The Elephant in the Room: Huge Rates of Nursing and Healthcare Worker Injury

Nearly all of us are aware of nurses with back pain—or we may suffer from it ourselves. What we may not realize is how enormous the problem is.

“My name is Elizabeth White. I am an RN who graduated in 1976 from the BYU College of Nursing. In December, 2003, I was working in the Surgical ICU at Arrowhead Regional Medical Center, the San Bernardino, California county hospital. My assignment that night was a 374 lb patient who was on a ventilator and also on spinal precautions. I was able to get help to turn and bathe him only once that shift. However, because he was on spinal precautions his mattress was flat, but had to be in reverse Trendelenberg because of the vent. He slid down to the foot of the bed, of course. Only one other staff member was available to help pull him away from the foot of the bed. By the end of the shift, I was in so much pain I could hardly walk. I ended up leaving clinical nursing; nearly six (6) years later I still have pain on a daily basis.”

Last year, over 71,000 nurses suffered a back injury—but these are only the injuries that can be directly traced to work. 48% of nurses complain of chronic back pain, but only 35% have reported a work related injury.1 Many of the injuries will simply be endured by nurses and healthcare givers, with no recourse to any compensation. The cumulative weight lifted by a health caregiver in one typical eight hour shift is 1.8 TONS.2 Back injuries are incremental and pain often presents in unrelated circumstances.

Cost of the problem
Nurses back injuries cost an estimated $16 billion annually in workers compensation benefits. Medical treatment, lost workdays, “light duty” and employee turnover cost the industry an additional $10 billion.2 Bureau of Labor Statistics show an inexcusable situation. Fig. 1 is a 2007 Bureau of Labor Statistics chart of the industries with the highest numbers of worker injuries.3 The top category: hospitals. In addition, the fourth and fifth categories are also of health care workers. In total, over 505,000 health care workers were injured. We know that a large percentage of these injuries are due to patient handling.

科学, 健康, and Courage: The Legacy of Florence Nightingale

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VISION STATEMENT

Our Vision

ASNA is the professional voice of all registered nurses in Alabama.

OUR VALUES

• Modeling professional nursing practices to other nurses
• Adhering to the Code of Ethics for Nurses
• Becoming more recognizably influential as an association
• Unifying nurses
• Advocating for nurses
• Promoting cultural diversity
• Promoting health parity
• Advancing professional competence
• Promoting the ethical care and the human dignity of every person
• Maintaining integrity in all nursing careers

OUR MISSION

ASNA is committed to promoting excellence in nursing.

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The President’s Message on Commitment

Debbie Faulk, PhD, RN
ASNA President

Most of you know that I am a nurse educator and that I love everything there is about teaching, well, almost everything. Those of you who are educators know that many times you learn more from your students than they learn from you. This is certainly the case with my students. I coordinate an RN to BSN program and the majority of my students bring a wealth of experiences to the classroom, which they readily share. I have to admit that I have kept clinically knowledgeable as a result. One such example of learning from a student came to mind as I began thinking about my message for this edition of the Alabama Nurse.

Many years ago a former student sent me a letter about two weeks after graduation to tell me how much she had learned about leadership, not so much from me or from the textbook, but from an actual experience. The student was involved with her classmates in developing an end-of-the-program project to show appreciation to the faculty. Although the project was her idea, she never thought that she would become the de facto leader. As I re-read the letter, I quickly realized that yes, she learned about leadership, and although she might not have realized at the time, applied what she had learned from the text and classroom discussions to the situation. Her comments related to having to “beg” her classmates to help her complete the project sparked my thoughts that she had probably also learned a great deal about commitment. She was committed to the outcome, while many of her classmates were not. She had made a pledge to herself and to the overall goal or mission of the project. Her classmates had not.

You might be asking about now, “what does this have to do with nursing or with ASNA”? I don’t think I need to belabor the point that nurses must be committed in order to fulfill obligations to society. ASNA has a volunteer board of directors and a small number of paid staff. In order to accomplish the mission of promoting excellence in nursing, there must be a strong, positive commitment to self and to a set of principles that serve as a foundational commitment to ASNA constituents, to the staff, the organization and all Alabama nurses. In the waning months of my role as President of ASNA, I must seize this opportunity to tell you that the board and the staff have a genuine commitment which has stood the test of time. I would be less than honest if I did not say that there has been wavering commitment at times, but as a whole, the staff and board are determined and persistent individuals. They understand that commitment is often difficult, especially during tough times and that it requires hard work. Someone once said that commitment is a two-way street, if you are willing to give it, you get it in return. I believe that the ASNA board has a reputation of integrity and commitment and that in return our constituents are committed to helping us be successful.

I believe this statement from Thomas J. Watson, Jr. a great business leader, sums up my message, “...the basic philosophy, spirit, and drive of an organization have far more to do with its relative achievements than do technological or economic resources, organizational structure, innovation, and timing. All these things weigh heavily in success. But they are, I think, transcended by how strongly the people in the organization believe in its basic precepts and how faithfully they carry them out.” (from A Business and its Beliefs-The ideas that helped build IBM, para 1).

And as always, in order to make a difference in health care, nurses must be united and COMMITTED. While we have many voices and diverse values, we can dialogue, agree to disagree, and yet show others that we speak with one strong CIVIL voice when it comes to providing quality access to care for Alabama citizens and to promoting excellence in nursing. We at ASNA strongly believe that this advocacy can be best accomplished through membership in ASNA. Thank you for your time and attention. I want ALL nurses in Alabama to know that ASNA is working with you, for you! If you are a member of ASNA, thank you! If you are not, JOIN us in promoting excellence in nursing.
The Year in Review

by Joseph F. Decker, II  Executive Director

Our annual legislative effort in 2010 met with some success and several disappointments. On the plus side, we were able to retain a total of $237,000 (same amount as in 2008, due to second consecutive year of proration) for nursing scholarships in the Education Trust Fund Budget despite a very tough financial environment in the legislature. This is significantly less than the $557,000 we garnered in 2007, but still well above the poorly funded $57,000 (or even zero in some instances) of previous years. These scholarships are primarily intended for RNs seeking graduate degrees–both Masters and Doctorate level–who intend to become instructors in our schools of nursing. These scholarships will allow us to continue our efforts towards working the issue of faculty shortages in our nursing schools, and by extension, help attack the overarching problem of the nursing shortage. We owe a great deal of thanks to Rep. Betty Carol Graham, Education Finance and Appropriations Chair Rep. Richard Lindsey, and Sen. Hank Sanders, Finance and Taxation–Education Chair for their support and efforts to get this done. In an unhappy surprise carried over from last year, the Alabama Board of Nursing budget for 2010 to get this done. In an unhappy surprise carried over from Richard Lindsey, and Sen. Hank Sanders, Finance and Education Finance and Appropriations Chair Rep. Lori Lioce. MASA simply refused to negotiate, insisting that Class III–V was far as they were willing to go, and further insisting that the BME retain DEA certification authority in Alabama was an unacceptable. We strongly believe that overall access to quality care in Alabama, and current underutilization of NPs are the driving issues. This is a fight that will eventually be won, despite strong opposition by MASA and other. The good news is that the subject has again been publicly broached and is on the table. Finally, H1 432/Human Trafficking (Rep. J. Williams) did pass this year. This is a bill ASNA endorsed and supported pursuant to a previous Resolution from the ASNA House of Delegates last year. During the annual legislative session you can track issues via our Legislative Updates on our website (www.alabamanurses.org); we posted 8 updates this year at roughly two week intervals, plus discussion pieces on the national Healthcare Reform debates.

Our political plans for 2011 are already taking shape, with the Nursing Scholarship bill and the NPAA bill opening up NP practice restrictions on the first page. We will be working with the members of the Alabama Nurses Coalition and partnering with AARP for another push. We will also be releasing the positions on the public policy platform of Women Voters and the Medicaid Commission on that subject. As you are aware, 2010 is an election year in Alabama, and it promises to be very interesting. The face of the legislature will change significantly with a number of retirements announced (Sen. Denton, Bishop, Dixon, Mitchem, Benefield, Penn; Rep. Hammett, Grantland, McDaniel); two legislators (McClain, Schmitz) jailed for felony fraud/theft convictions, and three deaths (Pat Lindsey, Rep Becky and Fite). K.L. Brown won Rep. Fite's seat in a special election earlier this year. Sen. Erwin vacated his seat to run for Lt. Governor, but lost to current State Treasurer Kay Ivey in the primary. Rep. Hilliard vacated his House seat to run for US Congressman Artur Davis’ seat, but was defeated in the primary. In recent special election results, Paul Sandel won the race for Sen. Griffith's seat in Huntsville; Rep. Priscilla Dunn won the race for Sen. McClain's vacated seat; Rep. Marc Keahey won the vacancy created by the death of Sen. Lindsey; and Will Williams won the seat in the House vacated by Rep. Schmitz. Special elections to fill the seats of Rep. Dunn and Keahey in the House were won by Lawrence McAdory and Elaine Bche. In addition, Rep. Ward has announced his intent to vacate his seat and support his own discharge, and Sen. Allen will oppose Sen. Poole in Tuscaloosa, Reps. Beasley and L. Baker (and former Tuskegee mayor and former state representative Johnny Ford) ran for Sen. Penn's Senate seat, with Rep. Beasley winning in a runoff, and Rep. Iorns has announced for Sen. Denton's seat. Several current members of the legislature lost their primary battles; Sen. French, Rep. Gipson, Gordon, Salla and J. Thomas. Current Sen. Harri Anne Smith was disqualified by the state Republican party, but intends to run as an Independent in November. ASNA member April Weaver (R) from Alabaster successfully ran for Rep. Ward’s open seat in Alabaster. (By the way, ASNA officially endorsed and supported Ms. Weaver in her campaign). In summary, there are now nine open seats in the Senate and fifteen seats in the House; we expect a number of others to be hotly contested. In the 2010 Governor’s race, Republican Rep. Robert Bentley of Tuscaloosa and Sec. of Agriculture Ron Sparks on the Democrat side will meet in November. To remind, all the legislators and statewide officials must run for election/campaign in November 2010. Remember to vote yours counts!

Our Alabama Nurse Foundation awarded six scholarships and a total of $8,000 this year (2010). Funding efforts continued, and the ANF Board led by President John Beard, Ralph Chester and Juanzetta Flowers, plans for a better year going forward, especially if the economy improves as hoped. To be brutally frank, we just don't have the funding for ANF or the possibility of awarding any scholarships at all next year will be in serious jeopardy.

On the business front, I am pleased to report that you, our ASNA members, have once again contributed an annual financial compilation from Wolf & Taunton, PC demonstrates that very clearly; the full report is available to members in the ASNA office. For the eighth year in a row, we were able to report a 10.8% increase in the Strategic Reserve fund. Strategic Reserve fund declined by nearly 30% last year (due to second consecutive year of proration) and rebound in the last 12 months, posting a (net) 10.8% increase. As an aside, you may recall that ASNA received a no-notice, random audit by the IRS in August of 2009. The IRS informed us in November 2009 that all of our financial records and tax returns were in good order and correct as filed.

Our annual ASNA Legislative Day, named Nurses at the Capitol 2010 in Montgomery, held on 27 January was an outstanding event. Over 1,500 nurses/nursing students attended. We had a series of excellent speakers on the State House steps: Sen. Kim Benefield, Rep. Greg Wren; John Hankins ADPH Director of Nursing; Dr. Ruby Morrison, AL Nursing Coalition President; our own Ruth Harrell, Nursing Hall of Fame member; Heather Rankin, CRNA and President of the Alabama Association of Nurse Anesthetists; Lori Lioce, NPAA President; all eceded by our President Dr. Debbie Fauk. In addition, Richard Brown, ASNA/ NPAA member, nurse practitioner and also an attorney, brought us up to speed on the state of the law and recent and ongoing efforts to expand Medicare coverage for nurses' services.

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Magnet Status: A Shift in the Skill Mix in Hospitals

“Being Prepared is a Virtue”

by Gregory Howard, LPN

As institutions reach for the ‘Preverbal Brass Ring’ nurses must be aware of the changes in the profession that have an economic impact on our lives. The newest trend is ‘Magnet Status’ in Hospitals.

So what is Magnet Status? This a designation given to hospitals where nurses deliver excellent patient care with very good outcomes, where nurses have a high level of job satisfaction, and where there is low staff turnover rates and appropriate grievance resolution. Guess what, isn’t this what should be happening already?

The title magnet is awarded by the American Nurse Credentialing Center (ANCC), an affiliate of the American Nurses Association to those facilities meeting their criteria. It measures the strength and quality of their nursing staff. There are fourteen separate areas that are assessed: quality of the nursing leadership, perception of the value of nursing by other health professionals, compensation and fringe benefits for nurses, quality of care, dedication to quality improvement, level of education and teaching offered to incoming nurses or students and management style. These and other areas of evaluation are called “Forces of Magnetism.” Even though I stated earlier that this is a new concept, it has actually been around for 20 years.

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Some members for each chamber already essentially are elected, after winning their respective primaries and not facing general election challenges in the fall. Among those in that category is April Weaver, a registered nurse who is the Republican Party nominee for a House seat from parts of Shelby and Bibb counties and faces no Democratic opposition in the fall.

ASNA will be fortunate to have a registered nurse in the Legislature next term. Ms. Weaver will be able to provide a perspective that has been lacking in the past. She knows how hard registered nurses work and what a tremendous service they perform for the community.

During the legislative quadrennium that begins next year, ASNA will face particularly important issues. For one thing, the Association is pursuing legislation to empower advanced practice nurses with greater prescriptive authority. Certified Registered Nurse Practitioners in Alabama have been given just about the least amount of authority of those in any state in the nation.

ASNA believes that our CRNPs are as intelligent and skilled as those in Georgia or Mississippi or any other state. They can be given greater prescriptive authority only by an act of the Legislature so it is important who is elected and who sits on key legislative committees.

ASNA also is working to restructure the state nursing scholarship program. Legislation on the books limits appropriations to the program to $57,000 per year, although we have gotten around that stumbling block through a line item in the budget directly to the Board of Nursing for scholarships.

Efforts in recent years have keyed on advanced degrees for nurse educators, because our nursing shortage is a direct result of a shortage of qualified nursing instructors in the state’s colleges and universities. Funds are short in state government, so ASNA has to fight for a scholarship appropriation each year.

Those are just some of the type issues ASNA is dealing with at the Legislature. Naturally, legislators supportive of nursing are more likely to help the Association reach its goals.

During the next few months, ASNA members have the opportunity to elect legislators who will be friendly to our causes. Every ASNA member can help by getting involved in local legislative campaigns. Make a contribution, put up a yard sign, stuff some envelopes at campaign headquarters, take literature door-to-door.

A candidate who is blessed with nurse volunteers will remember who helped after he/she is elected.

Our hard work now could pay significant dividends during the next four years. So call a legislative candidate and sign up to help today.
Healthcare worker injuries were three times the number of any other industry. Also, the RATES of injury are six times the rates of construction workers and dock workers. Why are we not angry? Perhaps it is because we are used to it, and figure that it can’t be any other way. After all, patients must be cared for, right?

THE CAUSES OF NURSING BACK INJURY, or, YOU MUST NOT BE USING GOOD BODY MECHANICS

Hospitals and nursing homes are well aware of the risks of back injury resulting from patient care. Virtually all of us have had numerous “back injury prevention” classes over our work life. Why then, are the injuries so high? Is it because we just don’t listen? Or, is it because there is no safe way to manually lift and care for patients? Just look at the diagram below for a comparison between the NIOSH lifting standards and everyday patient care reality.

There are physiological reasons for this. William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University has made extensive studies on what happens to the human back under stress.5

Basic anatomy lesson: the intervertebral disc is fibrous, dense tissue with a resilient gel filled center. The outer fibrous ring is called the annulus fibrosis, and the center the nucleus pulposus. It has no blood supply, and no nerve endings. It receives its fluid and nutrients by osmosis from the adjacent vertebrae bone through the end plate, which also attaches the disc to the vertebrae.

Pathophysiology, or, We all have our limits

When lifting tolerances are exceeded, the end plate of the intervertebral disc is damaged with tiny tears called microfractures. No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein agglutinens and scar tissue which is thicker and less permeable than the normal tissue. Over time, with many microfractures occurring, most of the end plate of the vertebrae converts to scar tissue. The disc can no longer absorb fluid and nutrients. It becomes weakened, porous, soft and dry, which is the condition we know as degenerated disc. The softer tissue then bulges into the spinal column causing pain and muscle spasm, or the gel in the center of the disc can even herniate through the soft porous outer tissue, causing much greater pain. With severe degeneration, the disc can collapse, which narrows the space available for the nerve root. This narrowed space puts pressure on the nerves, causing pain and muscle spasm.

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Tasks which exceed safe spinal loading, requiring Safe Patient Handling Equipment:

- **Transfers:** bed to bed, or gurney to bed
- **Transfers:** bed to chair, chair to shower
- **Bed repositioning:** Side to side turn, and pull away from the side rail
- **Bed repositioning:** Boosting to the head of the bed
- **Bed repositioning:** Linen changes and bathing
- **Sling placement:** Bending and lifting to roll a patient on to a sling
- **Assisting patient to stand**
- **Assisting a patient up from the floor**

**Bed to bed transfer**

This is a mattress that uses a blower to inflate a mattress, which then slides on a cushion of air. The brand name is Hover Matt. It removes most of the friction so the force needed for transfer is minimal.

**Bed to wheelchair transfer**

A ceiling lift can facilitate transfers, after placing the patient on a sling. This is an Arjo lift.

**Bed repositioning: Side to side turn**

Advanced hospital beds have skin saving programs, and some abilities to reposition patients. This is the Hill-Rom Versa-Care bed. Some mattress overlays available will turn the patient by inflating the mattress on one side, then another.

**Linen changes and bathing of bedridden patients**

Ceiling lifts can use repositioning slings to move the patient around for linen changes and bathing. Placing the patient on a sling:

The Liko ceiling lift repositions a patient using a loop sling. It will also lift for side to side turns, linen changes and bathing.

The Arjo 4-point spreader bar puts the patient in a comfortable semi-reclined position. There are also vehicle transfer solutions, Liko has a video on its web site.

The HoverJack, from HoverTech, inflates to lift a patient from the floor.

**Bed Repositioning: Boosting patients up in bed**

The ErgoNurse, designed for bed repositioning, boosts a patient using the sheets. It will also lift for side to side turns, linen changes and bathing.

**Companies offering Safe Patient Handling equipment:**

- ArjoHuntleigh/Diligent Services
- xXtraHand, LLC
- Barton Medical Corporation
- Dane Technologies, Inc.
- Ergolet
- ErgoNurse
- ERGOng, Division of NuStar, Inc.
- EZ Way
- Goldmann Inc.
- Hill-Rom, Inc.
- HoverLifting Systems, Inc.
- HoverTech International
- Jamar Health Products, Inc.
- Joerns Healthcare, Inc.
- LiftSeat
- Medicare Products
- Molift, Inc.
- Optima Products, Inc.
- Prism Medical
- RecoverCare
- Rehab Seating Systems
- Rifton Equipment
- Sizewise
- Stryker
- SureHands Lift & Care Systems
- Techmition Medical, a Division of Ergo-Asyst Technology
- Vancare, Inc.

**COST EFFECTIVE**

Safe Patient Handling equipment is very cost effective. When associated factors such as lost work days, modified duty, worker retraining, employee turnover, and even bedsores are factored in, the hospital recoups its investment in less than two years. Those who have instituted Safe Patient Handling programs have learned that not only is equipment needed, but training, education and surprisingly, enforcement. Though it may seem a paradox, many times caregivers resist change. They’ve been doing it one way for their entire working careers as caregivers, and feel that it takes too much time, or is inconvenient. Yet, they continue to incur injuries at high rates. However, when a no-lift policy is implemented (and if necessary, enforced), the staff will adopt the safe patient handling equipment especially as they realize their back pain and injuries diminish. Oregon SAIF, the State Worker Comp Company, instituted pilot Safe Patient Handling programs, and has seen injury rates and costs plummet. Harris Methodist Ft. Worth, in Ft. Worth Texas, also instituted a pilot program, and went to zero injuries. Their pilot unit has had no injuries in 2 ½ years. We know that these injuries are entirely preventable.

- “Tuisy-Main, Kate, “Why manual handling should be eliminated for resident and carer safety,” Geriactica, 1997, 15(10)
- “Marras, W, A Comprehensive Analysis of low-back disorder risk and spinal loading in patient handling”, Ergonomics, 1999, 42(7) 904-906
- “Blowick, Donald, Professor of Ergonomics at the University of Utah, “Manual Material Handling”
- “Marras, 2009 op cit
- Dougherty, M, “Handle With Care,” Strategies for Nurse Managers, April 2008
ALABAMA BOARD OF NURSING

Continuing Education (CE) became a requirement for nursing license renewal in Alabama in the early 1990s when the Alabama Legislature amended the Nurse Practice Act to require CE. [Alabama Nurse Practice Act § 34-21-23 (f)]

The Alabama Board of Nursing’s Administrative Code expands on the statute by clearly stating that the registered nurse and the licensed practical nurse are individually accountable for continued competency to practice nursing including knowledge and compliance with applicable statutes and regulations [Administrative Code Rule 610-X-10-.02(1), 610-X-6-.04(2)(a)(i) and 610-X-6-.05(2)(a)(i)].

An example of the applicable regulations the nurse must know and demonstrate compliance with is the Continuing Education Chapter, Chapter 610-X-10, found in the ABN Administrative Code.

As such, registered nurses and licensed practical nurses are individually responsible and accountable to obtain and accurately report appropriate continuing education. Nurses are responsible to know if providers are approved or recognized by the Alabama Board of Nursing and if the content is directly applicable to nursing practice as defined in the following definition found in the ABN Administrative Code Rule 610-X-10-.01(a):

“The Board requires nurses to maintain an updated individual record of continuing education content and hours that is complete, accurate, and indicates compliance with the continuing education requirements of the ABN. The individual record must be available for review by the Board or its authorized representatives at any time.”

PROVIDERS OF Continuing Education

ABN Approved Providers of CE

Providers who are approved by the Alabama Board of Nursing have an assigned ABNP number and have completed an application process designed to ensure that they meet the standards of the Continuing Education Chapter. Approved providers that meet Board criteria for approval may be:

• Individual;
• Partnership;
• Association;
• Organization;
• Educational institution;
• Governmental agency;
• Licensed health care facility, including hospitals, nursing homes, clinics, home health agencies, and other organized health care facilities.

Recognized Providers of CE

Additional providers may be recognized by the Board and may include a national or regional agency, journal, Alabama regulatory agency or board, or another Board of Nursing recognized by the Alabama Board of Nursing as providing or approving continuing education in accordance with criteria that are substantially the same as those required of Alabama Board of Nursing approved providers of continuing education and which have been approved by the American Nurses Credentialing Center (ANCC) or the International Association of Continuing Education and Training (IACET) or are recognized by the Board if the content requirements found in the rules are met.

CONTENT

Acceptable Content

Content must be directly applicable to nursing practice to be acceptable for CE and include:

• Clinical technology, procedures, and nursing implications.
• Specialty areas of nursing practice.
• Nursing practices related to care of the patient, including but not limited to counseling, patient teaching, infection control, and safety factors.
• Administration, management, and supervision in health care delivery.
• Social, legal, and ethical aspects of nursing.
• Nursing education.
• Professional theory, and practice issues.
• Quality improvement and management, accrediting standards, and processes.
• Academic credit earned from liberal arts, sciences, business, and general education courses obtained after initial licensure from an institution accredited by an educational accrediting body.
• Professional conduct.

Unacceptable Content

Courses that are not directly applicable to nursing practice are NOT acceptable for CE.

Provide the following:

• Courses taken for self-improvement such as weight loss, self-awareness, self-therapy, changes in attitude, and yoga.
• American Heart Association and American Red Cross classes designated for Lay People.
• Courses taken for personal economic gain e.g., business, etc.
• Orientation programs—specific activities designed to familiarize employees with the policies and procedures of an institution or specific job duties, or general orientation in-service.

ACCEPTABLE LOCATIONS OR SITES

As of March 30, 2009, the Board eliminated the distinction between attended and independent study CE. All CE hours are now equal. The nurse must complete 24 contact hours of continuing education through the following venues, remembering that the provider must be approved or recognized and the content must be directly applicable to nursing practice:

• Workshop.
• Seminar.
• Classroom.
• Web cast.
• Internet (online) courses.
• Intranet courses.
• Home study courses.

The contact hour does not include non-learning activities such as lunch or breaks.

The unit of measurement for approved providers of Continuing Education is 1 contact hour equals 50 minutes. The contact hour does not include non-learning activities such as lunch or breaks.

Nurses should not enter classes by Board-Approved Providers of CE on their Individual CE Record. Approved Providers of Continuing Education agree to electronically transmit contact hours earned by the nurse directly to the Alabama Board of Nursing. Many Approved Providers will allow the nurse to swipe their license card and others may choose to manually enter the course after the nurse has manually recorded their license number. Courses and associated contact hours provided by an approved provider must be manually entered as CE into the nurse’s CE record.

For a list of approved CE providers visit www.abn.alabama.gov.

To enter these hours, the nurse should:

• Access the ABN website (www.abn.alabama.gov).
• Click on “Continuing Education” in the gray boxes on the left.
• Click on “Access Individual CE Record” (under General CE Information for Licensed Alabama Nurses).
• Enter the license number and last four digits of the social security number.
• Verify or correct demographic information.
• Click on “Individual CE Record”.
• Click “Add Course”.
• Leave the Alabama Provider Number blank.

Since Alabama nurses should not enter courses by Approved Providers, there should not be an ABNP provider number on the certificate.

To enter the content hours, the nurse should:

• Enter the name of the provider.
• Enter the city and state where you took the course.
• Enter the complete title of the course.
• Enter the date of the course using the format “mm/dd/yyyy.” If the course lasted more than one day, enter the final date of the course.
• Enter the total contact hours obtained.

• The Board may accept contact hours(s) earned from a continuing education provider that uses different units of measurement. For example, if the Alabama Board of Social Work Examiners awards 4 CEUs for a course, the nurse must receive the actual number of contact hours obtained as 4.

• Contact the Board for clarification for any CEUs that are not accepted.

• Note that continuing education classes and activities may NOT be repeated within the earning period for credit. A class may be audited (no credit awarded) if allowed by the continuing education provider.

• For CEUs completed after the conversion period, the Alabama Board of Social Work Examiners allows up to 6 CEUs to be earned for each contact hour earned during the conversion period.

• The Board allows the nurse to add CEUs to their Individual CE Record, if they are approved, up to the maximum hours allowed for renewal.

• Be sure to click on “Save This.”

• It may take 24-48 hours for the course to show up on the Individual CE Record.

Continuing Education is a requirement for license renewal. Each nurse has the individual responsibility and accountability for assuring the required number of hours is earned in order to renew the nursing license. For additional information, go to www.abn.alabama.gov and click on “Continuing Education.”
ANA Convention/House of Delegates 2010

The 2010 ANA national Convention and House of Delegates was held June 16-19 in Washington, DC at the Washington Hilton Hotel). ASNA was ably represented at Convention by our President, Dr. Debbie Faulk and delegates Vanessa Barlow, Paula Gasser, Dr. Jean Ivey, Dr. Arlene Morris, Dr. Ruby Morrison and Helen Wilson. ASNA President-elect Dr. Joyce Varner and Executive Director Joe Decker also attended. In addition to the business of the House of Delegates, President Barrack Obama addressed the crowd.

I Stand for Nursing

Voncile Stallworth, LT. COL. USAR-Ret, MSN-DCF, BSN

The seed was planted early in my Nursing Career. Fortunately, I had the opportunity to attend a Nursing School–Tuskegee Institute in Tuskegee, Alabama that required the Nursing Students to be members of American Nurses Association (ANA) and Alabama State Nurses Association(ASNA). We attended ASNA Conventions every year. I have been an active member since 1964 because I realized that physical involvement in ASNA activities is needed to maintain high standards for Nursing locally, statewide, nationally and globally. I am a retired nurse who is actively involved in ASNA activities including Conventions, Mobile County Nurses Society activities and Continuing Education because I enjoy being in the environment of dedicated, compassionate, and caring active and retired nurses in ASNA. I will always “Stand for Nursing.”
Science, Healing, and Courage: The Legacy of Florence Nightingale

by Kate Payne, JD, RN
Ethics Director, Saint Thomas Hospital

2010 is a special year for nurses as it marks the 100th anniversary of Florence Nightingale’s death (1820-1910). During National Nurses Week, May 6-12, many hospitals celebrated Nightingale’s work and life. Nightingale is generally recognized as the founder of modern nursing. I find myself asking what a woman who lived 100 years ago has to say to modern nurses today? Quite a lot, actually. Any study of Nightingale will reveal a woman and nurse to admire. She wasn’t a saint, but her values were reflected in her life and practice. Three tenets or principles stand out and tell us something of her ethics: the importance of science, the humanitarian work that is nursing, and the need for courage.

Nightingale heralded the transition of nursing from pre-scientific practice, based on female care giving, to the scientific profession it is today. The story most often told relates to her efforts in the Crimean War. In 1854 Sir Sydney Herbert, the Secretary of War for the British Army, asked Nightingale to join the war effort and organize a corps of nurses to care for soldiers. The army was faced with destruction, and loss of the war, mainly from malnutrition, exposure and disease. When Nightingale reached the front, it is reported there were 3,000-4,000 hospitalized soldiers in a facility meant for 1,700. With her were 38 nurses, some were sisters, others nurses from London hospitals. In six months they were able to decrease the mortality rate from 42.7% to 2.2%. Remarkable to note, nurses just responded. Like Nightingale, they looked at what needed to be done and did it. For Nightingale, nursing is part of the humanitarian response that sees the other as an extension of self. She was a nurse; she believed that nursing was about restoration and promotion of health of humanity. Celebrate nursing everyday, not just during National Nurses Week.

Nightingale observed the patients closely, documenting what worked, what didn’t. She would particularly observe the sickest patients at night, earning her the title of “Lady with the Lamp.” Nightingale was also a mathematician and turned her observations into statistics and diagrams. Such practice-based evidence helped push for reform in military and later civilian hospitals in construction, administration, and care. Due to her reputation, plans for the Johns Hopkins Hospital in Baltimore were taken to England for her review. She also influenced medical and nursing education in England and beyond.

For Nightingale, nursing was humanitarian work. She described it as a divine calling to serve others. Nightingale’s philosophy was about healing, not just caring for the sick, and this reflected a change in nursing practice which persists today. For her, nursing was holistic, bringing body, mind, and spirit together. Caring for the whole person required integration and collaboration with medicine, environment, family and society. Nightingale believed that nursing was about restoration and promotion of health and it didn’t end with the patient. Healing was multifactorial and depended on the active participation of the nurse with the patient. She insisted on the same notion of service of each nurse to the other. With the flooding in and around Nashville this spring many nurses responded to that broader call of service to others, literally diving in to save people, and later helping restore homes and lives. No one asked, nurses just responded. Like Nightingale, they looked at what needed to be done and did it. For Nightingale, nursing is part of the humanitarian response that sees the other as an extension of self. She was a problem solver, looking for solutions, grounded in human needs and the natural world. To help the soldiers she knew that bathing them, freeing them of dirty, gross caked uniforms, feeding them, nurturing them was the path towards healing. In her later years, nurturing took center stage, rather than direct care, due to illness contracted in the Crimea. Her letters to the nurses in training urged them to find strength from within, and to develop a deep human capacity to respond to need, to blend inner life and outer life. She challenged nurses to seek a deeper connection with self and God, seeing nursing as part of God’s caring for humanity; a manifest in compassion, love and empathy for others.

It takes a tremendous amount of courage to go against one’s family, society, and authority. Nightingale felt called to nursing at the age of 16. Discouraged by her family and her society, she answered that calling by educating herself, seeking out connections and experiences that would help her. She also influenced medical and nursing education in England and beyond.

To honor Nightingale’s legacy, a coalition of nursing, educational, and health care organizations around the world have launched a sustained public awareness initiative. The goal is to demonstrate the nursing community’s commitment to improving health care locally, nationally, and internationally through nursing practices that reflect Nightingale’s principles. The 2010 International Year of the Nurse (2010 IYNurse) is to both celebrate nursing and seek a global commitment from the world’s nurses—estimated at 15 million—to promote health in their own communities and beyond. The founding organizations include Sigma Theta Tau International (STTI) the Honor Society of Nursing; the Nightingale Initiative for Global Health (NIGH); and the Florence Nightingale Museum. The American Nurses Association (ANA) is also one of the sponsors as part of its commitment to advancing the nursing profession. For more information about how you can be involved visit: http://www.nursingworld.org/HomPage/Category/Announcements/TNC.aspx

We are the nurses that Nightingale envisioned. With 15 million worldwide, nurses can be a powerful force for the health of humanity. Celebrate nursing everyday, not just once a year. Stand with Nightingale for evidence-based practice (science), real human caring (humanitarian work), and make it a reality (courage).

If you want to learn more about Nightingale’s life, philosophy and work, the book “Florence Nightingale Today: Healing, Leadership, Global Action,” published by nurserebooks.org, is an excellent resource. 

*References available by contacting cglass@tmainlight.org

Reprinted with permission from The Tennessee Nurses Association.
Researchers examined data representing 71 million U.S. children from the National Health and Nutrition Examination Survey and found that black and Mexican American boys aged 12 to 19 are most likely to be severely obese. Poverty is also a risk factor. This may be explained in part because of the availability of cheap junk food and the dearth of affordable fresh produce in inner city areas, not the researchers.

More than a third of severely obese children face significant health risks and meet criteria of the adult metabolic syndrome: large waistlines, high triglyceride levels, high cholesterol, high blood pressure, and high blood sugar levels. Further, more than 400,000 adolescents may meet criteria to have bariatric surgery; that is, their BMIs classify them as morbidly obese.

Unfortunately, many severely obese children will carry their weight problems into adulthood, because clinical and behavioral programs to combat obesity may not be covered by insurance. What’s more, physicians who provide these services may not be reimbursed; thus, there is little incentive to provide them in combating the current obesity crisis in children. This study was funded in part by the Agency for Healthcare Research and Quality (T32HS00063).


KFM

Reprinted from March, 2010 Research Activities

Poverty, Race, and Gender are All Factors in the Epidemic of Severely Obese Children

Children whose body mass indexes (BMIs) are in the 99th percentile for their age and gender are considered severely obese, which can lead to chronic health conditions, including diabetes and cardiovascular disease. A new study finds that an estimated 2.7 million U.S. children are severely obese. This number jumped more than 300 percent since 1976 and 70 percent since 1994.

Unfortunately, many severely obese children will carry their weight problems into adulthood, because clinical and behavioral programs to combat obesity may not be covered by insurance. What’s more, physicians who provide these services may not be reimbursed; thus, there is little incentive to provide them in combating the current obesity crisis in children. This study was funded in part by the Agency for Healthcare Research and Quality (HS13901).


KFM

Reprinted from March, 2010 Research Activities

Neighborhood Surroundings May Affect Whether Children are Overweight

Children who live in low-income neighborhoods tend to live close to many fast food restaurants and are at higher risk for being overweight than children who live in affluent areas, a new study finds. Massachusetts researchers used geographic information systems to pinpoint locations of fast food restaurants, proximity to public transportation and schools, and availability of recreation areas. They then used height and weight data in medical records to determine the prevalence of overweight and obese children in Massachusetts neighborhoods.

The 3,334 children from high income areas (average household of $123,006) tended to live farther from fast food restaurants and have fewer burger joints to choose from than the 3,346 children from low-income areas (average household income of $35,800). The researchers estimate that a child in a low-income area could find fast food within 7 minutes of home, but a wealthier child faced a 21-minute hike to an unhealthy feast.

Children from wealthy neighborhoods tended to walk an average of 30 minutes to school and have access to open play areas, while children from low-income areas walked just 12 minutes to school and had fewer open areas to play in. Only 12 percent of the children from high-income towns were obese compared with 29 percent of the children from low-income towns. The authors suggest that children who live in affluent areas encounter more environmental features that promote energy expenditure and exercise, while less affluent children have limited opportunities for exercise and ample access to junk food. This study was funded in part by the Agency for Healthcare Research and Quality (T32HS00063).


KFM

Reprinted from April 2010 Research Activities

Signing of the Nurse Day Proclamation
# Call for Abstracts

## Elizabeth Morris Annual Clinical Sessions–FACES ’11

**Oral, and Poster Presentations**  
Tuesday, 26 April 2011  
Montgomery, Alabama

### Requested Topics

- Any clinical focused topic (priority)
- Innovations in Nursing Care
- Innovations in teaching
- Research

### Abstract Submission

- Length not to exceed one single-spaced, typed page on 8-½ x 11–inch paper with one-inch margins
- Include a theoretical overview/abstract and no more than 2-3 objectives (objectives may be on second page if needed)
- Include biographical information an Terms and Conditions for all authors.
- Indicate which authors will be present.

### Presentation Requirements

- Oral presentations are for one (1) hour
- Poster presentations are accepted for tabletop or easel only
- Abstracts that are e-mailed or faxed do not need to be mailed.
- Abstracts should have a face sheet indicating title, names and contact of all authors.
- The theoretical overview/abstract, title and objectives should be on a blind copy.
- Indicate presentation preference--oral (1 hour) or Poster

### Send Abstracts to:

Charlene M. Roberson, MEd, RN, BC  
Alabama State Nurses Association  
360 North Hull Street  
Montgomery, Alabama 36104-3658  
Telephone 334-262-8321 or 800-270-2762  
Fax 334-262-8578  
E-mail charlenerasna@alabamanurses.org

### Deadline for Submission:  
January 10, 2011

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### TERMS AND CONDITIONS FOR PRESENTERS

This document has been developed to better inform you of Alabama State Nurses Association's (ASNA) policy. Please review each item, check your response, sign the document and return to ASNA.

### Activity/Poster Title: ___________________________________________________

<table>
<thead>
<tr>
<th>TERMS &amp; CONDITIONS</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have disclosed to ASNA all potential bias with any commercial interest that exist or have existed within the last 12 months. I understand that these relationships will be shared with the learner by ASNA.</td>
<td></td>
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<tr>
<td>2. I will prepare fair &amp; balanced presentations that are objective &amp; scientifically rigorous. Content will be well-balanced, evidence based where possible &amp; unbiased.</td>
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<tr>
<td>3. If addressing unlabeled &amp;/or unapproved uses: I will clearly acknowledge the unlabeled identification of the investigational nature of drug products and/or devices to the learners.</td>
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<tr>
<td>4. I will use generic names to the extent possible when discussing specific health care products or service. If I need to use trade names, I will use the trade names from several companies when available, &amp; not just trade names from any single company.</td>
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<tr>
<td>5. Validation of content: I have reviewed the proposed content for this activity and find, to the best of my knowledge, the following:</td>
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<tr>
<td>A. This presentation is based on acceptable principles that are generally accepted as valid by the profession.</td>
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<tr>
<td>B. This content is based on conclusions or inferences about the evidence that are accepted in the general health care community as valid and sound.</td>
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<tr>
<td>C. Scientific research referred to in this presentation conforms to generally accepted standards of experimental design, data collection, &amp; analysis.</td>
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<tr>
<td>D. Content is accurate based on best information available at the time the presentation was developed.</td>
<td></td>
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</tr>
<tr>
<td>6. If I have been trained or utilized by a commercial entity or this agent as a speaker for any commercial interest, the promotional aspects of that presentation will not be included in any way with this activity.</td>
<td></td>
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</tr>
<tr>
<td>7. If I am presenting research funded by a commercial company, the information presented will be based on generally accepted scientific principles &amp; methods, &amp; will not promote the commercial interest of the funding company.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The handouts and slides will not include my company logo other than on the first slide. (The copyright symbol may be included on each of the slides).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I understand that ASNA may need to review my presentation &amp;/or content prior to the activity &amp; I will provide educational content and resources in advance as requested.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have carefully read and considered each item in this attestation form, and have completed it to the best of my ability.

Signature (may be electronic): ___________________________  
Date: ___________________________

### Return form to:

ASNA  
360 N. Hull St.  
Montgomery, AL 36104 OR  
charlenerasna@alabamanurses.org  
OR  
2010 Alabama State Nurses Association Annual Convention  
Fax 334-262-8578
Name, Degrees, Credentials: ________________________________

Address: ________________________________________________

City ___________________________ State __________________

Zip: ___________________________________________________

Day Telephone: _______________________ Email: __________________________

Present Position (Title) & Employer: ______________________________

Faculty/Content Expert Information: Describe your expertise in this topic: ___________

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Presenter Conflict of Interest Statement

If you are in a position to control the content of this educational activity, you must disclose whether or not you have a conflict of interest. Conflict of interest disclosure identifies the presence or absence of any potentially biasing relationship of a financial, professional or personal nature. A perceived conflict of interest would occur, for example, if you have or a member of your family has, within the past 12 months, received a salary, royalty, speaking honorarium, research appointment, board of directors remuneration, or consulting fee from an organization whose product or service is being discussed in the learning activity or if you or a family member own stock in such a company. Conflict of interest would also occur if you have any potential to benefit personally or professionally from the presentation (work for a proprietary company presenting the learning activity, have written a book about the topic, provide consulting services related to the topic, etc).

All information disclosed must be shared with the audience on the program handouts, advertising and/or audiovisual presentation.

Conflict of Interest:  
Is there a perceived financial, professional or personal conflict of interest (self or family)?
☐ Yes ☐ No

If yes, describe perceived conflict: ___________________________________________

Resolution of Conflict:
1. I have discussed this conflict of interest or potential bias if applicable for this activity: (Check all that apply)
2. I have signed a statement that says I will present information fairly & without bias.
3. In conjunction with 1 & 2, I understand that the nurse planner or designee will monitor session to ensure conflict does not arise.
4. Not applicable since not conflict of interest.
5. Other: Describe: _______________________________________________________

Off-label Use:
Presenter/Content Specialist discussion of off-labeled uses:
☐ Yes ☐ No

If yes, you must disclose this information during your presentation. How will you do this?
1. Verbal statement during the presentation
2. Information provided on handouts
3. Information provided in audiovisuals (slides, overhead, powerpoint, etc).
4. Other: Describe: _______________________________________________________

In regard to the above requirements, please check ONE of the following:
☐ My presentation(s) will not refer to products, drugs or devices of a commercial company with which I have a significant relationship. I have not accepted a fee from a commercial company for this presentation.

☐ I have a significant relationship with the following commercial company(s) whose products I will refer to in my presentation. I will disclose my relationship with the commercial company to the participants during the introduction of my session. I will refer to other products equally in my presentation. I have not accepted any fees from a commercial company for this presentation.

List Company(s): ____________________________________________________________

Signature: ___________________________ Date: ________________________________

Electronic Signature Acceptable

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Nonverbal Communication

Authors: Charlene M. Roberson, MEd, RN-BC, Director of Leadership Services, Alabama State Nurses Association, Behavioral Health Staff Nurse, Baptist Medical Center, author discloses no conflict of interest

Objectives: At the completion of this course the participant should be able to:
1. List at least four (4) clues that indicate readiness to learn new material.
2. Describe how handshakes reflect a personal profile.
3. Identify conversational clues, which help manage a conversation.
4. Compare various body positions in groups.
5. Deduce how nonverbal communication clues enhance patient education.

Directions: Read the monograph Nonverbal Communication: Complete the Post Test/Evaluation and return completed forms to ASNA (360 N. Hull Street, Montgomery, Alabama 36104 or (F) 334-262-8578). A Continuing Nursing Education certificate of completion will be sent to you upon successful completion of the post-test and evaluation sheet. You must score at least 80% on the post-test to pass. Should you score below 80%, you will be notified and offered the opportunity to retake the post-test for an additional cost of $5.00.

Board of Nursing Transcript: ASNA will enter the course on your Alabama Board of Nursing transcript (you will be unable to successfully enter the course on your transcript) within two weeks of successful completion of the activity.

Contact hours & Accreditation: This 2.0 contact hour course (60 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association. The Alabama State Nurses Association is an accredited provider of continuing nursing education by the American Nurses Credentialing Center Commission on Accreditation (ANCC).

This 2.4 contact hour course (50 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association, which is approved by the Alabama Board of Nursing, provider number ABNP002 (valid through 30 March 2013). The activity is valid until 15 August 2012.

Intended Audience: Nurses

Fees:
ASNA Member: $15 Non-member: $20
Shipping and Handling: $4.00 (if sent from ASNA)

A $30 fee will be assessed for all returned checks or dishonored check/payments.

Nonverbal Communication continued on page 14
Part I–Generalizations

Americans routinely use about 30 different gestures and not all of these have been studied in detail. The use of gestures occurs below the conscious level so individuals will not be aware of their own movements. An exception is trained actors who consciously learn and practice control of gestures. An example that we all can relate to is resorting to hand gestures when verbal communication becomes difficult.

Handshakes–Handshakes provide many clues about patients and their families. Wisely use this clue to your advantage. The expectation when you shake someone’s hand is for your hand to be grasped with equal firmness. If this does not occur you may feel diminished or let down. The origin of this practice dates back to medieval times when combatants sealed a truce by shaking hands or grasping each other’s weapon. The following are types of handshakes with an interpretation of possible personality traits.

1. Dead Pan–The person does not smile, does not let mouth when uneasy.
2. Rough–This handshake is not painful but has an inappropriate amount of force and roughness. This person wants to appear tough and outgoing and may be hiding feelings of insecurity.
3. Limp–The hand feels like it has no bones. This person may have a negative outlook in life, be a chronic pessimist or doubter, and often wears dark clothes.
4. Bone Crushing–This handshake hurts; in fact your hand may hurt for a day or so. This person is usually out to impress but deep down feels inferior, insecure, and has emotional insecurity.
5. Hesitant–May begin to shake hands but quickly withdraws the hand if the other person does not respond quickly. This person is often indecisive about everything in life.
6. Close to the Body–The elbow is bent at right angles to the body. A common characteristic of this handshake style is a person who never sticks their neck out, usually cautious and conservative.
7. Compulsive–Shakes every hand at every opportunity. They have a need to be noticed and accepted and often are politicians.
8. Non-Grip–This person refuses to give the entire hand and usually only their fingers. You should not take their handshake too seriously as they do not want to become involved with you. This is the handshake that we offer to family members that we want to keep at a distance. This is also the handshake that Queen Elizabeth II uses.
9. Jackhammer–This person pumps your hand in a series of short mechanical jerks. Watch out, as this person is usually determined, strong-willed, rigid and inflexible.
10. Captive Audience–They will not let your hand go until they have made their point. They may even grasp your forearm. This is a handshake used by salesmen or someone promoting opportunities. This person is often manipulative, opportunistic, and may use people to obtain own goals.
11. Normal–No hidden messages

Hand Movements–Faces can usually be controlled with practice but not our hands. An example is a gambler who has a “poker face”; however, cannot stop the small joints of the hands when under stress (watch Poker Tournaments on the television and you can detect the players small, brief hand movements or twitches). Agitation and/or stress are evident with a very fine hand tremble and small finger movements such as drumming, tapping, picking at counter. Other examples include perspiration on the palms or slight arm movements.

Another gesture is a covert filtration exercise occurring below the conscious level by teenaged girls. When they are around attractive guys and a favored one looks her way she will place her hand on her hip each time he glances her way. This ritual may occur many times during the encounter. All the while the hands are moving they will casually control their eye gaze (may observe this at the mall or a ball game).

Hair gestures–Females groom hair, sweep or pat when agitated. They will twirl hair when the world seems to be closing in and thus feeling a need for the security of an earlier life. Teachers often comment that these girls may seek help facing current life issues. Girls who play with hair ends are usually bored in class. Males will sweep hair back when on the defensive or when they know they are wrong as a gesture to say, “So—I was wrong.”

Head & Arms–When a person is asked a question their head and hands elevate ever so slightly and the eyelids open wider. At the end of a statement the person’s head, eyelids, and hands will move downward ever so slightly. Also you may notice that the eyes will laterally dart to the other side. If it is a touchy/comfortable subject, females will cross arms over the chest. Nail biters & cuticle biters are usually tense, uptight and often project the image of needing understanding. Both sexes will remove & replace eyeglasses &/or cover mouth when uneasy.

Common Gestures–It is important not to assign value to just one gesture. Look at the person and the situation as...
a whole before making judgments about their non-verbal behavior. No two people will read all of the following behaviors.

1. Rejection—Common behaviors include crossed arms or legs, head tilted forward, movement of body backwards, touching or rubbing the nose, eye, and forehead. imagined

2. Readiness—Hands are placed on hips or knees. If seated they may sit on edge of chair and move closer to the speaker.

3. Cooperation—The person will sit on edge of chair, place hands on the face, unbolted coat, and tilt head very slightly to the side, another sign of readiness.

4. Framing—You may notice short breaths, patting back of neck, clenching hands, and wringing hands.

5. Confidence—This person will sit up straight & maintain eye contact, have decreased eye blinking, steetle and the more confident the higher the steeple; place feet on desk or chair; touch or lean against people or objects, e.g., car, spouse, etc. to show ownership; lean back and support head with both hands.

6. Nervous—Common behaviors include clearing throat, whistling, and fidgeting.

7. Interrupt—An individual may raise their hand to car or lip and exhibit flicking hand movements.

8. Self-control—Hands will be clenched behind their back (Prince Philip or Prince Charles), locking ankles when sitting (dentist chair), or gripping chair arms. (Note: both Prince Philip and Prince Charles are ex-military.)

9. Boredom—Behaviors include drumming fingers on a table, tapping the feet, clicking a pen, holding head in hands, doodling, or staring blankly.

10. Acceptance—The person may place hands on the chest, touching someone/something, or move closer.

11. Reassurance-seeking—This individual may clench their hands; rub thumbs together; pinch their hand or lip; grasp a table; place fingers on their face; or cuticles; place pen, pencil, paper clip, etc. in their hands; rub thumbs together; pinch their hands, chest, touching someone/something, or move closer.

12. AGITATION—This person is orientated and may have a rigid personality. They are discussed you are expected to look at each other.

13. Lip-in-Smile—“Coy Girl” lower lip is drawn slightly to one side called CLEM (Conjugate Lateral Eye Movements).

14. People who glare at you pause and look directly at the other person. If you pause and look directly at the other person. By finished

15. People who look away when someone is talking.

16. Generally women look or gaze more than men.

17. In small discussions such as “backyard barbecues” people raise their eyebrows to ask a question and lower them to express themselves with facial expressions as compared to

18. Facial expressions

19. The muscles of the face make more

20. A cold

21. A smile is associated with joy and contentment. One way to measure if people are comfortable is to watch for a smile. A smile indicates that they wish to enter the conversation.

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29. A smile is associated with joy and contentment. One way to measure if people are comfortable is to watch for a smile. A smile indicates that they wish to enter the conversation.

30. A smile is associated with joy and contentment. One way to measure if people are comfortable is to watch for a smile. A smile indicates that they wish to enter the conversation.
A few advertising axioms

1. Alchohol looking beautiful women attract the most attention but sell few products.
2. Brunettes receive more attention from women than blondes.
3. Brunettes are perceived to have more “class”; they talk slower and are taller than blondes; therefore they sell sophisticated serious products.
4. Blondes have more fun; always seen getting on an airplane (but rarely getting off an airplane because they may signal the end of a vacation).
5. Prettiness in men is uninteresting.
6. Women look at women more in pictures than men.
7. Men look at men more in pictures.
8. Handsome, beautiful children are perceived as brighter than “ugly” children.

Touch—The following are general axioms related to touch:

1. Females of all ages are more receptive to tactile stimulation.
2. Generally males respond better to visual stimuli than touch.
3. Children make better grades if they are hugged and comfortable steady positions for a period of time.
4. We are capable of assuming about 1,000 different graceful looking poses.

4. Most postures are logical and predictable sets of behaviors for communication; whereas, facial movements occur below the conscious level
5. Body language is cultural and many flare-ups are a result of misused body language. A good actor gives you credibility to words with body movements and vice versa. A bad actor can often be seen as a noted sports figure acting as a commentator.
6. Posturing in Groups—
   a. Disengagement—If a TV program has a fast tempo you lean forward, body tense, with eyes fixed on TV. As the action climaxes or slows down individuals will shift posture and disengage by turning the head or body away from the TV. (NOTE: every role we play involves disengagement to a new set of behaviors).
   b. Cocktail Party/Groups—People will talk and the group will form a circle to exclude others even when standing in line. The end members of the group will turn inward to maintain the circle.
   c. Gender relaxation and position will be the male of highest rank.
   d. If you need to break through a line you will look through the middle but the end.
   e. In class settings members of a group will hold heads and extremities in same way—called congruent posture.
   f. Sometimes people in authority will assume incongruent posture to remind people of their place in life or to show authority.
   g. When a couple engages in private matters during the sermon at her demeanor especially posture and degree of relaxation and observe the rate of putting the infant. The tenser the Mother becomes the faster she pats.

Individual Postures—Tenseness & relaxation markers

1. Men—tense when threatened by other men.
2. Males—overly relax when another man is disliked but poses no threat.
3. Women—show dislike for men and women with extreme relaxation poses no threat.

Posture as a Body Message—

1. When a couple sitting in private matters during group work, other group members will show annoyance by thrusting one of their legs between the couple if sitting or if standing part of their body (arm or shoulder) will be thrust between them.
2. When a person becomes argumentative or belligerent group members will box in using their legs.
3. Men & women seated closely in a non-intimate, social situation will cross legs or lean back from each other. Additional clues will include a voice of lower pitch and people will lean toward each other, and use arms and/or legs to close circle. If a third person comes to the couple they will assume a congruent posture by facing the third person and crossing arms or legs.
4. Both men and women will probably avoid direct body orientation to women of a lower status. In conversation women will be approached at an angle and this will be maintained. Men of a lower status are faced.
5. The “male defiant” message is spreading legs and placing thumbs in belt (noted in adolescents and young adults).
6. A “selling posture” is sitting back in the chair.
7. Dominant males will lean forward to lesser status male.

Furniture & Postural Behavior—

1. Families with clear-cut views on politics, religion, etc. and having clear views on the man-woman relationships usually tend toward to traditional décor in living rooms.
2. Families new to money and/or those climbing socially often have living rooms in modern décor.
3. Most individuals are invited to an area that has a pleasant atmosphere, contains proper lighting, and plants.
4. Most individuals choose to leave an area if there is overcrowding (or high density population), lack of chairs, uncomfortable seating, and high or intense lighting.
5. To Send a message:
   a. “I want to be alone”—sit away from door or sit facing the door. Place a table and face the door.
   b. Benches—sit on end if you want someone to join you. Two people on each end—no one will sit in the middle.

Clothing Clues

1. Self-controlled/self confident individuals who are not “boat rockers” and will not defy authority usually wear comfortable, practical, clothing.
2. Sympathetic and gregarious (often not an A+ student) individuals are not at all well-dressed but wear the latest style and are very fashion conscious.
3. A conservative, traditional individual who will not “rock the boat” usually tend to wear the latest style.
4. Individuals, who are self-conscious, efficient, and precise, often tend to buy what is on sale and consider vintage clothing stores a “good buy.”

Part II—Specific to Nursing Care

Nonverbal communication is a definite asset to understanding human behavior when used as an integral part of verbal interactions. It is important to remember that our words assume a diminished meaning when conflicting with body language. Utilizing learned skills of interpretation of nonverbal clues is an essential tool for all patient education and compliance. Nonverbal communications govern most of our interactions and when we do not identify and interpret these messages we miss much of the data the patients are sending to us. Compliance continues to be a troubling issue with patients. Certainly it is not always a lack of understanding on their part; however, a portion is related to the inability to process the facts presented. For example the stress of illness or the desire to leave the health care premises as soon as possible often preclude internalization of essential information. It is very helpful to watch for facial and body clues to indicate understanding. Very often both patients and family members will indicate their verbal understanding but when observing carefully you may discover symptoms of distress (tenseness, body posture, etc). When factoring in shortened actual patient contact (hospital stays and/or office visits), there probably will be no way to change these patterns when we present essential information. Therefore, it becomes essential to “stack the cards” in our favor to enhance as much compliance as possible. If we could reduce engagement to words alone there would be fewer conflicts; but this will not take place. As a result we as nurses need additional interpretation skills to enhance our patient care.

Selected Bibliography

Thompson, J.J., (1973), Beyond Words, Citation Press, New York, New York.

Nonverbal Communication continued from page 15
Part I
Select the one (1) best answer for each question and place on Evaluation/Post Test

1. Nonverbal communications
   A. modifies verbal communications.
   B. makes up about 50% of all communications.
   C. is an exact science.
   D. is an enhancer of communication.

2. Americans routinely use about _______ different gestures.
   A. 20
   B. 25
   C. 30
   D. 35

3. Lawyers often use a Dead Pan handshake.
   A. True
   B. False

4. If a person returns your handshake in a “bone crushing” manner this may indicate that patient education may be problematic due to their:
   A. refusal to accept new information.
   B. belief that you can not teach them anything new.
   C. anxiety.
   D. insecurity about accepting and internalizing new information.

5. You have already provided discharge information (follow up appointments) and have left area and returned. You notice the patient has some arm movements and picking at the counter. The best nursing response would be which of the following:
   A. Nothing
   B. Provide a reminder about the appointments
   C. Engage them in conversation about other topics
   D. Either B or C

6. Eyelids open wider when a person is asked a question?
   A. True
   B. False

7. You are reinforcing teaching that has been provided by another nurse about symptoms of hyperglycemia. The patient has arms crossed over the chest. Your interpretation is that the person
   A. is not listening to you.
   B. needs the content repeated.
   C. is thinking about what you are saying.
   D. Both A and B

8. In the preceding question the patient has placed a hand on the chest. Your interpretation is that the person
   A. is not listening to you.
   B. needs the content repeated.
   C. is thinking about what you are saying.
   D. Both A and B

9. You are requesting directions and the person points to the right but tells you to turn left. You will turn
   A. left.
   B. right.

10. Americans are permitted to stare at another person for a total of _______ seconds before it becomes uncomfortable.
    A. 1
    B. 2
    C. 3
    D. 4

11. If you are scolding someone and they divert their eyes to one side you _______.
    A. anger.
    B. relief.
    C. remorse.
    D. None of the above

12. You are providing essential information to group of family members. Some are showing signs of interest and some are obviously bored. You know that you must make the dominant person aware of this information for compliance. A signal that you look for is the person who
    A. gazes at you intently.
    B. keeps trying to excuse you.
    C. drums fingers in their lap.
    D. looks away while you are talking.

13. Autistic children usually have good eye contact.
    A. True
    B. False

14. When being provided information, women will gaze at you longer than men.
    A. True
    B. False

15. When confused you tend to _______ your eyebrows.
    A. raise
    B. lower

16. Men show emotions with facial expressions more readily then women.
    A. True
    B. False
    C. No difference in children
    D. No difference in adulthood

17. Scientific studies of patient in critical care have found that touch
    A. is annoying to critical patients.
    B. recovery is accelerated.
    C. is usually reassuring only to patients who are able to verbally respond.
    D. has limited impact on recovery.

Part II
Briefly provide at least four (4) nonverbal techniques and describe how you can incorporate into your practice to enhance patient education and/or dealing with others.

1. __________

2. __________

3. __________

4. __________

Evaluation/Post Test—Nonverbal Communication

2.0 (ANCC) 2.4 (ABN) contact hours

Goal: To synthesize frequently encountered nonverbal practices, which can then be used to enhance your interpretation of their behavioral clues.

Name, Credentials: ____________________________________________ __________ Member ($15.00)

Address: ___________________________________________________ __________ Non Member ($20.00)

City State Zip

ABN License #: ______________________________

Phone: ______________________________ Email: __________________________________________________

Credit Card Number __________ / __________  Signature

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Part IV
Briefly provide at least four (4) nonverbal techniques and describe how you can incorporate into your practice to enhance patient education and/or dealing with others.

1. __________

2. __________

3. __________

4. __________

ACTIVITY EVALUATION

Circle your response using this scale: 3—Yes 2—Somewhat 1—No

Objectives & Goals were appropriate.

Rate your achievement of the objectives for the activity

1. List at least four (4) open ended questions that indicate readiness to learn new material.
   A. True
   B. False

2. Describe how handshakes reflect a personal profile.
   A. True
   B. False

3. Identify conversational clues, which help manage a conversation.
   A. True
   B. False

4. Compare various body positions in groups.
   A. True
   B. False

5. Deduce how nonverbal communication clues enhance patient education.
   A. True
   B. False

Program free of commercial bias.

On a scale of 1–5 knowledge of topic before home-study

1. 2. 3. 4. 5. 1

On a scale of 1–5 knowledge of topic after home-study

1. 2. 3. 4. 5. 2

How much time did it take you to complete the program? _____ hours _____ minutes.

ADDITIONAL COMMENTS: