ISNA®
INDIANA STATE NURSES ASSOCIATION
www.indiananurses.org

The ISNA Bulletin is the Official Publication of the Indiana State Nurses Association

ADVOCATING ON BEHALF OF REGISTERED NURSES SINCE 1903.

Volume 35, No. 2 February, March, April 2009

ISNA Needs You

Call For ISNA Candidates 2009 Election

Consent-to-Serve Forms are due in the ISNA office April 15, 2009

The Indiana State Nurses Association Committee on Nominations is seeking the names of qualified ISNA members to fill the vacancies in the following offices which occur in September 2009: You can nominate a colleague or you can self-nominate.

BOARD OF DIRECTORS:	
President/ANA & Delegate	Two-year term
Vice President	Two-year term
Secretary	Two-year term
Treasurer/ANA Delegate	Two-year term
Three Directors	Four-year term
COMMITTEE ON NOMINATIONS	
Five Members	Two-year term
DELEGATES TO ANA	
Six Members	Two-year term

The forms and complete information are available on the ISNA web site www.IndianaNurses.org.

Return completed forms to ISNA via US Mail, FAX 317/297-3525, or email to member@IndianaNurses.org **no later than April 15, 2009**.

ANA
AMERICAN NURSES ASSOCIATION

The American Nurses Association Works Toward a Consensus Agreement on a Core Set of National Priorities in Health Care

Improving Performance Measurement and Public Reporting in the United States

SILVER SPRING, MD—The American Nurses Association (ANA), the National Quality Forum (NQF), along with representatives of 26 other major national health care organizations will join forces on Monday, November 17, 2008, by publicly releasing its report, *Aligning Our Efforts To Transform America's Healthcare Goals* designed to set national priorities and goals to achieve a high-performing, health care system delivering quality care to all.

"The National Priorities Partnership represents something unique in health care—a diverse range of high-impact stakeholders working to align their efforts on a core set of high-leverage areas of

ANA Works Toward a Consensus continued on page 2

President's Message

Ella Harmeyer

2009! Was it not a short time ago that 2009 seemed very far away? Of course the New Year must bring New Year's resolutions! There was a time when I thought all of us really seriously meant to work on all our New Year's resolutions. Now as we sit around and talk of resolutions it is clear that there are categories of resolutions: 1) serious—we really hope to start a new habit or change an old one; 2) wishful—it would be nice to achieve but it probably takes too much effort and we just do not think we have the energy, but maybe we will try; and, 3) who are we kidding? It is sometimes said seriously, but mostly we know when we say it that there is no chance that we have the time and energy to make it happen.

So I thought about what are my resolutions related to ISNA for 2009. And in keeping with my categories, I also want to be as honest as I can. So here goes.

Serious—at least three times a week I will work on something related to the profession of nursing outside my day to day job. (Once you learn to write behavioral objectives, you are stuck with writing goals that are specific and measurable. Oh the good old days when one could just say "I'll pay more attention to my profession!") I need to be honest and say that as President of ISNA, there are issues that often cross my desk which means this may be easier than it sounds. Being an ISNA officer forces me to pay attention to this resolution, so I really think it sounds like a loftier goal than it is.

Serious—every day I will set an example for my students and colleagues of what it means to be a professional registered nurse. We all take our professional responsibility very seriously, but sometimes we just get so overwhelmed we forget that small behaviors make a big impression such as helping a colleague instead of criticizing her/him.

Serious—at least once a week I will ask one nurse I know to consider ISNA membership. I have written a lot about membership in this column previously, so enough said.

Wishful—at least once a month I will attend a nursing related meeting in which I can speak about ISNA and encourage membership. I would like to meet more nurses across the state. My schedule is often a deterrent to this happening, but I am always hopeful. Please extend an invitation if you have something you believe would be helpful for me to attend.

Wishful—during this legislative session, I will read the Legislative Alert on the ISNA website at least once a week. I have good intentions each year, but usually find myself cramming to catch up either before legislative conference or if someone calls me to be active on responding to a bill that has become controversial.

Who am I kidding—I will respond to my ISNA/ANA email within 24 hours of receipt! There has to be a way of trying to make this happen. Even as I say it part of me believes that the only way this will happen is if I change my email address and do not update ANA!! Not a good plan. So I will muddle along doing the best I can.

Who am I kidding—I will work on completing all projects by the deadlines requested! As you read this, if you are now falling down laughing, that means you know me fairly well. It seems that one of the habits I have perfected over the years it that "date due" has become "date to begin project." I am notorious for needing that extra 24–48 hours to finish whatever project is current on my desk. Even I put due dates in my calendar that are 3 days ahead of needed in order to hopefully be done on time. Any one working with me is smart to do the same, just tell me it is due 2-3 days sooner than you need it.

In creating this list, of course I am compelled to end with what I would hope YOU would also add to your resolutions for nursing and ISNA. I really wish for each of you to spend just 5 minutes thinking about what you can do to make nursing in Indiana better by the end of 2009 than it is today. Will you begin checking the ISNA website at least once a week? Become more familiar with ISNA resources and how we advocate for nurses each and every day. How can you be a leader for your colleagues just once over the next month? Set an example; be the best of professional nursing. Consider adding ISNA member to your list of credentials. We need you to continue representing nurses in Indiana every day. Have a great 2009.

Inside This Issue

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ANA Works Toward a Consensus continued from page 1

improvement. It is important for all partnerships related to health care quality to include the perspective of registered nurses in order to transform the health care system. Nursing is the largest component of the health care workforce and provides the greatest amount of direct patient care. This collective force will deliver fundamental and transformative improvements to America's health care system," said ANA Chief Executive Officer Linda J. Stierle, MSN, RN, NEA-BC.

The priorities and goals of the partnership were selected to address four major challenges in health care: eliminate harm, eradicate disparities, reduce disease burden, and remove waste. The Partners focused only on National Priorities and Goals that would, if implemented broadly, dramatically improve our nation's healthcare quality.

Working together the partners will:

- Engage patients and their families in managing health and making decisions about care
- Improve the health of the population
- Improve the safety and reliability of America's healthcare system
- Ensure patients receive well-coordinated care across all providers, settings, and levels of care
- Guarantee appropriate and compassionate care for patients with life-limiting illnesses
- Eliminate waste while ensuring the delivery of appropriate care

The Partnership's core list of priorities will yield real dividends in the form of improved care, equity, safety, and efficiency over the next three to five years. The absence of national priorities and goals for performance improvement impedes the efforts of those involved in all facets of performance measurement, improvement, and reporting. A sizable amount of resources and energy are currently being invested in the development of performance measures by many organizations including accrediting bodies, professional societies and boards, government organizations, and others.

To date, NQF has endorsed approximately 400 performance measures and practices, and many more are in the "measure pipeline," some in the early stages of development and others moving through the NQF endorsement process. In spite of all these activities, it is unclear whether attention and resources are being focused on "high leverage" areas—aspects of performance for which improvement will yield the greatest gains in terms of better health and healthcare. ANA recognizes that national priority-setting must be a collaborative process with other key stakeholders who engage in priority-setting efforts of their own. In response, the National Priorities Partnership was established to address these concerns.

For more information, please visit http://nursingworld.org/HomepageCategory/NursingInsider/ANA-Works-Toward-a-Consensus-Agreement.aspx.

Membership Board of Directors Meeting

Friday, November 21, 2008
ISNA Headquarters
SUMMARY

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

CALL TO ORDER: Ella Harmeyer, President, called the meeting to order at 10:00 am, EDT. A quorum was established and the Agenda as amended was approved.

INTRODUCTIONS: The Board welcomed Judy Morgan, Vincennes, new Director, who was appointed to replace Katie Willock who has moved out of state.

ACTION ITEMS:

- Reaffirmed ISNA's Policies on Anti-trust activities and Conflict of Interest. Approved new policies on: Conflict of Financial Interest, Whistle Blowers, Compensation Determination, and Joint Venture Activities.
- Reaffirmed 2008-09 ISNA Goals
- Established 2009 Board meeting dates February 13, April 24, June 5, August 7.
- Accepted the Board meeting Minutes and the Meeting of the Member Minutes of October 4, 2008.
- Transferred income over expenses from the ISNAP Workshop on October 3, 2008 to the Needs Assistance Fund.
- Accept the proposal from Ent & Imler CPA Group for 2009 audit and accounting services.
- Accepted recommendations for investments
- Adopted a balanced 2009 ISNA Budget.
- Approved the Committee on Approval's new policy on extension of provider status.
- Deferred discussion and action on the 2008 Meeting of the Members evaluation until next board meeting.
- Accepted a revised Administrative Assistant position description.

REPORTS: President Ella Harmeyer: Reported on activities at the November 2008 American Nurses Association Constituent Assembly. She noted that the group requested the ANA Board to schedule an additional meeting of the Assembly before next November. She reported that the next meeting of the Tri-Council would be January 23, 2009.

Vice-President Barb Kelly and Director Jennifer Embree reported on the Indiana Nursing Workforce Development Coalition workshop on November 7, 2008.

Treasurer Paula McAfee reviewed the September Financial Statement.

Ernest Klein, Executive Director, reviewed his written report and the written ISNAP report. He reviewed proposed legislation for certified operating room technicians.

He reported that on November 20 ISNA supported the Philippine Nurses Association request to the Board of Nursing to eliminate the CGFNS Qualifying Exam as a requirement for licensure. Mr. Klein also noted that the Indiana State Board of Nursing accepted ISNA's draft language for the proposed change in the Board's rules.

ISNA BULLETIN

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Web site: www.indianansurses.org

ISNA MISSION STATEMENT

ISNA works through its members to ensure quality nursing care.

ISNA accomplishes its mission through advocacy, education, information, and leadership.

ISNA is a multi-purpose professional association serving registered nurses since 1903.

ISNA is a constituent member of the American Nurses Association.

BULLETIN COPY DEADLINE DATES

All ISNA members are encouraged to submit material for publication that is of interest to nurses. The material will be reviewed and may be edited for publication. To submit an article mail to ISNA Bulletin, 2915 North High School Road, Indianapolis, IN 46224-2969 or E-mail to klein@indianansurses.org.

The **ISNA Bulletin** is published quarterly. Copy deadline is December 15 for publication in the February/March/April *ISNA Bulletin*; March 15 for May/June/July publication; June 15 for August/September/October, and September 15 for November/December/January.

If you wish additional information or have questions, please contact ISNA headquarters.

Welcome to New Members and Reinstated ISNA Members

Barbara A. Bartley, Jasper
Tina Marie Baxter, Anderson
Katherine Mary Bell, Evansville
Kathy Ann Bitar, Noblesville
Linda Boone, Indianapolis
Cathy M. Bowlin, Lafayette
Sara Browning, Evansville
Crystal Rene Caswell, Owensburg
Anne Warrick Chalker, Indianapolis
Sheila M. Cochren, Evansville
Sharon Cornelious-Ellis, Crown Point
Diane Marie DeBerry, Lafayette
Martha Dick, Evansville
Gloria Dillman, Munster
Jessica Lynn Durbin, Terre Haute
Scott Gilbert Eddy, Decatur
Lisa Ferrin, Indianapolis
Michelle A. Figley, Bloomington
Michelle Wood Gansman, Greenwood
Melissa Mikki Gremp, Valparaiso
Barbara Habermann, Indianapolis
Carolyn M. Harlan, Kokomo
Gloria Owens Heldeman, Fort Wayne
Jennifer Jansen, Crown Point
Tamara E. Jones, New Albany
Kaley Kaul, Bloomington
Verna Kay Kelley, Logansport
Jerry Kish, Cedar Lake
Jeanie Langschied, Fort Wayne
Bernadette Rose Linne, Troy
Rachel Ann Moody, La Porte
Heather Renee Myers, Winchester
Elizabeth Melanie Onofre, South Bend
Laura J. Pryor, Trafalgar
Elizabeth Ratcliff, Lafayette
Andrea Nicole Richardson, Franklin
Andrea G. Shourds, Newburgh
Elaine Deanne Showalter, Alexandria
Joyce R. Sines, Fort Wayne
Olivia D. Taylor, Ferdinand
Heather Rene Tegtmeyer, Fort Wayne
Renee Kathryn Twibell, Muncie
Matilde S. Upano, Indianapolis
Dana J. Watters, Bloomington
Ann Wilber, Cheshire, CT
Suellen Williams, Franklin
Sara Clemons Williams, Lafayette
Lucia D. Wocial, Indianapolis
Thelma Lynn Young-Bolden, Bloomington
Wendy Zeiher, Fishers

Membership News Names in the News

The American Nurses Association has announced the appointment of two ISNA members to ANA Committees:

Karen Yehle appointed to a two-year term on the Subcommittee on Jessie M. Scott Award.

Louise Hart, Winchester, we re-appointed to a two-year term on the House of Delegates Reference Committee.

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

APPLICATION FOR RN MEMBERSHIP in ANA and ISNA

Or complete online at www.NursingWorld.org

PLEASE PRINT OR TYPE

_____
Last Name, First Name, Middle Initial

_____
Street or P.O. Box

_____
County of Residence

_____
City, State, Zip+4

_____
Home phone number & area code

_____
Work phone number & area code

_____
Preferred email address

_____
Name of Basic School of Nursing

_____
Graduation Month & Year

_____
RN License Number State

_____
Name of membership sponsor

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

_____ **ELECTRONIC DUES PAYMENT PLAN, MONTHLY**

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 notification thirty (30) days prior to the deduction date.

_____
Signature for Electronic Dues Payment Plan

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

Indiana Nurses Calendar

Date/Time	Event/Location	Contact Information
March 16-April 24	**Clinical Faculty: A New Practice Role Web Based Course**	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
April 28-29	**Nurse Aide Program Director & Instructor Training Details** Holiday Inn Express, Greenwood	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive–NU 107, Indianapolis, IN 46202
May 4-June 12	**"Getting Started as a Staff Educator"** Web-Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive–NU 107, Indianapolis, IN 46202
May 6	**Qualified Medication Aide (QMA) Instructor Education** Holiday Inn Express, Greenwood	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
May 13-July 24	**Critical Care Nursing: "Adult Critical Care"** Web Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
May 13-July 24	**"Neonatal Intensive Care"** Web Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
May 13-July 24	**"Pediatric Intensive Care"** Web-Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
May 16-21	**National Teaching Institute (NTI) & Critical Care Exposition.** Sponsor: American Association of Critical-Care Nurses (AACN) Ernest N. Morial Convention Center, New Orleans, LA	Phone: 800/899-2226 Fax: 949/362-2020 ntimail@aacn.org, Website: www.aacn.org/nti
June 1-7	Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program (four courses) **"Getting Started: An Introduction to Choosing and Using Web Course Management Software"**	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
June 15-22	Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program: (four courses) "**Designing Web Pages for Web Course**"	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202

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Date/Time	Event/Location	Contact Information
July 6-12	Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program: (four courses) **"Teaching and Evaluation in Web-based Courses"**	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
July 20-August 14	Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program: (four courses) **"Practicum: The Development of a Web Course"**	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
August 10-September 18	**"Clinical Faculty: A New Practice Role"** Web Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
August 25-26	**Nurse Aide Program Director & Instructor Training** Holiday Inn Express, Greenwood	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
August 26-December 14	Nursing Informatics: A Web-based Professional Certificate Program (four courses) **"Clinical Information Systems"**	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
August 26-November 6	**"Pediatric Intensive Care"** Web-Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
August 26-November 6	Critical Care Nursing: **"Adult Critical Care"** Web Based Course	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
Open Enrollment	**"Being a Preceptor in a Healthcare Facility"** This course will acquaint you with the role of preceptor for new nurses, nurse graduates and nursing students. Self paced format.	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202
Open Enrollment	**"Being a Preceptor in a School of Nursing."** This course will acquaint you with the role of preceptor, working with the faculty/instructor and students from a school of nursing. Self paced format.	Phone: 317/274-7779 Fax: 317/274-0012 censg@iupui.edu Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202

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.

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 March 16 for the May/June/July issue of the *ISNA Bulletin*.

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, implementation, evaluation, and quality assurance of continuing nursing education is eligible to seek approval as a provider. Information must be submitted describing three different educational activities planned, presented, and approved by the Indiana State Nurses Association in the two years preceding the application and should be representative of the types of educational activities usually provided. Applications are reviewed by the Committee on Approval at their biannual meetings in May and November. For information contact the ISNA office, e-mail ce@IndianaNurses.org, or visit the ISNA web site www.IndianaNurses.org/education. The following are continuing education providers approved by the ISNA Committee on Approval.

Provider	Contact	Approved to:
Bloomington Hosp & Healthcare System P.O. Box 449 Bloomington, IN 47402-1149	Ronda Hendricks 812-353-5121 rhendricks@bloomingtonhospital.org	June 01, 2010
Clarian Health Partners, Inc. P. O. Box 1367 Indianapolis, IN 46206	Sandra Piercy 317-962-8728 spiercy@clarian.org	June 01, 2010
Clarian North Medical Center 11700 N Meridian Street Carmel, IN 46032	Deborah A. Green 317-688-2470 dagreen@clarian.org	Dec. 01, 2009
Columbus Regional Hospital 2400 E 17th Street Columbus, IN 47201	Sharon Erwin 812-376-5788 serwin@crh.org	June 01, 2009
Community Health Network 1500 N Ritter Avenue Indianapolis, IN 46219	Romma Woodward 317-355-5059 rwoodward@ecommunity.com	June 01, 2009
Deaconess Hospital 600 Mary Street Evansville, IN 47747	Ellen Wathen 812-450-7249 Ellen_wathen@deaconess.com	Dec. 01, 2010
EHOB, Inc. 250 N Belmont Street Indianapolis, IN 46222	Christie Sprinkle 317-972-4600, Ext. 123 Christie.sprinkle@ehob.com	Dec. 01, 2009
Good Samaritan Hospital 520 S 7th Street Vincennes, IN 47591	Judith A. Morgan 812-885-3313 jmorgan@gshvin.org	June 01, 2009
Health Care Education & Training, Inc. 9640 N Augusta Drive #432 Carmel, IN 46032	Joyce Alley 317-247-9008 jballey@hcet.org	Dec. 01, 2009
Health Care Excel, Inc. 2902 Ohio Boulevard, Suite 112 P.O. Box 3713 Terre Haute, IN 47803-0713	Terri Neaderhiser 812-234-1499, Ext. 302 tneaderhiser@inqio.sdps.org	June 01, 2009
King's Daughters' Hosp & Health Services One King's Daughters' Drive Madison, IN 47250	Larry Cummins 812-265-0524 cummins@kdhhs.org	June 01, 2010
LaPorte Regional Health System PO Box 250 LaPorte, IN 46352-0250	Janeen R. Arnett 219-326-1234, Ext 3130 j.arnett2@lph.org	Dec. 01, 2009
Lutheran Health Network 7950 West Jefferson Boulevard Fort Wayne, IN 46804-4160	Rose Marie Pennell 260-435-7451 rpennell@lutheran-hosp.com	June 01, 2010
Major Hospital 150 W Washington Street Shelbyville, IN 46176	Karen Burton 317-421-5698 kburton@majorhospital.org	June 01, 2010
MCV & Associates Healthcare Inc. P.O. Box 68194 Indianapolis, IN 46268	Cora Vizcarra 317-872-7786 Consultmcv@mcvassociates.com	Dec. 01, 2009
Memorial Hospital & Health Care Center 800 W 9th Street Jasper, IN 47546	Paula Martin 812-481-8502 pamartin@mhhcc.org	Dec. 01, 2010
Memorial Hospital of South Bend 615 N Michigan Street South Bend, IN 46601	Diane Parmelee 574-284-7179 ddparmelee@memorialsb.org	Dec. 01, 2009
Methodist Hospitals 600 Grant Street Gary, IN 46402	Cynthia Thompson 219-886-4455 cthompson@methodisthospitals.org	June 01, 2011
Parkview Health System 2200 Randallia Drive Fort Wayne, IN 46805	Debra Stam 260-373-7051 Deb.stam@parkview.com	June 01, 2009
Porter Education & Rehabilitation Center 1401 Calumet Avenue Valparaiso, IN 46383	Debbie VanKeppel 219-263-4811 debbie.vankeppel@porterhealth.com	June 01, 2009
Purdue University Continuing Nursing Education 502 N University Street West Lafayette, IN 46907-2069	Patricia Coyle-Rogers 765-494-4030 pcrogers@purdue.edu	Dec. 01, 2010
R.L. Roudebush VA Medical Center 1481 W 10th Street Indianapolis, IN 46202	Janet Lutz 317-988-4243 Janet.lutz@med.va.gov	Dec. 01, 2010
Reid Hospital & Health Care Services 1100 Reid Parkway Richmond, IN 47374	Karen Everett 765-983-3094 karen.everett@reidhosp.com	June 01, 2010
Schneck Medical Center 411 West Tipton Street Seymour, IN 47274	Karen Werskey 812-524-3342 kwerskey@schneckmed.org	June 01, 2011
Scott Memorial Hospital 1451 N Gardner Street Scottsburg, IN 47150	Shannon Carroll 812-752-8572 Shannon.carroll@jhsmh.org	Dec. 01 2010
St. Francis Hospital & Health Centers 1600 Albany Street Beech Grove, IN 46107	Kathy Fox 317-783-8312 Kathy.fox@ssfhs.org	June 01, 2011
St. Joseph Regional Medical Center 801 E LaSalle Street South Bend, IN 46617	Joanne Weaver 574-237-7643 weaverjo@sjrmc.com	Dec. 01, 2009
St. Margaret Mercy 5454 Hohman Avenue Hammond, IN 46320	Laura Dosen 219-932-2300 ext. 34549 laura.dosen@ssfhs.org	June 01, 2009
St. Mary's Medical Center 3700 Washington Avenue Evansville, IN 47750	Suzanne Buchanan 812-485-4302 Sbuchanan@stmarys.org	June 01, 2009
St. Vincent Hospital & Health Care Center 2001 W 86th Street Indianapolis, IN 46240	Wanda K. Powell 317-338-6820 wkpowell@stvincent.org	Dec. 01, 2010
The Community Hospital 901 MacArthur Boulevard Munster, IN 46321	Colette Lewandowski 219-836-4504 clewandowski@comhs.org	Dec. 01, 2009
VA Northern Indiana Health Care System 1700 E 38th Street Marion, IN 46953	Laura A. Johnson 765-674-3321, Ext. 73291 Laura.johnson2@med.va.gov	Dec. 01, 2009
Valparaiso University College of Nursing LaBien Hall Valparaiso, IN 46383	Julie A. Koch 219-464-5291 Julie.koch@valpo.edu	Dec. 01, 2009
Wishard Health Services 1001 W 10th Street Indianapolis, IN 46202	Norma Wallman 317-630-7536 norma.wallman@wishard.edu	Dec. 01, 2009

CE Activities Approved

The Indiana State Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The Indiana State Nurses Association (ISNA) has long been supportive of and involved in continuing nursing education (CNE). Indiana was one of the first states in the nation to develop and implement a process to assure that continuing nursing education activities meet high educational standards. A statewide plan for CNE in Indiana was developed in 1972-1973 and implemented during 1973-76 through a grant from the W.K. Kellogg Foundation. Effective January 1, 1977, the Indiana Statewide Program for Continuing Education in Nursing (ISPCEN) officially became a part of the Association. ISNA has been continuously accredited as an approver of continuing nursing education since 1977.

The ISNA program is administered through the Committee on Approval. Individual activity applications are reviewed throughout the year and should be submitted at least eight weeks in advance of the presentation date. Review fees are based on the number of contact hours to be awarded and the date of submission. Approval is awarded for two years if the content, objectives, and time frame remain the same. If you wish additional information, contact the Indiana State Nurses Association by mail, telephone, or fax or send an e-mail to ce@IndianaNurses.org.

As continuing education programs are approved, they are posted on ISNA's web site at 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:

Ethics Principles and Practices
Hendricks Regional Health Education Services
Margie Stewart, BSN, RN, Education Coordinator
1000 W. Main St. , Danville, IN 46122,
mastewa@hendricks.org, 6.25 contact hours

Press Ganey 2008 National Client Conference
Lori Gordon
404 Columbia Place, South Bend, IN 46601
lgordon@pressganey.com
maximum of 16.8 contact hours

The Late Preterm Infant
Mead Johnson/Fire and Rain
Karen Lundgren, MS, RD
5330 Whiting AV, 1.0 contact hour

Practical Application for Cancer Care 2009
Susan Walker, Community Cancer Care, Inc
115 W. 19th St, Indianapolis, IN 46202
sswalker@cccoutreach.com

The American Nurses Association on Behalf of the Larger Nursing Community Announces the Release of a First of its Kind Study on the Economic Value of Nursing

SILVER SPRING, MD—The American Nurses Association (ANA) is pleased to announce, on behalf of the larger nursing community, the release of a first of its kind study quantifying the economic value of nursing. The study was conducted by the Lewin Group, supported by grants from Nursing's Agenda for the Future, the ANA and a coalition of nursing associations dedicated to addressing nursing workforce issues. The research, first proposed in 2003 and published in the current issue of the journal *Medical Care*, is the result of years of analysis of data on the correlation between patient outcomes and nurse staffing levels. **To read the complete article please visit www.lww-medicalcare.com**.

"Nurses are a vital component to the health care system," said ANA President Rebecca M. Patton, MSN, RN, CNOR. "This nursing funded study provides a model that shows how nurses affect the delivery of cost-effective, high quality care, and prevent adverse events. This project was the culmination of years of research that could not have been possible without the tireless work and cooperation of The American Association of Critical Care Nurses, the American Association of Colleges of Nursing, the Oncology Nursing Society, the American Organization of Nurse Executives, and the 85 other nursing organizations who contributed to the project. I applaud their outstanding efforts, and commend them on this significant contribution to the nursing profession."

The research culled findings from 28 different studies that analyzed the relationship between higher RN staffing and several patient outcomes: reduced hospital-based mortality, hospital-acquired pneumonia, unplanned extubation, failure to rescue, nosocomial bloodstream infections, and length of stay. The findings demonstrate that as nursing staffing levels increase, patient risk of complications and hospital length of stay decrease, resulting in medical costs savings, improved national productivity and lives saved.

"Estimates from this study suggest that adding 133,000 RNs to the acute care hospital workforce would save 5900 lives per year. The productivity value of total deaths averted is equivalent to more than $1.3 billion per year, or about $9900 per additional RN per year." The additional nurse staffing would decrease hospital days by 3.6 million. More rapid recovery translates into increased national productivity, conservatively estimated at $231 million per year. "Medical savings is estimated at $6.1 billion, or $46,000 per additional RN per year. Combining medical savings with increased productivity, the partial estimates of economic value averages $57,700 for each of the additional 133,000 RNs."

The research findings suggest significant policy related issues. First and foremost, healthcare facilities cannot realize the full economic value of professional nursing due to current reimbursement systems. Additionally, the economic value of nursing is "greater for payers than for individual healthcare facilities."

Certification Corner

by Sue Johnson, PhD, RN, NE-BC

Sue Johnson

How many certified nurses do you know? A few years ago, you may have been able to count them on one hand, but that is no longer the case. Many of my colleagues are now certified in a variety of specialties and many of these folks now have more than one certification or are currently pursing additional certifications. That's a newer trend. Many nurses now want to be recognized for their clinical expertise in varied specialties. As this trend intensifies, new certifications are developed by numerous professional nursing organizations.

Just wanting to have some new initials after your name is not enough. Preparation for these certification examinations is rigorous and many applicants work full-time and have busy family lives. So, why do they take the time to study for and take another examination? For many of them, it's the challenge to compare their skills with others in the specialty and prove to themselves that they are up to that challenge.

Certification is not for the faint of heart. It's for nurses who demonstrate leadership in these skills and is a recognized credential anywhere they go. Many nurses, who are reluctant to enroll in formal education programs, are eager and enthusiastic to attain certification to recognize their clinical accomplishments. Certification means that the nurse has met stringent standards and is entitled to wear those initials with pride.

Who knows, certification may instill a desire for an advanced degree in the future! As we enter 2009, congratulations to all our certified nurses and to those who will be certified this year!

I'd like to hear from you and publish your certification stories in this column. Please contact me at Sue.Johnson@parkview.com to share your experiences.

Professional Liability Checkup

Four Common Gaps Often Found in Employer-Provided Liability Coverage

Are you at risk?

You go to work every day, take care of your patients and have comfort knowing if something happens, your employer's professional liability coverage will protect you. However, as generous as your employer-provided coverage may be, you should review your coverage to make sure you're not at risk from any of these common gaps often found in employer-provided liability policies:

Gap #1: Coverage for volunteer work or other care while "off duty."

Many employer-provided policies protect you while you're performing the duties of your job, while on the job. But once you go "off duty," you may not be covered.

Take the case of RN "Julie." She answered a flyer hanging on her employer's bulletin board to help residents impacted by a recent hurricane that devastated their area. Over a long weekend, "Julie" cared for dozens of people. One resident claimed she was negligent with her care. When "Julie" contacted her employer's insurance company to seek help with the claim, she learned her employer coverage didn't cover her for "volunteer work."

Even though she spent her own free time helping and the initial contact came through her employer, she was left to pay for everything—attorney fees and court costs to settle the claim.

If you enjoy volunteering or even if you want to help a family member, friend or neighbor who may need care, you could be at risk if you're sued and your employer's policy doesn't cover off-duty care.

Gap #2: Coverage for claims made after terminating employment.

If you leave employer #1 for a better job or pay with employer #2, you may no longer be covered for any situations that occurred while with employer #1, but didn't arise until after you left.

RN "Martinez" found this out two months after he left his previous employer. A claim was made against him for care he provided six months ago while he was still employed there. Martinez called the employer's HR office only to discover his employer-provided coverage only covered him while employed with them. It offered him no coverage after he left, regardless of the fact that the incident occurred while he was employed there. And his new employer policy only covered him for claims made while employed with them—not previous employers.

What if you leave your current employment and decided to take time off between jobs? Or what if your new employer only covers you for claims made while under their employment, not previous employers? You could be left paying for all expenses out of your own pocket if you're not covered.

Gap #3: Liability limits could reach the maximum allowed if there's a large lawsuit or settlement

What if your employer and several fellow employees were involved in a large lawsuit that led to a significant settlement for the plaintiff—maxing out the limits of liability provided in the employer policy? Then, what if a smaller unjustified claim was made against you?

That's what happened to RN "Jamie." When a claim was made against her, she sought help from her employer-provided coverage. But when she contacted them, she learned that her employer's policy maximum was met for the year and therefore, it couldn't provide the funds to pay her attorney fees or settlement costs. She was left to pay for these out of her own pocket.

Gap #4: Coverage is provided for the best interests of the employer, not its employees.

What if you and your employer are named in the same lawsuit…who do you think the attorneys will work harder to defend? Usually, the attorneys working on the case will look out for the best interests of the employer first.

This happened to RN "Pat." A lawsuit was filed naming her and her employer for negligence. The attorneys worked steadfastly to clear the employer in any wrong doing, but did little to defend her. In fact, many of the questions they asked during trial implied she was at fault. The jury found her negligent, not the employer. Since she was found negligent, her employer policy said she was liable for some of the plaintiff's award.

How can you fill these gaps?

The bottom line is you need to make sure you have your own policy working to protect your personal interests—whether you volunteer a lot, need coverage that goes from employer to employer, require higher coverage limits based on your professional needs, and one that looks out for and protects you.

The ISNA has made it easy for you to obtain your own personal liability coverage. ISNA exclusively endorses the liability insurance offered by Chicago Insurance Company, and administered by Marsh Affinity Group Services, and works directly with them to provide the best coverage for our members.

The ISNA-endorsed Professional Liability Coverage through Marsh offers you liability limits up to $2 million per claim/$4 million annual aggregate and also includes:

- ♣ Protection while volunteering or providing "Good Samaritan" efforts.
- ♣ Coverage for claims made while your policy is in force—regardless of when they actually occurred and even if you've changed employers.
- ♣ Personalized policy limits based on you alone—not your company and colleagues.
- ♣ Defense costs—to pay legal fees, court costs, help clear your good name, pay settlement claims—regardless if a suit is groundless, false or fraudulent.

To get a free, no-obligation rate quote, simply visit www.proliability.com. For more information on the ISNA-sponsored Professional Liability coverage, call 1-800-503-9230 or www.proliability.com.

Please note: The names and circumstances provided herein are fictitious. But the situations described are common and do happen. That's why it's important you review your employer-provided coverage to make sure you're not at risk.

Independent Study

Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal

INDEPENDENT STUDY

This independent study has been developed for nurses who wish to learn more about identification and treatment of alcohol abuse, dependence, and withdrawal in patients.

1.16 contact hour will be awarded for successful completion of this independent study.

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

Expires 12/2009.

DIRECTIONS

1. Please read carefully the enclosed article "Identification and Treatment of Alcohol Abuse, Dependence and Withdrawal."
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 Ohio Nurses Foundation, Nursing Dept.LB-12, P. O. Box 183134, Columbus, Ohio 43218-3134.
   A. The post-test;
   B. The completed registration form;
   C. The evaluation form; and
   D. The fee: $15.00 for ISNA members and $20.00 for non-members.

The post-test will be reviewed. If a score of 70% or better is achieved, a certificate will be sent to you. If a score of 70% is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70% 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, 614-448-1027, or Sandy Swearingen, 614-448-1030, Ohio Nurses Foundation at (614) 237-5414.

OBJECTIVES

Upon completion of this independent study, the learner will be able to:

1. Discuss the prevalence of alcohol abuse and dependence in the general population and in the population of people seeking health care.
2. Discuss why it is important to quickly identify a person who is experiencing alcohol withdrawal.
3. Identify several effective screening and assessment tools.
4. Describe the indicators of alcohol abuse and dependence in physical assessment of the neurological, gastrointestinal, cardiovascular and immune system.
5. Describe the indicators of alcohol abuse and dependence in laboratory findings.
6. Describe the intervention and referral actions the RN should take upon identification of the patient at risk of withdrawing from alcohol.

This independent study was developed by: June A. Tierney, MSN, RN, CS, Instructor, Wright State University-Miami Valley, and Therapist, South Community, Inc., Dayton, Ohio. The author and planning committee members have declared no conflict of interest.

There is no commercial support for this independent study.

Study

Alcohol abuse and dependence are patient problems that are consistently underestimated, under-assessed, and under-reported in the health care system (Cyr & Wartman, 1988; Moore et al., 1989; Ruppert, 1996). Though recognition of problem drinkers can be easily carried out with fair accuracy, health care providers do not regularly assess for alcohol abuse or dependence.

Alcohol has adverse effects on every organ system including the cardiovascular, gastrointestinal, genitourinary, endocrine, reproductive, neurological, hematopoietic, and immune systems (Burns, 1994; Rotman, 1995). Alcohol abuse and dependence affect both genders and patients of all socioeconomic, educational, and cultural groups (Burns, 1994). Although alcohol's impact is physiologically wide-ranging and withdrawal from it is dangerous and potentially fatal, the physical signs and symptoms of dependence may not be immediately evident from observation (Burns, 1994).

Patients with a significant risk of undergoing withdrawal syndrome may appear completely normal upon admission to the hospital. Identification of alcohol abuse or dependence can make, at the very least, a positive difference in the treatment of a patient, and may be instrumental in saving the patient's life.

Definitions of Alcohol Abuse and Dependence

Alcoholism, or alcohol dependence, has been defined by the National Council of Alcoholism and Drug Dependence and the American Society for Addiction Medicine (Morse, 1990,p.1)

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol despite adverse consequences, and distortions in thinking, most notably denial.

Alcohol dependence implies tolerance and the existence of withdrawal symptoms when alcohol intake is interrupted. The withdrawal syndrome is unique to each patient, dependent on a variety of factors, and may range from mild anxiety and discomfort to seizures and delirium tremens (Hokenson, 1994).

Alcohol abuse differs from dependence in that it does not include tolerance, withdrawal, or a pattern of compulsive use (Rotman, 1995). Alcohol abuse implies the harmful consequences of repeated use such as failure to fulfill major social role obligations, incurring a physical hazard or legal problems, and having persistent interpersonal problems exacerbated by alcohol use (American Psychiatric Association, 1994).

Prevalence

A U. S. Bureau of Census survey (1992) reported that as many as 37.5 percent of respondents drank five or more alcoholic drinks in any one day. Anywhere from 5 percent to 10 percent of the general population suffers from alcohol dependence, and among hospitalized patients as many as 20 percent to 35 percent have significant alcohol problems which are never detected or adequately treated (Burns, 1994). The prevalence of alcohol dependence among elderly inpatients is estimated to be between 11 percent and 20 percent in acute care settings, however these estimates are thought to be low (Adams, Yuan, Barboriak & Rimm, 1993). The reported prevalence of alcohol dependence for elderly patients in acute care settings is as high as the prevalence of myocardial infarction in that population (Adams et al., 1993). Alcohol is implicated in at least 10% of all deaths yearly in the U. S. (Moore et al., 1989).

Withdrawal Syndrome and Screening Tools

Alcohol abuse and dependence have significant prevalence in patients entering into the health care system at any level, however the problem frequently goes unrecognized. Physicians often have not been trained to identify alcohol abuse or dependence, perceive they lack the skill to do so, or possess attitudes which are barriers to diagnosis (Moore et al., 1989). Little research has been conducted to determine the assessment skill of the registered nurse in identification of alcohol dependence or abuse. Hoffman and Heinemann (1987) discovered through a national survey of nursing programs that there were a relatively small number of required instructional hours in substance abuse in proportion to the scope and prevalence of substance abuse problems in patient populations.

All patients entering the health care system should be assessed, however briefly, for alcohol abuse and dependence. Early identification of the abusing or dependent patient will aid in timely treatment and management of the many complications that can emerge due to alcohol's impact on the body (Burns, 1994). Common examples of these complications are the need for additional anesthesia or more intense pain management strategies, prolonged recovery, altered wound healing, and possible untreated alcohol withdrawal. Undiagnosed and untreated alcohol withdrawal can result in the patient's death. Alcohol withdrawal is experienced by the patient as one of three stages or syndromes.

Stage I Withdrawal

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunction such as increased heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Stage I withdrawal is common among persons who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

Symptoms of early withdrawal begin within 5 to 10 hours after the person's last drink (Braunwald et al., 1987). If there are to be physiological complications during mild withdrawal, they will begin 48 to 72 hours after the last drink (Bluhm, 1987). The patient may be flushed, severely tremulous, tachycardic, anorexic, over-alert, unable to sleep, irritable, and easily startled at the peak of mild withdrawal (Adams & Victor, 1985). The symptoms normally subside without complications (Wilson, 1994).

Stage II Withdrawal

Severe or Stage II withdrawal is experienced by 5 percent of alcohol dependent persons (Hokenson, 1994). The person will be in a state of confusion, often accompanied by visual, tactile, and auditory hallucinations (Braunwald et al., 1987). The hallucinations are vivid and can be persistent. Other signs and symptoms include tremulousness, irritability, nausea, diaphoresis, tachycardia, and high blood pressure (Wilson, 1994). Seizure activity may occur for a small percentage of persons experiencing Stage II withdrawal within 24 to 48 hours after the last drink (Raimond & Taylor, 1986).

As the person progresses through Stage II withdrawal, the ability to dream, suppressed by alcohol use, returns. Nightmares are common during this stage of withdrawal (Wilson, 1994).

Stage III Withdrawal

Stage III alcohol withdrawal, commonly known as delirium tremens (DTs), is characterized by profound confusion, delusions, agitation, hallucinations, and increased autonomic nervous system activity such as tachycardia, fever, dilated pupils, and diaphoresis (Hokenson, 1994). DTs occur 4 to 7 days after the last drink and are considered to be a medical crisis (Bluhm, 1987). The person may demonstrate violent or paranoid behavior, will be unable to sleep, and hallucinations will be intense and vivid.

The mortality rate is 5 percent or less for persons with delirium tremens, however the mortality rate increases if the person has a concurrent medical illness (Hokenson, 1994). Complications frequently include concurrent infections, respiratory problems, fluid loss, and physical exhaustion (Wilson, 1994). Seizures are a particular problem during Stage III withdrawal. They can occur within 12 hours of having the last drink or begin as much as a week later. The seizures due to alcohol withdrawal will most always be tonic-clonic, or grand mal seizures (Wilson, 1994). The most common causes of death

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during alcohol withdrawal are cardiac dysrhythmia, respiratory arrest, excessive psychomotor activity, severe dehydration, and massive infections (Hokenson, 1994). If DTs are unrecognized and untreated, they can result in death.

Screening Tools

Every person who presents for medical treatment of any kind should be screened for alcohol abuse and dependence (Burns, 1994; Cyr & Wartman, 1988; Hokenson, 1994; Rotman, 1995). The registered nurse is in an excellent position, no matter what his or her role is in the health care system, to incorporate simple screening tools into the nursing assessment.

The screening technique used for alcohol abuse and dependence most frequently by all health care providers includes the question: "How much and how often do you drink?" Skinner & Sheu (1982) demonstrated that reports of the frequency and quantity of consumption of alcohol are often inaccurate, and questioned the validity of such an approach to screening.

The simplicity and ease of asking this kind of short, pointed question in the context of a health assessment interview should not be ignored, however, Cyr and Wartman (1988) outlined a similar simple question approach that did prove highly sensitive in screening for alcohol abuse and dependence. The questions asked were: "Have you ever had a drinking problem?" and "When was your last drink?" The highly sensitive results of this set of questions were unexpected as it is commonly thought that alcoholics will deny or minimize their drinking problems when questioned.

Cyr and Wartman point out that even though a patient's denial may be a barrier to screening, straight-forward questions can greatly improve the chance that the person will relate helpful, accurate information about their alcohol use. In order to obtain the most sensitive screening, the two questions should always be asked together. Although the person may fail to recognize their drinking habits as problematic, they are often able to admit to recent drinking.

Cyr and Wartman found that drinking alcohol within the 24 hours before a medical appointment should increase the suspicion of alcohol abuse or dependence. A positive response on the first question and reported alcohol use in the past 24 hours before the interview indicates a high risk for both alcohol dependence and subsequent alcohol withdrawal.

A second simple, effective tool is the CAGE questionnaire, developed in 1970 by Ewing (Ewing, 1984). CAGE is an acronym for four questions asking whether a person has thought about cutting down on drinking, if they have been annoyed by criticism from others about their drinking, if they feel guilty about drinking, and if they need an eye-opener to steady their nerves or cure a hangover. The questions elicit yes or no answers, and a single positive answer should alert the interviewer to the high likelihood of alcohol abuse (Beresford, Low, & Adduci, 1982). Two or three positive responses identify alcohol dependence (Mayfield, McLeod, & Hall, 1974).

Despite efforts to incorporate these screening tools for alcohol abuse and dependence into the nursing assessment, the person at risk may not be identified. There is no single sign or symptom that is specific to alcohol abuse, and recognizing the dependent individual is an inexact process (Burns, 1994; Rotman, 1995). Denial plays a large part in maintaining alcohol abuse and dependence, and therefore the person may answer screening questions in a fashion which does not suggest a problem.

Health History, Physical Assessment, and Laboratory Clues to Alcohol Use

Clues may be discovered in the health history, physical assessment, and laboratory findings of a patient. Familiarization with these clues can augment the nurse's ability to screen the patient at risk during the nursing assessment.

Health History

The risk of alcohol dependence can be at least partially explained through biological and genetic factors (National Institute on Alcohol Abuse and Alcoholism {NIAAA}, 1990). The major risk factor for alcohol dependence is a positive family history (NIAAA, 1986). Up to 50% of women with alcohol problems have alcoholic fathers (Sandmaier, 1981). Having a significant family history of depression is associated with a higher than average risk for alcohol dependence (Winokur, 1970). Taking a detailed family history and constructing a genogram can give useful information in screening for alcohol abuse or dependence.

A past history of recurrent accidents and illnesses, motor vehicle accidents, falls, burns, pneumonia, tuberculosis, sexually transmitted diseases, hepatitis, and HIV infection may be indicative of alcohol abuse or dependence (Burns, 1994). Frequent references to drinking, an alcohol focus in a person's leisure or social activities, and drinking to relieve stress, anger, anxiety, or insomnia may indicate abuse. Note the person's work record for absenteeism. frequent job changes, and tardiness. Citations for driving under the influence, fights, family violence, and financial problems without another explanation are also warning signs of alcohol abuse.

Assessment of the Neurological System

Alcohol affects the neurological in both the short and long term. It is a central nervous system depressant that is dose dependent, with specific signs and symptoms varying with the concentration of alcohol in the blood (Burns, 1994). Intoxication with alcohol alters the level of consciousness and behavior, and these changes are modulated by the amount of alcohol ingested, the individual's tolerance, and factors such as ingestion of food and rate of alcohol ingestion.

Symptoms of intoxication range from impaired sensory function, euphoria, slurred speech, incoordination, and increased reaction time with less than 6 drinks (12 oz. beer, 4 oz. glass of wine, 1 1/2 oz of distilled liquor), to nausea and vomiting, inability to remain upright without support, heavy breathing, amnesia, decrease in action of respiratory centers on CNS, coma and possibility of death with 7 to 25 drinks (Burns, 1994).

Withdrawal symptoms, mentioned previously, are a result of hyperactivity of the autonomic nervous system in rebound from the depressant effects of alcohol. Think of the response as a kind of pendulum effect; the further the pendulum has been pushed to the depressed side with alcohol abuse or dependence, the further it will swing back to the hyperactive side when alcohol ingestion has ceased, causing a more serious withdrawal syndrome.

Alcohol is neurotoxic and is responsible for producing a dementia secondary to chronic alcohol use (Eckhardt & Martin, 1986). The dementia is the second most common dementia following Alzheimer's Disease (Burns, 1994), and is experienced by approximately 9 percent of all alcohol dependent individuals. The person will have problems with new learning, visuospatial function, abstract thinking, and psychomotor skills.

Advanced alcohol dependence is also associated with Wernicke-Korsakoff syndrome. The neurotoxicity of the alcohol and the nutritional deficits that accompany alcohol dependence cause nerve cells to become demyelinated and necrotic, causing symptoms such as paralysis of gaze, nystagmus, ataxia, dull mentation, impairment of recent memory, and amnesia (Burns, 1994).

Assessment of the Gastrointestinal System

Malnutrition is a common problem associated with alcohol dependence. Adult drinkers may get more than 10 percent of their total daily caloric intake from alcohol (Williamson et al., 1987). Alcohol intake also interferes with the metabolism of most vitamins, proteins, carbohydrates, and lipids, causing the person to suffer anemia, neuropathy, liver disease, pancreatic disease, thinning hair, bruising, tongue inflammation, abdominal distension, peripheral edema, and tetany (Burns, 1994). Large amounts of alcohol can cause acute gastritis, epigastric pain, nausea, and vomiting. A complaint of steady, dull epigastric pain radiating toward the back may indicate acute alcohol-mediated pancreatitis.

The liver is the primary site of alcohol metabolism and is damaged by direct alcohol toxicity (NIAAA, 1990). The three primary types of alcohol mediated liver damage are hepatic steatosis (fatty liver), alcoholic hepatitis, and cirrhosis. Hepatic steatosis and alcoholic hepatitis are reversible with removal of alcohol from the system, while cirrhosis is not. Cirrhosis is the ninth leading cause of death in the United States (NIAAA, 1986).

Assessment of the Cardiovascular System

Chronic alcohol use is associated with hypertension, ischemic heart disease, and cerebrovascular disorders (NIAAA, 1990). Alcohol affects the heart muscle directly and causes cardiomyopathies and dysrhythmia. Transient atrial and ventricular dysrhythmia may follow several days of heavy drinking (Frances & Miller, 1991). As many as 5 percent to 24 percent of all cases of hypertension may be caused by alcohol use (Klatsky, 1987; Lange & Kinnunen, 1987). Blood pressure increases substantially during and shortly after intoxication (Lange & Kinnunen, 1987). Hypertension may regress substantially or even completely with abstinence from alcohol (Benzer, 1987; Criqui, 1986; Klatsky 1987; Miller & Gold, 1987).

The vasodilation caused by alcohol gives the user a reddened, flushed appearance. The person using alcohol may feel very warm while their core temperature can actually reach dangerously low levels due to rapid heat loss (Burns, 1994).

Assessment of the Immune System

Alcohol abuse will alter the immune system, depressing natural killer cell activity and lymphocyte transformation (NIAAA, 1990). The person will have an increased susceptibility to infections such as tuberculosis, pneumonia, and virus-associated head and neck cancers (NIAAA, 1990).

Laboratory Findings

There is no specific laboratory test that can identify alcohol abuse or dependence. The results of several laboratory tests can point toward dependence, however these results are not specific to alcohol use.

An elevated GGT (y-glutamyl transpeptidase) level is the most specific liver function test for alcohol abuse (Burns, 1994). GGT is elevated in approximately 75 percent of heavy drinkers with no other evidence of alcoholic liver disease (Lieber, 1991). A variety of common medications such as anticonvulsants, anticoagulants, and oral contraceptives can elevate GGT levels. Some medical conditions, such as non-alcoholic liver disease, gallbladder inflammation, lipid disorders, and obesity can also raise GGT levels. Normal GGT values are 8-30 U/L in men and 5-29 U/L in women (Rosman & Lieber, 1990). Less than half of alcoholic patients will have an elevated MCV, which is a measure of the size of red blood cells (Rosman & Lieber, 1990). Normal values are 86-98 μm^3. Folic acid deficiency, B12 deficiency, hypothyroidism, non-alcoholic liver disease, and leukemia can also increase red cell size. The liver enzymes involved in amino acid metabolism, aspartate aminotransferase (formerly SGOT) and alanine aminotransferase (formerly SGPT), will be increased with heavy alcohol use. Normal aspartate

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aminotransferase in adults is 0-35 U/L, and normal alanine aminotransferase is 0-35 U/L (Burns, 1994).

Moderate consumption of alcohol (2-3 drinks each day) can elevate serum HDL. The normal average HDL for men is 44-55 mg/dl and for women is 55 mg/dl. HDL will decrease with cirrhosis (Rosman & Lieber, 1990).

Interventions (Referral to community resources).

Suspicion that a patient in any level of the health care system is abusing or is dependent on alcohol should be brought to the attention of the physician and the health care team, as well as to the patient. Not all persons who abuse alcohol will be subject to withdrawal, however early identification of alcohol abuse can set the stage for modification of the abusive behavior and stop the progression to dependence.

It will be essential for the nurse to let the person know what has been assessed and make recommendations for intervention. Having local Alcoholics Anonymous meeting schedules is helpful, as well as AlAnon or Adult Children of Alcoholics group schedules for family members. The person may not know how to contact their mental health or substance abuse services if they belong to an HMO or other managed health care program, and will need guidance to contact a provider. Above all, maintaining a professional, non-judgmental, and warm relationship with the person who may be abusing alcohol is essential to linking them with useful services.

Treating Withdrawal Syndrome

If the nurse suspects the person is in danger of withdrawal syndrome, immediate action to begin treatment must be taken. Many complications of withdrawal can be avoided by early diagnosis and treatment of the symptoms.

Nursing management of withdrawal is focused on maintaining safe detoxification of the patient. Treatment will include meeting rest, safety, hydration, nutritional and sedation needs (Hokenson, 1994). The ideal method to maximize patient treatment and staff safety is for the institution to formulate an alcohol withdrawal protocol with established standing orders to guide the nurse (Hokenson, 1994). Withdrawal symptoms can begin within hours of the patient's last drink and progress rapidly to more serious complications. The tools needed for management of detoxification should be immediately available.

For patients experiencing early withdrawal, vital signs and level of consciousness should be monitored every 30 minutes at first, and every three hours if vital signs are stable. A restful, nonstimulating environment will help the patient maintain orientation. Sedative medications such as oxazepam (Serax), diazepam (Valium, Vazepam), lorazepam (Ativan, Alzapam), or chlordiazepoxide (Librium, Lipoxide) may be ordered to serve as substitutes for the withdrawn alcohol. These long-acting central nervous system depressants will ease the "swing of the pendulum" in the central nervous system toward hyperactivity, hallucinations, and seizures. Large loading doses are given initially with a dose tapering over the next 3 to 4 days. Dosing should be individualized, especially with the geriatric patient (Ruport, 1996).

It will be important to orient the patient to person, place and time. Explain all procedures in a calm and quiet manner to avoid further exciting the patient. Do not force fluids unless it has been established that the patient is dehydrated. Keep an accurate record of intake and output, but remember that fluid will also be lost due to profuse perspiration and agitation. Seizures are a risk during withdrawal, therefore seizure precautions must be in place.

The patient should be allowed to ambulate ad lib if they are stable enough and if ambulation is ordered. Vitamin supplements may be ordered. Initially a "banana bag" containing 1,000 cc of normal saline, 2 gm of magnesium sulfate, 1 mg of folic acid, and an ampule of multivitamins can be infused at 50 to 150 cc/hour (Wilson, 1994). Small, frequent, high carbohydrate feedings that are easily digested can be given if the patient can tolerate solids. The stool should be tested for guaiac to determine if there is any gastrointestinal dysfunction. The patient and family will require calm, nonjudgemental support during and after the withdrawal period (Beare & Myers, 1990).

Discharge planning must include referral to a community-based substance abuse program. The program should meet the needs of the individual. Criteria in making the decision for a particular referral include age of the patient, severity of the problem, degree of social support, degree of psychologic impairment, presence or absence of other medical problems, and relapse history (Ruppert, 1996).

Conclusion

Treatment of alcohol related problems begins with recognition and early diagnosis. Providing the person who is abusing alcohol with information about the impact on their body can encourage modification of that behavior. The safety of the patient and of nursing staff depends on an accurate assessment of alcohol use, no matter who the patient is or at what level they are entering the health care system. In order to minimize or eliminate the dangers of alcohol withdrawal, treatment must begin before the patient's symptoms are severe. A working understanding of prevalence, simple screening tools, signs of alcohol abuse and dependence in health history, physical assessment, and laboratory findings can achieve these goals.

Independent Study continued on page 13

Independent Study continued from page 12

Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal

Post-Test and Evaluation Form

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

NAME_____

FINAL SCORE _____

1. _____ There are several signs and symptoms which are specific to alcohol abuse.
2. _____ One positive response to the CAGE questionnaire alerts the interviewer to the high likelihood of alcohol abuse.
3. _____ HDL is elevated for a person who consumes alcohol moderately.
4. _____ A person who is abusing alcohol, but who is not yet dependent, can be at risk for withdrawal.

Please circle the **ONE** correct answer.

5. The physical signs and symptoms of alcohol dependence:
   A. Are easily observable through a nursing assessment.
   B. May not be immediately evident from observation.
   C. Include decreased blood pressure and increased heart rate.
   D. Do not include changes in the immune system.

6. Alcohol abuse differs from alcohol dependence in that:
   A. Alcohol abuse implies tolerance, whereas dependence does not.
   B. Alcohol abuse does not involve the defense mechanism denial, whereas dependence does.
   C. Alcohol abuse does not include compulsive use, whereas dependence does.
   D. Alcohol abuse does not exacerbate interpersonal problems, whereas dependence does.

7. Which of the following statements in reference to the prevalence of significant alcohol problems is true?
   A. As many as 35% of hospitalized patients have significant alcohol problems.
   B. Up to 50% of the general population abuses alcohol.
   C. Alcohol is implicated in 5% of all deaths yearly in the U. S.
   D. Alcohol dependence among elderly inpatients in acute care settings is less than 10%.

8. Stage I withdrawal from alcohol:
   A. Happens only when an alcohol dependent person stops drinking.
   B. Begins 1 to 2 days after the person takes their last drink.
   C. Can often result in serious physical complications.
   D. Includes increased body temperature as a symptom.

9. A patient withdrawing from alcohol is unable to sit still, is sweating profusely, is dehydrated, complains of "snakes moving through the walls and crawling on my skin," is hitting out at staff when they approach, and has not slept in 24 hours. The nurse understands that:
   A. Petit-mal seizures are possible and seizure precautions should be in place.
   B. One in twenty patients with these symptoms may die if not properly treated.
   C. Fluids should be forced in order to avoid dehydrating from profuse sweating.
   D. Solid food should be avoided at this time.

10. The most useful question/s the nurse can ask a patient to screen for alcohol abuse or dependence is/are:
    A. How much and how often do you drink?
    B. Have you ever had a drinking problem?
    C. When was your last drink?
    D. A and B
    E. B and C

11. When obtaining a health history, which of the following would be the most indicative of a risk factor for alcohol dependence?
    A. The patient has been late to work frequently in the last month.
    B. The patient relates that her mother seems depressed.
    C. The patient has a history of having several sexually transmitted diseases in the last year.
    D. The patient describes her father as a "binge drinker."

12. The damage done to the gastrointestinal system by alcohol:
    A. Is caused indirectly in the liver by vitamin deficiency.
    B. May cause thinning hair and tetany.
    C. Includes interference with protein and carbohydrate metabolism, but not lipid metabolism.
    D. May cause a dull epigastric pain indicating acute gastritis.

13. Which serious physical condition will not regress with abstinence from alcohol?
    A. Hypertension
    B. Cirrhosis
    C. Ventricular dysrhythmia
    D. Pancreatitis

14. Which of the following lab results would be most indicative of alcohol abuse?
    A. GGT 40 U/L
    B. MCV 112 µm3
    C. HDL 60 mg/dl

15. The best way to avoid serious complications in the patient withdrawing from alcohol is:
    A. Administer sedative medications to patients in all stages of withdrawal.
    B. Use an established alcohol withdrawal protocol and individual sedative dosing.
    C. Frequently rouse the patient to cough and ambulate.
    D. Restrain the patient who is experiencing delirium tremens.

16. A client complains to the nurse at the local family practice clinic that she is mad at her sister for telling the client to cut down on her drinking. She also complains of financial problems. The nurse understands from this information that there is a high likelihood of:
    A. Alcohol abuse.
    B. Alcohol dependence.
    C. Alcohol dependence and subsequent withdrawal.

17. DT's occur:
    A. 8 hours after the last drink.
    B. 48 hours after the last drink.
    C. 3 days after the last drink.
    D. 4-7 days after the last drink.

18. Which laboratory finding can specifically identify alcohol dependence?
    A. GGT
    B. HDL
    C. MCV
    D. None of the above

19. The main barrier to screening a client for alcohol abuse or dependence is the:
    A. Lack of a reliable screening tool.
    B. Existence of denial in the client.
    C. Complexity of sensitive tools.
    D. Difficulty of incorporating tools into the assessment.

20. The typical alcohol withdrawal symptoms of agitation, elevated vital signs, and anxiety are caused by:
    A. Rebound of the autonomic nervous system.
    B. Depression of the autonomic nervous system.
    C. Neurotoxic action of alcohol.
    D. Relative concentration of alcohol in the blood.

Independent Study continued on page 14

Independent Study continued from page 13

Evaluation

	YES	NO
1. Were the following objectives met?		
a. Discuss the prevalence of alcohol abuse and dependence in the general population and in the population of people seeking health care.	____	____
b. Discuss why it is important to quickly identify a person who is experiencing alcohol withdrawal.	____	____
c. Identify several effective screening and assessment tools.	____	____
d. Describe the indicators of alcohol abuse and dependence in physical assessment of the neurological, gastrointestinal, cardiovascular and immune systems.	____	____
e. Describe the indicators of alcohol abuse and dependence in laboratory findings.	____	____
f. Describe the intervention and referral actions the RN should take upon identification of the patient at risk of withdrawing from alcohol.	____	____

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? _____

_____

_____

INDEPENDENT STUDY
Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal
Registration Form

Name: _____
(Please print clearly)

Address: _____
Street City/State/Zip

Daytime phone number: (___)_____ _____ RN _____LPN

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

Please email by certificate to: _____
Email Address (please print clearly)

ISNA 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.