President’s Message

Wow! A year has passed since I sat down to write my first editorial. Many things have happened and it is with some amazement (and sometimes panic) that time seems to be passing so quickly. There is so much to consider and so many things to do, and yet somehow it all seems to happen so quickly. This past year has been one of change; although all years seem to carry that adjective in the recent past.

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So I will finish with two challenges. The first challenge is to MEMBERS—how can we encourage you to be an ACTIVE member of ISNA? The few cannot do this alone. We need your ideas. We need all of us to make nursing’s voice strong in Indiana.

Dorene Albright chairs the current Nominations Committee. Send her an email through ISNA (info@indiananurses.org) and volunteer to join a committee, run for office, even run for the Board of Directors. Please email me and we can discuss ways for you to be involved (harmeyer@saintmarys.edu). Make yourself a note to attend the Legislative Conference at the beginning of 2009 (date pending). We want to see you!

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IN MEMORIAM

Ruth Elaine Davidhizar, DNS
Aug. 9, 1946–Sept. 11, 2008

Ruth was employed at Bethel College, Mishawaka, since 1987. She was a professor and dean of the school of nursing and on the faculty in the MSN program. She also served as an adjunct professor and consultant at Ball State University, Muncie, Ind., and a research consultant to the graduate programs at Andrews University, Berrien Springs, Mich. She was a frequent preceptor for graduate students. In addition, she was on the faculty at Memorial Hospital of South Bend School of Nursing and the Director of Nursing at Logansport State Hospital, Logansport, Ind.

She is survived by her husband, Goshen; father, Ralph Holderman, Glendye, Mont.; stepfather, Cindy Mullet, Glendye, Mont.; and adopted brother, James (Mary Ann) Holderman, Glendye, Mont.

Dr. Davidhizar’s formal education began in Alaska where she lived with her parents in small Eskimo villages in the Arctic Circle. When she was ready for high school, she attended Western Mennonite High School in Oregon. After graduating from high school, she decided on a career in nursing and spent her first year of college at Eastern Mennonite College in Harrisonburg, Va. She then transferred to Goshen College School of Nursing in Goshen, Ind. Dr. Davidhizar earned her BSN from Goshen College and her MSN in Psychiatric Nursing Education and DNS in Psychiatric Nursing Research from Indiana University. She was board certified as a psychiatric nursing practitioner and a fellow in the Academy of Nursing. She was designated in 2006 as a Transcultural Nursing Scholar by the Transcultural Nursing Society.

She held a number of state and national positions. She was the co-chair of the Expert Panel on Cultural Competency for the Academy of Nursing. She was a member of the State of Indiana Health Care Professional Development Commission. She was a Sigma Theta Tau writing mentor and expert speaker on writing for publication and cultural competence. She also served as an ACCN Dean mentor.

She was a regular presenter of cultural competency and other health related topics throughout the United States to nursing, educational and other health related groups. She was a member of Sigma Theta Tau; NLN; Transcultural Nursing Society; Association of Black Nurses; Northern Indiana Organization of Nursing Executives; Indiana State Nurses Association; Council of Indiana Deans of Nursing Schools; and was an executive board member of Nursing 2000 North Central Indiana Region.

Names in the News

Victoria L. Champion, associate dean for research at the Indiana University School of Nursing, has been appointed to the National Cancer Advisory Board. The 18-member board advises the secretary of the Department of Health and Human Services and the director of the National Cancer Institute.

Rep. Peggy Welch, Bloomington, was honored at a reception in July as incoming president of the Women’s Legislative Network, National Conference of State Legislators. [Note photo]

(1) Janet Haebler, MSN, RN, Associate Director, ANA State Government Affairs; Rep. Peggy Welch, RN; Rural Gonzalez, MPH, RN, Director, ANA Government Affairs.
APPLICATION FOR RN MEMBERSHIP
Or complete online at www.NursingWorld.org

PLEASE PRINT OR TYPE

Last Name, First Name, Middle Initial

Home phone number & area code

County of Residence

Work phone number & area code

City, State, Zip+4

Preferred email address

________

Full Pay – CHECK

______________

Card Number

VISA/Master card

Exp. Date

Signature for Bankcard Payment

1. SELECT PAY CATEGORY

Full Dues – 100%
Employed full or part time.
Annual-$269
Monthly (EDPP)-$22.92.

Reduced Dues – 50%
Not employed; full-time student, or 62 years or older.
Annual-$135.50,
Monthly (EDPP)-$11.71.

Special Dues – 25%
62 years or older and not employed or permanently disabled.
Annual $67.25.

2. SELECT PAYMENT TYPE

FULL PAY – CHECK
FULL PAY – BANKCARD

Card Number

VISA/Master card

Exp. Date

Signature for Bankcard Payment

3. SEND COMPLETED FORM AND PAYMENT TO:
Customer and Member Billing
American Nurses Association
P.O. Box 504345
St. Louis, MO 63150-4345

ARTICLES OF MEMBERSHIP

The Indiana State Nurses Association is a Constituent Member of the American Nurses Association

The Electronic Dues Payment Plan (EDPP) provides for convenient monthly payment of dues through automatic monthly electronic transfer from your checking account.

To authorize this method of monthly payment of dues, please read, sign the authorization below, and enclose a check for the first month (full $22.92, reduced $11.71).

This authorizes ISNA to withdraw 1/12 of my annual dues and the specified service fee of $0.50 each month from my checking account. It is to be withdrawn on/after the 15th day of each month. The checking account designated and maintained is as shown on the enclosed check. The amount to be withdrawn is $________ each month. ISNA is authorized to change the amount by giving me (the undersigned) thirty (30) days written notice.

To cancel the authorization, I will provide ISNA written notice thirty (30) days prior to the deduction date.

Signature for Electronic Dues Payment Plan

Welcome to New Members and Reinstated ISNA Members

Rhonda Anders, Indianapolis
Kathryn Arnold, Carmel
Barbara Bartley, Jasper
Sara Browning, Evansville
Katherine Callahan, Noblesville
Chona Carbonell, Crown Point
Eunjin Choi, Valparaiso
Shu-Yu Chung, Terre Haute
Sharon Cornelious-Ellis, Crown Point
Sherrri Crawford, Indianapolis
Martha Dick, Evansville
Gloria Dillman, Munster
Jessica Durbin, Terre Haute
Michelle Easterday, Peru
Steven Fields, Rensselaer
Vickie Fortune, Haubstadt
Sandra Gardner, South Bend
Rose Gesaman, North Webster
Carol Green, Corydon
Irma Hocking, Evansville
Jennifer Jansen, Crown Point
Laura Jenkins, Plainfield
Theresa Knott, Indianapolis
Jeanie Langschied, Fort Wayne
Jodi Loyd, Jeffersonville
Debra Mallory, Terre Haute
Judith Matanic, La Porte
Elizabeth McGee, Fort Wayne
Amanda Meehan, Vicki Meek, Odom
Marti Michel, Indianapolis
Valerie Miller, Edinburgh
Jane Mobley, Indianapolis
Rachel Moody, LaPorte
Patricia Nietch, South Bend
Chuck Nordyke, Hobart
Linda O’Malley, Nineveh
Elizabeth Onofre, South Bend
Gloria Owens Heldeman, Ft Wayne
Janet Phelps, Indianapolis
Mary Placek, Terre Haute
Christine Prince, Indianapolis
Elizabeth Ratcliff, Lafayette
Abby Recker, Jasper
Vicky Rosa, Indianapolis
Bethany Shae, Albion
Susan Shelko, Pickerington
Elaine Showalter, Alexandria
Joyce Sines, Fort Wayne
Elizabeth Souza-McClain, Bloomington
Dana Walters, Bloomington
Kristin Wood, Crown Point
Michelle Wood Gansman, Greenwood
Vicki Wysong, Connersville
Thelma Young-Bolden, Bloomington
## Indiana Nurses Calendar

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Enrollment</td>
<td>RN Refresher Course</td>
<td>Ariane Smith 317/921-4988 1/800/732-1470, pres 2 for staff, ext 4988 <a href="mailto:asmith608@ivytech.edu">asmith608@ivytech.edu</a></td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>“Being a Preceptor in a Healthcare Facility”</td>
<td>Website: <a href="http://nursing.iupui.edu/lifelongLearning">http://nursing.iupui.edu/lifelongLearning</a> Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive–NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>“Being a Preceptor in a School of Nursing”</td>
<td>Website: <a href="http://nursing.iupui.edu/lifelongLearning">http://nursing.iupui.edu/lifelongLearning</a> Contact information: Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive–NU 345, Indianapolis, IN 46202, by phone: (317) 274.7779, by fax: (317) 274.0012 or by email: <a href="mailto:censg@iupui.edu">censg@iupui.edu</a></td>
</tr>
<tr>
<td>November 20, 2008 8:30 am</td>
<td>Indiana State Board of Nursing Conference Center Auditorium 302 West Washington Street, Indianapolis</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td>November 21</td>
<td>ISNA Board Meeting</td>
<td>ISNA HQ, 2915 North High School Road, Indianapolis <a href="mailto:info@IndianaNurses.org">info@IndianaNurses.org</a>, (317) 299-4575</td>
</tr>
<tr>
<td>December 10, 2008 8:30 am</td>
<td>Indiana State Board of Nursing Conference Center Auditorium 302 West Washington Street, Indianapolis</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
<tr>
<td>January 15, 2008 8:30 am</td>
<td>Indiana State Board of Nursing Conference Center Auditorium 302 West Washington Street, Indianapolis</td>
<td>317/234-2043 or <a href="http://www.pla.in.gov">www.pla.in.gov</a></td>
</tr>
</tbody>
</table>

Raise your organization’s visibility by having its nursing events posted to the Indiana Nurses Calendar. Exclusively for nurses, this calendar appears in every edition of the quarterly ISNA Bulletin and is updated regularly on ISNA’s web site at [www.indiananurses.org/events/calendar.htm](http://www.indiananurses.org/events/calendar.htm).

The ISNA Bulletin reaches over 100,000 RNs, LPNs and nursing students in Indiana. The web site receives more than 6,000 unique visitors each month.

For $15 per event your information will be posted on the ISNA web site and in the ISNA Bulletin. Your organization’s events will appear in each edition of the Bulletin prior to the activity and are immediately posted to the web calendar. Contact ISNA for information by calling 317/299-4575 or via E-mail ce@IndianaNurses.org.

The Indiana Nurses Calendar provides an easy, one-stop location for everyone to read about nursing-related meetings and events. Please contact ISNA by phone (317-299-4575) or email (ce@indiananurses.org) to have your events listed or for more information. The next copy deadline is December 15 for the February/March/April issue of the ISNA Bulletin.

The Indiana State Nurses Association is accredited as an approver of Continuing Nursing Education by the American Nurses Credentialing Center’s Commission on Accreditation.

As continuing education programs are approved, they are posted on ISNA’s web site at [www.indiananurses.org](http://www.indiananurses.org). Click on the “education” link.

The following continuing education activities have been approved for contact hours by ISNA since the last Bulletin copy deadline:

**14th Annual DONA International Convention**

**From head To toe: Meeting the Many Needs of the Newborn.** October 9, 2008, Maggiano’s, 1901 E. Woodfield, Schaumburg, IL. Provider: Mead Johnson Nutritionals, 1645 W. North Ave. #4, Chicago, IL, 60622. Contact: Rhiannon Nashlund, 773-988-9258 or rhiannon.nashlund@hms.com. Contact Hours: 6.7.

**Nourishing the Neonate.** October 6, 2008, Irving, TX. Provider: Mead Johnson Nutritionals, 3404 Bentley Court, Highland Village, TX, 75077. Contact: Holly Jennings, 214-437-0909 or holly.jennings@meadjohnson.com. Contact Hours: 7.5.

**Immunizations for Infants, Children, & Teens.** Self-Study. Provider: Mead Johnson Nutritionals, 5330 Whiting Ave., Edina, MN, 55439. Contact: Karen Lundgren, 952-829-0380 or karen.lundgren@hms.com. Contact Hours: 2.5.

**Evidence Based Practice: The Heart of Quality.** October 17, 2008, The Center at Purdue University. Provider: IN Center for Evidence-Based Nursing Practice, 2200 196th Street, Hammond, IN, 46323. Contact: Jane Walker, 219-989-2822 or walkerj@calumet.purdue.edu. Contact Hours: 5.2.
## Continuing Education Programs

### Approved Providers

The ISNA Committee on Approval approves continuing nursing education providers to award nursing contact hours to the individual activities they develop and present. Any individual, institution, organization, or agency in Indiana responsible for the overall development in May and November. To provide information contact the ISNA office, e-mail ce@IndianaNurses.org or visit the ISNA web site [www.IndianaNurses.org/education](http://www.IndianaNurses.org/education). The following are continuing education providers approved by the ISNA Committee on Approval.

<table>
<thead>
<tr>
<th>Provider</th>
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<th>Approved To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington Hosp &amp; Healthcare System</td>
<td>Ronda Hendricks 812-353-5121 <a href="mailto:hendricks@bloomingtonhospital.org">hendricks@bloomingtonhospital.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>Clarian Health Partners, Inc. P.O. Box 1367 Indianapolis, IN 46206</td>
<td>Sandra Piercy 317-962-8728 <a href="mailto:spiercy@clarian.org">spiercy@clarian.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>Clarian North Medical Center 11700 N Meridian Street Carmel, IN 46032</td>
<td>Deborah A. Green 317-698-2470 <a href="mailto:dagreen@clarian.org">dagreen@clarian.org</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Columbus Regional Hospital 2400 E 17th Street Columbus, IN 47201</td>
<td>Helen Carter 812-376-5651 <a href="mailto:bcartcr@ehsb.org">bcartcr@ehsb.org</a></td>
<td>June '09</td>
</tr>
<tr>
<td>Community Health Network 1500 N Ritter Avenue Indianapolis, IN 46219</td>
<td>Romma Woodward 317-355-5059 <a href="mailto:rwoodward@community.com">rwoodward@community.com</a></td>
<td>June '09</td>
</tr>
<tr>
<td>The Community Hospital 901 MacArthur Boulevard Munster, IN 46321</td>
<td>Colette Lewandowski 219-836-4504 <a href="mailto:clcwandel@comhs.org">clcwandel@comhs.org</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Deaconess Hospital 600 Mary Street Evansville, IN 47747</td>
<td>Ellen Wathen 812-450-7249 <a href="mailto:Ellen.wathen@deaconess.com">Ellen.wathen@deaconess.com</a> <a href="http://www.deaconess.com">www.deaconess.com</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>EHOIR, Inc. 250 N Belmont Street Indianapolis, IN 46222</td>
<td>Christie Sprinkle 317-972-4600, Ext. 123 <a href="mailto:christie.sprinkle@ehb.com">christie.sprinkle@ehb.com</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Good Samaritan Hospital 520 S 7th Street Vincennes, IN 47591</td>
<td>Judith A. Morgan 812-485-3313 <a href="mailto:jmorgan@rchvin.org">jmorgan@rchvin.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>Health Care Education &amp; Training, Inc. 9640 N Augusta Drive #421 Carmel, IN 46032</td>
<td>Joyce Alley 317-347-9608 <a href="mailto:jhalley@choet.org">jhalley@choet.org</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Health Care Excel, Inc. 2902 Ohio Boulevard, Suite 112 P.O. Box 3773 Terre Haute, IN 47803-0713</td>
<td>Terri Neaderhiser 812-234-1499, Ext. 302 <a href="mailto:tneaderhiser@inqio.sdps.org">tneaderhiser@inqio.sdps.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>King’s Daughters’ Hosp &amp; Health Services One King’s Daughters’ Drive Madison, IN 47250</td>
<td>Kathleen Trader 812-265-0494 <a href="mailto:Tradktrd@kbhs.org">Tradktrd@kbhs.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>LaPorte Regional Health System PO Box 250 LaPorte, IN 46355-0250</td>
<td>Jannen R. Arnet 219-326-1234, Ext. 3100 <a href="mailto:jarnett2@lrb.org">jarnett2@lrb.org</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Lutheran Health Network 7900 West Jefferson Boulevard Fort Wayne, IN 46804-4216</td>
<td>Jan Colone 260-435-7452 <a href="mailto:jcolone@lutheran-hosp.com">jcolone@lutheran-hosp.com</a></td>
<td>June '10</td>
</tr>
<tr>
<td>Major Hospital 150 W Washington Street Shelbyville, IN 46176</td>
<td>Lisa Reboulet 774-884-6170 <a href="mailto:lreboulet@majorhospital.com">lreboulet@majorhospital.com</a></td>
<td>June '10</td>
</tr>
<tr>
<td>MCV &amp; Associates Healthcare Inc. P.O. Box 68194 Indianapolis, IN 46286</td>
<td>Cara Vizzarra 317-872-7786 <a href="mailto:Consultmcv@mcvassociates.com">Consultmcv@mcvassociates.com</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Memorial Hospital &amp; Health Care Center 800 W 9th Street Jasper, IN 47546</td>
<td>Kelly Hartwick 812-481-8502 <a href="mailto:khartwick@mhbc.org">khartwick@mhbc.org</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Memorial Hospital of South Bend 615 N Michigan Street South Bend, IN 46601</td>
<td>Diane Parmalee 574-284-7179 <a href="mailto:dparmalee@memoriallab.org">dparmalee@memoriallab.org</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Methodist Hospitals 600 Grant Street Gary, IN 46402</td>
<td>Cynthia Thompson 219-886-4455 <a href="mailto:cthompson@methodisthospitals.org">cthompson@methodisthospitals.org</a></td>
<td>Dec. '08</td>
</tr>
<tr>
<td>Parkview Health System 2200 Randallia Drive Fort Wayne, IN 46805</td>
<td>Debra Stain 260-373-7933 <a href="mailto:dbstain@parkview.com">dbstain@parkview.com</a></td>
<td>June '09</td>
</tr>
<tr>
<td>Porter 814 LaPorte Avenue Valparaiso, IN 46383</td>
<td>Carol Walker 219-283-4743 <a href="mailto:carol.walker@porterhealth.org">carol.walker@porterhealth.org</a></td>
<td>June '09</td>
</tr>
<tr>
<td>Purdue University Continuing Nursing Education 502 N University Street West Lafayette, IN 47907-2060</td>
<td>Patricia Coyle-Rogers 765-494-4030 <a href="mailto:prcuro@purdue.edu">prcuro@purdue.edu</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Reid Hospital &amp; Health Care Services 1401 Chester Boulevard Richmond, IN 47374</td>
<td>Karen Everett 765-983-3094 <a href="mailto:karen.everett@reidhs.org">karen.everett@reidhs.org</a></td>
<td>June '10</td>
</tr>
<tr>
<td>R.L. Roudebush VA Medical Center 1481 W 10th Street Indianapolis, IN 46202</td>
<td>Janet Lutz 317-988-4243 <a href="mailto:janet.lutz@med.va.gov">janet.lutz@med.va.gov</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>St. Francis Hospital &amp; Health Centers 1600 Albany Street Beech Grove, IN 46137</td>
<td>Kathy Fox 765-783-1312 <a href="mailto:kathy.fox@sfsa.org">kathy.fox@sfsa.org</a></td>
<td>Oct. '08</td>
</tr>
<tr>
<td>St. Joseph Regional Medical Center 801 E LaSalle Street South Bend, IN 46617</td>
<td>Joanne Weaver 574-237-7643 <a href="mailto:weaverj@strmc.com">weaverj@strmc.com</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>St. Margaret Mercy 5454 Holman Avenue Hammond, IN 46320</td>
<td>Mary Ann Adamson 219-932-2300, Ext. 34549 <a href="mailto:Mary.ann.adamson@sfsb.org">Mary.ann.adamson@sfsb.org</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>St. Marie’s Medical Center 3700 Washington Avenue Evansville, IN 47750</td>
<td>Sue Miller 812-485-4812 <a href="mailto:jmiller@stmarys.org">jmiller@stmarys.org</a></td>
<td>June '09</td>
</tr>
<tr>
<td>St. Vincent Hospital &amp; Health Care Center 2001 W 86th Street Indianapolis, IN 46240</td>
<td>Wanda K. Powell 317-338-6820 <a href="mailto:wpowell@dtnvincent.org">wpowell@dtnvincent.org</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Schneck Medical Center 431 West Tipton Street Seymour, IN 47274</td>
<td>Karen Werskey 812-524-3342 <a href="mailto:kwerskey@schneckmed.org">kwerskey@schneckmed.org</a></td>
<td>June '11</td>
</tr>
<tr>
<td>Scott Memorial Hospital 1431 N Gardner Street Scottsburg, IN 47170</td>
<td>Shannon Carroll 812-752-8572 <a href="mailto:shannon.carroll@bhs.org">shannon.carroll@bhs.org</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>University of Southern Indiana College of Nursing &amp; Health Professions 8660 University Boulevard Evansville, IN 47712</td>
<td>Margaret A. [Poggy] Graul 812-465-1161 <a href="mailto:pgraul@usi.edu">pgraul@usi.edu</a></td>
<td>Dec. '10</td>
</tr>
<tr>
<td>Valparaiso University College of Nursing LaBienen Hall Valparaiso, IN 46383</td>
<td>Julie A. Koch 219-464-5281 <a href="mailto:julie.koch@valpo.edu">julie.koch@valpo.edu</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>VA Northern Indiana Health Care System 1700 E 38th Street Marion, IN 46953</td>
<td>Laura A. Johnson 765-674-3321, Ext. 3531 <a href="mailto:laura.johnson@med.va.gov">laura.johnson@med.va.gov</a></td>
<td>Dec. '09</td>
</tr>
<tr>
<td>Wishard Health Services 1001 W 10th Street Indianapolis, IN 46202</td>
<td>Norma Wallman 317-630-7536 <a href="mailto:norma.wallman@wishard.edu">norma.wallman@wishard.edu</a></td>
<td>Dec. '09</td>
</tr>
</tbody>
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ISNA Annual Meeting Of The Members

CRH has been closed except for the Emergency Department. It is expected to begin readmitting patients and performing procedures in October.

Janet Myers talked about the challenges of admitting patients; they didn’t know who were coming. Communications were compromised due to the flooding. Cell phones and radios were overloaded. In many instances, text messaging and ham radio operators were the only means of sharing information. Both Cheri and Janet spoke of the commitment to keeping the CRH staff employed and integrating nursing and medical personnel into the existing structures at Schneck.

The Issues Forum

Ernest Klein, Executive Director, provided background information for the rational for many of the proposed ISNA Bylaws Amendments. He reviewed the history of the development United American Nurses and the Center for American Nurses. He discussed the Board of Director’s decision to disaffiliate as an Associate Affiliate of the UAN and not to renew as a full organizational member of the Center for American Nurses. The proposed bylaw amendments were reviewed and questions answered.

Annual Meeting

Ella Sue Harmeyer, President, chaired the meeting. The members heard reports from the President; Judy Barbeau, Secretary; Paula McAfee, Treasurer; Ernest Klein, Executive Director; and Cindy Stone, Chairperson ISNA-Nurse PAC Board of Trustees. Written reports were reviewed from the Committee on Approval of Continuing Nursing Education, ISNA Paych Chapter, Elkhart Kosciusko County Chapter, and the Assistance Program. The PAC Board challenged members to contribute and over $1,200.00 was raised for the PAC. Reports were also heard from ISNA’s organizational affiliates: Indiana Association of Nurse Executives and the Indiana Association of School Nurses.

Several members joined the meeting via telephone conference call and the amendments were adopted as proposed. Dorene Albright, Chairperson of the Committee on Nominations encouraged attendees to identify leaders who will be elected at ANA Delegates and Board members at the next Annual Meeting. There was no new business and the meeting adjourned at 2:50 PM.

ISNA would like to acknowledge and thank the Arthur L. Davis Publishing Agency, Marsh Affinity Group Services a service of Seabury & Smith, and Bank of America for their generous support of the meeting.

ISNAP's Annual Conference

ISNAs held the third annual Indiana State Nurses Assistance Program conference on Friday October 3, 2008. Jackie Fazeli, MSW, RN and Dr. Michael Wilkerson, Medical Director of Bradford Health Services, Warrior, AL gave a presentation on Relapse in Nurses. Both speakers stressed the importance of understanding that relapse is a process which begins long before the individual begins to use drugs and/or alcohol again. They delineated specific behaviors and attitudes that eventually lead to a return to use of drugs and/or alcohol.

Toni Black, private therapist, substance abuse counselor at Gallahue Mental Health Center Indianapolis, presented information on how denial can persist even after the individual becomes abstinent. Some of her clients shared the internal and external triggers of relapse with which they have struggled.

Jim Ryser, Program Coordinator, Chronic Pain Rehabilitation, Clarian Behavioral Health, Indianapolis; Brenda Gardner St. Francis, EAP, CD Specialist; Beth Harrison HR Business Consultant, St. Vincent Hospital and Health Services; and Roxanne Thomas, ISNAP Case Manager, participated in a panel discussion on how employers respond to nurses who relapse.

Four nurses shared the painful consequences of their addiction and the benefits of their recovery. They also spoke about the benefits of being monitored by ISNAP and how the ISNAP program helped to save their careers and yes, even their lives.

Eighty nurses, physicians, and other treatment providers rated the conference “good to excellent.” One person wrote: “Thank you for another very informative day. Using the blend of theory and actual recovering nurses is very effective.”

We would like to thank the following sponsors for their generous support of the conference:

GOLD LEVEL
Tara Treatment Center, Inc.
Clarian Health

SILVER LEVEL
Witham Toxicology Lab
Fairbanks Hospital, Inc.

EXHIBITORS
Richard L. Hinchman, M.D.
St. Vincent Stress Center
Community Health Network
Valle Vista Health System
Marie Hamrick, RN, MS, CCRN is the clinical educator for critical care at Parkview Health, in Fort Wayne. In her role, Marie received numerous requests to provide a CCRN study course. With the help of a unique on-line program, Marie began her first review course on August 7, 2007. The program consists of 10 two-hour sessions and participants come on their own time to complete the course.

You may ask “What’s so special about Marie’s course?” In less than one year 23 RNs have successfully passed the CCRN exam after completing the review course. Ten additional RNs have just filed their applications for the Fall 2008 exam. There have been no failures since the beginning. This year at NTI, numerous nurses were asking Marie about why this program is so effective.

The course was developed by a MSN-prepared nurse who, for one set fee, provides all materials and guarantees results. He is so positive that nurses will succeed that he is willing to tutor any nurse who does not pass the exam after completing the course requirements and pay the re-examination fee! That’s a guarantee that usually isn’t given when you buy a product!

You may wonder how Parkview celebrated so many new CCRNs in such a short time. Each nurse receives a name tag with the letters “CCRN” in large print. When asked by patients and families about the meaning of these initials, each nurse proudly explains “I am certified in my clinical specialty!” Recently, the newest group of 10 CCRNs celebrated with a dinner at a local restaurant provided by their managers, where the Hospital COO spoke to them expressing the organization’s pride in their accomplishment.

Certification does make a difference in quality of care and this organization plans to promote this in other clinical areas as well. Marie’s course has been very successful. Your organization can also make a commitment to certification for nurses. Please encourage them to do this. Your nurses and your patients deserve no less!

Thanks, Marie, for sharing your story!

Certification Corner
Summer 2008

Marie Hamrick, RN, MS, CCRN is the clinical educator for critical care at Parkview Health, in Fort Wayne. In her role, Marie received numerous requests to provide a CCRN study course. With the help of a unique on-line program, Marie began her first review course on August 7, 2007. The program consists of 10 two-hour sessions and participants come on their own time to complete the course.

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Summaries: Board of Directors Meetings
Friday, August 22, 2008

PRESENT:
   Ella Harmeyer, President; Barbara Kelly, Vice
   President; Paula McAfee, Treasurer; Eleanor
   Donnelly, Vicki Johnson, Michael Fights, Directors;
   Ernest C. Klein, Jr., CAE, Executive Director

ABSENT WITH NOTICE:
   Judy Barbeau, Secretary and Jennifer Embree,
   Director.

INTRODUCTIONS
   Andrea Seymour new ISNAP staff member

ACTION ITEMS
   Approved “The President or designee continue
to be an associate member of the Center for
American Nurses. This membership will be paid
for by ISNA and continuation of this membership
will be evaluated after a period of one year.”
   Accepted the Board Minutes of June 6, 2008.
   Re-appointed David Miller for three year term
on the Committee of Approval
   Accepted recommendations from the Bylaws
Committee regarding language changes to the
Bylaws both deletions and changes. (Attached to
file copy.)
   Accepted the Agenda for the Meeting of the
Members on October 4th, 2008.
   Approved the budget for the Meeting of the
Members October 4th, 2008.
   Directed the Committee on Nominations place
a call to the membership and recommend to the
BOD someone to replace Katie Willock.

REPORTS
   Pres. Ella Harmeyer reported on activities of
delegation at ANA convention.
   Treasurer Paula McAfee review the June 30,
2008 Financial Statement:
   Executive Director Ernest Klein reviewed his
written report. It was noted that the ISNAP
program served approximately 500 participants.
He also mentioned that building maintenance and
improvements are coming in the next physical
year and consideration for financing these projects
needs to happen.

ANA Appointments:
   Karen Iseminger PhD, FNP, was re-appointed
to the ANA Center for Ethics and Human Rights
Advisory Board.
   Mary McHugh PhD, RN was appointed to ANA
Committee for Nursing Practice Information
Infrastructure

Saturday, October 4, 2008

PRESENT:
   Ella Harmeyer, President; Barbara Kelly, Judy
   Barbeau, Secretary Vice President; Paula McAfee,
   Treasurer; Eleanor Donnelly, Jennifer Embree,
   Michael Fights, Directors; Ernest C. Klein, Jr., CAE,
   Executive Director

ABSENT WITH NOTICE:
   Vicki Johnson.
   Others Present: Brandee Sullivan and Merry
   Addison.

Action Items:
   Approved the Minutes of August 22, 2008
   Accepted contract proposal for two-year
contract with LegisGroup Affairs, LLC d/b/a SDS
Group for government affairs assistance.
   Finalized plans for Meeting of the Members.
   Appointed Judy Morgan, Vincennes to fill a
vacancy on the Board of Directors.
   Received reports from:
   President Harmeyer.
   Vice-President Kelly.
   Executive Director Klein.

The ANA Advances
the Prevention of the
Unethical Recruitment
of Foreign-Educated
Nurses

Business, Labor, Educators and Advocates
Unite, Release Code of Conduct for the Ethical
Recruitment of Foreign Educated Nurses to the
United States

SILVER SPRING, MD—The American Nurses
Association (ANA) along with representatives of
unions, health care organizations, educational and
licensure bodies, and recruiters joined forces today
by publicly releasing the Code of Ethical Conduct
for the Recruitment of Foreign Educated Nurses.
The Code provides voluntary guidelines that aim
to ensure the growing practice of recruiting
foreign-educated nurses (FENS) to the United States
is done in a responsible and transparent manner.

“Recruitment of foreign-educated nurses (FENSs) to
the United States is growing in response to the
U.S. nurse shortage. While there is disagreement
over the causes of the nursing shortage and
whether international nurse recruitment is part
of the solution, there is widespread agreement
that if it is occurring it should be conducted in an
ethical manner that balances diverse stakeholder
interests. Adoption of this Code will safeguard the
rights of FENs and enhance high-quality patient
care, both domestically and abroad,” remarked
ANA President Rebecca M. Patton, MSN, RN,
CNOR.

ANA has long advocated for the ethical
recruitment of foreign-educated nurses. In April
2008, the association filed an amicus brief in New
York supporting a motion to drop criminal charges
against the group of Filipino registered nurses
charged with patient endangerment after resigning
their positions. These nurses have come to be
known as the “Sentosa nurses.”

The nurses had been recruited by the Sentosa
Recruitment Agency to work at specific nursing
home facilities on Long Island. When they arrived
in the U.S., they discovered they actually were
working for a staffing agency, Prompt Nurses
Employment Agency. Over a period of months,
the nurses said, the agency refused to pay them
according to the terms of their contracts. They also
said they were not properly trained for their new
jobs and were required to care for more patients
than they believed were safe.

The Code is designed to increase transparency
and accountability throughout the process of
recruitment and provides guidance to health care
organizations and recruiters on ways to ensure
recruitment is not harmful to source countries.

In addition to the ANA, the Code has also been
endorsed by numerous groups, the American
Association of International Healthcare
Recruitment, the National Council of State Boards
of Nursing, the National Association for Home
Care and Hospice, several large recruiters, and
multiple associations of foreign educated nurses.

A copy of the Code of Conduct is available on
ANA’s web site at www.nursingworld.org in the
Announcements section.
The Indiana University School of Nursing (IUSON) has received a $712,000 3-year Advanced Nursing Education Grant from the Health Resources and Services Administration (HRSA) at the U. S. Department of Health and Human Services. According to Dr. Dan J. Pesut, PhD, APRN, BC, CCNS, FAAN, Associate Dean for Graduate Programs at IUSON, “This is a significant award that will help meet the need for advanced practice psychiatric mental health nurses in the state of Indiana and nationally. The program planned is accessible, innovative and cutting edge.”

This proposed project addresses the Bureau of Health Professions’ National Goals of improving access to quality health care through appropriate recruitment and education of health professionals. The project focuses on the outcomes of increasing the number, diversity, and distribution of advanced practice psychiatric mental health nurses in rural and underserved regions of Indiana, by making advanced education available through the development of a distance-accessible program. It will serve to educate those who are committed to being psychiatric/mental health clinical nurse specialists (CNS), psychiatric nurse educators and/or faculty, as well as those seeking post-master's psychiatric certification. By increasing the numbers of Psychiatric Mental Health Advanced Practice Nurses (PMHAPNs), more practitioners and educators will be available in the community and in academic settings who will have the potential to improve the quality of care.

The prestigious grant provides financial support and resources for faculty to develop and evaluate a distance accessible program as well as resources to market and recruit nurses from around the state, with a special emphasis on those living in rural areas and/or from culturally diverse backgrounds.

Sara Horton-Deutsch, PhD, CNS, RN, Associate Professor and Coordinator of the Graduate Psychiatric Nursing Program is the Project Director and Angela McNeilis, PhD, CNS, RN, Associate Professor and Director of Special Projects for Undergraduate Programs is the Co-Project Director. Dr. Horton-Deutsch's scholarship focuses on reflective practices as a guide to expanding relational capacity of healthcare providers, leadership and interpretative pedagogies. Dr. McNeilis's interests include simulation, program evaluation, and advancing nursing education through innovation in nursing education. Openings in the Graduate Psychiatric Nursing Program are currently available. For more information contact Dr. Sara Horton-Deutsch at 317-274-2425 or sahortond@iupui.edu.

Purdue Calumet Also Receives Grant

To help stimulate an increase in the number of advanced practice nurses in the workplace, Purdue University Calumet’s School of Nursing has received a $430,192 federal grant to develop and implement an online platform for its master's degree program.

Awarded by the U.S. Department of Health and Human Services’ Health Resources and Services Administration, the grant, written by Leslie Rittenmeyer and Charlene Gyurko enables Purdue Calumet to offer in distance educational format each of its graduate nursing options: family nurse practitioner, clinical nurse specialist in adult health and/or critical care nursing, as well as post-masters certificates in those options and nursing education.

“The grant will eliminate time and distance barriers that often prevent talented nurses from pursuing graduate education,” said Charlene Gyurko, Purdue Calumet assistant professor of nursing and principal investigator for the grant. “The need for advance practice nurses is critical for improving the level of health care delivery within our country. Purdue Calumet’s School of Nursing now will be able to reach and develop more of these nurses regionally and nationally.”

The rationale for this proposal is to design programming that addresses: 1) the need for non-traditional curricular offerings that increase enrollments and retention and graduation rates, 2) the shortage of faculty and nurses with specialized skills, 3) recruitment of minority and economically disadvantaged graduate students, 4) the need to decrease health barriers, 5) the need to provide practitioners that affects the goal of reducing healthcare disparities.

Purdue Calumet’s School of Nursing has already admitted students for part-time study for this fall in the online program.

In addition to transforming curricula into a distance educational format, grant support will be used to develop innovative pod casts and train faculty members to support students’ technological needs. A distance continuous improvement plan also will be implemented to ensure quality. Faculty certification as distance educators will be mandated. Additionally, all courses must meet criteria for Inter-Institutional Quality Assurance in Online teaching.

“By removing time and space barriers we expect this initiative will lead to increased enrollments and retention by making graduate study more feasible for a diverse group of graduate students, thereby, enhancing nursing education and practice,” Purdue Calumet School of Nursing Dean Peggy Gerard said. “The School of Nursing has been involved in distance learning since 1997 and currently offers an online option within the Bachelor of Science completion program for nurses with associate degrees.”

More information about the master’s degree online curricula can be obtained by contacting the School of Nursing at 219/989-2615 or 800/HI-PURDUE, ext. 2815.
Surgical errors cost nearly $1.5 billion annually. Potentially preventable medical errors that occur during or after surgery accounted for nearly $1.5 billion a year, according to new estimates by researchers William E. Encinosa, M.D., and Fred J. Hellinger, Ph.D., of the Agency for Healthcare Research and Quality (AHRQ).

The study found that insurers paid an additional $28.2 billion (52 percent more) and an additional $19.4 billion (48 percent more) for surgery patients who experienced acute respiratory failure or post-operative infections, respectively, compared with patients who did not experience either error. The authors also found these additional costs for surgery patients who experienced the following medical errors compared with those who did not:

- Nursing care associated with medical errors, including pressure ulcers and hip fractures—$12,196 (33 percent more).
- Metabolic problems associated with medical errors, including kidney failure or uncontrollable blood sugar—$11,797 (32 percent more).
- Blood clots or other vascular or pulmonary problems associated with medical errors—$7,838 (25 percent more).
- Wound opening associated with medical errors—$1,426 (6 percent more).

The study also found that 1 of every 10 patients who were hospitalized for 90 days or more died within 90 days of surgery, so because of a preventable error and that one-third of the deaths occurred after the initial hospital discharge. The study was based on a nationwide sample of more than 161,000 patients age 18 to 64 in employer-based health plans who underwent surgery between 2001 and 2002.

Indicators to identify medical errors. Drs. Encinosa and Hellinger conclude that studies that focus only on medical errors incurred during the initial hospital stay may underestimate the financial impact of patient safety events by up to 30 percent. For details, see the “Impact of medical errors on 90-day costs and outcomes: An examination of surgical patients,” by Drs. Encinosa and Hellinger in the July 2008 Health Services Research. Reprints (AHRQ Publication No. 08-09870) are available from the AHRQ Publications Clearinghouse.

RNs are key to detecting, correcting, and preventing medical errors during critical care

Nurses play a pivotal role in preventing or reducing the impact of medical errors during critical care, interventions should be focused on facilitating their efforts in preventing, intercepting, or correcting these errors, suggests a new study.

Using entries in daily logbooks maintained by a random sample of 501 critical care nurses over a 28-day period, Ann E. Rogers, Ph.D., R.N., of the University of Pennsylvania School of Nursing, and colleagues examined the type and frequency of medical errors detected by critical care nurses. They found 367 errors identified by 184 of the nurse participants during the data-gathering period (most commonly, wrong drug, wrong dosage, or dose not given) were the most frequent problems. The researchers spent 30 minutes with each nurse participant to review their entries and analyze the information of which involve giving the wrong dosage of a prescribed medication. Procedural errors were the next most common (115 errors reported), followed by charting errors (55 instances), and transcription errors (55 instances).

The nurses caught only 43 of the 367 errors—medication errors, specifically, that occurred before they reached the patient. Yet, nurses were particularly effective at discovering and reporting medication errors that the patients had been exposed to by other nurses and other members of the health care team. The incredibly busy pace of critical care units may play a role in errors, with an average of 187 activities performed for each patient each day. Heavy workloads and fatigue are also factors that may affect the ability of RNs to intercept or correct medication errors. The nurses did not show differences in error types or rates based on the size of the critical care unit or of the hospital.

Because procedures for administering medications vary across health care facilities and similar across health care institutions despite how they are organized or their size, the researchers suggest that future studies focus on system- and process-related factors. Their study was funded in part by a grant from the Agency for Healthcare Research and Quality (R01 HS17451). More details are in “Role of registered nurses in error prevention, discovery, and correction,” by Drs. Rogers, Grace E. Dean, Ph.D., R.N., Wei-Ting Huang, Ph.D., and Linda S. Nace, Ph.D., R.N., in the April 2008 Quality and Safety in Health Care 17(2), pp.117-121.

Voluntary reporting identifies adverse drug events affecting children

Clinicians typically use medical chart review, voluntary reporting, or computerized adverse drug event (ADE) surveillance to identify pediatric ADEs. However, a new study found that surveillance did not detect ADEs in children as well as in adults.

The best approach to detecting pediatric ADEs is voluntary reporting in tandem with target chart review and computerized surveillance, conclude Jeffrey Ferranti, M.D., M.S., and Duke University colleagues. They found that voluntary reporting efficiently identified administration errors, while chart and computerized surveillance excelled at detecting ADEs caused by high-risk medications and identifying evolving conditions that may provoke imminent patient harm.

The researchers evaluated all medication-related events detected by the Duke University Hospital’s computerized surveillance and safety reporting systems over a 1-year period. They scored ADEs for severity and causality and assigned each a drug event category. Of the total 98 medication-related ADE reporting system, 93 caused patient harm, resulting in an ADE rate of 1.0 events per 1,000 pediatric patient-days. In the two methods of detecting ADEs did not duplicate each other, but were complementary.

The most common events identified by the voluntary safety reporting system were failures in the medication use process (27 percent), drug omissions (16 percent), and dose- or rate-related events (13 percent). The most frequently implicated ADE surveillance categories were nephrotoxins (21 percent), narcotics and benzodiazepines (19 percent), and anticoagulants (11.5 percent). Most voluntarily reported ADEs originated in intensive care units (72 percent), whereas surveillance events were split evenly across intensive and general care. The study was supported by the Agency for Healthcare Research and Quality (HS14882).


Intimate partner violence affects the abused women as well as the care use and costs of their children

Over 40 percent of women suffer from intimate partner violence (IPV)—physical or sexual abuse, threats, or controlling behaviors—during their adult lives. Since 1992, about 1 million women each year have been abused, and their care costs were 24 percent higher. A group of researchers compared health care use and costs of children of mothers with a history of IPV and were significantly greater for mental health services, primary care visits and costs (15 percent higher), and laboratory costs. Even after IPV was reported to have ended, children of abused mothers were three times more likely to use mental health services and had 16 percent higher primary care visits and costs than the children of nonabused mothers, although their overall costs were no higher.

Children whose mothers’ abuse ended before the children were born used significantly more mental health services, primary care visits and costs (15 percent higher), and laboratory costs. Even after IPV was reported to have ended, children of abused mothers were three times more likely to use mental health services and had 16 percent higher primary care visits and costs than the children of nonabused mothers, although their overall costs were no higher.

One important limitation of the study was that the researchers did not know if the children were also abused. The study was supported by the Agency for Healthcare Research and Quality (HS10909).


Incident reporting system can reduce falls by nursery home residents

A structured questionnaire that helps nursing home staff document falls by residents can improve the quality of fall documentation and subsequent safety analysis to identify correctable factors that increase fall risk. That is the conclusion of a study that compared incident reporting of resident falls by nurses using two different incident reporting systems over a 1-year period. They scored ADEs for severity and causality and assigned each a drug event category. Of the total 98 medication-related ADE reporting system, 93 caused patient harm, resulting in an ADE rate of 1.0 events per 1,000 pediatric patient-days. In the two methods of detecting ADEs did not duplicate each other, but were complementary.

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of 207 residents in the 6 nursing homes, who fell and met the eligibility criteria (age 65 years or older, not in a coma, and not receiving hospice services). The intervention group (104 residents) included significant changes in the nursing homes using the structured questionnaire than in the control nursing homes. These results were also true for the 103 residents who had fallen within 6 months of the beginning of the study period, and fell again during the study (47 in the intervention group and 43 in the control group).

Additionally, researchers suggest that the use of paper or electronic systematic assessment forms can capture readily available information about fall risk factors that are not captured in a narrative record. Nursing homes using a structured questionnaire could also use the information to improve staff compliance with policies related to fall assessment, and to measure the success of specific fall interventions (such as bed alarms) by identifying a reduced number of falls. The study was funded in part by the Agency for Healthcare Research and Quality (HS13683).

For more details on this study, see "Mind the gap in health care coverage: Does the length of a child's coverage gap matter?" (Krois, M.P.H., and others in the March-April 2008 issue of Ambulatory Pediatrics 8(2), pp. 129-134.

Reducing community contacts by half within 7 days may allow for local control of a flu pandemic if it is a flu pandemic, up to 35 percent of the U.S. population could develop the disease. Fifty percent of infected people will seek medical care and about 20 percent of them will be hospitalized. Up to 2 percent of those infected will die, according to the national plan to implement flu pandemic strategies. Clearly, the massive surge of sick patients would outstrip the surge capacity of local hospitals. However, it's not clear there would be enough supply of antiviral medications or vaccines or that they would be sufficiently effective in the event of a flu pandemic. In that worst-case scenario, reducing community contacts by half within 7 days may control a local epidemic without the reliance on outside support, suggests a new study. This social distancing would include closing schools and churches, banning public gatherings and encouraging people to work from home if possible.

George Miller, Ph.D., of the Altarum Institute in Ann Arbor, Michigan, and colleagues came to this conclusion based on two models to simulate disease contact and transmission based on public health interventions and to simulate diagnosis and treatment. They used the models for hypothetical scenarios based on the response plans, infrastructure, and demographic data of the states of California, Texas, and Texas, with a population of 14.1 million.

Delaying the decision to restrict contacts outside the household from 7 to 21 days would result in a surge of demand that would exceed the supply of hospital beds. However, hospitals were able to meet the surge when social distancing was doubled. The study results also illustrate the importance of quick action to reduce community contacts in the face of a pandemic for which vaccine and antiviral medications are not available. The study was supported by the Agency for Healthcare Research and Quality (HS13683).

See “Delaying the decision to restrict contacts outside the household from 7 to 21 days would result in a surge of demand that would exceed the supply of hospital beds. However, hospitals were able to meet the surge when social distancing was doubled.” (Geier, R.C., and others in the April 2008 Issue of Infection Control and Hospital Epidemiology 29(4), pp. 329-326.

Pneumonia is the most common reason for hospitalization. More than 1.5 million Americans—roughly equivalent to the population of Dallas—were hospitalized for pneumonia in 2006, making this infection the most common reason for admission to the hospital other than for childbirth, according to data from the Agency for Healthcare Research and Quality (AHRQ).

Treatments: Pneumonia cost hospitals $10 billion in 2006 (see table below). The disease, which can be especially deadly among the elderly, occurs when the lungs fill with fluid from infection or inflammation. Cyanotic bacteria or a virus.

This analysis is based on 2006 data in Hcup/pt (http://hcupnet.ahrq.gov). AHRQ's free, online query system based on data from the Healthcare Cost and Utilization Project, HCUPnet provides reporters and others last and easy access to health statistics on hospital inpatient and emergency department utilization. 2006 estimated hospital admissions and hospitals' costs for common conditions

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<thead>
<tr>
<th>Condition</th>
<th>Estimated admissions</th>
<th>Hospital costs</th>
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<tbody>
<tr>
<td>Pneumonia</td>
<td>1,200,000</td>
<td>$10 billion</td>
</tr>
<tr>
<td>Hardening of the arteries</td>
<td>1,198,000</td>
<td>$17 billion</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>1,099,000</td>
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<td>Chest pain</td>
<td>857,000</td>
<td>$4 billion</td>
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<td>Injuries to the mother during birth</td>
<td>818,000</td>
<td>$2 billion</td>
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<tr>
<td>Other complications of labor and delivery</td>
<td>767,000</td>
<td>$3 billion</td>
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<tr>
<td>Heart rhythm problems</td>
<td>749,000</td>
<td>$7 billion</td>
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<tr>
<td>Osteoarthritis</td>
<td>735,000</td>
<td>$10 billion</td>
</tr>
<tr>
<td>Heart attack</td>
<td>675,000</td>
<td>$12 billion</td>
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</tbody>
</table>
Ohio Nurses
Foundation

Arthritis—Rheumatoid and Osteo
ONF-07-13-I

This independent study has been developed for nurses who wish to learn more about identification and treatment of arthritis. 1.26 contact hour will be awarded.

The Ohio Nurses Association [OBN-001-91] is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Commission on Accreditation. Expires 7/2009

DIRECTIONS
1. Please read carefully the attached article entitled, “Arthritis—Rheumatoid and Osteo.”
2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the Indiana State Nurses Association, 2915 North High School Rd, Indianapolis, IN.
   1. The post-test;
   2. The completed registration form;
   3. The evaluation form; and
   4. The fee: $15.00 ISNA members; $20 non members

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a certificate will not be issued. A letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 80 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, Ohio Nurses Association at (614) 448-1030.

OBJECTIVES
Upon completion of this independent study, the learner will be able to:
1. Differentiate between rheumatoid and osteoarthritis.
2. Describe the methods used to diagnose each form of arthritis.
3. Discuss the management, including patient teaching, of both forms of arthritis.

This independent study was developed by: Barb Nash, MS, RN, C, CN5, President, LifeWise, Inc., Columbus, Ohio. The author and planning committee members have declared no conflict of interest.

There is no commercial support for this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

Arthritis—Rheumatoid and Osteo
ONF-07-13-I

About Arthritis
Affecting one percent of the total population, arthritis is one of the oldest and most common disease processes found in peoples throughout the world. Arthritis, referring to the inflammation of a joint, affects all ages, usually lasts a long time and for many, may never go away. In fact, arthritis, and the rheumatic diseases in general, constitute the major causes of chronic disability in the United States. There are more than 100 different types of arthritic conditions, depending upon their cause, but the two main types are rheumatoid arthritis and osteoarthritis.

Rheumatoid Arthritis
Classified as a collagen disease and considered an autoimmune disorder, the exact cause of rheumatoid arthritis (RA) is unknown. The presentation of a relevant antigen to an immunogenetically susceptible host is believed to trigger RA, but more is known about immunogenetic susceptibility than about causative agents. RA may be due to infection, or possibly a genetic disorder with an inherited predisposition to the disease. It is known that physical and emotional stress can lead to the onset of acute attacks.

In RA, the body produces abnormal antibodies against its own cells and tissues. Abnormal IgG antibodies are produced within synovial joints. Acting as antigens, they react with IgG and IgM antibodies. The specific IgM antibody created is known as the rheumatoid factor (RF). Immune complexes are formed within the joint, causing inflammation, swelling and increased synovial fluid. As this chronic, systemic condition progresses, surrounding cartilage, tendons and ligaments become involved. Thickening of synovial tissue eventually leads to calcification of the joint, joint pain, limited mobility and deformity. In a substantial percentage of persons with RA, the disease progresses to invasion of bone and cartilage. If not successfully treated, this progressive joint destruction results in loss of function, disability and increased mortality. The time from onset of symptoms to joint destruction is sometimes measured in months rather than years, but for 75 percent of persons with RA, the onset is gradual. Unfortunately, the time from disease onset to need for therapy is often prolonged, allowing development of irreversible joint destruction.

In a very high percentage of cases, the joints of the hand and wrist are affected initially. RA is usually bilateral, symmetric and poly articular. As the disease progresses, shoulder, elbow, hip, knee, ankle and cervical spine joints become affected. Other areas of the body where connective tissue is present may also be involved such as the lungs, heart, blood vessels and pleura. Early symptoms include malaise, fever, weight loss and morning stiffness of the joints. One or more joints may become swollen, painful and inflamed. Typically, there are increasing severe and frequent attacks with subsequent joint damage and deformity. Deviation of the fingers to the ulner side and swan neck or boutonniere deformities of the fingers usually indicate RA.

Joint pathology in RA progresses through four stages. First, there is proliferative inflammation of the synovium with increased exudate, which eventually leads to thickening of the synovium. Secondly, there is formation of a layer of granulation tissue (pannus) which produces enzymes and destroys the cartilage, and eventually spreads to contiguous areas causing destruction of the bone caput and part of the synovium which affect the joint. The third stage is fibrous ankylosis resulting from the invasion of the pannus by tough fibrous tissue, and finally there is bony ankylosis as the fibrous tissue becomes calcified.

There is also atrophy of muscles, bones and skin adjacent to the affected joint, causing people with RA to appear under-nourished and chronically ill. Persons with RA feel sick during flares or exacerbations of the disease. They experience decreased appetite, lose weight, run a low-grade fever, and have little energy. Many become anemic due to the effect of the disease on blood-forming organs. Erythrocyte sedimentation rate is elevated and white blood cells may be slightly elevated. One-fifth of people with RA develop subcutaneous rheumatoid nodules along the pressure points of the extensor surface of the ulna. Dry eyes and a dry mouth are common, resulting from inflammation of tear glands and salivary glands (sicca syndrome). Although rare, vasculitis affecting the skin, nerves and other organs or...
tissues can occur. For most people, the problems caused by RA occur mainly in the joints. The course of the disease is always variable and may remain moderate and stable at any given time. However, a positive serum RA factor and bone erosive changes on x-ray imply a poor prognosis. Generally, one-third will have some functional limitation and one-third will become severely handicapped. Even though chronic RA is a very disabling and debilitating disease and needs constant care, the majority of those with RA do not become severely handicapped. About one in ten people with RA will have a single episode of disease activity and a spontaneous long-lasting remission.

Rheumatoid arthritis is perceived to occur more frequently in women, although it affects men and women equally, because three times as many men as women develop symptoms. Men usually develop symptoms at an earlier age and are more severely affected. In the United States, OA affects 10 percent in those over 65 years. The disease is infrequent in young adults.

A fundamental understanding of the pathophysiology of RA and identification of critical initiating or perpetuating mechanisms of the disease remain elusive. Current research is focused on the genetic and environmental factors that influence the development of RA. It is thought that perhaps RA does not have a single cause.

Osteoarthritis is sometimes called degenerative joint disease, arthritis, osteoarthritis or hypertrophic arthritis; it is one of the oldest and most common diseases of man. The onset of osteoarthritis (OA) begins in middle age and by age 70, most people have some degeneration. Up to age 45, it is more common in men. Beyond 45, the disease is more common in women. As men develop symptoms severe enough to require medical attention, RA can occur at any age, but usually strikes between ages 20 and 40. For women it is often diagnosed in later childbearing years. Hormones appear to play a role as women on oral contraceptives are less likely to develop RA. The prevalence of RA in adults under 35 years is less than 0.3 percent and exceeds 10 percent in those over 65 years. The disease is infrequent in young adult males.

Inflammation separates RA from the more common osteoarthritis. OA is a “wear and tear” disease characterized by the slow and steady progressive destructive changes of the joint. It is a noninflammatory, noninflammatory disorder causing bones and joints to degenerate. OA begins with disintegration of the cartilage that covers the ends of the bones. As the cartilage wears away, the roughened surface of the bone is exposed, and pain and stiffness result. In severe cases, the center of the bone wears away and a bony ridge is left around the edges. This ridge may restrict movement of the joint.

The breakdown of joint tissue caused by OA occurs in phases. In phase one, the smooth cartilage surface softens and becomes pitted and frayed. When this happens, the cartilage loses its elasticity and is more easily damaged by excess used or by injury. Over time, large sections of cartilage may wear away completely (phase two), causing the bones to rub together. In phase three, the joint may lose its normal shape. The bone ends thicken and form bony growth, or spurs, where the ligaments and capsule attach to the bone. In phase four, fluid-filled cysts may form in the bone near the joint. Bits of bone or cartilage may float loosely in the joint space. The result is pain when the joint is moved.

The etiology of OA is unknown, but several predisposing or risk factors have been identified: heredity, obesity, injury and repeated overuse of the joint with OA. Inflammation plays a part through synovial fluid. The bone ends thicken and form bony growth, or spurs, where the ligaments and capsule attach to the bone. In phase four, fluid-filled cysts may form in the bone near the joint. Bits of bone or cartilage may float loosely in the joint space. The result is pain when the joint is moved.

Although OA can affect any joint, weight bearing joints of the lower extremities, the hands and cervical and lumbar vertebral are most frequently affected. It also affects the joint at the base of the great toe which can be aggravated by wearing tight shoes or high heels. OA rarely affects wrist, elbows, shoulders, ankles or jaw except as a result of injury. Symptoms include early morning stiffness, pain after exercise, joint enlargement, loss of motion and limitation of movement. Symptoms are often not apparent as the disease progresses.

Osteoarthritis is less debilitating than rheumatoid arthritis, but activity is a challenge to those with OA. Affected joints hurt most after overuse or after long periods of inactivity. If the muscles surrounding the joint are not moved, the joint becomes weaker. Too much exercising of the muscles, in an effort to strengthen the joint and the joint pain increases. Compounding the problem is that for many, coordination and posture are not as good as they once were, making exercise even more difficult.

Since osteoarthritis and rheumatoid arthritis are both common, it is quite possible for a person to have both of these conditions. A comparison of OA and RA points out some of the differences. OA Usually begins after age 40 RA Usually begins between ages 20 and 40 OA Usually develops slowly, over many years RA Often develops suddenly, within weeks or months OA Often affects the joints on only one side of the body at first RA Usually affects the same joint on both sides of the body OA Usually does not cause redness, warmth or swelling of the joints RA Causes redness, warmth and swelling of the joints OA Affects only certain joints, rarely affects elbows or shoulders RA Affects many joints, including elbows and shoulders OA Does not cause a general feeling of malaise RA Often causes a general feeling of malaise and fatigue, as well as weight loss and fever

Diagnosis of Rheumatoid Arthritis

The diagnostic criteria for RA are constantly being re-evaluated. Not all who meet the American Rheumatism Association’s criteria for definite RA actually prove to have the disease. As with any disease, it is important to begin with a good history and physical examination. Assessment findings and the results of laboratory tests are then compared to the Association’s eleven criteria.

1. Morning stiffness
2. Pain on motion or tenderness in at least one joint
3. Soft tissue swelling in at least one joint
4. Swelling of at least one other joint within past three months
5. Symmetric joint swelling
6. Subcutaneous nodules
7. X-ray changes: decalcification adjacent to affected joint
8. Positive rheumatoid factor
9. Poor mucin precipitate from synovial fluid
10. Histologic changes in synovium
11. Histologic changes in nodules.

For a diagnosis of:

Classic RA 7 of the 11 criteria and numbers 1 through 5 must be continuously present for at least 6 weeks.

Definite RA 5 of the 11 criteria and numbers 1 through 5 must be continuously present for at least 6 weeks.

Probable RA 3 of the 11 criteria and one of the numbers 1 through 5 must be present for at least 6 weeks.

For a diagnosis of possible RA, 2 of the following:

6 criteria and joint symptoms must be present for at least 6 weeks:

1. Morning stiffness
2. Pain on motion or tenderness recurring or persisting for three weeks.
3. History or observation of joint swelling.
4. Subcutaneous nodules
5. Elevated sedimentation rate or C-reactive protein
6. Iris

Unfortunately, there is no single blood test that can establish or exclude the diagnosis of rheumatoid arthritis. Rheumatoid factor (RF) appears in the serum and synovial fluid several months after the onset of RA and is present for up to one third.
to years after therapy. This macroglubulin type antibody produced in the synovium appears in the presence of autoimmunity, chronic infections or connective tissue defects, and is not affected by analgesia or anti-inflammatory medications. RF, though not specific for rheumatoid arthritis, is very helpful in its diagnosis, as high titers correlated with weight-bearing joints, tenderness, and erosion has a sensitivity of 80% or more. Diseases such as chronic active hepatitis, cirrhosis, subacute bacterial endocarditis, infectious mononucleosis, tuberculosis, leprosy, viral infections, diabetes mellitus, and others also produce a positive RF. A percentage of people with rheumatoid arthritis have a negative rheumatoid factor. All of these possibilities underscore the importance of integrating laboratory test results into the overall assessment findings for each individual.

A few additional laboratory test may also be helpful, as anemia is not uncommon in RA, and an increased sedimentation rate is usually present.

Differential Diagnosis

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Rheumatoid Arthritis</th>
<th>Osteoarthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Adults under 40</td>
<td>Middle age</td>
</tr>
<tr>
<td>Etiology</td>
<td>Non-specific or infectious</td>
<td>Metabolic disturbance or repeated use/trauma</td>
</tr>
<tr>
<td>Mode of onset</td>
<td>Usually insidious; Occasionally acute</td>
<td>Insidious</td>
</tr>
<tr>
<td>Involvement</td>
<td>Periarticular and synovial, no effusion</td>
<td>Spurring and lipping of bones at joints</td>
</tr>
<tr>
<td>Joints Affected</td>
<td>Many, large and small</td>
<td>Weight-bearing and distal phalangeal joints</td>
</tr>
<tr>
<td>Results</td>
<td>General debility; joint ankylosis and deformity</td>
<td>General health; good; no ankylosis; mainly pain</td>
</tr>
<tr>
<td>Diagnostic aids</td>
<td>Increased sed rate, RBCs</td>
<td>Absence of decrease in platelet count; absence of infection</td>
</tr>
<tr>
<td>X-ray findings</td>
<td>Rarefaction of ends of bones; thinning of joint space</td>
<td>Spurring and lipping of bones</td>
</tr>
<tr>
<td>Course</td>
<td>Chronic with acute exacerbations</td>
<td>Chronic</td>
</tr>
</tbody>
</table>

Dagnosis of Osteoarthritis

The diagnosis of osteoarthritis is made from the symptoms presented and examination of the joints that are enlarged and tender. As there is a loss of joint cartilage and bone hypertrophy in OA, x-ray shows a narrowing of joint spaces and gross irregularities on the surface of the bone. Pain is the chief symptom of OA. The characteristic pain of OA is the mechanical type, increasing with movement and decreasing or ceasing with rest. The pain is worst when starting movement after rest; however, it then eases, but later increases after extended periods of movement.

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Nursing Management of Arthritis

Nursing management of arthritis revolves around assisting those affected with two main issues: pain control and promotion of functional ability. Pain is almost always present in arthritis; it is among the most distressing features of disease, and it is a key reason for loss of function. Medications are one of the most important therapeutic tools in arthritis. Pharmacology of the anti-inflammatory drugs and analgesics are described in other units. The goal of the nurse is to encourage self care with the nurse as a resource, a wise use of the health professional, and allows those with arthritis the ability to participate in their own diagnosis and control. The nurse must act as nurse, teacher, sounding board, referral center, cheerleader, and even inventor to meet the challenges of arthritis.

The following are examples of the nursing diagnoses that may be applicable to either form of arthritis, potential goals and possible nursing interventions. It is important to remember that each person is unique and that the course of these disease will differ from individual to individual. The nurse is faced with the problem of how to relieve the pain may be:

- Pain, chronic, related to swollen, inflamed joints. For OA: pain, chronic, related to joint tenderness and rheumatoid arthritis. In both cases, the goal would be to decrease the pain and improve function. An equally important goal may be the appropriate use of medications, as following the prescribed medication regimen is an important aspect of arthritis. The nurse needs to assess for allergies, past reactions, possible side effects and appropriate usage. Alternative pain control methods such as heat/cold, and proper body alignment may decrease the need for analgesics.

- Areas of concern to the nurse may be the only thing needed to relieve the stiffness and pain that interfere with dressing and grooming. For others, a concern with their physician about using a TENS unit to control pain may not be of prime importance. With arthritis, many people type in their computers for several hours a day.

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A warm bath or shower may be the only thing needed to relieve the stiffness and pain that interfere with dressing and grooming. For others, a concern with their physician about using a TENS unit to control pain may not be of prime importance. With arthritis, many people type in their computers for several hours a day.

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Drug Management of Rheumatoid Arthritis

Traditionally, drug management of RA is based upon a treatment pyramid. The basic pyramid consists of education. Rest, exercise, counseling and salicylates or other nonsteroidal anti-inflammatory drugs or NSAIDS. Level two is analgesics and gold therapy, and the third level is corticosteroids. The tip of the pyramid represents experimental drugs and procedures. Throughout the pyramid orthopedic treatments and corticosteroids are used as needed for flares or exacerbations.

It is difficult to be functional when you have rheumatoid arthritis or osteoarthritis. The major disease process, factors that contribute to symptoms, measures to control symptoms, prevention of complications, treatment options, or home care management. Any one of these areas can present an opportunity for teaching by the nurse. So many misconceptions exist about arthritis and clients are so eager for relief that they often become easy prey for those offering business cures. Teaching the individual and the family can reduce their vulnerability, promote informed decision making and reduce these areas can present an opportunity for teaching by the nurse. So many misconceptions exist about arthritis and clients are so eager for relief that they often become easy prey for those offering business cures. Teaching the individual and the family can reduce their vulnerability, promote informed decision making and reduce predictors. The disease process, factors that contribute to symptoms, measures to control symptoms, prevention of complications, treatment options, or home care management. Any one of these areas can present an opportunity for teaching by the nurse. So many misconceptions exist about arthritis and clients are so eager for relief that they often become easy prey for those offering business cures. Teaching the individual and the family can reduce their vulnerability, promote informed decision making and reduce predictors. The disease process, factors that contribute to symptoms, measures to control symptoms, prevention of complications, treatment options, or home care management. Any one of these areas can present an opportunity for teaching by the nurse. So many misconceptions exist about arthritis and clients are so eager for relief that they often become easy prey for those offering business cures. Teaching the individual and the family can reduce their vulnerability, promote informed decision making and reduce predictors.
Nursing interventions involve monitoring the individual's response to the drug and monitoring CBC and liver function tests.

Gold salts is an effective anti-inflammatory agent, but potentially more toxic than many other drugs. Side effects include diarrhea, nausea, vomiting and jaundice. Weekly or biweekly monitoring of blood counts to prevent gold-induced thrombocytopenia, neutropenia or proteinuria is necessary. Orally administered gold (auranofin) is less toxic than the injectable forms, but is not as effective. The beneficial effects of gold salts may take three to four months to appear, and the nurse should stress the importance of keeping all appointments with the physician.

Low-dose methotrexate (5 to 15 mg once weekly) is now being used more often, before therapy with gold salts or penicillamine, with improvement in symptoms, although the mechanism of action is debatable. The potentially serious side effects of methotrexate include hepatic and pulmonary fibrosis among others. NSAIDS, salicylates and sulfonamides increase methotrexate toxicity and is debatable. The potentially serious side effects in symptoms, although the mechanism of action is still unknown. It is thought to have both anti-inflammatory effects and immunosuppressive effects. Gastrointestinal toxicity is the most common side effect and the incidence appears to be higher when first initiating therapy. Nursing interventions center on preventing GI toxicity, avoiding sunlight and watching for signs of superinfection.

Corticosteroids used to control RA flares act to decrease the inflammation, decrease pain, and increase mobility, but cause adverse reactions that are usually dose- or duration-dependent. Side effects include insomnia, fluid retention, gastrointestinal irritation, muscle wasting, impaired wound healing, and moon face. Abrupt withdrawal of corticosteroids can be fatal. Nursing interventions include teaching about dosage, proper administration with food, and monitoring weight, sleep patterns and serum potassium.

The current armamentarium for RA treatment has a disappointing record in terms of preventing the joint destruction of RA. Those drugs originally believed to be “disease-modifying” have shown little impact. At best, they reduce the destructive component of the disease modestly and inconsistently. A potential approach to treating RA is to neutralize the cytokines that are suspected of producing the damage. Anti-cytokine therapies are currently being tested with encouraging clinical results. There is, however, concern about toxicities arising from the long-term neutralization of cytokines. Investigations are also under way to attempt to induce tolerance to supposed arthritogenic antigens by monoclonal antibodies, other biologic agents, and vaccination or oral administration of antigen. Given the many pathways that seem to be involved in the pathogenesis of rheumatoid arthritis, a combination of two or more approaches may be necessary to suppress joint destruction.

Drug Management of Osteoarthritis

Compared to rheumatoid arthritis, drug management of osteoarthritis appears straightforward. The approach is mainly symptomatic; relieve pain and control inflammation if present.

Acetaminophen is an often overlooked, but effective, pain reliever for OA. A danger with acetaminophen is self-dosing and the possibility of severe liver damage, especially when alcohol ingestion potentiates the hepatotoxicity of this drug even at therapeutic levels. Acetaminophen does not reduce swelling or inflammation, but over-the-counter or prescription NSAIDS can reduce joint pain, stiffness and swelling. Medication teaching is always warranted with OTC drugs. Tramadol is a non-narcotic analgesic currently under investigation, which may help older people with OA who do not respond to acetaminophen or NSAIDS for pain control. Narcotic analgesics should only be used on a short-term basis in acute pain.

Corticosteroids may be injected directly into the affected joint following joint aspiration, to relieve the pain and swelling of OA if inflammation is present. This procedure must be limited to three or four times a year, as repeated injections in weight-bearing joints can result in cartilage damage.

Pain relief may also be obtained by the use of pain-relieving creams, rubs or sprays applied to the skin. Some topical analgesics may contain combinations of salicylates, skin irritants and local anesthetics. Methyisalicylate acts by decreasing the ability of the nerve endings in the skin to sense pain. Irritants stimulate the nerve endings of the skin to cause a feeling of cold or warmth which interferes with the sensation of pain. Topical capsaicin reduces the amount of substance P which sends pain signals to the brain. Skin irritations, and tolerance to the action of these topical agents may result from overuse.

The latest treatment for OA involves injecting affected knee joints with sodium hyaluronate, to relieve pain for those who do not get adequate relief from analgesics, exercise and physical therapy. Hyaluronate, a natural chemical normally found in high amounts in joint tissues and synovial fluid, acts as a lubricant and shock absorber. In OA, there may not be sufficient
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amounts of hyaluronate, and there may be a change in the quality of the hyaluronate that is present. Injectable sodium hyaluronate is manufactured from rooster combs, and persons with allergies to feathers, eggs or poultry may not be candidates for this treatment. After a series of three to five injections, pain relief can last for up to six months or longer. Some physical activities must be avoided for 48 hours following each injection. Possible side effects include pain, swelling, heat and/or redness of the knee joint. These reactions are generally mild and do not last long. The safety and effectiveness of repeated treatment cycles with sodium hyaluronate has not bee established. Nursing interventions could center on education about the treatment and its possible side effects.

Along with the current available treatments for both forms of arthritis, antidepressants and/or sleep medications may be helpful at times. Research into future treatments for OA includes delivering therapeutic reagents to joints in the form of genes, and autologous chondrocyte implantation for repairing cartilage defects.

Non-Drug Management of RA and OA

In general, the non-drug management of both the rheumatoid and osteo forms of arthritis are similar. Most have already been mentioned under nursing management: counseling and/or support groups for depression and coping, stress management, relaxation techniques, massages and TENS units. At the other end of the spectrum, joint repair or joint replacement surgery may be necessary. There are disease management interventions, however, that those with arthritis can implement on a daily basis which may assist in delaying or avoiding surgical intervention.

A well-balanced diet is important for two reasons. First, is the issue of weight control to reduce the strain on joints. Some arthritis sufferers see an improvement in symptoms by weight loss alone. Secondly, poorly nourished individuals are prone to infections and infection results in exacerbation of RA symptoms. There is some evidence that fatty acids, derived from fish or plants, when substituted for the arachidonic acid found in animal fats can effect clinical improvement in RA. Both those with RA and OA should have an adequate intake of protein and calcium.

Following an activity and exercise program is important to keep joints flexible, muscles strong, and heart and lungs fit. Range of motion exercises and isometric exercises should be performed even during flare-ups of RA. With OA, exercise can improve functional capacity without exacerbating symptoms. Days of exercise should alternate with days of rest and stretching exercises. The Arthritis Foundation certified aquatics program is an excellent resource. Aquatic exercises can be done comfortably even when inflammation is present. Learning how to properly use heat or cold to prepare for exercise, and for short-term relief from pain and stiffness, reduces dependence upon chemical pain relief. Soaking in a warm bath or using microwaveable heat packs relaxes aching muscles. Pain persisting two hours after exercise should prompt a decrease in exercise intensity or duration. Repetitive motion exercises and occupations should be avoided.

Joint protection is paramount and nonpharmacologic modalities cannot be overstated. A simple elastic bandage improves knee proprioception, which would improve gait. Walking aids or assistive devices can improve joint position, avoid excess joint stress, and decrease pain. Consistent, proper use of these devices can prevent unwanted additional harm to joints and muscles.

Nursing should be instrumental in teaching people how to integrate self-care techniques into their lives, empower them to take control of their arthritis and cheer them on over the long course of the disease.

Independent Study continued on page 18
“Arthritis—Rheumatoid and Osteo”

ONF-07-13-I

INDEPENDENT STUDY

Registration Form

Name: ____________________________ Final Score: ____________________

Address: ____________________________ ____________________________
Street City/State/Zip

Daytime phone number: (____) ____________________________

RN LPN

Fee: _____ ISNA Member ($15) _____ Non-ISNA Member ($20)

INSA OFFICE USE ONLY

Date Received:_______Amount:_______ Check No _______

MAKE CHECK PAYABLE TO THE INDIANA STATE NURSES ASSOCIATION.
Enclose this form with the post-test, your check, and the evaluation and send to: Indiana State Nurses Association, 2915 North High School Road, Indianapolis, IN 46224.

Ohio Nurses Foundation

Independent Study

Arthritis—Rheumatoid and Osteo

ONF-07-13-I

Post Test and Evaluation Form

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

Name: ____________________________ Final Score: ____________________

Please circle the correct answer. There is only one correct answer for each question.

1. In rheumatoid arthritis:
   a. The mechanism of the disease is well defined and understood.
   b. The cause may be related to a host/antigen response.
   c. There is no suspected genetic component.
   d. One cannot link life-style to the course of the disease.

2. Joint pathology in RA begins with:
   a. Fibrous ankylosis
   b. Bone ankylosis
   c. The formation of pannus
   d. Synovitis

3. Associated signs and symptoms of RA may include:
   a. Fatigue and weight loss
   b. Elevated sed rate and anemia
   c. Sicca syndrome
   d. All of the above

4. Osteoarthritis (OA):
   a. Is always accompanied by inflammation
   b. Has no relationship to excess use of joint
   c. Begins with the cartilage at the ends of the bones
   d. Is a rapidly progressive disease

5. OA usually affects:
   a. The wrists and shoulders
   b. Knees and fingers
   c. Elbows and ankles
   d. Jaw and thoracic vertebrae

6. It is possible for an individual to have both RA and OA at the same time.
   a. True
   b. False

7. Which of the following statements about rheumatoid factor is not correct?
   a. RF appears in the serum and synovial fluid
   b. RF is not affected by analgetics or NSAIDS
   c. RF is the definitive diagnostic test for RA
   d. RF may be seronegative in a person with arthritis

8. An associated symptom that aids in the diagnosis of osteoarthritis is:
   a. Heberden’s nodes
   b. Deviation of the fingers to the ulnar side
   c. Boutonniere deformities of the fingers
   d. All of the above

9. Nursing management of the pain of arthritis should include encouraging the use of narcotics for pain relief especially with OA.
   a. True
   b. False

10. People with RA can be susceptible to offers of unproved interventions.
    a. True
    b. False

11. Drug management of RA begins with:
    a. Antimalarials and gold therapy
    b. Salicylates or NSAIDS
    c. Methotrexate
    d. Sufasalazine

12. Possible side effects of aspirin and other NSAIDS can include:
    a. GI irritation
    b. Prolonged bleeding time and easy bruising
    c. Liver toxicity
    d. All of the above

13. Methotrexate can be safely given with sulfonamides, aspirin and NSAIDS.
    a. True
    b. False

14. Sufasalazine is an FDA approved treatment for RA.
    a. True
    b. False

15. There may possibly be a vaccination in the future that protects people against RA.
    a. True
    b. False

16. A new treatment option available for OA involves:
    a. A substance made from rooster combs
    b. Sodium hyaluronate injected into knee joints
    c. Substance that can provide pain relief for up to six months
    d. All of the above

17. Diet modifications that can be helpful in the management of RA are:
    a. Decreasing protein and calcium
    b. Substituting fatty acids for arachidonic acid
    c. Increasing caloric intake
    d. Severely limiting calories

18. The management of arthritis depends greatly upon:
    a. Education and counseling
    b. Exercise and rest
    c. Anti-inflammatory and analgesic drugs
    d. All of the above

19. Nursing management of persons with arthritis involves fostering independence and a sense of control.
    a. True
    b. False

Evaluation:

1. Were the following objectives met? YES NO
   a. Differentiate between rheumatoid and osteoarthritis.
   b. Describe the methods used to diagnose each form of arthritis.
   c. Discuss the management, including patient teaching, of both forms of arthritis.

2. Was this independent study an effective method of learning? YES No
   If no, please comment:

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

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