying continues to be a significant workplace issue in the 21st century.

Nancy Hughes RN, MS, Director of the ANA Center for Occupational and Environmental Health reported at the 2010 MARN spring conference that, "Bullying behaviors are typically unpredictable, irrational and unfair, and they happen with great regularity within the workplace." Although nurse-on-nurse bullying is described in different ways—*a problem in itself because, it's hard to call something out of the closet if you don't know it's name*—the consistent and central principle generally involves abuse of power and control, which frequently occurs when nurse managers or supervisors inappropriately use their position of authority to bully a subordinate nurse, which often blur the lines of perception.

If you have a story you'd like to share, please write to us at info@marnonline.org

Nurse-on-nurse bullying affects more than just the direct victim of abuse. It has been noted to have a ripple effect and cause harm to co-workers as well. The literature discusses that both direct victims of abuse and co-worker are likely to suffer any combination of anxiety, depression, feelings of isolation, nervous tension, headaches, eating disorders, sleep disturbances, and/or an onset of chronic illnesses. Additionally, there is evidence suggesting that nurse-on-nurse bullying is associated with high rates of employee turnover… who wants to continue to endure a negative job experience?

Many of us will remember when we were asked, "Do nurses eat their young?" The question coined a phase that entered our lexicon in 1986, when Judith Meissner asked, if as a profession we engage in a series of destructive acts aimed at student and novice nurses. The 1986 editorial caused a fire storm of discussion on the ways in which nurses are educated and socialized into the profession. Meissner revisited the question in 1999, and found once again "A disturbing picture." In fact a decade or so later, it is still disturbing to hear reports of wide spread nurse-on-nurse bullying. Some nurses actually believe that the problem is worse than ever before.

Is nurse-on-nurse bullying still alive and well? Have we, as a caring profession not called out of the closet this nasty dark secret that has plagued our profession for so many years? Do we really still stand back and watch our young colleagues get "eaten alive?" Are we ready to say enough is enough and create Bully-Free Zones?

Over the coming months, MARN will be discussing nurse-on-nurse bullying in the hopes of raising awareness, educating ourselves and advocating for nursing education programs, employers, all nursing organizations, the Board of Registration in Nursing, and others to unify around a policy statement denouncing nurse-on-nurse bullying and then collaborating on developing other strategies to finally eliminate bullying from our profession.

If you have a story you'd like to share, please write to us at info@marnonline.org and remember you are not alone—many have survived the pain of nurse-on-nurse bullying and together we can end, what some call a "rite of passage"…I say, Hell No! Enough is enough.

References:

Hutchinson, M., Vickers,m., Jackson, D., and Wilkes, L. (2006). Workplace bullying in nursing: towards a more critical organizational perspective. Nursing Inquiry; 13(2): 118-126

Dellasega, C. (2009). Bullying among nurses. American Journal of Nursing; vol. 109, No. 1. The 1986 editorial…can you cite this?

Meissner, J. (1986). Nurses are we eating our young.

The Birth of MARN continued from page 1

Wisdom galore shaped the new association as its leaders brought to bear their long experience in organizational leadership. Marie Snyder,* a nurse and attorney, drew up the Articles of Organization to incorporate the new Association. Its purposes were:

> fostering the continued development of professional nurses and high standards of nursing; [and], providing an environment which encourages exploration of common interests and develops collaborative relationships with other nursing groups within the Commonwealth; initiating and influencing legislation and affecting public policy; providing for quality in nursing practice, nursing education, and the continuing education of nurses; and such other legal purposes as are consistent with a professional nursing organization (March 23, 2001).

MARN's inaugural officers included: Karen Daley, President; Barbara A. Blakeney, Vice-president; Margaret T. Barry, Treasurer; and, Cynthia A. LaSala, Secretary. The Directors were: Peggie Griffin Bretz, Maura K. Fitzgerald, Jackie Hayes, David M. Keepnews, Mary J. McKenzie and Eleanor V. Vanetzian. Others who signed the document on March 19, 2001 were: Linda Moniz, Mary Anne MacKusick, Donna Mae Donahue, Sherry Merrow, Elizabeth Grady, Carmela Townsend, Patricia M. Brigham, Claudia Ellis and Judith Mealey.

Karen Daley

Barbara Blakeney

Margaret T. Barry

Cynthia A. LaSala

Maura K. Fitzgerald

David M. Keepnews

Mary J. McKenzie

Eleanor Vanetzian

MARN marks its tenth anniversary on March 23, 2011 with Anne Manton its president and Karen Daley, MARN's first president, now the president of ANA. MARN members from the edge of the Atlantic Ocean to the hills of the Berkshires are joined with nurses throughout the country. These ANA members are a powerful force as health care reform begins to improve the quality of care for all.

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Editorial

Mid Term Life

Myra F. Cacace, GNP/ADM-BC, CDE

We usually talk about the Mid-Life Crisis and I think I am in the middle of having mine. After almost 17 years I stopped being an "employee" to begin an independent practice providing comprehensive diabetes management and primary care in the greater Fitchburg/Leominster community. This is a totally new business model for me (scary) but a chance to make a difference (energizing). As I experience my midlife crisis, I am mindful that our nation is in the middle of a *mid-term crisis*.

The midterm elections are history and the new congressional leadership is filling the airways with disturbing rhetoric about repealing the Patient Protection and Affordable Care Act (PPACA). Years of hard work and a good beginning for health care reform are destined to be undone unless nurses stand up and fight to preserve the hard earned gains aimed at correcting a broken system. We cannot sit back and watch! The Republican controlled congress has as its first agenda item the dismantling of the progress made thus far with the new law.

The issues are confusing and most people only listen to the sound bites and form opinions based on who has the best slogan. Shouldn't they be listening to members of the "most trusted" occupation in the nation? As nurses, we have the responsibility to stand up and fight to preserve the hard earned gains aimed at correcting a broken system. We cannot sit back and watch!

When President Barak Obama called former ANA President Rebecca Patton on the eve of signing PPACA into law last March, her first response to him was "Good. Now it is time to get to work." As nurses we have the responsibility to take the time to understand the new regulations affecting the lives of our patients. We cannot afford to react to policies that eliminate hard earned gains. Nurses have the responsibility and expertise to act by letting our representatives know that we are watching them. We want to help them make good decisions about improving our broken health care delivery system by increasing affordability and availability of health insurance and pharmaceuticals. So get informed . . . get involved . . . and what better way to get involved than by being a part of a nursing organization that is at the table and in the front row (see Clio's Corner, front page) of the decision making process? Nurses can become a part of the MAT (MARN Action Team) and use their collective expertise to make an impact. See the Bulletin Board on p. 12 for more information.

I hope you enjoy this edition of the MAssachusetts Report on Nursing. This year will feature articles aimed at identifying and eliminating workplace violence in all its forms. MARN President Anne Manton and Gino Chisari discuss two distinct aspects of this on p. 4. Do you have a story to share? We'd love to hear from you!

We are also introducing a new feature called "Outside the Popcorn Box (see p. 14)." I thank our New Hampshire neighbor Sandra McBournie for sharing her love of movies and reviews with us. So, happy reading and hopefully by the time you receive this the weather will warm, cooler heads will prevail and our legislators will not undo the hard work that has already been done to improve health care for all.

CE Unit

The Highs and Lows of Thyroid Diseases

MARN wishes to thank our colleagues from Ohio for partnering with us to provide you with high quality continuing education units through the years.

Ohio Nurses Foundation

Author: Barbara Walton, MS, RN, NurseNotes, Inc. Milan, Michigan

INDEPENDENT STUDY

This independent study has been developed for nurses to better understand thyroid diseases and related nursing implications. 1.33 contact hours will be awarded for successful completion of this independent study.

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. Identify signs and symptoms of hyperthyroidism and hypothyroidism.
2. Identify nursing implications in caring for a patient with hyperthyroidism or hypothyroidism.

This independent study was developed by: Barbara Walton, MS, RN, NurseNotes, Inc. Milan, Michigan. The author and planning committee members have no conflict of interest. There is no commercial support for this independent study.

The Thyroid Gland and Hormones.

As you will recall, the thyroid gland lies just below the thyroid cartilage (Adam's apple) and is made up of two lobes connected by a strip of tissue referred to as an isthmus. The gland may be palpated by having the patient swallow; the gland moves upward. The gland is very vascular and is composed of follicular cells. The follicular cells produce and store two hormones: Thyroxine (T_4) and Triiodothyronine (T_3). Collectively T_3 and T_4 are known as thyroid hormone. Hormone levels are controlled via a feedback loop. When T_3 and T_4 levels drop, the hypothalamus releases thyrotropin releasing hormone (TRH). TRH causes the anterior pituitary gland to release thyroid stimulating hormone (TSH). TSH binds to receptor sites on the thyroid gland and causes it to immediately release stored T_3 and T_4 into circulation. TSH also stimulates the thyroid gland to produce more T_3 and T_4 and increases the uptake and use of iodine. Once thyroid hormone levels return to normal, this feedback loop is completed. Feedback loops are important in maintaining the correct hormonal levels. A disruption in the feedback loop can result in either a deficit or an excess of T_3 or T_4.

Ninety percent of the hormone produced by the thyroid gland is in the form of T_4, while the remaining 10% is produced in the form of T_3. Most T_4 is bound to proteins; with a small amount being free T_4. T_4 is converted to T_3 through the uptake of iodine. T_3 has the greatest physiologic effects. While many of us think of the metabolic effects of thyroid hormones, there are actually many body systems affected by these hormones. The actions of thyroid hormones are listed in the following table.

Hyperthyroidism

Hyperthyroidism results when a patient produces too much T_3 and T_4. Keeping in mind the feedback loop, the cause can be identified. Perhaps a particular patient has a tumor of the hypothalamus that hyper-secretes TRH; a tumor of the pituitary gland that hyper-secretes TSH, or a problem with the thyroid gland itself. Diffuse toxic goiter, or Graves' Disease is caused by antibodies in the blood that stimulate the thyroid to grow and secrete too much hormone. This type of hyperthyroidism tends to run in families and is not well understood, yet it is the most common cause of hyperthyroidism.

Toxic nodular or multinodular goiter (Plummer's Disease) usually seen in an elderly patient, is another type of hyperthyroidism. In this situation, one or more nodules of the thyroid gland become hyperactive for unknown reasons. An important factor in the nursing assessment of a patient with a large goiter is to assess for esophageal or tracheal compression. Some goiters can become large enough over a period of time and may compress or narrow the airway causing breathing difficulties. Patients may develop hyperthyroidism due to an infection and acquire a resulting thyroiditis, yet no specific bacteria or virus has been identified. Hyperthyroidism may also result from a tumor of the thyroid gland, or when a patient who has hypothyroidism takes too much thyroid hormone replacement.

When a patient reveals abnormal laboratory values and signs and symptoms, indicating hyperthyroidism, it is called *thyrotoxicosis. Thyroid storm* occurs when a patient with thyrotoxicosis further decompensates, in other words it is the extreme version of hyperthyroidism. Thyroid storm is rare, but can be life threatening, with 20 to 50% of the patients dying. Thyroid storm may be precipitated when a patient with hyperthyroidism becomes ill or sustains an injury, or may occur with sudden discontinuation of medication. Therefore, as with any medication, the patient should be taught to never discontinue medication without consulting a healthcare professional.

Thyrotoxic Myopathy is a neuromuscular disease that is linked to Graves' disease and hyperthyroidism. This condition is also referred to as Graves' myopathy, hyperthyroid myopathy, Basedow's myopathy or Basedow paraplegia. It is possible for a patient to have thyrotoxic myopathy alone, without hyperthyroidism or Graves' disease. But we need to be particularly watchful for this complication in our patients who have been diagnosed with hyperthyroid conditions. In thyrotoxic myopathy the patient experiences excessive levels of the thyroid hormone thyroxine, just as they do with hyperthyroidism. It is believed the excessive levels of thyroxine over extended periods of time accelerate lipid oxidation, mitochondrial oxygen consumption and protein degradation, all of which can result in muscle fiber damage. Left untreated, the muscle loss may result in rhabdomyolysis. One of the complications of rhabdomyolysis is kidney failure as large protein molecules from the degradation of the muscles occlude and damage nephrons and capillary beds in the kidney.

Primarily muscles of the pelvic girdle, shoulders, torso, eyes and eyelids are affected. Loss of torso muscles (back and abdomen) accompanied by loss of pelvic girdle muscles puts a patient at risk of falling, resulting in further injury. Some patients may experience severe attacks of thyrotoxic myopathy that can result in a periodic paralysis. The paralysis results when there is a massive influx of potassium into the intracellular space, yielding a low extracellular potassium level. In extreme situations, this can lead to respiratory and or cardiac arrest. Thyroid myopathy is treated with the same modalities we use to treat any other hyperthyroid condition. We will be discussing treatment a little later in this paper.

In thinking about the signs and symptoms of hyperthyroidism, simply remember what all the thyroid hormone actions are and amplify these. For example, you already know that thyroid hormone exerts a positive inotropic (increased heart rate) and positive chronotropic (increased force of contraction) effect on the heart.

Therefore, if one has too much thyroid hormone, these effects will be exaggerated and the patient may experience tachycardias, bounding pulses and a pounding sensation in the chest. This may be very detrimental to a patient who has pre-existing heart disease, and may even bring on angina or heart failure. Other signs and symptoms of hyperthyroidism may include: nervousness, irritability and agitation up to and including overt psychosis; hyperreflexia, tremors, fatigue; and difficulty sleeping including insomnia; abdominal pain and cramping, diarrhea; heat intolerance, hyperthermia, warm, moist, flushed oily skin; weight loss in spite of a healthy appetite; rales, pulmonary edema, goiter (enlarged thyroid gland), and retracted eyelids (exophthalmos seen with Graves' disease).

Some patients with Graves' disease experience what is called **"Graves' orbitopathy."** In Graves' orbitopathy patients can suffer from disfiguring exophthalmos, orbital pain, corneal ulcerations, diplopia, and optic neuropathy with compression of the optic nerve to the point of vision loss. The first line of treatment is to restore a state of euthyroidism. It is felt these patients should also be referred to an ophthalmologist and/or a neuro-ophthalmologist for follow up. Generally, for neuropathy and or corneal ulcerations, treatment may include IV glucocorticosteroids. However if steroidal treatment is not helpful within one to two weeks, surgical decompression of the optic nerve may be necessary to prevent vision loss. Because visual acuity is so important to our quality of life, we need to take a more aggressive stance in addressing this issue of Graves' orbitopathy on behalf of our patients.

Other eye conditions may include photophobia, excess tearing, diplopia, eye pain, periorbital edema, a feeling of grittiness in the eyelids and a decrease in visual acuity. Because of the role thyroid hormone plays in the development of the skeletal system, in states of hyperthyroidism, a patient can suffer bone loss. This bone loss occurs as the body is not able to keep up with the demands for bone salts to produce more bone. Thus bone salts are harvested from existing bone in an effort to produce new bone. The overall effect is bone loss. Should this occur in a postmenopausal woman, who may also have osteoporosis, the risk for hip and or vertebral fractures greatly increase.

Hyperthyroidism in the elderly may present very atypically. In the elderly, a blunted affect and or slowed response to questions may actually be hyperthyroidism versus dementia. In an elderly patient, hyperthyroidism may present as via agitated behaviors or as an increased level of confusion in someone who is already in a confused state. While tachycardia is a common symptom of hyperthyroidism, only half of the elderly patients with hyperthyroidism have an elevated heart rate.

Once you suspect hyperthyroidism in a patient, the diagnosis is confirmed with simple blood tests. If the patient's problem arises from a hypothalamic or pituitary tumor, the TSH levels will be high, due to a tumor hyper-secreting too much TRH or TSH. Too much TRH or TSH will in turn make the T_3, T_4 and Free T_4 levels become elevated. If the patient's problem arises within the thyroid gland, the T_3, T_4 and Free T_4 levels will be high while the TSH will be normal or low. It is important to include the TSH, T_3, T_4 and Free T_4 in diagnosing thyroid disease. Evaluating just the TSH may lead one to believe a patient does not have thyroid disease, as it may appear normal. A complete laboratory profile, as well as patient history, will help one identify the cause of their disease. Once laboratory results are known, the physician may want to order other diagnostic tests such as a thyroid scan or cerebral CT or MRI scans.

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Body System	Effects of T_3 and T_4
Metabolic anD Digestive	• Increases secretion of digestive juices and increases motility. • Enhances ability to absorb glucose. • Increases metabolic rate via glucose uptake, thus increasing oxygen consumption and body heat. • Increases protein synthesis and fat metabolism. • Lowers blood cholesterol by increasing cholesterol excretion.
Nervous	• Promote normal development of fetal nervous tissues
Respiratory	• Increases rate of oxygen use and production of carbon dioxide.
Cardiovascular	• Increases the force of cardiac contractility (positive inotropic effect) and cardiac output. • Increases heart rate (positive chronotropic effect)
Musculoskeletal	• Enhances bone growth until adulthood. • Stimulates protein synthesis necessary for muscle contraction and relaxation.
Integumentary	• Controls sweat and oil glands, to keep skin moist and supple.

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Below is a table illustrating the possible laboratory profiles.

Test	Normal Ranges	Hypothalamus or Pituitary Problem resulting in Hyperthyroidism	Thyroid Problem resulting in Hyperthyroidism
TSH	0.3 to 5 mIU/L	High	Low
Free T_4	0.7 to 2 ng/dL	High	High
T_4	5 to 12.5 mcg/dL	High	High
T_3	80 to 200 ng/dL	High	High

There are a number of different ways to treat hyperthyroidism, and there are nursing implications for each of these methods.

Drugs: There are *antithyroid agents* such as methimazole (Tapazole®) and propylthiouracil (PTU) that block the conversion of T_4 to T_3, thus having an overall effect of lowering circulating hormone levels. These medications are generally taken orally once daily. Of the two medications, methimazole has a longer duration of action and may give more consistent hormone levels. Methimazole and propylthiouracil have adverse reactions of which patients should be aware. These adverse reactions include rash, jaundice, fever, joint pain and sore throat. Should these adverse reactions occur, patients should immediately stop taking their medications and contact their physician for follow up blood studies?

Iodine solutions such as Saturated Solution of Potassium Iodide (SSKI) or Lugol's Solution may also be given orally in combination with an antithyroid medication. These iodine solutions prevent the release of hormone from the thyroid gland and prevent Free T_4 from binding with cell receptor sites. Usually a few drops of these solutions are diluted in water, milk or juices and given after meals to avoid stomach irritation. It is also important to have the patient drink these solutions through a straw to avoid tooth discoloration. Another solution, sodium iodide may be given IV over a 24-hour period of time. To counteract the cardiac effects of hyperthyroidism, *beta adrenergic blocking agents* may be given.

Medications such as propranolol (Inderal®), atenolol (Tenormin®), metoprolol (Lopressor®), or nadolol (Corgard®) may be used to help decrease the accelerated heart rate and contractility experienced by some patients. These medications are particularly helpful if the patient has pre-existing heart disease. Another medication consideration is that the treatment of hyperthermia that may result in hyperthyroidism. It is preferable to treat hyperthermia with acetaminophen (Tylenol®) versus aspirin. Aspirin has the tendency to release T_4 from proteins, thus making it available to attach to cell receptor sites and will worsened hyperthermia and hyperthyroidism. Patients should be advised to use acetaminophen to treat any kind of fever and to avoid aspirin. Of course the best advice to any patient is that they should always ask their healthcare professional before taking any other medications, especially over the counter medications. Another important piece of patient education is that the patient should be instructed to always take their prescribed medications and if possible take these medications at the same time each day. This will give them the most consistent hormone levels.

Routine follow up for hyperthyroidism includes monitoring blood levels of T_4 and TSH at four to twelve week intervals until normal results are achieved. This is also called "euthyroidism." Once euthyroidism is achieved, the physician may choose to lower the dosage of medications while continuing to monitor blood levels at three to four month intervals. Other aspects of routine follow up care would include assessing the patient for changes in their weight, blood pressure, heart rate, and exacerbation of any other pre-existing health problems, such as heart disease. Should the patient experience weight changes, dosing of medications may be necessary. Routine follow up care for a patient experiencing some of the eye problems previously mentioned would include sunglasses for photophobia and artificial tears for a feeling of grittiness. Sleeping with the head elevated or diuretics may be used to treat periorbital edema The patient may also need to be seen by an ophthalmologist.

Healthcare providers should also be made aware of and ask regarding any over the counter, vitamin, or herbal supplements or non-traditional treatment the patient may be undertaking for thyroid disease or other health concerns. These items may affect thyroid disease and treatment.

There are some special considerations should the hyperthyroid patient also be pregnant. In poorly controlled pregnant women, there is an increased likelihood of fetal loss. Propylthiouracil is the drug of choice during a pregnancy because it has a shorter half-life thus allowing for easier control of dosing. The demands of pregnancy may actually reduce the demand for the amount of medication; thus dosing may be frequently changed throughout the pregnancy. Some patients find during the third trimester, medication may actually be discontinued. During the postpartum period the patient needs to be closely monitored for a return of hyperthyroidism with medications being re-instituted. Be sure to watch the postpartum hyperthyroid patient for thyroid storm and assess the newborn for signs of hyperthyroidism.

Radioactive Iodine: The thyroid gland readily takes up iodine to make thyroid hormone. In the 1930's it was discovered that radioactive iodine could be given to a patient and the radioactive iodine would be taken up by the thyroid gland. The radioactive iodine over the next 6 to 8 weeks will destroy thyroid tissues, thus limiting the production of thyroid hormone. Careful calculations are done to determine the dosage of radioactive iodine, but occasionally patients may require a second dosing. More commonly, hypothyroidism (underactive thyroid) results over a period of several months to years, following radioactive iodine treatment. This resulting hypothyroidism is easily treated with a daily supplement of thyroid hormone. Radioactive iodine is administered either as a capsule or a liquid solution. It is not given to pregnant patients as the radioactive iodine will damage the thyroid gland of the developing fetus. Because the patient will remain radioactive for up to 3 days after treatment, patients should avoid close contact with others, especially small children during this time. They generally should not sleep in the same room with another person for the next 7 days.

Other radiation precautions should be discussed and given to the patient at the time of treatment. It is also important to instruct the patient they are to discontinue antithyroid medication one week prior to radioactive iodine treatment. However they should continue taking any beta adrenergic blocking agents before, during and after radioactive iodine treatment. Bear in mind it may take a few weeks before the patient will benefit from the radiation treatment and they will still have high levels of thyroid hormone present. They will therefore need these beta adrenergic blocking agents to help control cardiac problems. It is also possible after radioactive iodine; patients will experience "thyroid storm," or an exaggeration of hyperthyroidism. This occurs when the damaged thyroid cells release their stored thyroid hormone into circulation.

Surgery: In some instances, physicians will recommend removal of part of or all of the thyroid gland. If a single nodule or lump is identified as being overactive, a partial removal of the gland is completed. The remaining gland will usually return to a normal level of functioning. If the entire gland is deemed to be overactive, and the patient is not a candidate for radioactive iodine therapy, the entire gland may be removed. In this instance the patient will then develop hypothyroidism and will require lifelong treatment. Postoperatively it is important to monitor the patient's airway patency. With swelling at the surgical site there may be some occlusion of the patient's airway.

Hypothyroidism

Hypothyroidism results when a patient has too little thyroid hormone. Again thinking of the feedback loop for the hormone, the primary problem may occur in the hypothalamus or pituitary gland resulting in low levels of TSH, or the problem may occur in the thyroid gland itself, resulting in low T_3 and T_4 levels. A patient, who was treated for hyperthyroidism, may have developed a hypothyroidism, as we just discussed in the previous section. Other causes of hypothyroidism include a chronic thyroiditis, insufficient treatment of hypothyroidism by not taking enough hormone supplements, or a history of taking lithium carbonate. Lithium carbonate blocks thyroid hormone synthesis. Patients taking lithium carbonate should be periodically evaluated for the development of a goiter, indicating hypothyroidism. If the goiter is allowed to continue growing, it may actually start to produce too much thyroid hormone, causing the patient to develop hyperthyroidism. Also as the goiter becomes larger, there is an increased risk of tracheal or esophageal compression. Hashimoto's thyroiditis is the most common cause of hypothyroidism and is believed to be an autoimmune process. The extreme of hypothyroidism is called myxedema coma. Myxedema coma is a life-threatening emergency. Myxedema coma can be triggered by a concurrent or severe illness, infection, trauma, surgery, anesthesia, exposure to cold, administration of narcotics or sedatives, or other forms of physical stress. Myxedema coma may be fatal, thus often requires intensive care and intravenous replacement of thyroid medications. Knowing the patient's history of hypothyroidism is helpful in identifying or preventing myxedema coma.

Think again of the effects of thyroid hormone on the body. Now imagine one does not have enough thyroid hormone. Signs and symptoms of hypothyroidism include: slow mentation, memory impairment, confusion up to and including coma; hoarse voice, slow speech; dull affect, facial puffiness, periorbital edema and non-pitting edema; goiter (The thyroid gland enlarges in an effort to produce more thyroid hormone.) may be present, cool dry skin up to hypothermia (body temperatures may be 91 to 95° F); loss of eyebrow and scalp hair, bradycardia; slow shallow respirations; and an exaggerated response to narcotics or sedatives.

The *elderly* may present very differently than a younger patient with hypothyroidism. Many of the signs and symptoms seen in an elderly patient with hypothyroidism will mimic other diseases. Weight loss versus weight gain is one common presentation of hypothyroidism in an elderly patient, which is just the opposite of what one would expect to see. Most patients with hypothyroidism experience weight gain. Pericardial or pleural effusions may be present and are often attributed to heart failure. Synovial effusions seen with hypothyroidism may be diagnosed as osteoarthritis or rheumatoid arthritis. In the elderly, hypothyroidism and hypertension often co-exist. Usually by treating the hypothyroidism, the hypertension will normalize. Because of the general slowing of metabolism that occurs with hypothyroidism, there can also be a slowing of ambulation. In elderly patients with hypothyroidism, it has been demonstrated they have compromised mobility. Therefore they are less able to walk and/or exercise with ease, undertake physical activity and maintain cardiovascular stamina. Impaired mobility also increases their risk of falling and sustaining further injuries.

Many patients with hypothyroidism also experience abnormal lipid profiles or *dyslipidemia*. Because hypothyroidism results in a slowing of metabolism, it is not unusual to see patients have elevated triglyceride, cholesterol, and LDL levels, while the HDL level will be low. Of course, all of this is a contributor to cardiovascular disease. The patient may not necessarily require treatment with one of the popular statin drugs. But treating the hypothyroidism and restoring a state of euthyroidism may well remedy the dyslipidemia problem, thereby avoiding the side effects of some of the statin medications.

In diagnosing hypothyroidism, again laboratory tests are done, just as we discussed with hyperthyroidism. Depending on test results and patient history, the physician may also obtain thyroid scans, CT or MRI scans as discussed in hyperthyroidism. Below is a table showing possible test results for hypothyroidism. As one looks at this table note that when the problem originates in the hypothalamus or pituitary gland a low TSH level along with low T_3, T_4 and Free T_4 levels exist. The low T_3, T_4 and Free T_4 levels exist because there is a low level of TSH coming from the pituitary gland, so there is a lower level of stimulation to the thyroid to produce its hormones. When the problem originates

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Test	Normal Ranges	Hypothalamus or Pituitary Problem resulting in Hypothyroidism	Thyroid Problem resulting in Hypothyroidism
TSH	0.3 to 5 mIU/L	Low	High
Free T_4	0.7 to 2 ng/dL	Low	Low
T_4	5 to 12.5 mcg/dL	Low	Low
T_3	80 to 200 ng/dL	Low	Low

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with a hypo-functioning thyroid gland, the TSH level will be high as the pituitary gland is responding to the low T_3, T_4 and Free T_4 levels. IN other words the pituitary gland produces more and more TSH in an effort to increase the T_3, T_4 and Free T_4 levels.

In reviewing the signs and symptoms of hypothyroidism, you will note many of these mimic some of the signs and symptoms of aging. As many as 1 in 10 people over the age of 65 years may have hypothyroidism and not know it. They may have no symptoms at all or may present with very vague symptoms such as fatigue or apathy. In many cases the elderly person is labeled as a dementia patient or they are told they're "old," while in fact, it may be hypothyroidism that is very treatable. The earliest sign of hypothyroidism in an elderly person is an elevated TSH level. Routine TSH and T_4 monitoring should be considered with every elderly patient so as not to overlook this problem. Hypothyroidism can accompany many other diseases and can often disguise itself as other diseases. Therefore, patients who are over the age of sixty, those with unexplained depression, cognitive dysfunction, confusion, autoimmune diseases or hypercholesterolemia should have routine monitoring of TSH levels performed.

Treating hypothyroidism is relatively simple. Here the patient lacks thyroid hormone, so he or she will be given hormone supplements. It is still controversial as to whether or not to treat an elderly patient with elevated TSH levels, yet their T_3 and T_4 levels remain normal and the patient is asymptomatic. Of elderly patients with elevated TSH levels only, 20% will progress to true hypothyroidism per year. It is something to be discussed with the physician, as some patients in this situation simply "just feel better" taking thyroid hormone supplements. Enough thyroid hormone is given to return the TSH level to normal or a state of euthyroidism. Studies have found that thyroid hormone will improve symptoms of fatigue, constipation, and poor energy. As with hyperthyroidism, patients who are being treated for hypothyroidism should routinely receive follow up care to include weight, heart rate and blood pressure screening as well as routine laboratory tests aimed at achieving euthyroidism.

If the patient experiences a weight change, medication dosages may also require changing. As the patient's age advances, it is imperative to continue to monitor for the effects of medications, adverse reactions and adjust medication dosages as necessary.

Drugs: There are a number of thyroid hormone supplements available. Since potency of generic thyroid products may vary, it is imperative the patient know what medication they are prescribed and they should not switch preparations without first discussing it with their health care professional. Below is a table of thyroid hormone supplements.

Medication	Brand Names ®	Nursing Considerations
Levothyroxine Sodium	Eltroxin, Levo-T, Levothroid, Levoxine, Oroxine, Synthroid	This is the preferred medication as it is synthetic T_4. There is constant absorption and conversion of the medication that gives a consistent level of T_3. The patient only has to take this once per day.
Iiothyronine Sodium	Cytomel, Tertroxin, Triostat	This is pure T_3 and is usually not used alone due to its rapid turnover rate. Remember T_3 is the active form of thyroid hormone. Because of its rapid effects, this medication is given usually twice per day. Use this with extreme caution with elderly patients or patients with heart disease, it may aggravate angina.
Iiotrix	Thyrolar	This is a combination of both T_3 and T_4. Patients generally take this once per day. Because of the component of T_3, again use with caution with patients who have heartdisease.
Thyroid Dessicated	Armour Thyroid, S-P-T, Thyrar, Thyroid Strong	These medications are thyroid hormone that has been harvested from beef and pork. These preparations may contain variable amounts of hormone, and because there are other more reliable synthetic preparations, these medications are not used as much. One may still encounter a patient taking these, however most patients have been switched to a synthetic preparation.

Here are some additional nursing implications regarding these medications. Patients are usually started on a lower dose of these preparations and medication dosage is adjusted to obtain a normal TSH level. Frequent monitoring is essential during the first few months of treatment to achieve the correct dosage and normal TSH. It is important for the patient to understand these medications will be taken for the rest of his or her life. They should take the medication at the same time each day so as to maintain consistent hormone levels. For example, breakfast is a good time to take their daily medications. These medications should never be discontinued unless directed by their health care provider, as myxedema coma may result. Switching medications should not be done without first discussing it with one's health care provider.

Elderly patients or patients with heart disease should be instructed to immediately report any angina, palpitations or stroke symptoms to their health care provider. If the patient also has diabetes mellitus, it may be necessary to adjust their insulin or oral diabetes medications. Remember thyroid hormone is going to enhance glucose metabolism and may thus effect insulin requirements as well. Patients should be instructed to closely monitor their blood sugar levels while initiating or adjusting thyroid hormone therapy.

Thyroid hormone supplements may also delay blood coagulation. Therefore patients may find it necessary to adjust dosages of anticoagulant therapy. All patients taking thyroid hormone supplements should be instructed to report any unusual bleeding or bruising problems. Women with hypothyroidism and who are taking estrogen products have increased thyroid hormone needs. Therefore careful monitoring of their thyroid hormone levels is necessary anytime estrogen or thyroid hormone dosages are being adjusted. The pregnant hypothyroidism patient may require an increase in medication due to the demands of the pregnancy. Careful monitoring of TSH levels during and after the pregnancy is imperative. Most patients will return to their pre-pregnancy dosages of medications postpartum. It is also important for healthcare providers to be aware if the patient is taking any over the counter medications, mineral, vitamin or herbal supplements, or using any non-traditional methods of treating their thyroid disease or any other health problems, as these modes of treatment may affect thyroid function and treatment.

Surgery: Nodules or lumps on the thyroid gland are very common and if a thyroid scan shows the gland to be functioning normally and hormone levels are normal, no treatment may be necessary. However, prior to any surgery the nature of the nodule must be determined. The patient may undergo a fine needle biopsy. If the nodule is deemed to be cancer or highly suspicious of cancer the patient will then undergo surgical intervention. Surgery may include partial or total removal of the thyroid gland. Again be sure to monitor airway patency postoperatively.

Of Special Note:

Patients who have *systemic lupus erythematosus* (SLE) have a predilection to also developing thyroid disorders. Most often the SLE patient will develop a hypothyroidism versus a hyperthyroidism, and most of these patients will be female. Graves' disease may also occur in the SLE patient, but as previously stated, usually to a lesser rate of occurrence than a hypothyroidism. Often the thyroid disorder will present subclinically, with the patient experiencing no overt symptoms of the thyroid condition. Therefore, all SLE patients should be monitored for the development of thyroid disorders, by having TSH, T_3 and T_3 levels monitored routinely.

Gastric bypass surgeries, often known as bilio-pancreatic diversion, have become popular for permanent weight loss in the severely obese. Some obese patients may already have been diagnosed with hypothyroidism, other patients, while subclinical for hypothyroidism, have not been diagnosed. Of course, the hypothyroidism may well be a contributing factor to their obesity problem. For patients who have undergone gastric bypass surgery, a portion of the stomach is removed and a pouch about the size of a walnut is created. The small size of this pouch greatly reduces the amount of surface area available for the absorption of nutrients. Some gastric bypass patients may develop malabsorption syndromes that can include iodine malabsorption. Initially the patient may be able to compensate, but eventually they will become iodine deficient. Iodine deficiency may result in hypothyroidism, especially if the patient had a pre-existing previously subclinical hypothyroidism. Therefore it is important that gastric bypass patients be monitored for malabsorption syndromes and possibly may be prescribed iodine supplements to prevent the development of hypothyroidism.

Patient Education: *The American Thyroid Association* is an excellent resource for patient education materials. The association web site is www.thyroid.org. There are a number of articles that have been developed for patients with either hyperthyroidism or hypothyroidism. These articles are free of charge and may be printed. There are also a number of professional articles available that may be printed, free of charge. The American Thyroid Association's mailing address is PO Box 1836, Falls Church, Virginia 22041.

The Pituitary Organization is another excellent resource for professionals and patients with pituitary problems. Their web site is www.pituitary.org/PituitaryLinks/htm. Their address and phone number is: The Pituitary Organization, PO Box 1958, Thousand Oaks, California 91358, 805-496-4932.

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CE Unit

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: _____ Final Score: _____

Please circle one answer.

1. T_4 is the active form of thyroid hormone and exerts the greatest physiologic effects.
   a. True b. False
2. Thyroid hormone has a positive chronotropic and positive inotropic effect of the heart.
   a. True b. False
3. Plummer's Disease is a form of hyperthyroidism that is caused by lead toxicity.
   a. True b. False
4. In Graves' Disease, the eyes appear sunken with eyelid drooping.
   a. True b. False
5. Hyperthyroidism in postmenopausal women may increase their risk for sustaining hip or vertebral fractures.
   a. True b. False
6. Methimazole has a longer duration of action than propylthiouracil and may yield more consistent hormone levels.
   a. True b. False
7. It is best to use aspirin to treat hyperthermia that may accompany hyperthyroidism.
   a. True b. False
8. Patients receiving radioactive iodine will remain radioactive for 3 days, but there are no special precautions to be instituted during this time.
   a. True b. False
9. Patients receiving radioactive iodine should stop taking all antithyroid medications and beta adrenergic blocking agents one week prior to therapy.
   a. True b. False
10. Patients taking lithium carbonate should be evaluated for hypothyroidism and the development of goiter.
    a. True b. False
11. Goiter can occur when the thyroid gland enlarges in an effort to produce more thyroid hormone.
    a. True b. False
12. Many of the signs and symptoms of hypothyroidism mimic aging.
    a. True b. False
13. Iiothyronine may easily be substituted for Iiotrix in treating hypothyroidism.
    a. True b. False
14. Armour thyroid is the preferred thyroid hormone supplement as it delivers consistent levels of T_3.
    a. True b. False
15. The patient is receiving the correct dosage of thyroid hormone supplement when the TSH level returns to normal.
    a. True b. False
16. When taking thyroid hormone supplements, elderly patients and or patients with heart disease should be cautioned to watch for the development of angina, palpitations or stroke.
    a. True b. False
17. Diabetic patients taking thyroid hormone supplements will not need to adjust insulin or anti-diabetic medications.
    a. True b. False
18. Thyroid hormone supplements may delay clotting times, therefore patients taking anticoagulants may have to adjust dosage of these medications.
    a. True b. False
19. Whether taking antithyroid medication or thyroid hormone supplements, it is important for the patient to take these medications at the same time each day.
    a. True b. False
20. The American Thyroid Association is a resource for both professional and patient education materials.
    a. True b. False
21. In experiencing adverse reactions to methimazole or propylthiouracil, the patient should immediately stop the medications and contact his or her healthcare provider.
    a. True b. False
22. Euthyroidism is achieved when the patient's blood levels for TSH and T_4 return to normal.
    a. True b. False
23. In hyperthyroidism, there is an increased need for anti-thyroid medications during a pregnancy.
    a. True b. False
24. Following delivery, it is important to monitor the newborn of a hyperthyroid mother for signs of thyrotoxicosis.
    a. True b. False
25. An illness or injury may precipitate thyroid storm or myxedema coma.
    a. True b. False
26. In an elderly patient, hypertension may accompany hypothyroidism.
    a. True b. False
27. Sunglasses, artificial tears, sleeping with the head elevated and diuretics may help alleviate some of the symptoms occurring in the eyes.
    a. True b. False
28. Over the counter medications will not affect the treatment of thyroid disease.
    a. True b. False
29. A pregnant woman with hypothyroidism will require less medication during the pregnancy.
    a. True b. False
30. In a patient who experiences weight changes and or advancing age, changes in medication dosing may be necessary.
    a. True b. False

Evaluation:

	Yes	No
1. Were the following objectives met?		
a. Identify the signs and symptoms of hyperthyroidism and hypothyroidism.	o	o
b. Identify nursing implications in caring for a patient with hyperthyroidism or hypothyroidism.	o	o
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?

DIRECTIONS

1. Please read carefully the enclosed article "The Highs and Lows of Thyroid Disease."
2. Please send the following:
   - The completed registration form
   - The post-test
   - The evaluation form
   - A check made out to MARN ($25 members; $35 non-members).
     to MARN Newsletter: P.O. Box 285 Milton, MA, 02186

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.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, ext. 1027, or Sandy Dale, ext. 1030, Ohio Nurses Association at (614) 237-5414.

INDEPENDENT STUDY: The Highs and Lows of Thyroid Disease
Registration Form

Name: _____
(please print clearly)

Address: _____

Day phone number: _____ RN

MARN Member: Yes No MARN Member Number: _____

MARN OFFICE USE ONLY:
Date Received: Amount: _____ Check No: _____

A New Legislative Session Brings New Faces to Beacon Hill

by Craven & Ober Policy Strategists, LLC

The November 2010 election brings many new faces on Beacon Hill. Pending one court challenge, 38 new members of the Massachusetts House of Representatives were sworn into office on January 5, 2011. Both Speaker Robert DeLeo and Senate President Therese Murray were re-elected by their peers to lead their respective chambers on the historic occasion and Senate President Murray became the first woman to swear in a Governor for Massachusetts, Deval Patrick, on the following day. Although the Governor has re-appointed most of his leadership team into their respective Secretariats and agency heads, some changes have taken place as the new session gets underway.

Representative Geraldo Alicea (D-Charlton) will be serving indefinitely until the Worcester Superior Court reviews the decision on recount of the November ballots indicating Alicea lost the seat by one vote to Republican Peter Durant. Provision in the state Constitution ensures any district in this situation has continued representation until the matter is resolved by the court. Meanwhile, the first two Asian-Americans to Massachusetts elected office were sworn into the House and the number of Republicans serving in that chamber this session has greatly increased.

Introducing the New Faces on Beacon Hill:

Republicans

Paul Adams (R-Andover)	Degree in international relations and economics has spent 3 years experiences as a public policy consultant and advisor on social, economic and fiscal issues
Richard Bastien (R-Gardner)	Served in the Navy during the 1990s Degree from Fitchburg State College Taught high school history. Replaces retiring Rep. Robert Rice Jr.
Matt Beaton (R-Shrewsbury)	Owns an energy efficient green building company in Shrewsbury
Nicholas Boldyga (R-Southwick)	A police officer Replaces two-term incumbent Rosemary Sandlin
Angelo D'Emilia (R-Bridgewater)	Small business owner of a general contracting company Fills the seat vacated by retiring House Dean David Flynn (Democrat)
Geoff Diehl (R-Whitman)	Worked in advertising and television and later as an account executive Replaces Rep. Allen McCarthy (Democrat)
Ryan Fattman (R-Sutton)	A Harvard University's Kennedy School of Government, Rappaport Institute for Public Policy fellowship recipient Replaces Jennifer Callahan (Democrat)
Kimberly Ferguson (R-Holden)	Has a master's of science degree in speech/language pathology Works in private practice as a consultant
Sheila Harrington (R-Groton)	An experienced attorney in the areas of real estate, family law, personal injury and workers' compensation. Replaces Robert Hargraves
Steven Howitt (R-Seekonk)	Business owner. Served as a delegate to the Massachusetts GOP state convention Replaces Steven D'Amico (Democrat)
Randy Hunt (R-Sandwich)	Certified professional accountant Won the open seat created by Rep. Jeff Perry's unsuccessful bid for Congress
Kevin Kuros (R-Webster)	Owns a small real estate firm. Defeated 16-year Democratic incumbent Paul Kujawski
Steven Levy (R-Marlborough)	Owns a small business accounting and finance firm Defeated Democrat Danielle Gregoire
Marc Lombardo (R-Billerica)	Human resources representative. Replaces retiring Democrat Rep. William Greene Jr.
James Lyons Jr. (R-Andover)	Owns a retail flower and ice cream business. Defeated Democratic incumbent Barbara L'Italien
Shaunna O'Connell (R-Taunton)	Self-employed court reporter Replaces Democrat James Fagan
George Ross (R-Attleboro)	Restaurant owner Served in the Army during Vietnam
David Vieira (R-Falmouth)	Worked in the Barnstable County Sheriff's office, for FEMA and the Department of Homeland Security Replaces Democrat Matthew Patrick
Daniel Winslow (R-Norfolk)	Attorney and presiding justice Served as Governor Romney's general counsel from 2002 to 2005
Don Wong (R-Saugus)	Third generation owner of the Kowloon Restaurant on Rte 1 in Saugus Replaces Democrat incumbent Mark Falzone

Democrats

Mark James Cusack (D-Braintree).	Worked as assistant to the Braintree Mayor Replaces Rep. Joseph Driscoll
Michael Finn (D-West Springfield)	Court officer for the Hampden Count Probate Court Replaces Rep. James Welch, now serving in the state Senate
Denise Garlick (D-Needham)	Registered nurse and former President of the Massachusetts Nurses Association Replaces Rep. Lida Harkins
Carlos Tony Henriquez (D-Dorchester)	Son of Sandra Henriquez (a current Obama Administration official)
Russell Holmes (D-Boston)	Mechanical Engineering. Replaces retiring Rep. Willie Mae Allen
John Mahoney (D-Worcester)	A business professional Replaces Rep. Bob Spellane
Paul Mark (D-Hancock)	An attorney for Verizon Succeeds Rep. Denis Guyer
Christopher Markey (D-Dartmouth)	Related to the former Mayor of New Bedford Replaces Rep. John Quinn
Rhonda Nyman (D-Hanover)	Fills the seat of her husband, Rep. Robert Nyman, who passed in a drowning accident in June 2010
Jerald Parisella (D-Beverly)	He is a Major in the Army Reserves. Replace the retiring Rep. Mary Grant (who was a voice for the nursing profession for years in the House)
Paul Schmid (D-Westport)	A former Marine Corps sergeant and Harvard University graduate
Chris Walsh (D-Framingham)	The only architect serving in the Legislature. Replaces Democrat Rep. Pam Richardson
Denise Andrews (D-Orange)	Chief Operating Officer and Consultant Replaces sheriff-elect Rep. Christopher Donelan
Paul Brodeur (D-Melrose)	Attorney who after serving as assistant district attorney joined the Executive Office of Elder Affairs as legal counsel
Gailanne Cariddi (D-North Adams)	Managers a small family owned company Replaces Democrat Rep. Daniel Bosley
Tackey Chan (D-Quincy)	Many years experience on Beacon Hill as state Senator Morrissey's legal counsel and legislative director before joining AG Coakley's office
Nick Collins (D-South Boston)	Became seriously interested in politics during the 2008 presidential campaign
Edward Coppinger (D-West Roxbury)	Residential Mortgage Loan Officer and community activist

Congress on Nursing Practice and Economics: A Staff Nurse's Perspective

by Gayle Peterson RN-BC

Gayle Peterson

I had no idea what to expect when I headed to Washington, D.C. last September as a newly elected member of the ANA Congress on Nursing Practice and Economics (CNPE). As a three term Massachusetts delegate to ANA's House of Delegates (HOD), I was familiar with the work sent to the Congress, but I had no idea about the inner workings of the group. Since the Congress is accountable to the ANA's Board of Directors and reports to the HOD, I looked forward to bringing a staff nurse's perspective to these various issues.

The CNPE is "an organized, deliberative body which brings together the diverse experiences and perspectives of the ANA members. The Congress focuses on establishing nursing's approach to emerging trends within the socioeconomic, political and practice spheres of the health care industry by identifying issues and recommending policy alternatives to the Board of Directors." Most of the 60 Congress seats are elected by the 660 member HOD. After the election, many delegates told me they voted for me *because* I am a staff nurse.

Most members of the Congress are nurse administrators, nurse educators, or nurse scientists and representative of several national and international nursing specialty groups including the Oncology Nursing Society, Emergency Nurses Association, Association of Peri-operative Registered Nurses, and the National Association of Orthopoedic Nurses.

First we reviewed the revised (2010) *Nursing Code of Ethics, Nursing Social Policy Statement and Nursing: Scope and Standards of Practice.* Prior to the meeting we identified which workgroup we wanted to participate in. Each group was led by two or three ANA legislative aides. The four groups were:

- Education/Position Statement Review—includes basic and advanced nursing education, professional development, interdisciplinary education and ongoing review of ANA's Position Statement
- Health Policy—includes health care reform, insurance reform, Medicare and Medicaid
- Practice / Regulation Policy—includes nursing practice, clinical issues, quality, state licensure, accreditation, certification and advanced practice
- Workforce—includes nursing shortage, nurse staffing and work environment.

I chose the Workforce group where we started by reviewing ANA's Strategic Plan and Mission Statement: "…nurses advancing our profession to improve healthcare for all." The core values include respect, unity, diversity, integrity and excellence. Our strategic imperative is advocacy for the workplace including the promotion of health information technology that captures the work of nurses.

Our group reviewed ten position statements related to pain, adult immunizations and HIV infections in teenagers. The group split to work on position statements according to interest and expertise. I chose use of placebos for pain management in patients with cancer because I am certified in pain management nursing and work as an oncology staff nurse. We created evaluative criteria to guide reviews of positions statements which were shared with the entire CPNE. We reviewed, reaffirmed, or retired statements based on group consensus using the following evaluative criteria:

1) Date of Position Statement—is it five years old?
2) References—dates of publication, validity of source and level of evidence
3) Relevance to nursing, ANA's strategic plan, health care, and society
4) Current experts within the nursing specialty
5) Accuracy

We recommended action items with rationale for our recommendation for each statement. After careful evaluation, we deferred to the Oncology Nursing Society position statement on placebos in cancer patients, recognizing them as the experts.

Our first assignment complete, we look forward to a new one in January. I will keep you updated on Congress activities. Visit MARN's Health Care Policy website at info@marnonline.org to see the work that we are doing on a state level. I urge you all (especially staff nurses) to join your professional organization. We need your voice because these issues affect nurses at the bedside.

Gayle Peterson is a staff nurse on an inpatient oncology unit at Massachusetts General Hospital in Boston. She is a member of MARN's Health Policy, and an ANA Policy Institute Fellow Committee.

Walking with My Head Up

Barbara A. Blakeney MS, RN

I was walking along with my head down, deep in thought, so I completely missed it. What I didn't miss with my eyes focused on the ground was the walker and the lower legs of an elderly woman, ankles swollen and sore looking, shoes run down. Thinking she might need help, I looked up to see a care-worn face framed by white hair. She was smiling and looking at something that I had just walked past. I was struck by the look of peace and happiness reflected in her face. Sensing my glance, she looked at me, smiled and said, "Isn't it beautiful?" and returned her gaze to a place just behind me. Of course I looked. There all by itself, framed by the light of a late autumn afternoon sun, was the most beautiful little sugar maple in all its splendid fall colors. I've never thought of red as a delicate color but there it was. With the sun shining just right, it was stunning in the majesty of its last burst of activity before its winter hibernation and I had walked past without seeing it. Perhaps it was the way the sun was shining on it, but that little tree was absolutely beautiful. We stood together for a few minutes, neither of us saying anything, just drinking it all in. On impulse I walked over and snapped off a few leaves and gave them to her. Her face lit up as she said "I was hoping to get some of those leaves!" She took great delight in having them and I was glad I had thought to get them for her. The sun had shifted and the spell was broken so we said goodbye and each went our separate ways.

Several times since then I have recalled that afternoon. I've reflected on how frequently I walk through the moment focused on something else and I wonder how often I've missed special moments such as the sugar maple and the old woman. I wonder about all of life's little gifts that I've been offered and have never seen because I was busy being in some other moment. Have I lost the art of simply experiencing the moment? What have I missed as a result? How often have I missed a subtle sign from a patient, colleague, friend or loved one? What's been lost in their lives and in my own as a result? How much richer would their lives and mine be if I had truly been there?

As I write this, it's a few days before Christmas. Tomorrow I'm going to decorate a gingerbread house with a 6 year old. I plan to be in every moment it takes to get it done and I just know it will be spectacular! As for the rest of the year, I'm going to try to remember to walk with my head up more often so that I can live in the moment.

Building a Gingerbread House with 6 year old cousin Jessica

ANA Appoints Board Liaison to MARN

Myra F. Cacace, GNP-BC

Jen Davis

A new American Nurses Association (ANA) initiative to increase communication and cohesiveness within the organization gives MARN the opportunity to welcome Jennifer (Jen) Davis, BSN, RN as our official liaison to the ANA Board of Directors! I met Jen at the 2010 ANA House of Delegates (HOD) when she was elected to the new Recent Nursing Graduate Board position and found her to be a remarkable young woman.

Jennifer Davis is a 2008 graduate from the University of Akron, College of Nursing. During her time as an undergraduate student Jennifer was heavily involved in the Student Nurses Associations at the local, state and national levels and finished off her academic career as President of the National Student Nurses Association. She spent her senior year traveling around the United States visiting with nursing leaders to discuss issues important to today's nursing student. Just prior to graduation Jennifer was also elected Chair of the International Council of Nurses, Student Network, and traveled to Japan and South Africa to represent nursing students on a global level.

In 2010 the ANA held its first ever election for a position on their Board of Directors reserved for a recent graduate. Jen won in a three-way race and now is the voice of the next generation of nurses at the national level. She is currently a Trustee on the Board of ANA's Political Action Committee, Secretary for the Greater Cleveland Nurses Association and is the Legislative Liaison for two state legislators on behalf of the Ohio Nurses Association. Jennifer is pursuing an MSN in Management from Kent State with an emphasis in Health Policy.

Jennifer is a staff nurse at the Cleveland Clinic with experience in both the ICU and Outpatient settings. She resides in Medina, OH, with her husband of 15 years and her 12 year old son and 9 year old triplets.

Jen says, "I was very excited to join ANA! The 2008 ANA HOD took place before I sat for my licensure exam so I couldn't attend as a member, but I was there representing student nurses when the motion to create my seat on the Board passed! I knew then that I would run for the position. It was a long two years of waiting for the opportunity, but worth every second."

"So far being on the Board has been remarkable. I am so fortunate to be in the presence of nursing greatness. My experiences in the NSNA prepared me to better understand the complex issues facing the ANA and the nursing profession. When I do feel a bit in the dark I know I have the support of the members of the Board, who take the time to explain the nuances of a topic prior to any formal decision. I remember the enthusiasm of the Massachusetts delegation at the 2010 HOD during the election of now ANA President Karen Daley. I am very excited to work with nurses in President Daley's home state."

Bulletin Board

Save the date!

April 29-30, 2011

Annual Living Legends in Nursing &
Annual Awards Banquet &
10th Annual Spring Convention

MaSNA Career Forum
Thursday, March 24, 2011
from 4-7pm
Massachusetts College of Pharmacy and Health Sciences, Boston, Griffin 6th Floor
For more information go to MARN website:
www.marnonline.org

The following continuing nursing education activities were approved by the Massachusetts Association of Registered Nurses, Inc., an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Bullying

Description: Bullying is both a national and international issue. Discussion will include an overview of bullying, the characteristics of the bully and their motivation to bully others. Interventions will be presented and their effectiveness.

Location: Regis College, Alumnae Hall, Upper Student Union Lounge

April 27, 2011

Contact Hours: 2

Fee: None

For more information, contact
Amy Anderson EdD RN, R

Regis College, 235 Wellesley St.
Weston, MA 02493

The Massachusetts Health Council presents

The 3rd Biennial Women's Health Conference:
Getting Healthy, Staying Healthy
Knowledge is Everything!

Westin Waltham Hotel ♦ Waltham, MA
Thursday, March 24, 2011

Designed to improve women's health and promote happier, more productive lives. Find balance between care giving and personal health.

- Latest information on stress reduction and disease prevention
- Learn to teach women to improve their health

For program information and registration materials, go to
www.mahealthcouncil.org
or call the MHC office at 617-965-3711

Application pending for 5 contact hours

The MARN Approver Unit
The only Professional Nursing Organization
ANCC Approver Unit
in the Commonwealth

Fully Accredited Through 2015!

Program reviewers: available to review your nursing education programs any time.

For up to date information about how to become an approved provider
(for a single activity or as an organization)
please visit the MARN Website
www.marnonline.org

Announcements


2010 Fall Clinical Conference:
Health Care Reform is Now:
Implications for Professional Practice

Thank you to our Conference Sponsors
ARTHUR L. DAVIS
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LAERDAL MEDICAL CORPORATION
UNIVERSITY OF MASSACHUSETTS AMHERST – SCHOOL OF NURSING
U.S. ARMY HEALTH CARE TEAM

Thank you to our Student Sponsors for MARN's Fall 2010 Conference:

Helen Taylor
Anne Manton
Theresa Spinelli
Kathleen Taylor
Margie Sipe
Mary Alexander
Margaret Blum
Judy Sweeney


Thank you to our Conference Planning Committee

Online Breast Health Course offered by the
MAURER FOUNDATION's
Institute of Breast Health Education
This course is designed to educate the learner about breast health and disease. Topics include: Breast Anatomy, Development, Pathology, Risk Reduction, Methods of Early Detection, Cultural Competency and Presenting a Breast Health Program.

Registration is ongoing

Contact hours: 5

Fee: $100
For more information, contact
www.maurerinstitute.com

Pink Diamond DINNER

MARN Mission Statement

Massachusetts Association of Registered Nurses (MARN) is committed to the advancement of the profession of nursing and of quality patient care across the Commonwealth.

ATTENTION POTENTIAL PROGRAM ADVERTISERS

Please be sure to clearly state if your educational program is approved by the MARN Approver Unit in all program submissions!

Policy for Accepting Announcements for the Newsletter:

MARN encourages organizations of higher education to submit announcements about continuing education opportunities and upcoming events that are of interest to nurses. Fees must be included with submissions.

The Fee Schedule is as follows:
Non-MARN Approved Providers/ Sponsors—$50
MARN Approved Providers/Sponsors—$25

Payment can be mailed to MARN, PO Box 285, Milton, MA 02186. Please include a copy of the announcement and contact information (name, address, telephone, Email) with the check. Please email copy to www.MARNonline.org.

Announcements are limited to 75 words.

Members Only

The **M**ARN **A**ction **T**eam—
MAT cordially invites you to join this new and exciting team, when you join you will be lending your voice to those matters affecting all nurses in Massachusetts.

Contact www.MARNonline.org
for more information

Bulletin Board

MARN Vision Statement

As a constituent member of the American Nurses Association, MARN is recognized as the voice of registered nursing in Massachusetts through advocacy, education, leadership and practice.

MOSBY'S NURSINGCONSULT ANA EDITION

Free access to the American Nurses Association Edition of Mosby Nursing Consult… just another example of the tools available to you as a member that help you become more successful in your career!

Now you can access a comprehensive integrated, user-friendly online application that opens the door to a compendium of monographs, practice guidelines, and peer-reviewed clinical updates representing the best, most current work of nursing experts and thought leaders throughout the profession. The compilation includes *evidence-based nursing monographs* (including current practice and synopses of current literature and specific recommendations for nursing care), *Practice guidelines* for more than 400 common health care diagnoses, conditions, and procedures, and *clinical updates*.

To access the ANA Edition of Mosby Nursing Consult, visit the members-only section of NursingWorld.org at www.nursingworld.org/Members/JustForMembers/MNC-ANA-Edition.aspx.

MEMBER BENEFITS

Your guide to the benefits of ANA/MARN membership...
It pays for itself

- Dell Computers—**MARN and ANA ANA are pleased to announce a new member benefit. MARN and ANA members can now receive 5%-10% off purchases of Dell Computers. To take advantage of this valuable offer, or for more details, call 1-800-695-8133 or Visit Dell's Web site at www.Del.com.**
- Walt Disney World Swan and Dolphin Hotel
- GlobalFit Fitness Centers—Save up to 60% savings on regular monthly dues at GlobalFit Fitness Centers.
- Professional Liability Insurance—a must have for every nurse, offered at a special member price.
- Nurses Banking Center—free checking, online bill paying and high yield savings all available to you 24/7 to fit any shift or schedule. at an affordable price—Liability/ Malpractice, Health Insurance, Dental and Vision.
- CBCA Life and Health Insurance Plans—Disability Income, Long Term Care, Medical Catastrophe, Medicare Supplement, Cancer Insurance and Life Insurance Plans provided by CBCA Insurance Services.
- Discounts on auto rental through Avis and Budget:
  Call Avis 1-800-331-2212 and give ID# B865000
  Call Budget 1-800-527-0700 and give ID# X359100
- Save on your hotel stays at Days Inn, Ramada Inn, Howard Johnson and more.
- Online discounts on all your floral needs through KaBloom.

Promote yourself: professional development tools and opportunities

- Members save up to $140 on certification through ANCC.
- Online continuing education available at a discount or free to members.
- Conferences and educational events at the national and local level offered at a discount to members.
- Member discounts on nursesbooks.org—ANA's publications arm.
- Up to 60% savings on regular monthly dues with GlobalFit Fitness program.
- Find a new job on Nurse's Career Center—developed in cooperation with Monster.com.

Stay informed: publications that keep you current

- Free subscription to The American Nurse—a $20 Value.
- Free online access to OJIN—the Online Journal of Issues in Nursing.
- Free subscription to the MAssachusetts Report on Nursing—a $20 value
- Free access to ANA's Informative listserves including—Capitol Update and Members Insider.
- Access to the new Members Only web site of NursingWorld.org.
- Free access to MARN's Member-Only Listserve

MARN News is an up to date information service about a variety of issues important to nurses in Massachusetts. You must be a MARN member to be included, so join today!

MARN member: Have you gotten your **MARN News** message? If not, then we don't have your correct email address. If you want to begin receiving this important information, just send an email to: info@MARNonline.org with "ADD" and your name on the subject line.

We also welcome any pictures that show MARN members in action…at work or at play. Interested persons, please contact Myra Cacace at myra@net1plus.com.

MARN is the Massachusetts affiliate of the American Nurses Association, the longest serving and largest nurses association in the country

Join us at www.MARNonline.org

Contact us at: 617-990-2856 or info@marnonline.org

Sponsor a Nursing Student or New Graduate Nurse for the 2011 MARN Spring Convention

Sponsor a nursing student or a new graduate to attend the 2011 MARN Spring Convention. Your sponsorship will provide the opportunity for novice future nurses to hear nurse experts; attend a special forum with MASNA students and network with nurses who share their passion for the profession.

See conference registration form on p. 2 for more details.

The names of all sponsors will be listed in the MARN Newsletter.

CALL FOR POSTERS
MARN 2011 Annual Convention

All convention participants are welcome to contribute posters that will be displayed near the exhibitors and available for all who attend to see.

For Poster Guidelines and Submission Form Go to www.MARNonline.org by ***April 4, 2011***

CE CORNER

Outcomes Evaluation

Sandra Reissour, BS, RN

Attendees at the MARN Provider Symposium on November 3, 2010 at Children's Hospital requested additional information about the topic of measuring and evaluating outcomes. Below is the information that they requested.

Introduction

Nurses are familiar with evaluation as part of the nursing process. Nurses involved in continuing education evaluate programs to identify success in teaching. Evaluation is not reserved for the end of an activity but can take place anywhere along the educational continuum. Evaluation is not only reserved for the learners. It is important to consider how faculty/content experts evaluate their activity as well as how nurse planners evaluate the activity and planning process.

Why evaluate?

Evaluation of continuing nursing education helps to determine if any learning has taken place and if the education makes a difference? This is particularly relevant for educational activities that are repeated to insure ongoing quality improvement. Evaluation is also required by accrediting bodies (i.e. American Nurses Credentialing Center (ANCC), the Massachusetts Association of Registered Nurses, Inc, (MARN) Accredited Approver Unit, the Joint Commission and others).

Evaluating Outcomes

Outcomes can be evaluated anywhere along the continuum of curriculum design. They are best measured in relation to program goal(s), learning objectives, knowledge enhancement, desired competence, attitude change, or skill attainment as specified in your activity documentation. Additionally, approved providers, should always evaluate the overall impact and measured outcomes of each program. Refer back your response to the section in the Provider application that requires *a description of an ongoing and systematic process to analyze the overall effectiveness of the provider unit in fulfilling its beliefs, goals, operations and in providing quality continuing nursing education which includes the who, what, when and how.* What did you want to evaluate? Who evaluates? How do you evaluate the item? When do you evaluate the item? The Comprehensive Overall Provider Unit Evaluation Plan addresses both administrative and operational procedures.

Some examples:

- If a goal of your Provider Unit was to increase attendance by a minimum of 20% over a 6-month period, compare the previous 6 month aggregate attendance with the current 6-month period.
- If your overall Provider Unit evaluation plan cited an area for improvement for the Provider Unit, such as the use of an audience response system (ARS) as a means of polling the learning needs of the target audience by determining their baseline knowledge, and subsequent knowledge level following the teaching, was the goal realized? Did this technology enhance the CNE?

The ultimate goal of CNE evaluation

- To augment the knowledge, skills and attitudes of nurses to enrich the nurse's contributions to quality health care and/or pursuit of professional career goals (ANCC, 2009, p71).

The breadth of evaluation and outcomes measures

- Not limited to planners of single continuing nursing education activities.
- MARN Approved Providers must submit an Annual Report to the ANCC which includes both quantitative and qualitative measures. A qualitative measure in the form of a question requesting an example of the positive difference CNE has made was instituted 3 years ago (See the References section below for details and web address).
- Accredited Approvers such as MARN, must also evaluate and measure outcomes and report to ANCC.
- The ANCC spent 2 years examining its processes and procedures and documenting them in accordance with International Standards for a Sustainable World (ISO), the largest standards-developing organization in the world. Certification from the ISO designates an organization as a provider of state-of-the-art products, services, processes, materials and systems. The voluntary 2-year self study earned ANCC a 3-year certification designating it as a world-class organization serving as the leader in the field of continuing nursing education. ANCC must submit an evaluation report annually to ISO. (Whitehead and Lacey-Haun, 2008).

Remember that submission of a Single Activity to MARN for contact hour eligibility is *voluntary.* The desire of individuals/institutions to become Approved Providers of CNE is *voluntary.* The desire by MARN to continue as an ANCC Accredited Approver was *voluntary.* The desire by ANCC for ISO Certification is *voluntary.* These goals/outcomes are measures of professionalism. Evaluation and outcomes measures are the hallmark of responsible professionals.

Summary

Evaluating and measuring outcomes of continuing education occurs at many levels and offers objective findings related to the value of CNE efforts toward improving healthcare, the health of the public and reaching professional nursing career goals.

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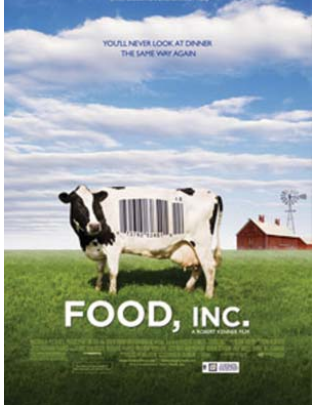
Looking at movies from…

Outside the Popcorn Box

Food, Inc. (2008)

by Sandra McBournie, RN, MEd.

Food , Inc. explores the root of the evil we call nourishment in this country. Everything to be believed about the quintessential American farmer, the effort of the Food and Drug Administration to protect us from harm, and eating chicken being better for you than eating beef will be challenged while watching Food, Inc. What can now be understood is that corn rules, food is poison, farmers are forced to be cruel to animals and the earth to survive, and the government agencies in place to protect you from harm are in cahoots with profit driven food corporations. The stories covered in this documentary may force viewers to become the most disillusioned genetically modified food eating consumers in history.



Take for instance the story about the chicken farmer Carole Morrison, who is expected to grow a chicken from egg to filet in six weeks. This requires an atmosphere for the chickens that, well, isn't very chicken like. No light, no room to move, and the inability to walk because they are so overgrown with steroids and an unnatural diet that their bodies are too heavy for their legs to carry them. When Carole who makes a measly $18,000/year raising and selling these chickens puts her foot down about this chicken abuse and fights the giant corporation that buys her chicken meat about not allowing light into her chicken house, they cancelled her contract.

Then there is the tragic story about an E.Coli breakout that caused the death of Barbara Kowalcyk's young son and her subsequent plight to put a stop to any such future tragedies. The story behind the story; well it turns out that the cows aren't supposed to eat corn, which allows unnatural bacteria to grow in their manure, which cows stand in up to their knee caps, unable to move, in an overcrowded corral. Nor is the rain water that runs through the feces filled cow farm supposed to be able to spill down into the spinach field next door. If you are wondering why we feed cows corn if it isn't part of their native diet, the answer is simple: cheap corn equals cheap feed, equals cheap meat, equals more meat sold, equals big profits for the meat company. Where is the Food and Drug Administration while all this filth is running through farms you ask? Not doing inspections apparently, for according to Food, Inc., they performed approximately 40,000 less inspections in 2006 than they did in 1972.

All these stories force the viewer to wonder about the American food consumer's lack of a relationship with their food; especially if that food once had eyes. Joel Salatin, a good old fashioned "natural" farmer in the film said "industrial food is not honest food" and he believes you can "meet the need without compromising integrity." In other words the consumer should demand that we let cows act like cows, and chickens act like chickens and let food corporations either cowboy up or squander. We should buy more locally grown, fresh, organic foods. Which begs another question the movie explores; "what if you can't afford it?" Everyone knows the cheaper the food is the worse it is for you (think *fast food*), and this film clearly points to big food business, with bigger profits, and gigantic heavy hands as the reason. Large food corporations rebuttal by saying they are doing us a huge favor with the level of efficiency they provide and that America would have a food shortage if it wasn't for their iron fisted national network. Food, Inc. sheds a beaming light on what now appears to be an obvious fact: efficiency equals bad food.

Is this corporation-farmer-consumer paradigm sounding familiar to caregivers reading this? Big business with big profits (pharmaceutical companies, insurance companies) forcing the middle man (nurse and other healthcare providers) to manipulate the product (caregiving) at risk to the consumer (patient). I highly recommend Food, Inc., if not for your own health and well-being, for the health and well-being of your patients.

Reviewer Rating: 4 out of 5 boxes of popcorn
Directed by: Robert Kenner
Available on DVD

Reviewer: Sandra McBournie, RN, MEd. is the Program Coordinator for the Center for Nursing Professional Development and Faculty member at NHTI, a member of the NHNA Commission on Continuing Education, and movie lover. Movies reviewed in this column are considered with enhancement of the nursing profession and practice, in mind and a little bit of thinking "outside the box." For more reviews by Sandra and to comment visit www.outsidethepopcornbox.blogspot.com

STATE NURSES ASSOCIATION MEMBERSHIP APPLICATION

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DATE _____

Last Name/First Name/Middle Initial

Credentials

Preferred Contact: Home _____ Work _____

Home Address

Home Address

City/State/Zip County

Employer Name

Employer Address

Employer City/State/Zip Code

Home Phone Number

Work Phone Number

Fax Number

Date of Birth

E-mail

_____ UAN member? _____ Not a Member of Collective Bargaining Unit

Member of Collective Bargaining Unit other than UAN? (Please specifiy)

Social Security Number

Basic School of Nursing

Graduation (Month/Year)

RN License Number/State

Membership Category (check one)

M Full Membership Dues

- ❍ Employed - Full Time
- ❍ Employed - Part Time

R Reduced Membership Dues

- ❍ Not Employed
- ❍ Full Time Student
- ❍ New graduate from basic nursing education program, within six months after graduation (first membership year only)
- ❍ 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues

- ❍ 62 years of age or over and not employed
- ❍ Totally Disabled

Please Note:

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the CMA is not deductible as a business expense. Please check with your CMA for the correct amount.

Choice of Payment (please check)

❍ **E-Pay (Monthly Electronic Payment)**

This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize my Constituent Member Association (CMA)/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.

❍ Checking: Please enclose a check for the first months payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.

❍ Credit Card: Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

Monthly Electronic Deduction Authorization Signature

❍ **Full Annual Payment**

Membership Investment _____
ANA-PAC (Optional – $20.04 suggested) _____
Total Dues and Contributions _____

Online: www.NursingWorld.org (Credit Card Only)

❍ Check (payable to ANA) ❍ VISA ❍ MasterCard

CREDIT CARD INFORMATION

Bank Card Number and Expiration Date

Authorization Signature

Printed Name

Amount: $ _____

❍ **Automated Annual Credit Card Payment**

This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize CMA/ANA to charge the credit card listed in the credit card information section for the annual dues on the 1st day of the month when the annual renewal is due.

Annual Credit Card Payment Authorization Signature

❍ **Payroll Deduction**

This payment plan is available only where there is an agreement between your employer and the association to make such deduction.

Signature for Payroll Deduction

Please mail your completed application with payment to

MARN c/o American Nurses Association
Customer and Member Billing
PO Box 504345
St. Louis, Missouri 63150-4345

* By signing the Monthly Electronic Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Abovesigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a $5 fee for any returned drafts or chargebacks.

Full Membership Dues: $249/year or E-Pay $20.75/month

Reduced Membership Dues: $124.50/year or E-Pay $10.38/month

Special Membership Dues: $62.25/year or E-Pay $5.19/month

Sponsor, if applicable _____

SNA membership #_____

MEMBERSHIP APPLICATION