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 317/297-3325, or email to member@IndianaNurses.org no later than April 15, 2009.

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-impact areas of

Consent-to-Serve Forms are due in the ISNA office April 15, 2009. You can nominate a colleague or you can self-nominate.

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 really find myself cramping 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 so too. 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 by being 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.
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 priority-setting must be a “high leverage” areas—aspects of performance for which improvement will yield the greatest gains. The Partnership’s core list of priorities will:

- Resolved 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.
- Resolved 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.
- Accepted the proposal from Ent & Inler 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 CCFNS 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.

ANA Works Toward a Consensus continued from page 1

**ISNA BULLETIN**

February, March, April 2009

An official publication of the Indiana State Nurses Association Inc., 2915 North High School Road, Indianapolis, IN 46242-2969. Tel: 317/299-4575. Fax: 317/295-3535. E-mail: info@indiananurses.org. Web site: www.indiananurses.org

Materials may not be reproduced without written permission from the Editor. Views stated may not necessarily represent those of the Indiana State Nurses Association, Inc.

ISNA Staff

Ernest Klein, C. Erin, CAE, Editor

ISNA Board of Directors

Officers: Ella S. Harmeyer, President; Barbara B. Kelly, Vice-President; Judy A. Barbazan, Secretary; and Paula McAfee, Treasurer.

Directors: Eleanor Donnelly, Jennifer Embree, Michael Fights, Vicki L. Johnson, and Judy Morgan.

**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 46242-2969 or E-mail to klein@indiananurses.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 publication; and September 15 for November/December/January publication.

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

**Advising Rates Contact**—Arthur L. Davis Publishing Agency, Inc., 517 Washington St., P.O. Box 216, Cedar Falls, IA 50613, 800-626-4081. ISNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

**ISNA**

Ella S. Harmeyer, President; Barbara B. Kelly, Vice-President; Judy A. Barbazan, Secretary; and Paula McAfee, Treasurer.

Eleanor Donnelly, Jennifer Embree, Michael Fights, Vicki L. Johnson, and Judy Morgan.

**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 46242-2969 or E-mail to klein@indiananurses.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 publication; and September 15 for November/December/January publication.

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

**Advising Rates Contact**—Arthur L. Davis Publishing Agency, Inc., 517 Washington St., P.O. Box 216, Cedar Falls, IA 50613, 800-626-4081. ISNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.
Welcome to New Members and Reinstated ISNA Members

Barbara A. Bartley, Jasper
Tina Marie Baxter, Anderson
Katherine Mary Bell, Evansville
Kathy Ann Bittar, 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 Owens Heldeman, Fort Wayne
Elizabeth Melanie Onofre, South Bend
Michelle Wood Gansman, Greenwood
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
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. Shourd, 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 Zeisher, 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 Jesse M. Scott Award
Louise Hart, Winchester, we re-appointed to a two-year term on the House of Delegates Reference Committee.

APPLICATION FOR RN MEMBERSHIP in ANA and ISNA

Please print or type

Last Name, First Name, Middle Initial
Street or P.O. Box
City, State, Zip+4
County of Residence
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

Please Complete Form and Payment To: American Nurses Association P.O. Box 504345 St. Louis, MO 63150-4345

1. Select PAY CATEGORY

Full Dues – 100%
Reduced Dues – 50%
Special Dues – 25%

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

Annual-$22.92, Reduced-$11.71.

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

Full Dues – $22.92, Reduced Dues – $11.71.

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

Preferred email address

City, State, Zip+4

County of Residence

Name of Basic School of Nursing

American Nurses Association and ISNA Written notification thirty (30) days prior to the deduction date.
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| 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                    | 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                          | 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 |
nitimal@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 |
(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 |
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 6-12</td>
<td>Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program: (four courses) “Teaching and Evaluation in Web-based Courses”</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>July 20-August 14</td>
<td>Teaching and Learning in Web-based Courses: A Web-base Professional Certificate Program: (four courses) “Practicum: The Development of a Web Course”</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>August 10-September 18</td>
<td>“Clinical Faculty: A New Practice Role” Web Based Course</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>August 25-26</td>
<td>Nurse Aide Program Director &amp; Instructors Training</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>August 26-December 14</td>
<td>Nursing Informatics: A Web-based Professional Certificate Program (four courses) “Clinical Information Systems”</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>August 26-November 6</td>
<td>“Pediatric Intensive Care” Web-Based Course</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>August 26-November 6</td>
<td>Critical Care Nursing: “Adult Critical Care” Web Based Course</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>“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.</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>“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.</td>
<td>Phone: 317/274-7779 Fax: 317/274-0012 <a href="mailto:censg@iupui.edu">censg@iupui.edu</a> Office of Lifelong Learning, Indiana University School of Nursing, 1111 Middle Drive—NU 107, Indianapolis, IN 46202</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.

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.
The ISNA Committee on Approval approves continuing nursing education providers to award 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.InianaNurses.org/education. The following are continuing education providers approved by the ISNA Committee on Approval.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact</th>
<th>Approved to</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington Hosp &amp; Healthcare System</td>
<td>Ronda Hendricks</td>
<td>June 01, 2010</td>
<td></td>
</tr>
<tr>
<td>Clarion Health Partners, Inc.</td>
<td>Sandra Piercy</td>
<td>June 01, 2010</td>
<td></td>
</tr>
<tr>
<td>Clarion North Medical Center</td>
<td>Deborah A. Green</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Columbus Regional Hospital</td>
<td>Sharon Erwin</td>
<td>June 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Community Health Network</td>
<td>Romma Woodward</td>
<td>June 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Deaconess Hospital</td>
<td>Ellen Wathen</td>
<td>Dec. 01, 2010</td>
<td></td>
</tr>
<tr>
<td>EHB, Inc.</td>
<td>Christie Sprinkle</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Good Samaritan Hospital</td>
<td>Judith A. Morgan</td>
<td>June 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Health Care Education &amp; Training, Inc.</td>
<td>Joyce Alley</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>King’s Daughters’ Hosp &amp; Health Services</td>
<td>Terri Neaderhiser</td>
<td>June 01, 2009</td>
<td></td>
</tr>
<tr>
<td>LaPorte Regional Health System</td>
<td>Janen R. Arnett</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Lutheran Health Network</td>
<td>Rose Marie Pennell</td>
<td>June 01, 2010</td>
<td></td>
</tr>
<tr>
<td>Major Hospital</td>
<td>Karen Burton</td>
<td>June 01, 2010</td>
<td></td>
</tr>
<tr>
<td>MCV &amp; Associates Healthcare Inc.</td>
<td>Cora Vizcarra</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Memorial Hospital &amp; Health Care Center</td>
<td>Paula Martin</td>
<td>Dec. 01, 2010</td>
<td></td>
</tr>
<tr>
<td>Memorial Hospital of South Bend</td>
<td>Diane Parmelee</td>
<td>Dec. 01, 2009</td>
<td></td>
</tr>
<tr>
<td>Methodist Hospitals</td>
<td>Cynthia Thompson</td>
<td>June 01, 2011</td>
<td></td>
</tr>
</tbody>
</table>

Approved Providers

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 47907-2609
Patricia Coyle-Rogers
765-494-4030
pcoylerogers@purdue.edu
Dec. 01, 2010

R.L. Roudebush VA Medical Center
1401 W 10th Street
Indianapolis, IN 46202
Janet Lutz
317-988-4243
janet.lutz@med.va.gov
Dec. 01, 2010

Reid Health Care & Health Services
1100 Reid Parkway
Richmond, IN 47374
Karen Everett
765-983-3094
karen.everett@reidthosp.com
June 01, 2010

Schneck Medical Center
417 E Tippton Street
Seymour, IN 47274
Karen Werskey
812-524-3342
kwerskey@schneckmed.org
June 01, 2011

Scott Memorial Hospital
1401 N Gardiner Street
Scottsburg, IN 47150
Shannon Carroll
812-722-6572
Shannon.carroll@hsh.org
Dec. 01, 2010

St. Francis Hospital & Health Centers
1600 Albany Street
Beech Grove, IN 46107
Kathy Fox
317-783-8312
kathy.fox@sfhs.org
June 01, 2011

St. Joseph Regional Medical Center
801 E LaSalle Street
South Bend, IN 46617
Joanne Weaver
574-237-7643
weaverjtc@srmc.com
Dec. 01, 2011

St. Margaret Mercy
5454 Hohman Avenue
Hammond, IN 46320
Laura Dosen
219-932-2300 ext. 34549
laura.dosen@ssfhs.org
June 01, 2011

St. Mary’s Medical Center
3700 Washington Avenue
Evansville, IN 47715
Suzanne Buchanan
812-485-4302
Sburchan@atmarvs.org
June 01, 2009

St. Vincent Hospital & Health Care Center
2001 W 86th Street
Indianapolis, IN 46240
Wanda K. Powell
317-338-6820
wpowell@atvincent.org
Dec. 01, 2011

The Community Hospital
901 MacArthur Boulevard
Munster, IN 46321
Colette Lewandowski
219-436-4504
clewandowski@comhs.org
Dec. 01, 2011

VA Northern Indiana Healthcare System
2001 E Shadeland Avenue
Marion, IN 46953
Laura A. Johnson
765-674-3323
laurajohnson@nuheal.org
Dec. 01, 2009

Valparaiso University College of Nursing
1001 W 10th Street
Valparaiso, IN 46383
Julie A. Koch
219-464-5291
julie.koch@valpo.edu
Dec. 01, 2009

Whithead Health Services
502 N University Street
Indianapolis, IN 46202
Norma Wallman
317-630-7536
norma.wallman@whithead.org
Dec. 01, 2009
The Hawaii Nurses Association (HNA) has long been supportive of and involved in continuing nursing education (CNE). Hawaii 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 Hawaii was developed in 1972-1973 and implemented during 1973-76 through a grant from the W.K. Kellogg Foundation. Effective January 1, 1977, the Hawaii Statewide Program for Continuing Education in Nursing (HSPCEN) officially became a part of the Association. HNA has been continuously accredited as an approver of continuing nursing education since 1977.

The HNA 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 Hawaii State Nurses Association by mail, phone, fax, or e-mail to ce@indiananurses.org.

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 education by the American Nurses Credentialing Center's Commission on Accreditation. 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.bhsn-medicalcare.com.

As continuing education programs are approved, they are posted on ANA's web site at www.indiananurses.org. Click on the "education" link.

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

**Ethics Principles and Practices**

Hendrick Regional Health Education Services
Margie Stewart, BSN, RN, Education Coordinator
1000 W. Main St., Davieville, IN 46122,
mastewa@hendricks.org, 6.25 contact hours

**Press Ganey 2008 National Client Conference**

Lori Gordon
404 Columbia Place, South Bend, IN 46601
L Gordon@pressganev.com
maximum of 16.0 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
swalker@cccreachout.com

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 earn their clinical credentials. 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.

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 earn their clinical credentials. 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.
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 decide 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 professional liability coverage 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 March 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.
This independent study has been developed for nurses who wish to learn more about identification and treatment of alcohol abuse, dependence, and withdrawal in elderly patients.

**Indicators of Alcohol Abuse and Dependence**

1. Discuss the prevalence of alcohol abuse and dependence among elderly inpatients is estimated to be low (Adams, Yuan, Barboriak & Rimm, 1993).

2. Discuss why it is important to quickly identify a patient at risk of 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.

**Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal**

**Study**

Alcohol abuse and dependence are patient problems that are consistently underestimated, under-assessed, and under-treated 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 immune system (Burns, 1994); the gastrointestinal, endocrine, reproductive, neurological, hemtopoietic, and immune systems (Burns, 1994; Ruppert, 1996). 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, it is a major cause of 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 and treatment of the patient at risk of withdrawal should be done as early as possible, as the patient at risk of alcohol withdrawal may have a fixed, 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 is a 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 distortion in thinking, judgment, and behavior.

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 drinking. Alcohol abuse implies the harmful consequences of repeated use such as failure to fulfill major social role obligations, impairment in physical or legal problems, or having persistent interpersonal problems exacerbated by alcohol use (American Psychiatric Association, 1994).

**Prevalence**

A U.S. Bureau of Census survey (1982) reported that as many as 37 percent of the 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, 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 infarcts in that population (Adams et al., 1993). Alcohol is implicated in at least 10 percent 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 that more than 60 percent of the patients admitted to the hospital had a problem with alcohol, while 40 percent had a problem with alcohol. In another study, there were a relatively small number of required instructional hours in substance abuse in proportion to the scope and prevalence of substance abuse problems across all 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 impact on the body (Burns, 1994).

Common examples of these complications are the need for additional anesthesia or more intensive pain management strategies, prolonged recovery, altered wound healing, and possible uncontrolled alcohol withdrawal. Undiagnosed and untreated alcohol withdrawal can result in the patient's death.

A Severe or Stage I withdrawal is experienced by the patient on 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 dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage II Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage III Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage IV Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage V Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage VI Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage VII Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage VIII Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage IX Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).

**Stage X Withdrawal**

Mild alcohol withdrawal, the most common syndrome, is characterized by nervousness, generalized anxiety, hand tremors, autonomic nervous system dysfunctions like pounding heart rate, increased blood pressure, increased body temperature, and nausea and vomiting (Hokenson, 1994). Symptoms of mild withdrawal begin within 5 to 10 hours after the patient's last drink (Braunwald et al., 1987). If there is no withdrawal reaction, patients are considered to be alcohol dependent who have consumed an excessive quantity of alcohol, whether or not they are physically dependent on alcohol (Wilson, 1994).
during alcohol withdrawal are cardiac dysrhythmia, respiratory arrest, excessive psychomotor activity, severe functional impairment, and seizures (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. There are no perfect tools for alcohol abuse and dependence into the interview indicates a high risk for both alcohol dependence and subsequent alcohol withdrawal. The risk of alcohol dependence can be at least partially explained through biological and genetic factors (NIAAA, 1990). The major risk factor for alcohol dependence is a positive family history of alcohol dependence. Adult drinkers may get symptoms that accompany alcohol dependence cause the person to suffer anemia, neuropathy, deficits that accompany alcohol dependence cause nerve cells to become demyelinated and necrotic, causing symptoms such as paralysis of gaze, myopathy, peripheral neuropathy, cerebellar ataxia and muscle weakness, negative effects from alcohol (Benzer, 1987; Criqui, 1986; Klatsky 1987; Lighter & 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 dependent individuals. 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 use (Burns, 1994). GGT is elevated in approximately 75 percent of heavy drinkers with no other evidence of alcoholic liver disease (Lieber, 1990). A variety of common medications such as anticonvulsants, anticoagulants, and oral contraceptives can elevate GGT levels. Being overweight and 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 9-29 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 μm². Folic acid deficiency, B12 deficiency, hypothyroidism, non-alcoholic liver disease, and leukemia can also increase red cell size. The liver is primary involved, liver function test metabolism aspartate aminotransferase (formerly SGOT) and alanine aminotransferase (formerly SGPT), will be increased with heavy alcohol use. Normal aspartate

Independent Study continued on page 12
ammonotransferase 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 (Ruppert, 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 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.
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 answered 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.
   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.

2. A positive response to the CAGE questionnaire alerts the interviewer to the high likelihood of alcohol abuse.
   A. There are several signs and symptoms which are specific to alcohol abuse.
   B. One positive response to the CAGE questionnaire is not enough to diagnose alcohol abuse.
   C. One positive response to the CAGE questionnaire alerts the interviewer to the high likelihood of alcohol abuse.
   D. The physical signs and symptoms of alcohol abuse are not always present.

3. HDL is elevated for a person who consumes alcohol moderately.
   A. There are several signs and symptoms which are specific to alcohol abuse.
   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.

4. A person who is abusing alcohol, but who is not yet dependent, can be at risk for withdrawal.
   A. There are several signs and symptoms which are specific to alcohol abuse.
   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.

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 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
    D. GGT 40 U/L

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.
Evaluation

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?  ____________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________