We’ll See YOU There!

It’s that time again, and the ASNA Board of Directors/AlaONL/AANS invites YOU to attend the 96th Annual ASNA Convention. We continue to offer the best continuing education, networking and participation opportunities for a fair price and in a convenient format to meet your needs.

Thursday, October 1, 2009 is the Mable Lamb Continuing Education Day from 10:15 a.m.–6:00 p.m. There is something for everyone and you may register separately for this event. We are having an Awarded Celebration Dinner Friday Night. Plan to come for the education or come early for the Convention and stay to meet and greet other nurses. It will be a lot of fun and a great networking opportunity for all who attend!

Friday, October 2, 2009 is the official kick-off for the 96th Annual Convention. The exhibits will be open on Friday from 8:00 a.m. to 3:00 p.m. and you’ll want to visit them all. The Silent Auction opens at 8:00 a.m. The official Opening Ceremony of the 96th Annual Convention will begin at 1:00 p.m. and you’ll want to be there for the Open Forums! This is your opportunity to have your voice heard. We’ll be discussing ANA changes, Resolutions, and other matters of importance to ASNA.

Saturday, October 3, 2009 will begin with Breakfast roundtables at 7:30 a.m. Voting polls will be open from 8:00 a.m. until 9:15 a.m. The ASNA House of Delegates will then convene at 11:00 a.m. We offer another opportunity for contact hours when you view the Poster Presentations available from 9:00 a.m.–12:00 Noon.

We hope you will join us and take advantage of the CE offerings, to network with old friends and make new ones, and to give yourself the gift of professional involvement. Several fun activities will be interspersed through out the meeting.

Mark your calendar now! Come be a part of Alabama nurses making a difference. Find out how good it can feel to represent your district and your profession as we address the critical nursing issues facing us today. Please use the Convention 2009 special pull-out section for all your registration needs.

We look forward to seeing YOU there!
ASNA Board of Directors

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Administrative Coordinator, Betty Chambless
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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 others
• Adhering to the Code of Ethics for Nurses
• Becoming more recognizable 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.

ADVERTISING

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Views expressed herein are not necessarily those of the Alabama State Nurses Association.

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2009 ASNA Awards

Any ASNA member, group or staff may submit nominations. The awards are as follows:

• Lillian B. Smith Award
• D. O. McClusky Award
• Outstanding Non-Member Award
• Outstanding New Member Award
• Lillian Holland Harvey Award
• Louise Barksdale Outstanding Nursing Practice Award
• Legislative Award
• Cindajo Overton Outstanding Nurse Educator-Academe & Service
• Outstanding Nursing Administrator Award-Academe & Service
• Outstanding Retired Nurse Award
• Outstanding Health Care Organization

You may use the form below or call Betty at the ASNA office for a brochure and nomination form. Awards are presented at the ASNA Annual Convention, but the Awards Committee needs all nominations by midnight July 22, 2009.

ASNA AWARDS NOMINATIONS FORM

NOMINEE INFORMATION

Name of Nominee:

Credentials:

Award Nominated For:

Home Address:

Business Address:

Home Phone:

Business Phone:

SUPPORTING INFORMATION

☐ Attach Narrative Statement (Required)*
☐ Attach Curriculum Vitae (Required)*
☐ Attach Letters of Support (Optional) Maximum of 3 letters)
☐ Attach Additional Pertinent Information (Optional) Maximum of 5 pages.

Must be included for the application to be considered.

SUBMITTED BY:

(Individual’s Name or Group Name)

Address:

District:

Date:

NOMINATIONS ARE DUE IN ASNA OFFICE BY JULY 22, 2009.
AUM Nursing Administrators at the Top of State Organizations

Auburn Montgomery School of Nursing graduates Dr. Debbie Faulk, ’94, and Carol Stewart, ’92, not only lend their expertise to their alma mater, but also to nursing colleagues statewide. They serve as presidents for two Alabama professional nursing organizations.

Faulk, coordinator of the Educational Advancement for Registered Nurses program at AUM, is president of the Alabama State Nurses Association for 2008-10. “ASNA’s mission is to promote excellence in nursing,” said Faulk. “This year, ASNA is advocating for funds for scholarships for nurse educators. We are also striving to eliminate smoking in public places, supporting the Nurse Practitioner Alliance of Alabama in their endeavors and supporting the school nurse bill.”

In addition to legislative issues, ASNA promotes excellence in nursing through continuing education programs. “To an attempt to increase membership, a task force is developing a membership video with production support from the AUM Information Technology department,” said Faulk. “We believe this endeavor will help us to bring a consistent message about ASNA, its mission, goals and benefits.”

Faulk also plans to utilize the technology that she employs regularly in the EARN program for ASNA, as she plans for the association’s first virtual board meeting in April.

Faulk’s personal goals as president of ASNA are to introduce more technology into the functioning of the association, increase membership and advocate for legislative issues that are of interest to members of ASNA and Alabama nurses.

Carol Stewart, director of Student Health Services at AUM, is president of the Nurse Practitioner Alliance of Alabama.

The purpose of the NPA is to represent the regional nurse practitioner groups in practice and educational issues effecting nurse practitioners.

“Legislation (SB 483) has recently been submitted in the state Senate that would help eliminate some of the practice barriers NP and certified nurse midwife practice within the state,” said Stewart. “Our primary goal is to increase access to care, focusing on the uninsured or under-insured and rural areas of Alabama.”

“There is a shortage of primary care providers in Alabama and NPs’ are one source to help alleviate this problem. NP’s are underutilized because of the barriers that exist. One of the issues addressed in our bill is for NPs and CNMs to have direct reimbursement for the services they provide. Most states have already mandated this but not Alabama,” Stewart said.

Because of the economic national crisis, funds are short for meeting health needs in Alabama, and it’s not expected to improve for some time, Stewart said.

“I meet people everyday who have recently lost their jobs and health insurance. It’s time for us to join forces to seek new and creative ways to solve our health care problems.”

As I began reflecting on what I wanted to convey to Alabama nurses in this third message as YOUR president of the Alabama State Nurses Association, I thought about endings. A number of events will have ended as you read this message. The current session of the Alabama Legislature will have ended; many nursing students will have finished nursing programs across the state and will have attended graduation ceremonies. Many of these former students will be anxiously preparing for, or awaiting, NCLEX results in order to assume the roles of nurses and to take their place as the future of the nursing profession. Finally, National Nurses Week will have come and gone. As I think about this last event, National Nurses Week and this year’s slogan: Nurses: Building a Healthy America, I would like to focus on this for the first part of my message.

I was personally excited about the slogan for the first time in a number of years. Why? I believe the slogan effectively reflects what nurses have been doing for a very long time… focusing on preventive health issues. I believe preventive health efforts are key to building a healthy America. About a month ago, I was the keynote speaker at IOTA Chapter of Sigma Theta Tau Research Day for Troy University School of Nursing. The theme was focused on healthy behaviors. Using the American Nurses Association’s Healthy People 2010 slogan, Nurses Week was my central theme, I talked about how important it is for nurses to continue to focus on preventive health care.

At the Congress of National Nurses Week I found keynote was that nurses must role model healthy behaviors and accept individual accountability for their health. This is the second reason why I believe nurses are instrumental in building a healthy America. Nurses must role model healthy behaviors and accept individual accountability for their health. This is the second reason why I believe nurses are instrumental in building a healthy America. Nurses must role model self-care. If we as nurses do not practice prevention activities, we might find ourselves living with the repercussions of the very chronic diseases that we see every day in our practice settings. Consumers of health care trust nurses and they are watching us!

Although a number of events will have ended as you read this message, a huge event will have begun. I am referring to health care reform. A few days ago the Congress began debating health care reform and what it will entail. The debates are in the early stages. I would like to appeal to you as advocates for the profession and for clients to keep informed as the dialogue takes shape. Remember in my second President’s message I said “nursing no longer has an option related to becoming involved in the political arena. It is now a mandate.” Fortunately YOUR American Nurses Association is a key player and has been invited numerous times to the White House to participate in health care reform conversations. The decisions that will be made about health care will impact you as a citizen, as a consumer of health care, and as a provider of care. Please stay informed and please participate in the process by writing, calling or meeting with your legislators. Do please not let others speak for nursing.

My final point within this third message is to give you an update on ASNA’s strategic plan for 2009-2010. Our initiatives include:

• Provide leadership for health policy and legislative activities
  • Joe Decker has done a phenomenal job of lobbying for the nursing scholarship bill, nurse practitioner bill and other issues impacting Alabama nurses.
  • Advocate for Alabama nurses on professional practice issues
  • ASNA’s lobbying presence in the legislature
  • Nurse’s Day at the Capitol–21 January, 2010.
• Provide for the continuing professional development for Alabama nurses
  • FACES was held the last of April and over 600 nurses and student nurses attended excellent oral presentations and poster presentations.
  • Commission on Professional Issues is developing information related to best practices for retaining the older Alabama nurse. This report will be provided to the membership and shared with all Alabama nurses in the near future.
• Improve the visibility and image of nursing
  • The ASNA membership video is within a week of being completed and ready for approval by the board of directors.
  • Nurse’s Day at the Capitol–21 January, 2010.
• Evaluate organizational effectiveness, relevancy, and efficiency
  • On-going process.

I will end with my promised continuing communication that in order to make a difference in health care, nurses must be united. While we have many voices and diverse values, we can dialogue, agree to disagree, and yet show others that we speak with one strong 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.
By Joseph F. Decker, II
Executive Director

As the third annual session (of four in the quadrennium) of the Alabama Legislature closes, we should review the results of actions (or lack of same) on issues we have followed this year. The Alabama Board of Nursing sunset legislation did pass without incident, extending the ABN for four more years. No adverse changes to the law were involved. We were also successful in garnering a total of $257,000 for nursing scholarships in the Education Trust Fund Budget for 2010, despite a bleak budget forecast and initially having only $57,000 set aside for that purpose. However, our Nursing Scholarship Bill (HB50) sponsored by Rep. (Dr.) Bentley again failed to even get scheduled for a hearing in committee in the House. We’re very disappointed in that lack of progress. The Senate version (SB51) sponsored by Sen. Benefield did clear committee but not the full Senate. We must redouble our efforts next year, and increase our profile to get this bill passed.

Sen. Figures’ bill prohibiting smoking in public places (SB130) cleared committee in the Senate, but was voted down twice in the upper body. It made no progress at all in the House. We were pleased that the School Nurse Bill (HB47/SB186) by Rep. (Dr.) Bentley did pass this year. This bill establishes a maximum of 5 LPNs to 1 RN supervisor in the school system; establishes an RN consultant in each district to oversee the school nurse program and report directly to the Superintendent; and establishes a state consultant.

The introduction by Sen. Coleman this session of the NPAA Nurse Practitioners bill (SB483) to improve practice privileges marked a major milestone. This bill would eliminate the requirement for a written Collaborative Agreement between nurse practitioners and physicians; set the Board of Nursing as the sole regulatory authority for NPs; restructure the current Joint Committee (ABN and BME) by retaining physicians in an advisory capacity only; declare NPs as Primary Care Providers and include them in direct reimbursement; and extend NP prescriptive authority to Class II-V. While very little progress through the system was made amid heavy opposition by MASA, this important issue has now been put on the table for future debate and action. The core issue is access to quality health care for Alabamians, especially those in underserved or rural communities. Nurse Practitioners can definitely fill this need. And the fact is that fewer and fewer physicians opt for primary care fields, preferring to specialize. This leaves an increasingly larger hole to fill in primary care providers. Because Alabama is arguably the most restrictive state in the union for NP practice, we absolutely must turn that around if all Alabamians are to have access to care. In addition, by taking that route the possibility of substantial cost savings to programs such as Medicaid are clearly evident. While this fight has only just begun, we believe that it is a fight we will eventually win, if for no other reason than the facts on the ground will demand it.

Our 2009 Elizabeth A. Morris Clinical Education Session–FACES on 21 April at the Eastmont Baptist Church in Montgomery was another huge success. We saw another 600 nurses/nursing students in attendance, with a terrific lineup of speakers and educational tracks. The lineup included NCLEX prep for students, three different clinical tracks, a research track, geriatrics, pediatrics, women’s health and parish nursing. A wonderful lunch was available at the church as well. The folks in attendance really enjoyed the day. If you missed it, you’ll get another chance next spring. Keep an eye out for the announcements in The Alabama Nurse and on our website at www.alabamanurses.org.

Finally, ASNA has recently completed work on an informational/recruiting DVD. Our President, Dr. Debbie Faulk of AUM took the lead in the development of this innovative idea, and many of our members played a part. We hope to field the finished edition by June at the latest. We look forward to sharing it with all nurses in the state.

Dates to Remember:
ASNA State Convention Nurses at the Capitol Rally
1-3 October 2009 21 January 2010
Marriott Shoals Hotel Florence, AL
Montgomery
FACES 2010 ASNA State Convention
Spring 2010 30 Sep-2 Oct 2010
Montgomery Riverview Plaza Hotel
Mobile, AL

Condolences:
Jean McLain in the death of her mother.
Edith Shaw, long-time ASNA member of District 5.
In those cases, the nurse has signed documentation indicating that a drug has been administered, but in reality it has not. Where does that leave the nurse on the next shift, who unbeknownst to her is dealing with erroneous records?

Pre-charting is something that can get a nurse into trouble with the Alabama Board of Nursing.

What if correction on the nursing notes is necessary, due to a mistake or change in circumstances? Of course, corrections are permissible, as long as they are done in the correct manner. Nurses should attempt to make any corrections on the shift for which the care was given, rather than days later.

And if a nurse draws two controlled substance tablets, but only gives one during the shift, then the notes should reflect what happened to the second pill. Of course, normally it would be wasted in the presence of a witness.

And registered nurses, advanced practice nurses in particular, should never depend upon a national credentialing agency to get paperwork to the Board of Nursing showing that necessary courses have been completed.

The agencies may do the reporting properly, but the advanced practice nurse should check to ensure that the paperwork got there anyway. I am aware of several cases in which nurse practitioners have relied upon a national credentialing agency to get the paperwork to the Board (even paid the agency a fee) only to learn that the Board had no notice that the credentialing had been completed.

Good registered nurses know these things. They should never get lax and should always follow good common sense practices to stay out of trouble with the Board of Nursing.

Numerous nurses have told me that the people at the Board seemed to have little sympathy for their unintentional mistakes. That’s my experience with the Board staff as well, so it behooves us to be especially diligent in ensuring that the rules are followed.

The good news is that if you’re a member of the Alabama State Nurses Association, you always have a friend in your corner. You can always contact ASNA and ask the professionals for advice and help.

In fact, if you do get a disciplinary notice from the Board (and if you are a current member), the ASNA attorney will accompany you through any necessary negotiation process and hearing.

So if you’ve not joined ASNA yet, now would be a good time to do it.
Schizophrenia

Schizophrenia is best described as a chronic/recurrent psychosis coupled with long-term deterioration of functional capacity. The patients exhibit behaviors worldwide with the incidence of about one out of every 100 people. There is no relationship among ethnic groups or geographic locations. The actual diagnosis is usually made in young adulthood. But before the diagnosis is made, those around individuals with Schizophrenia notice a withdrawal from reality, disorganized and regressive behavior, impaired communication and interpersonal relationships, and acute psychotic episodes. Often a complete personal history reveals subtle functional impairments noted at an early age. Many times these subtle impairments include communication difficulties, social ineptitude, poor school function, blunted, and/or inappropriate (odd) behaviors. It is important to note that this cluster of symptoms is not a precursor to Schizophrenia. Not everyone who exhibit these behaviors go on to be diagnosed as a Schizophrenic. For many years the literature has stated that Schizophrenics are from lower socioeconomic levels. In reality they do make up greater numbers of the homeless population and have a downward drift in qualities levels. In reality they do make up greater numbers of the homeless population and have a downward drift in qualities levels. In reality they do make up greater numbers of the homeless population and have a downward drift in qualities levels. In reality they do make up greater numbers of the homeless population and have a downward drift in qualities levels. In reality they do make up greater numbers of the homeless population and have a downward drift in qualities levels.

Pathophysiology:
There is no clear-cut definitive cause for Schizophrenia. Most researchers believe it to be a combination of both genetic and environmental factors. Schizophrenic brains are smaller and do have a tendency toward larger sulci lateral and third ventricles. A definite correlation has not been established at this time. Symptoms:
The four (4) basic symptom clusters are positive and negative symptoms, cognitive impairments, and affective disturbances. 1. Positive symptoms are delusions, hallucinations, and disorganized thinking. This term is synonymous with psychosis and the definition refers to the active quality of a symptom which tends to persist over the years. The good news is that these symptoms react most favorably to medications. And some patients may even have a complete remission of symptoms with pharmacological treatment; however, most have only a reduction in intensity. 2. Negative Symptoms are either absence or diminution of normal behaviors. Examples include the following:
   a. Alogia—diminished production of thoughts or speech characterized by loss of interest or ability—
   b. Avolition—decreased or absence of goal directed behavior.
   c. Anhedonia—lack of pleasure in actions normally pleasurable or lack of satisfaction when activities are performed well.
   d. Attentional impairment—loss of interest in interacting with family, friends, etc. Relationships once important to individuals are neglected and new relationships are not established or sought after.
3. Cognitive Impairments are noted in all aspects of a Schizophrenic’s life. Areas impacted include language, attention, memory, and executive function (diverse range of abilities exerting higher-level control over behavior and adjusting the behavior in response to changing task requirements). Patient history often reflects cognitive impairments present from birth with only a slight decline during the lifespan. This can be evaluated by an assessment of both school scores and performance. The average Schizophrenic’s IQ is 80–85 which is greater than one standard deviation from the normal IQ of 100. There is no definitive answer regarding IQ loss over the lifetime. Some authorities state there is a slight decline around 5–7 years of age whereas other authorities believe that it remains constant during the lifetime. Cognitive impairments are much like negative symptoms regarding treatment. Medications have not been able to ameliorate and psychosocial therapy can reduce the impact but has limited effect on the impairment itself.
4. Affective disturbance is common with all Schizophrenics. Most individuals have blunted, inappropriate, and odd expressions. Affective disturbances are noted as 60% of all Schizophrenics experience dysphoria (excessive anguish), demoralization, and depression during acute episodes. Mood swings are noted about four times more frequently than the “normal” population. Most often the depression becomes evident following a psychotic exacerbation. There is a passively aggressive manifestation as to whether the depression follows the psychotic episode or is it easier to recognize after the psychosis has cleared.

Diagnostic Types (DSM-4)
The diagnostic type refers to the type of positive symptoms exhibited. The diagnostic types should not be confused with symptom domains. Schizophrenic patients tend to remain in the same diagnostic subtype for the entire disease course.
1. Paranoid—This type should not be confused with individuals who have persecutory ideations. This refers to any type of delusion or hallucination. The delusions are often fixed around a single organized theme of persecution or grandeur and often coupled with anxiety and autonomic symptoms related to the delusion. This type has the least functional impairment and carries the best prognosis. A Schizophrenic patient who has family and friends, and are able to live independently probably has this type. A typical client reflects some or all of the following behaviors: grandious, guarded, suspicious, anxious, hostile, or maybe violent. Onset is usually later in life and is associated with the least regressive behavior. It has the best prognosis. However, the suicide rate is the highest probably because they have relatively good insight and higher executive functions, which enables them to appreciate and react to their diagnosis.
2. Disorganized—These individuals have prominent disorganized thoughts and a bizarre affect. The typical profile includes some or all of the following behaviors: incoherent, flat affect, disorganized and primitive behavior, appear odd or silly, have unusual movements, out of context facial expressions, hypochondriasis (multiple physical complaints), socially inept, delusions and hallucinations which are fragmented and poorly organized, and daydreaming. At one time these individuals were classified as hebephrenics. They carry the poorest prognosis because these symptoms are not compatible with functioning in the world. This is the most commonly hospitalized Schizophrenic and make up most of the institutionalized patients. The onset is usually early in life. On history these individuals have impaired adjustment problems, which continue to decline after the diagnosis is made. Their symptoms do not respond well to antipsychotic medications.
3. Catatonic—This type has marked disturbances with psychomotor activity and lack of interaction with the environment. It is characterized by bizarre posturing, meaningless gestures or postures, psychomotor retardation or excitement (patient may fluctuate between the two), or maintaining awkward position into which they lapse. At times one of these individuals lived a normal life. Catatonia tends to occur episodically and it is not limited to Schizophrenia. It may be noted with depression, mania or mood disorders.
4. Undifferentiated—The largest group of Schizophrenics are classified as undifferentiated. They do not fit neatly into any one category. They display psychotic symptoms (delusions, disorganized behavior, hallucinations, and incoherence). During the course of the illness there is a tendency for many patients to drift toward the undifferentiated type. Their prognosis is somewhere between paranoid and disorganized types.
5. Schizophreniform disorder—This diagnosis is given to individuals who have the symptoms of a Schizophrenia sub type but have had them for less than six months. A diagnostic subtype is not given because many of these cases resolve on their own or develop into a more clear cut diagnosis.
6. Schizoaffective disorder—The relationship of this disorder to Schizophrenia is ambiguous in the literature. Some believe that it is a separate diagnosis from Schizophrenia and some sources classify these as separate disorders. An individual with this diagnosis has periods of psychosis without affective symptoms and periods of affective symptoms while psychotic.
7. Residual—This is a partial remission of symptoms. The patient remains in the residual phase and continues to have some degree of negative symptoms, i.e., blunted or inappropriate affect, slightly illogical
Schizophrenia continued from page 6

Diagnosis

Schizophrenia is characterized by the presence of psychotic symptoms, which include hallucinations, delusions, disorganized speech, and flattened affect. These symptoms are often accompanied by negative symptoms, such as social withdrawal, lack of motivation, and apathy. The diagnosis is typically made when these symptoms are present for at least 6 months and cause significant impairment in functioning. The diagnosis is often confirmed through the use of standardized rating scales and structured interviews.

Psychosocial Therapy—A hallmark of Schizophrenia is the inability to form and/or maintain meaningful interpersonal relationships. This is often reflected in their difficulty forming and maintaining close relationships with family members, friends, and peers. Social isolation is common in people with Schizophrenia, and they often have difficulty engaging in activities that require social interaction.

Atypical Antipsychotic Medications

Olanzapine (Zyprexa) and Sertindole (Zeldax) are atypical antipsychotics that are less likely to cause extrapyramidal side effects and may be better tolerated by patients with Schizophrenia. These medications are often used in combination with other antipsychotics to achieve better control of symptoms.

Nursing Interventions

During an acute episode patients may require additional support, including medication management, symptom monitoring, and education about the importance of medication adherence. Nurses should also be aware of the potential side effects of antipsychotic medications and provide vigilant monitoring to ensure safe and effective treatment.

Drug Interactions

Combining antipsychotics with other medications can result in significant side effects. Nurses should be aware of the potential for drug interactions and should consult with prescribing physicians before initiating or altering medication regimens.

Nursing Management

Psychosocial Therapy—A hallmark of Schizophrenia is the inability to form and/or maintain meaningful interpersonal relationships. Therefore the main focus of interventions is to help the client develop and maintain meaningful social interactions within their ability. The following can foster this:

- Encourage participation in social activities
- Provide opportunities for one-on-one interaction with others
- Support the development of social skills and communication
- Foster a sense of belonging and acceptance

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Diagnostic Evaluations

Diagnostic criteria for Schizophrenia are based on the presence of psychotic symptoms, such as hallucinations and delusions. These symptoms are often accompanied by negative symptoms, such as social withdrawal, lack of motivation, and apathy. The diagnosis is typically made when these symptoms are present for at least 6 months and cause significant impairment in functioning. The diagnosis is often confirmed through the use of standardized rating scales and structured interviews.

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Psychosocial Therapy—A hallmark of Schizophrenia is the inability to form and/or maintain meaningful interpersonal relationships. This is often reflected in their difficulty forming and maintaining close relationships with family members, friends, and peers. Social isolation is common in people with Schizophrenia, and they often have difficulty engaging in activities that require social interaction.

Atypical Antipsychotic Medications

Olanzapine (Zyprexa) and Sertindole (Zeldax) are atypical antipsychotics that are less likely to cause extrapyramidal side effects and may be better tolerated by patients with Schizophrenia. These medications are often used in combination with other antipsychotics to achieve better control of symptoms.

Nursing Interventions

During an acute episode patients may require additional support, including medication management, symptom monitoring, and education about the importance of medication adherence. Nurses should also be aware of the potential side effects of antipsychotic medications and provide vigilant monitoring to ensure safe and effective treatment.

Drug Interactions

Combining antipsychotics with other medications can result in significant side effects. Nurses should be aware of the potential for drug interactions and should consult with prescribing physicians before initiating or altering medication regimens.

Nursing Management

Psychosocial Therapy—A hallmark of Schizophrenia is the inability to form and/or maintain meaningful interpersonal relationships. Therefore the main focus of interventions is to help the client develop and maintain meaningful social interactions within their ability. The following can foster this:
Schizophrenia continued from page 7

1. Therapeutic Nurse-Client relationship—The goal of this intervention is for the client to attain a sense of self worth and acceptance. Once trust has been established the client can learn and practice new skills, be given non judgmental feedback about their progress, and thus they can continue to gain and accept support and encouragement. The nurses’ focus will be limited to having the client develop interpersonal communications and socialization skills, independence issues, and survival skills for post hospitalization.

Schizophrenia Post-Test Questions

Answer the following:

1. Schizophrenia affects about 1 out of 100 people worldwide.
   A. True B. False

2. Examples of positive symptoms include aloxia and avolition.
   A. True B. False

3. About 75% of all Schizophrenics have hallucinations and disorganized thoughts.
   A. True B. False

4. Positive symptoms react favorably to medications.
   A. True B. False

5. Blunting relates to the loss or inability to express self.
   A. True B. False

6. The average IQ for a Schizophrenic is 95–105.
   A. True B. False

7. Paranoid Schizophrenics always have persecutory ideations.
   A. True B. False

8. Paranoid Schizophrenics usually have a later onset in life.
   A. True B. False

9. Suicide rates are higher with Disorganized Schizophrenics.
   A. True B. False

10. A person diagnosed with Schizophreniform disorder has been diagnosed with Schizophrenia for less than 6 months.
    A. True B. False

11. 50% of all Schizophrenics attempt suicide.
    A. True B. False

12. Mental deterioration from the premorbid state continues to decline through out a Schizophrenic lifespan.
    A. True B. False

13. Schizophrenics occupy about one half of all mental health beds.
    A. True B. False

14. The presence of psychosis is a criterion for involuntary hospitalization.
    A. True B. False

15. Many of the unpleasant medication side effects disappear within two (2) weeks of starting treatment.
    A. True B. False

16. Antipsychotic medications reduce active symptoms to a tolerable level in about 70% of all clients.
    A. True B. False

17. Disintegrating tablets (Olanzapine and Risperidone) are absorbed transmucosally.
    A. True B. False

18. Examples of Conventional antipsychotic drugs include Haloperidol (Haldol), Thiothixene (Mellaril), and Ziprasidone (Geodon).
    A. True B. False

19. Over ½ of Schizophrenics abuse alcohol or other drugs.
    A. True B. False

20. Diabetes and the Metabolic Syndrome are frequent treatment complications related to antipsychotic medications.
    A. True B. False

21. One primary nursing focus is to help the patient develop meaningful socializations within their ability.
    A. True B. False

22. If a Schizophrenic remains on medication they are usually able to maintain long-term employment.
    A. True B. False

23. Groups that are focused on insight development are effective groups for individuals with Schizophrenia.
    A. True B. False

24. Clients who take medication sporadically have a poor prognosis overall.
    A. True B. False

25. Discharge criteria includes willingness to sign a “No Harm Contract”
    A. True B. False

2. Behavior Modification—Usually behavior modification techniques are much more effective for clients with Schizophrenia than insight-oriented groups. The goal is to reinforce appropriate behaviors and conversely negatively reinforce inappropriate behaviors. Initially the client must have a thorough assessment to determine abilities, strengths, and deficits. Then specific behaviors are targeted. Positive techniques include praise, privileges, or tokens, which may be exchanged for food or cigarettes. Negative behaviors are ignored or not rewarded. This is only effective with the client’s understanding and cooperation.

3. Group Therapy—Selective types of groups are effective but must be tailored to the client’s needs and abilities. Groups that depend on insight development, problem-solving, or personality reconstruction are ineffective for individuals with Schizophrenia. They need/benefit from groups which provide education, motivation and support. Low functioning individuals need a low stress group—one that provides positive reinforcement for any achievement. Types of issues discussed might include activities of daily living, hygiene, relaxation techniques, identification and support of strengths, socialization skills, etc. Also all clients need to be involved in a discussion about their personal vulnerability in social situations. This discussion should involve avoidance of personal injury and ways not to be taken advantage of by society. Mentally ill individuals have a higher incident of victimization than the non-mentally ill population.

4. Family Therapy—Family support goes a long way to prevent relapse of a person with Schizophrenia. The main focus of family therapy is to provide education about the disease process and provide a vehicle for dialogues about their problems dealing with the family member with Schizophrenia. The client and family/significant others need to understand that this is a lifetime disease. These symptoms wax and wane over time but rarely, if ever, completely disappear. Usually, early, consistent institution of treatment improves the symptom management. Clients who go on and off their medications have a poorer prognosis overall.

Discharge Criteria

The following general concepts indicate a person is ready for discharge.

• State a decrease or absence of hallucinations (NOTE: individuals with Chronic Schizophrenia may never be totally free of hallucinations but develop mechanisms to cope and they need closer supervision)
• Verbalize the relationship between increased stress and anxiety and developing hallucinations
• List several appropriate ways to reduce stress/anxiety
• Have a support network of family or friends or caretakers
• Know how to contact physician, clinics, etc.
• Exhibit an understanding of the importance of medication compliance as well a general knowledge about the medications
• Be able to state personal responsibility in own wellness—aftercare, preventative health concepts, taking medications, keeping appointments, etc.

This disease can be frustrating for both the client and the family/significant others. One of the best support mechanisms to help them understand how the disease process often waxes and wanes. Medications compliance often goes a long way to prevent exacerbations and importantly the fact that support is available when the health care system is accessed.

Schizophrenia

2.08 (ANCC) or 2.5 (ABN) contact hours

Name: ____________________________  Activity #: 4-0.894

Fee and Payment Method

Address: ____________________________  ASNA Member ($18)

City State Zip

Non Member ($25)

Phone: ____________________________  Check—Make Payable to ASNA

Visa MC Discover AmEx

ABN License Number ______________________

Email Address: ____________________________

Fee and Payment Method

Email Address: ____________________________

ACTIVITY EVALUATION

GOAL: Review current status of schizophrenia.

Circle your response using this scale:

3 – Yes 2 – Somewhat 1 – No

Rate the relationship of the objectives to the goal of the activity

3 2 1

Rate your achievement of the objectives for the activity

3 2 1

Objectives:

1. Contrast various system clusters for schizophrenia
   A. True B. False

2. List at least 5 types of schizophrenia
   A. True B. False

3. Describe the disease course
   A. True B. False

4. Examine nurse management interventions
   A. True B. False

How effective was this activity as a teaching/learning resource? 3 2 1

Was activity free of commercial bias? 3 2 1

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

5 4 3 2 1

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

5 4 3 2 1

How many hours did it take you to complete the program? _______ hours _______ minutes.

ADDITIONAL COMMENTS:
Nominations and Election of Officers

Alabama State Nurses Association’s (ASNA) nomination and election of Officers shall be conducted in accordance with Robert's Rules of Order, 10th Edition during the official meeting of the ASNA House of Delegates (HOD).

1. NOMINATIONS
   A. Nominations Committee
      a. Nominations from the Nominations Committee shall be accomplished according to ASNA Bylaws.
      b. Nominations from the floor of the HOD shall be accomplished according to Robert's Rules of Order, 10th Edition.

2. ELECTION OF OFFICERS
   A. Elections will be by secret ballot.
   B. Only credentialed delegates will be allowed to vote.
   C. Voting times and polling location will be announced at the House of Delegates.
   D. Election monitor(s) will verify eligibility of delegates (current membership card, delegate ribbon, and photo I.D.) at the entrance to the polling area.
   E. No campaigning will be permitted in the polling area.
   F. Each delegate will place his or her completed ballot into the designated container.
   G. Once the delegate has finished voting he or she must exit the polling area.
   H. Polling area will be open and closed promptly at specified time.
   I. Ballots will be controlled and counted by a minimum of three (3) tellers.
   J. One Teller will give each delegate one (1) ballot as the delegate enters the polling area.
   K. One Teller will monitor the ballot box to assure that each delegate places a single ballot into the container.
   L. One Teller will monitor the polling area to be sure delegates exit after voting.
   M. Once the polling area is closed the Tellers will count the ballots.
   N. The Head Teller will complete the Teller's Report.
   O. The Head Teller will present the official election results to the President in accordance with Robert's Rules of Order, 10th Edition.
   P. The President will report the result to the HOD in accordance with Robert's Rules of Order, 10th Edition.

Preliminary Ballot for ASNA Convention
Candidates for 2009-2011

The following slate will be voted on at the ASNA Convention by the elected ASNA Delegates.

<table>
<thead>
<tr>
<th>Position</th>
<th>Candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice President</td>
<td>Jackie Williams, MSN, RNC</td>
</tr>
<tr>
<td>Secretary</td>
<td>Mardell Davis, PhD, RN</td>
</tr>
<tr>
<td>Commission on Professional Issues</td>
<td>Richard Brown, MSN, CRNP, JD</td>
</tr>
<tr>
<td></td>
<td>Stuart Pope, RN</td>
</tr>
<tr>
<td></td>
<td>Jean Ivey, DSN, RN, CRNP</td>
</tr>
<tr>
<td></td>
<td>Cam Hamilton, MSN, RN</td>
</tr>
<tr>
<td></td>
<td>Michelle Schutt, Ed.D., RN, CNE</td>
</tr>
<tr>
<td>Nominating Committee</td>
<td>Glenda Smith, RNC, MSN, NNP</td>
</tr>
<tr>
<td></td>
<td>Cindy McCoy, PhD, CCRN, BC</td>
</tr>
</tbody>
</table>

*ANA Delegates will be elected by ballot mailed in the Jun/July/Aug issue of the Alabama Nurse. All other positions will be elected by the ASNA House of Delegates at ASNA Convention October 1-3, 2009 in Florence, AL.
### 2009 Convention

#### Alabama State Nurses Association
#### Alabama Organization of Nurse Leaders
#### Alabama Association of Nursing Students

**Annual Convention**

**1-3 October 2009**  
Marriott Shoals Hotel & Spa  
(on the Robert Trent Jones Golf Trail)  
Florence, Alabama

Convention details may be located at [www.alabamanurses.org](http://www.alabamanurses.org)

<table>
<thead>
<tr>
<th>Thursday, 1 October 2009</th>
<th>Mabel Lamb Pre Convention Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:15 AM</td>
<td>“Climb for the Cause (featuring the women of Mt. Kilimanjaro)”, Dr. Penny Wright</td>
</tr>
</tbody>
</table>
| 11:30 AM–1:00 PM         | AlaONL Annual Meeting  
AlaONL Key Note Address  
Speaker TBA  
(sponsored by Hill-Rom)  
Lunch (provided) |

**Concurrent Sessions**

<table>
<thead>
<tr>
<th>1:30–6:00 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop I</td>
</tr>
</tbody>
</table>
| Clinical Nursing  
AlaONL Track–Nursing Sensitive Indicators: Quality and Cost Implications |
| Workshop II  |
| Mental Health Leadership Competency Series |
| Workshop III |
| Workshop IV  |

<table>
<thead>
<tr>
<th>6:00 PM</th>
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<tbody>
<tr>
<td>President’s Reception (provided)</td>
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<table>
<thead>
<tr>
<th>6:30 PM</th>
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</thead>
</table>
| Supper (provided)  
To Follow  
ASNA Game Night or ASNA Board of Directors Meeting |

(Note: AANS schedule TBA)

<table>
<thead>
<tr>
<th>Friday, 2 October 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:15 AM</td>
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<tr>
<td>8:00 AM–3:00 PM</td>
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<tr>
<td>8:00 AM</td>
</tr>
</tbody>
</table>

**Education Sessions**

<table>
<thead>
<tr>
<th>8:00 AM–12 Noon</th>
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</thead>
</table>
| “Nurses Around the World”  
Dr. Sue Morgan |
| “Nursing Education—a Global Focus”  
TBA |
| “Environmental Safety—What’s in Our Water”  
Nelson Brook |

<table>
<thead>
<tr>
<th>12 Noon</th>
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</thead>
<tbody>
<tr>
<td>Lunch (provided in exhibit area)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>1:00 PM– 5:30 PM</th>
</tr>
</thead>
</table>
| House of Delegates  
Key Note Address  
Dr. Lynda Harrison |

<table>
<thead>
<tr>
<th>6:00 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awards Celebration and banquet</td>
</tr>
</tbody>
</table>

(Note: AANS schedule TBA)

<table>
<thead>
<tr>
<th>3 October 2009</th>
</tr>
</thead>
</table>
| 7:30 AM        | Breakfast Roundtable Sessions  
“Best Practices in Nursing” |
| 8:00 AM–8:45 AM | Polls open |
| 9:00 AM–12 Noon | Posters |
| 9:15 AM        | Human Trafficking  
Helen Wilson |

<table>
<thead>
<tr>
<th>10:15 AM</th>
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</thead>
</table>
| Political Forum  
State Legislators invited |

<table>
<thead>
<tr>
<th>11:00 AM</th>
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<tbody>
<tr>
<td>House of Delegates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12:30 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunch (provided)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1:00 PM</th>
</tr>
</thead>
</table>
| Alabama Board of Nursing Update  
N. Genell Lee, JD, MSN |
Registrations postmarked or received after Sept. 15, 2009 will be considered “at-door”.

Total Enclosed: $ ________________

Additional Meal/Function Tickets

Received after September 1, 2009
ASNAMember–$170/day Non Member–$195/day

Received on or before August 3, 2009
ASNAMember–$165/day Non Member–$180/day

Daily Registration *

Received after September 1, 2009
ASNAMember–$270 Non Member–$295

Non Delegates–Full convention *

Received on or before August 3, 2009–$239 Received after September 1, 2009–$255

ASNA Delegates Only (must register for entire convention)*

2.) Convention, Friday and Saturday, October 2-3, 2009 (includes tickets to all meal functions listed in this application)–Select one of the following choices:

Track I Clinical

Track II AONL (Quality & Cost Implications) ASNA member $119 Non-member $339

Track III Mental Health

Track IV Leadership

NOTE: Add $10 to above fees if received after August 31, 2009

2009 Convention Plemimy Sponsors & Exhibitors

SPONSORS:

GOLD

Arthur L. Davis Publishing Agency, Inc.

2009 CONVENTION EXHIBITORS

Alabama Auxiliary of the Gideons International
Alabama Organ Center
Beijo Handbags & Accessories
Cengage Learning/Delmar Press
DCH Health System
Emory University School of Nursing
First Fidelity Group
Hurst Review Services
Jackson Hospital
Middle Tennessee School of Anesthesia
Rinehart & Associates
Sylvia Rayfield & Associates/Ican Publishing
Troy University School of Nursing
University of Alabama-Capstone College of Nursing

The Alabama Organization of Nurse Leaders (AONL) will again partner with ASNA at the ASNA Convention offering a luncheon meeting with a featured speaker from Hill-Rom on October 1, 2009. The luncheon meeting will include continuing education. AONL appreciates the opportunity to work with ASNA to share healthcare policy updates and future trends. AONL will also offer a Leadership Track at the Convention focusing on Nursing Sensitive Indicators: Quality and Cost Implications. Nursing-sensitive indicators reflect the structure, process and outcomes of nursing care. Patient outcomes that are determined to be nursing sensitive are those that improve if there is a greater quantity or quality of nursing care and include pressure ulcers, falls, and intravenous infusions. CEs will also be awarded for this track. AONL is partnering with Alabama Quality Assurance Foundation (AQAF) to provide an all day workshop. Annual AONL Leadership Conference. The National Patient Safety Goals: Clinical and Academic Partnership will be offered on Friday, August 21, 2009 in Montgomery. Please contact Dr. Linda Roussel (lroussel@usouthal.edu) for details.

Alabama Organization of Nurse Leaders and ASNA Partner at the Convention

Dr. Linda Roussel, AONL President
lroussel@usouthal.edu

2009 Convention

Alabama Nurse • Page 11
Being a Delegate to a state convention can be an exciting experience but one that also has some inherent responsibility. As you may know, the House of Delegates (HOD) is the governing and official voting body of the Alabama State Nurses Association (ASNA). The House meets annually. Members of the HOD have a crucial role in providing direction and support of the work of the Alabama State Nurses Association. Delegates are elected to the HOD to work for the betterment of ASNA and the nursing profession. Each delegate is expected to study the issues thoroughly, attend each session of the HOD (including the Open Forums), and engage in active listening and debate. Also, delegates are encouraged to use the extensive resources and collective knowledge available at each meeting to provide direction and support for the work of the organization. Such a commitment benefits the individual delegate, the association, and the nursing profession.

If a delegate in unable to attend the 2009 ASNA House of Delegates, his/her district nurses association (DNA) should be notified at once. When alternate delegates are substituted for delegates, it is the responsibility of the District President to notify ASNA of the change immediately.

Important information for ASNA Delegate Registration

Delegates are encouraged to register for convention in advance to expedite the on-site credentialing process. See the registration form in the pull out section of this issue for registration fees. Full registration includes, Friday Evening Awards/Celebration Dinner, Saturday and Sunday breakfast and lunch. Additional tickets can be purchased for these events. Utilize the special pullout section of The Alabama Nurse to register for convention. Please note the cut off date for the hotel discount is August 31, 2009. ASNA has blocked a certain amount of rooms for this convention. Please consider that off-site hotel registration of delegates causes a financial hardship to the organization if the room block is not met.

To ensure eligibility for the credentialing process, delegates are required to present their current ANA membership card and one picture ID at the Delegate Registration desk. If you do not have a current membership card please contact April Bishop, Programs Coordinator for assistance. Each delegate will be issued a name badge, a delegate ribbon, and informational materials upon proof of identification. The name badge and delegate ribbon must be worn in order to be admitted to the floor of the House of Delegates.

Please call the ASNA office at 1-800-270-2762 or 334-262-8321 if you have questions or concerns.
“Most people know they can’t get into the hospital without a doctor: What they don’t know is that they won’t get out of one— at least not alive— without a nurse,” Joan Lynaugh, Nursing Historian

How do we define “profession” and “professionalism”? What do these terms mean to Registered Nurses? What do these terms mean to society? What should be the entry level to practice education be for RNs? How do we characterize attributes of the professional RN? What does the future hold for the nursing professional?

The meaning of professionalism has been the subject of much debate for decades, perhaps centuries. The Carnegie Foundation produced one of the first papers on this subject in 1910. The Flexner Report focused on the profession of medicine and tendered the incentive for future writings, discussion and efforts to define this concept. The Flexner Report suggested activities must be intellectual in their pursuit as opposed to physical; they must be based on knowledge. Additionally, it was recommended that there must be ‘teachable’ techniques and that practitioners must be motivated by altruism. Author Abraham Flexner is quoted “If the sick are to reap the full benefit of recent progress in medicine, a more uniformly arduous and expensive medical education is demanded” (1910).

Another report produced by Bixler and Bixler (1959) stated the characteristics of a profession must have a specialized body of knowledge and use that body of knowledge to expand and improve the techniques, education, and service through scientific research methods, it must entrust the education of its practitioners at institutes of higher education, and help formulate professional policies and control of the professional activities.

As a profession, we must agree that nursing is a profession, act professionally, and propel our profession forward. We clearly have some work to do in this regard. There are many important issues ‘we’ must address, and decisions to be made on these matters so as to strengthen and advance the nursing profession. As counter-intuitive as it may feel or counter to conventional wisdom, we should use and exploit the current critical shortage of nurses to advance our position, our evidenced-based practices, re-examine and resolve the entry-level to professional practice issue and be assertive in our evidenced-based practices, re-examine and resolve the entry-level to professional practice issue and be assertive in controlling the practice of nursing as physicians did in the early 20th century. We can not merely permit our professional significance to be defined by arbitrary regulation, a union contract, or a hospital policy or procedure,” nor can we sit idly by while policy makers dictate our patient care load, the hours we work, or the education of our future nursing professionals. It is up to YOU, it is up to me, it is up to ‘we’ as part of the nursing profession to reshape our image into a strong, competent, capable, and powerful profession that is intellectually demanding, exciting, rewarding and challenging. This is not up to hospital CEO’s, Senators and Congressmen, it is up to us.

Burch and Gordon (2006) so aptly describe the work which is necessary to our success and voicing our silence as we work to improving the image of nursing and sharing with the world our professionalism and importance: “This will be hard work indeed. It means fighting against deeply rooted stereotypes…visibility is not an option, it’s an obligation…and if we fail to make our work visible, we are betraying our mission, our patients present and future, and society itself” (p. 275). Are you ‘just a nurse’, no YOU are something MORE, do not diminish what you do, who you are and what this profession means to the world.

(See Appendix A)

I’m just a nurse.
I just make the difference between life and death.
I just have the educated eyes that prevent medical errors, injuries and other catastrophes.
I’m just a nurse.
I just make the difference between pain and comfort.
I’m just a nurse.
I’m just a nurse researcher who helps nurses and doctors give better, safer, and more effective care.
I’m just a professor of nursing who educates future generations of nurses.
I just work in a major teaching hospital managing and monitoring patients who are involved in cutting-edge experimental research.
I just educate patients and families about how to maintain their health.
I’m just a nurse practitioner who makes a difference between an elderly person staying in his own home or going to a nursing home.
I just make the difference between dying in agony and dying in comfort and with dignity.
I’m just a nurse.
I’m just the real bottom-line in health care.
Wouldn’t you like to be just a nurse, too?

Appendix A

Just a Nurse
by Suzanne Gordon

I’m just a nurse.
I just make the difference between life and death.
I just have the educated eyes that prevent medical errors, injuries and other catastrophes.
I’m just a nurse.
I just make the difference between pain and comfort.
I’m just a nurse.
I’m just a nurse researcher who helps nurses and doctors give better, safer, and more effective care.
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I just educate patients and families about how to maintain their health.
I’m just a nurse practitioner who makes a difference between an elderly person staying in his own home or going to a nursing home.
I just make the difference between dying in agony and dying in comfort and with dignity.
I’m just a nurse.
I’m just the real bottom-line in health care.
Wouldn’t you like to be just a nurse, too?

Caring for the Little Ones ~ 2009 Annual Pediatric Update
In collaboration with UAB Pediatric Pulmonary Division
August 29, 2009
6:16 Contact Hours (ANCC)
7.4 Contact Hours (ABN)
Rainbow City, Alabama

Goal: Update pediatric knowledge.
8:00 am Registration
8:15 am Pediatric Orthopedic Injuries Linda Wilkinson, CRNP
9:15 am Pediatric Obstructive Sleep Apnea David Lezamo, MD
10:15 am Break
10:30 am Pediatric Behavior Modification Krivin Avis, Ph.D., CRISP
11:30 am Lunch provided
12:15 pm Latino Healthcare & Cultural Considerations Isabel Soreci, Ph.D.
1:15 pm Common Pediatric Vision & Eye Problems Marcela Frazier, OD, MPH, FAAO
2:15 pm Break
2:30 pm Pediatric Seizures & Seizure Management Sula Gillespie, CRNP
3:30 pm Evaluation & Comments

Objectives:
At the conclusion the participant should be able to:
1. List common pediatric orthopedic injuries.
2. Explore reasons for pediatric obstructive sleep apnea.
3. Discuss parental involvement with pediatric behavior modification.
5. Review common pediatric eye problems.
6. Discuss pediatric seizure management.

Cost: Members: $59
Non-Members: $79

After August 14, 2009 add $15

Continuing Education: The Alabama State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center
Alabama Board of Nursing (valid through March 20, 2013).

Refunds: If cancellation is received in writing prior to August 14, 2009 a refund minus a $250 processing fee will be given. After August 14, 2009 no refunds will be given. We reserve the right to cancel the program if necessary. A half refund will be made in this event.

I’m just a nurse.
I just make the difference between life and death.
I just have the educated eyes that prevent medical errors, injuries and other catastrophes.
I’m just a nurse.
I just make the difference between pain and comfort.
I’m just a nurse.
I’m just a nurse researcher who helps nurses and doctors give better, safer, and more effective care.
I’m just a professor of nursing who educates future generations of nurses.
I just work in a major teaching hospital managing and monitoring patients who are involved in cutting-edge experimental research.
I just educate patients and families about how to maintain their health.
I’m just a nurse practitioner who makes a difference between an elderly person staying in his own home or going to a nursing home.
I just make the difference between dying in agony and dying in comfort and with dignity.
I’m just a nurse.
I’m just the real bottom-line in health care.
Wouldn’t you like to be just a nurse, too?

Caring for the Little Ones ~ 2009 Annual Pediatric Update
August 29, 2009 – Rainbow City Library/Community Center
5702 Rainbow Drive, Rainbow City, AL 35906

Name: ________________________________
Nursing License No.: _______________
Address: ________________________________
Phone: ________________________________
Office Phone: __________________________
Email: ________________________________
Credit Card #: ________________________________
CVV Code: ________________________________
Exp. Date: ________________________________

Register Online at www.alabamanurses.org
OR
Send registration and payment to ANSA, 360 North Hall St. Montgomery, AL 36104 or Fax to 334-262-8578

CONFIRMATIONS WILL BE SENT BY EMAIL ONLY.
Ms. Lori Lioce, a graduate of the University of Alabama in Huntsville College of Nursing and President-elect, Nurse Practitioner Alliance of Alabama, was one of nine nurses statewide awarded the Alabama League for Nursing Lamplighter Award. A banquet in honor of the nominees was held at the Marriott Grand Hotel, Point Clear, Alabama on April 2, 2009.

The ALN Lamplighter Award is part of a prestigious recognition program designed to pay tribute to individuals who have made a substantial contribution to the nursing profession and/or society. Ms. Lioce is an active member of the Alabama State Nurses Association, and serves on the ASNA Legislative Committee and Advanced Practice Council. She also served as the Committee Chair for Advanced Practice Nursing in Retail Clinics, a subcommittee of the American Nurses Association (ANA) Congress on Nursing Practice. She is currently the co-chair of the ANA Congress on Nursing Practice and Economics Health Reform Care Coordination Subcommittee. Ms. Lioce is both a practitioner in advance practice nursing and an educator.

New/Renew Members

District 1:
Frances Gillespie, RN
Sheila Shoek, RN
Donna Everett, RN, BS, CIC
Sharon Flanagan, LPN
Cheryl Bailey, BSN, RN, MBA
Mark Hodges, RN, NP-C
LaTanya Ashford, BSN, RN
Rebecca Viall, RN
Rebecca Wierenga, RN, ADN

District 2:
Brenda Clearman, RN
Rhonda Snow, RN
Betty Odom, RN
Sandra Warren, MSN, RN

District 3:
Terry Hill, RN, CM, AND
Mary Franklin, RN
Judith (Kay) Morris, MSN, RN
Ronda Bush, RN
Elizabeth Gulledge, MSN, RN
Teresa Holt, RN
Avis McKay, RN
Michelle Stubbs, RN
Linda Taylor, RN
Marilyn West, RN
John McCarter, RN
Jamie Sessions, RN
Rhonda Thomas, BSN, RN

District 4:
Mary H. King, RN

District 5:
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Mildred Negron, RN
Angela Nix, RN
Gwendolyn White, RN

Members, if your credentials are incorrect please accept our apologies and contact April Bishop at memberasna@bellsouth.net with corrections.
Leaving Your Job? What About Your Retirement Account?

by Mark Miehle

Let’s say you leave your job for whatever reason. You get another job, you are ready to retire or you unfortunately are let go. What should you do about your retirement account? This is a big question for a lot of people. When you leave your job you have to choose between one of three alternatives. Let’s examine what those alternatives are.

The first alternative I name after an old Beatles song: “Let It Be”. That is to do nothing and leave your retirement account where it is. Now since you are no longer working at your former employer, you are no longer able to make any more contributions. If you are no longer making any more contributions your former employer will no longer contribute to your retirement. The account value of your retirement account is only going up or down based on market conditions.

The second option is to roll your current retirement account into a new retirement account. If you are going to work at another job, you may roll your previous retirement account into your new employers 401(k) or 403(b) retirement plan. Not knowing how long you are going to stay at that the new position your money is probably better off than leaving where it was.

What most financial advisors will recommend is that you roll your retirement account into a traditional Individual Retirement Account (IRA). By rolling your retirement account into your own IRA, typically you have a little more control of your retirement account and more choices of what you can invest in.

For example, IRA's offer you not limited to investing in cash, bonds, or mutual funds (stocks). Depending on how you set up your IRA you can invest in other products that are guaranteed not to go down in value, but also offer upside potential if the market goes up or if the market doesn’t go up still offer a fixed rate of return.

You can set up an IRA with most brokers, bankers or financial advisors. Be sure to ask them a number of questions such as: What will they do?, Will there be any fees? and others. For a list of questions contact me directly and I will send you a free of a list of “10 Tough Questions To Ask a Financial Advisor.”

Perhaps the most important thing in rolling over is to make sure that you never actually take receipt of the money in the retirement account. You want to make sure that the money rolls directly from one retirement account to another retirement account. This is why it is important to have an experienced advisor help you do it correctly.

Now your last option is the definitely the worst of the three alternatives. The third alternative is to cash out of your retirement account. No matter if you are cashing out an IRA, 401(k), or 403(b) there are strict guidelines and laws as to when and how you can access your money. With any of this money you can not access it until you reach the age of 59 ½. If you take your money out early not only do you have to pay income tax on that money, but you also have to pay a penalty to IRS in the amount of 10%.

For example, let’s say you have $10,000 you are cashing out of your retirement account. Assuming you are under the age of 59 ½, the first thing you get hit with is a 10% penalty or $1,000. Then you have to pay taxes on the $9,000 which will be about $2,800 (assuming a 28% state and federal marginal tax rate). So when you thought you were going to get $10,000 you end up with $6,200. Now you can wait until you are 59 ½ and avoid paying the penalty, but you will never avoid paying the taxes.

Now sometimes there are circumstances or situations where cashing out of a retirement account is necessary to address some financial crisis and despite the penalty, can not be avoided. But most advisors will tell you that you should try all legal means to try not to cash your retirement account in.

If you leave a job for whatever reason, don’t forget that you have three alternative as what you can do with your retirement account. Just like none of you would forget about a patient under our care, don’t forget to care about your retirement account and decide which alternative is best for you.

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Financial Corner

The Myths About Long-Term Care

Long-term care issues have been everywhere in the news lately—from stories of people needing these services to how the government is responding. But there is also a lot of conflicting, and even mistaken, information. Misconceptions may have prevented you from including long-term care services in your financial plans.

Myth #1: I’ll never need long-term care

Most people can’t imagine themselves needing long-term care services. But, the U.S. Department of Health and Human Services indicates that people age 65 face at least a 40% lifetime risk of entering a nursing home sometime during their lifetime. Living a long life may increase your 40% lifetime risk of entering a nursing home sometime during their lifetime.1 Long-term care planning can be a critical component to any comprehensive retirement plan. So now is the time to dispel these myths.

Myth #2: Long-term care is only for the elderly

Actually, a surprising amount of long-term care services are actually able to stay at home, with or near families, and have access to professional care. With the advances in medical science, long-term care services are actually able to stay at home, with or near families, and still get the professional care they need.

Myth #3: I’ll pay for my own long-term care expenses

In 2008, nursing home costs averaged over $76,400 a year nationally, but in some regions these costs are sometimes twice that amount.2 How long can you pay for these expenses without jeopardizing your financial plans? Spending nearly all of your own money on your own care before the government will step in to help.

Myth #4: Medicare will cover my long-term care expenses

Medicare does pay for nursing home care, but only for a maximum of 100 days and if the 3-day qualifying hospital stay requirement has been met. In addition, Medicare will only pay as long as you are showing progress towards recovery. Once your condition becomes stable, even if you are not fully well or back to a completely healthy state of being, Medicare rules indicate that benefits will stop. Also, Medicare does not pay for individuals to attend an adult day care or for the room & board expenses at an assisted living facility.

Myth #5: Medicaid will cover my long-term care expenses

Medicaid was developed partially to cover long-term care costs for Americans of any age who need help paying for these services. Medicaid is currently the largest payer of long-term care costs in the United States, primarily for care in nursing homes. However, Medicaid focuses on helping people with limited or minimal income and assets, and in order to qualify for benefits, you have to demonstrate a financial need for help. Qualifying means spending nearly all of your own money on your own care before the government will step in to help.

Myth #6: My family will take care of me

The financial, physical and emotional stress that full-time care-giving may place on families can be overwhelming. Many families have struggled to provide care for parents or siblings only to eventually realize that the care required is more than they can provide. The truth is, sometimes the best way for a family to take care of a loved one needing long-term care is to make sure that they have access to professional care. With the advances in home care services, many people needing long-term care are actually able to stay at home, with or near families, and still get the professional care they need.

Myth #7: Long-term care insurance covers only nursing homes

Everyone wants to stay at home. Long-term care insurance can offer valuable benefits that may keep you at home for as long as possible. Long-term care insurance can also help cover the cost of care in other locations, such as adult day care centers, assisted living facilities and hospice care.

With long life comes long-term planning. Make a plan for you and your family today. For more information on long-term care insurance, please contact Scott Key, Agent, New York Life Insurance Company at 334-274-4789, E-mail: uskey@newyorklife.com

The purpose of this piece is solicitation of insurance. An insurance producer (agent) may contact you. New York Life Insurance Company long-term care insurance is issued on policy form series ILTC-5000 and INH-5000 with a state identifier and edition date. Examples: For Idaho ILTC-5000 (ID) (1001) and INH-5000 (ID) (1001) and for North Carolina ILTC-5000 (NC) (1001) and INH-5000 (NC) (1001) (Rev. 06/06) and for Pennsylvania ILTC-5000 (PA) (1001), FLTC-5000 (LP) (PA) (0303), for Tennessee ILTC-5000 (TN) (1001) and INH-5000 (TN) (1001) and for Texas ILTC-5000 (TX) (1001) and INH-5000 (TX) (0305). New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010.


Editorial Note: The financial articles presented in this column are for informational/educational purposes only. No endorsement by ASNA is given or implied.
Some pregnancy-related complications are minimized for women undergoing bariatric surgery. As we contemplate further research, we would like to hear about your experiences with lifting equipment and practices at multiple hospitals, including intervention programs and health/safety outcomes, in order to identify and promote evidence-based best practices.

Low cost is a vested interest in taking care of those who help take care of us and our families when we need medical attention. It is likely that the implementation of the research presented here will significantly reduce injuries and illnesses for healthcare workers and increase the quality of patient care. In turn, reducing MSDs among nurses will help take care of those who help take care of us and our families when we need medical attention. It is likely that the implementation of the research presented here will significantly reduce injuries and illnesses for healthcare workers and increase the quality of patient care.
Our annual Elizabeth A. Morris Clinical Education Sessions—FACES 2009 was held on Tuesday, 21 April at the Eastmont Baptist Church in Montgomery. We had another tremendously successful event, with over 600 attendees, an outstanding lineup of excellent speakers and presenters, and a list of terrific exhibitors. This was our fourth year at Eastmont, and the church staff was, as always, very supportive and welcoming. Those of you that enjoyed lunch at the church can also testify that the prepared meal was delicious; never mind the great desserts! This year we had an extensive series of tracks from which to choose: AANS; three different clinical tracks: Education and Research; Geriatrics; Pediatrics; Women’s Health and Parrish Nursing. In addition, the poster presentations were excellent, with 1st place winners Diane Bilotta, MSN, RN, CPAN, Deborah Wagner, RN, CNOR, Shellie Miles, RN, Guy Harrell, RN & Patrick Lux, RN, CCRN (Building a Safe Patient Handling Program...) and Dr. Tina Holloway, (Does Patient Perception of Quality Impact Health Outcomes). Honorable Mention (the Geriatric Units for Maintaining Functional Levels), Elizabeth Drinkard, Christian Killingsworth, Lisa Kopec and John Pinkston. Please see a list of our sponsors and exhibitors elsewhere in this issue.
Changing the Look of CE for Nurses in Alabama

Katie Drake-Speer, MSN, RN
Nurse Consultant, Continuing Education
Alabama Board of Nursing

Alabama licensed nurses are required to have 24 contact hours (not CEUs) of continuing education to renew their nursing licenses. Rules and regulations regarding continuing education are published in the Alabama Administrative Code. The Alabama Board of Nursing (ABN) revised the continuing education rules, effective March 30, 2009, to clarify course content, method of obtaining the contact hours, and to address contact hours allowed by standardized national programs.

Continuing Education Content
Continuing education is planned, organized learning experiences designed to augment the knowledge, skill, and attitudes for the enhancement of the practice of nursing to the end of improving health care to the public. To answer frequent questions about courses not directly related to nursing practice, the ABN included specific examples in the revised rules of types of courses/classes that are not acceptable to use as contact hours. The unacceptable types of courses include:
- Self improvement classes (weight loss, self-awareness, self-therapy, changes in attitude, and yoga).
- Classes designed for lay people.
- Classes taken for personal economic gain (investment, retirement, financial planning).
- Orientation programs (specific activities designed to familiarize employees with the policies and procedures of an institution or specific job duties, or general orientation inservice).

Continuing Education Contact Hours
To allow the licensed nurse flexibility in selecting which method to obtain continuing education contact hours, there is no longer a distinction between attended or independent study continuing education contact hours. In the old rules, licensed nurses were limited to 12 continuing education contact hours for independent study.

Continuing education earned from a Board-approved or Board-recognized provider in any of these activities is acceptable and the licensed nurse can earn all required continuing education contact hours from these activities (ABN Administrative Code, Rule 610-X-10-.05): workshop, seminar, classroom, web cast, internet courses, intranet courses, home study courses, continuing education contained in journals and pod cast.

If approved by a Board-approved provider, a licensed nurse can earn continuing education for the development and oral presentation of a paper before a professional or lay group (on a subject that explores new or current areas of nursing theory, or practice); authoring or contributing to an article, book, or publication; or designing or conducting a research study. Licensed nurses can earn one time credit for a single presentation or project. Board-approved providers may award credit for presentations or research activities that are not part of regular job requirements e.g., if a job requirement includes instructing in ACLS courses, continuing education credit should not be allowed. If however, a licensed nurse presents a segment or entire ACLS course as a professional endeavor outside the job, the Board-approved provider may choose to award contact hours in accordance with the degree of participation. The Board-approved provider must electronically transfer the award of contact hours to the ABN. The licensed nurse cannot enter the class information to his or her own individual continuing education record.

Standardized National Programs
The ABN recognizes continuing education offered by national approved bodies and by providers who offer standardized national programs. The ABN accepts standardized national programs for continuing education in accordance with ABN Administrative Code, Rule 610-X.10. The national provider determines the number of hours and the ABN staff contacts these providers to obtain the number of contact hours identified for each program.

The licensed nurse must maintain evidence of the number of hours awarded by maintaining the certificate or card awarded upon completion of the coursework.

The hours listed in the rule and seen below are the maximum number of contact hours the Board shall recognize, unless an Alabama Board of Nursing-approved provider awards more in accordance with Rule 610-X.10-.04 of the ABN Administrative Code. The ABN accepts the following standardized courses:
- Basic Life Support Healthcare Provider Initial Course: 4.5 contact hours.
- Basic Life Support Healthcare Provider Renewal Course: 3 contact hours.
- Advanced Cardiac Life Support Initial Course: 13.5 contact hours.
- Advanced Cardiac Life Support Renewal Course: 9 contact hours.
- Pediatric Advanced Life Support Initial Course: 14 contact hours.
- Pediatric Advanced Life Support Renewal Course: 8.5 contact hours.
- Oral presentation of a paper before a professional or lay group.
- Cardiopulmonary Resuscitation/Automatic External Defibrillator (CPR / AED) for Professional Rescuer: 8 contact hours.
- Neonatal advanced life support or neonatal resuscitation program: The Board may recognize the total contact hours awarded by a Board-approved or Board-recognized provider.

Submission of Hours
The ABN receives frequent inquires from licensed nurses regarding how and when to add class information to their online individual continuing education record.

Since January 2006, all ABN-approved providers are required to electronically transfer class information to the ABN. Class information submitted by the Board-approved provider will populate the licensed nurse’s individual online continuing education record. The licensed nurse cannot edit the entries made by the Board-approved provider. However, licensed nurses can add class information from recognized providers to their record. Licensed nurses can access their online individual record at the ABN web site, www.abn.alabama.gov by clicking on Administrative Code and then selecting Chapter 610-X.10 Continuing Education for Licensees.

The Continuing Education Earning Period
The Continuing Education Earning Period is the two-year period of time during which contact hours are earned for license renewal. The license renewal year for licensed practical nurses occurs every odd year. The license renewal year for registered nurses occurs every even year. Effective January 1, 2008, the earning period for licensed practical nurses is the same as the period license. The earning period is from January thru December. Although the earning period is January 1, 2008 through December 31, 2009, for the 2009 LPN renewal nurses may use continuing education earned between October 1, 2007-December 31, 2009 to meet the continuing education renewal requirement.

Effective January 1, 2009, the earning period for registered nurses is the same as the license period. RNs renewing in 2010 must earn their continuing education contact hours from January 1, 2009 through December 31, 2010.

The changes in the new CE rules should assist all licensed Alabama nurses in meeting the continuing education requirements for license renewal. If you have questions please contact the continuing education area, 1-800-466-5318, katie.drake-speer@abn.state.al.us or vanessa.mathis@abn.state.al.us.

For a detailed review of the rules, you can access them at www.abn.alabama.gov by clicking on Administrative Code and then selecting Chapter 610-X.10 Continuing Education for Licensees.