



ISNA Needs You Call For ISNA Candidates 2009 Election

Consent-to-Serve Forms are due in the
ISNA office May 29, 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 October 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
Two Directors	Four-year term

COMMITTEE ON NOMINATIONS

Five Members	Two-year term
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DELEGATES AND ALTERNATES TO ANA

Six (at least) Members	Two-year term
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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 May 29, 2009.**

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current resident or



Ella Harmeyer

President's Message



It is almost April 1st as I write this. Ahh... Spring! Of course just two days ago it snowed in South Bend. What is that old saying about tempting fate?!

Spring is here and often seen as a time for new beginnings. At this time when there are many of us seeming unsettled with the economic climate in general and the economic challenges in health care specifically, I thought of what new beginnings I might dream of for nursing and ISNA. I have focused on two ideas that are my wishes for the near future. One revolves around nursing and health care; the other just general issues of everyday life.

For as long as I can remember, nursing seems to bear the brunt of economic struggles in our health care system and currently that seems to once again be the case. I acknowledge that nursing is what I know and therefore I could be making a biased assessment, but as I talk to nurses both in Indiana and from other states, I repeatedly hear that nursing positions are frozen and hiring is on hold. What is puzzling to me is that more often than not another part of the discussion includes comments concerning mandatory overtime for the nursing staff. Do you find these two issues as confusing and contradictory as I do? Covey states that "you have to make the first thing the first thing"—health care needs to be about patient safety and quality of care. We cannot continue to do this with fewer nurses working more and more hours. Thus, we have to be assertive and become part of the solution rather than part of the problem or a silent player.

It seems that the current health care system is not working and has not been working for a relatively long time. Nurses are in a position to be proactive rather than reactive to the needs of health care for the next decade and beyond. We need to step forward and be involved. If we want change, we have to be willing to be part of developing that change. If your place of employment is in the throes of reassessment, I ask that you step up and be involved in the problem solving. Nursing has always required us to be creative thinkers to care for our clients; we are masters of doing much with little. We must push ourselves to think of new ways of doing things; always keeping patient safety as "the first thing." During my tenure in the nursing profession, nurses have also been the champions of health promotion and prevention. Monies directed at prevention will have the biggest payoff in time. But often health care and society in general has not been willing to be patient and invest the dollars in prevention that will pay off a few years from now. Nurses know how to invest in the future and we can lead in this arena too. This makes me believe that we can be very helpful at this time of redesign.

My second wish relates to our lives in general. I want to see a culture shift that requires each of us to be nicer to one another. The general mood seems to have slowly slid down to be one of cutthroat competition, negative thinking, "me first" selfishness, and demanding outcomes without effort. I'd like to see a new consciousness that reverses these trends. Don't mistake my comments for complete negativity. I know lots and lots of wonderful people who are doing great things and go out of their way

President's Message continued on page 2



ANA Testifies Before the Institute of Medicine on Nursing's Priorities for Health Care Research Spending

As part of its long-standing commitment to enacting meaningful healthcare reform, the American Nurses Association (ANA) testified March 20 before the independent Institute of Medicine (IOM), identifying how the work of nurses can be included in studies aimed at improving patients' health and determining outcomes from nursing interventions.

"How we keep people healthy is as important as how we treat their diseases," said ANA's Chief Programs Officer Mary Jean Schumann, MSN, MBA, RN, CPNP. "Comparative effectiveness research must address the maintenance of health in addition to treatment of disease."

IOM invited ANA, along with the American Medical Association, American Academy of Family Physicians and other groups to provide recommendations on how to spend \$400 million allocated in the American Recovery and Reinvestment Act of 2009 (the Stimulus Bill) toward comparative effectiveness research (CER), which evaluates how different treatment

therapies for a certain health condition compare to each other. The Stimulus Bill requires the IOM to submit a report to Congress and the U.S. Department of Health and Human Services by June 30, 2009, that provides recommendations for spending the comparative effectiveness research funds.

ANA emphasized that nursing's perspective in evaluating how to improve care and decrease costs comes from its constant vigilance and engagement in the healthcare system, regardless of setting, population or specialty.

Among the recommendations ANA offered to the IOM Committee on Comparative Effectiveness Research Priorities were:

- Incorporate the nursing performance measures tracked by ANA's National Database of Nursing Quality Indicators® (NDNQI®), such as patient falls and hospital-acquired pressure ulcers, into the CER agenda.
- Base research priorities on the six priorities and goals identified by the National Priorities

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President's Message continued from page 1

to be giving individuals to the world around them. But as a society we do not seem to celebrate those individuals as we do the negative side of life. We are allowing the news and media to dictate the emotional climate of our lives. Most of the people in my world are moderate political thinkers, yet when I turn on the evening news or talk shows or read the newspaper, I am bombarded by the extreme sides of most issues. I only hear those who believe that there is only one side to an issue and we must have "all or nothing." Those are not the folks who live on my street.

Just as I believe that each of us have to step up to make a difference in health care redesign, I also want all of us to ask for a new cultural message to be the priority. Thus, my newest crusade is to want the news to focus on how the culture and country is working, not on how 'broken' we are. I want to click on the 6 o'clock news and hear about the new mentor program at the public library. I want to hear about the sports teams who organized a can drive to replenish the shelves at the food pantry. I want Habitat for Humanity and Rebuild Together to be the lead story at 6 and 11, as well as the teaser that

shows up during prime time. Who decided that the meth lab that blew up was what most of us wanted to hear as news. I want to know that Meals on Wheels has more drivers than they can use, and are willing to share with other social service programs. I would like to turn on Channel 8 and have them talk of 90% employment (rather than 10% unemployment) and how those of us employed can help those struggling without a job right now.

I am asking for a return to 'glass half full' thinking, rather than gloom and doom. I am working on simplifying my life. I want to stop allowing myself to be convinced that in order to be successful I have to be too busy. I'm working on successful as being completely in the moment. I want the person I'm talking to or who is talking to me to be the most important thing at that time. I want to stop wishing away today because I'm so focused on tomorrow.

Thank you for allowing me to share my current soap box with all of you. For me it is a call to be reminded that how we get caught up in each day is a choice, and I want to be more aware of choosing the positive rather than the negative. After all, spring is here and once again it gives us an opportunity for new beginnings.

Happy Spring!

ANA Testifies continued from page 1

Partnership, a group of national organizations, including ANA, working toward health care system change. The Partnership, established by the National Quality Forum, supports goals such as engaging patients in managing their health, coordinating care, improving safety and eliminating overuse of care.

- Study the systems and delivery models that incorporate registered nurses, advanced practice registered nurses (APRNs) and other professions to determine the best provider mix and most effective collaboration models to provide the best care outcomes.

NURSING'S VOICE HEARD AT THE HEALTH REFORM DIALOGUE

The American Nurses Association (ANA) continues to work toward achieving meaningful health care reform through its participation with

the Health Reform Dialogue group, a gathering of leaders from widely diverse national organizations that have pledged their mutual commitment to federal health care reform. Using the Health Reform Dialogue process, the group brought together stakeholders representing the health industry, providers, consumers, and business to build consensus on health care reform and to create political momentum among political leaders for passing significant health reform legislation.

ANA CEO Linda J. Stierle, MSN, RN, NEA-BC, served as the principal representative to the Health Reform Dialogue, and ANA was the only nursing organization at the table. The Health Reform Dialogue group reached accord on several key issues, such as expanding health coverage, focusing on prevention and wellness, and increasing funds for developing the primary care workforce including education, loan forgiveness programs, and payment reforms.

ANA was instrumental in contributing language to the discussion that will result in gains for nurses and the patients we serve. ANA advocated for strengthening public safety-net programs that would increase coverage for all and for the inclusion of incentives that would allow all clinicians—not just physicians—to implement health IT. ANA was also instrumental in including the Institute of Medicine (IOM) language of primary care that is key to recognizing APRNs as primary care providers.

The Health Reform Dialogue is a noteworthy step in the health reform process. ANA is proud to have represented nurses in the endeavor and will continue to advocate for high-quality, affordable health care for all.

The ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its constituent member nurses associations and its 24 specialty nursing and workforce advocacy organizations that currently connect to ANA as affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

ISNA BULLETIN

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ISNA Staff

Ernest C. Klein, Jr., CAE, Editor

ISNA Board of Directors

Officers: Ella S. Harmeyer, President; Barbara B. Kelly, Vice-President; Judy A. Barbeau, 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 46224-2969 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, and September 15 for November/December/January.

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

Advertising Rates Contact—Arthur L. Davis Publishing Agency, Inc., 517 Washington St., P.O. Box 216, Cedar Falls, IA 50613, 800-626-4081, sales@aldpub.com. 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 and Reinstated ISNA Members

- Melissa Dawn Abbott, Lyons
- Cynthia Modlin Adams, West Lafayette,
- Catherine A. Adler, Terre Haute
- Kelly S. Barlow, Roanoke
- Karen Gerette Beckman, Saint Anthony
- Diane M. Billings, Brownsburg
- Doris Annabella Bleah, Brownsburg
- Beverly Lucinda Bowling, Scottsburg
- C. Ann Bowman, Noblesville
- Raven Brust, Evansville
- Suzanne Buchanan, Evansville
- Linda R. Burkett, Kendallville
- Catherine M. Cale, Nashville
- Me'lisa J. Carter-Chenoweth, Valparaiso
- Byrd Ellen Cherrie, Lebanon
- Darlene Christmon, Fishers
- Heather L. Clark, Newburgh,
- Erin T. Colgan, Indianapolis
- Shannon L. Colter, Greenfield
- Gary Douglas Cudney, Mary Esther, FL
- Yvonne M. Culpepper, Brownsburg
- Gloria Dillman, Munster
- Paige L. Dooley, Pendleton
- Jean Dworniczek, Valparaiso
- Lavonne M. Eddy, Peru
- Natalie J. Eddy, Valparaiso
- Mary Elizabeth Eversole, Liberty,
- Rebecca M. Falbo, North Judson,
- Elizabeth Finley, South Bend
- Mary Jane Fleener, Bloomington
- Amy Fortune, Greenwood
- Sherri Lynn Fugit, Greenwood
- John Gitau, Fort Wayne
- Angela Gold, Avon
- Angelina Hackleman, Pendleton
- Lisa M. Hartman, Fishers
- Rebecca F. Helton, Indianapolis
- Christine Herr, Carmel
- Erik R. Homkes, Russiaville
- Elizabeth A. Ilic, Valparaiso
- Joan E. Kahl, Burnettsville
- Jeffrey L. Kauffman, Goshen
- Kristen F. Kirby, Attica
- Karla, Sue Larson, Marion
- Judith Irene Leach, Marion
- Lori M. Luebbehusen, Jasper
- Michelle Leigh Luttrell, Chandler
- Caitlyn Mack, Carmel
- Kristen L. Mauk, Valparaiso
- Angela B. McBride, Lafayette, IN
- Jennifer L. McElveen, Wabash
- Nancy A. McNiece, Indianapolis
- Scott Ryan Netherton, Indianapolis
- Julia Nikas, Columbia City
- Patricia Nikolov, Westfield
- John Phillip Oesterling, Indianapolis
- Faith A. Ornelas, Crown Point
- Bianca Irene Painter, Wilkinson
- Pamela S. Petry, North Vernon
- Amy Janell Pettit, Seymour
- Susan Mary Rawl, Indianapolis
- Divina Reyes Indianapolis
- Amanda Roesch, Indianapolis
- Jody L. Root, Bloomfield
- Barbara Ann Smith, South Bend
- Lynette S. Smith, Clinton
- Rachel Spalding, Evansville
- Shasta Jo Stacy, Westville
- Carin A. Steele, Fort Wayne
- Beverly Kay Stewart, Sellersburg
- Marcy L. Strine, Avon
- Norma Taylor, Indianapolis
- Christina E. Tebbe, Indianapolis
- Beth S. Tharp, Cicero
- Michelle R. Turner, La Porte
- Julie D. Vittori, Evansville
- Linda Carol Wells-Freiberger, Salem
- Anna-Frances Z. Wenger, Goshen
- James West Jr., Indianapolis
- Lisa Marie Wisz, Lake Station
- Patricia M. Zuppardo, Kokomo



The ISNA 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	Name of Basic School of Nursing
Street or P.O. Box	Home phone number & area code
County of Residence	Graduation Month & Year
City, State, Zip+4	Work phone number & area code
	RN License Number State
	Preferred email address
	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 ANA 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. ANA is authorized to change the amount by giving me (the under-signed) thirty (30) days written notice.

To cancel the authorization, I will provide ANA 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
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
May 21	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043, www.in.gov/pla/nursing.htm
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 5	ISNA Board of Directors , 2915 N. High School Road, Indianapolis, IN 46224	info@indiananurses.org Phone: 317/299-4575 Fax: 317/297-3525
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
June 18	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043, www.in.gov/pla/nursing.htm
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 16	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043, www.in.gov/pla/nursing.htm
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 7	ISNA Board of Directors , 2915 N. High School Road, Indianapolis, IN 46224	info@indiananurses.org , Phone: 317/299-4575 Fax: 317/297-3525
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 20	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043, www.in.gov/pla/nursing.htm
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
September 7-13	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
September 14-21	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
September 14–October 23	“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
September 17	Indiana State Board of Nursing , Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043 www.in.gov/pla/nursing.htm
October 5-11	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
October 5–November 6	“E-Learning for Staff Educators” 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
October 15	Indiana State Board of Nursing , Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043 www.in.gov/pla/nursing.htm
October 16	ISNAP Workshop “Co-Occurring Disorders” Indianapolis	Phone: 317/295-9862
October 19–November 13	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
October 23	ISNA Annual Meeting of Members 2915 N. High School Road, Indianapolis, IN 46224	info@indiananurses.org Phone: 317/299-4575 Fax: 317/297-3525
October 27-28	Nurse Aide Program Director and 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
November 19	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043 www.in.gov/pla/nursing.htm
December 10	Indiana State Board of Nursing Conference Center Auditorium, 302 W. Washington Street, Indianapolis	Phone: 317/234-2043 www.in.gov/pla/nursing.htm
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

Board Summaries

ISNA BOARD EXECUTIVE COMMITTEE

Monday, January 19, 2009
Conference Call

PRESENT: Ella Harmeyer, President; Barbra Kelly, Vice President; Paula McAfee, Treasurer; Judy Barbeau, Secretary; Ernest C. Klein, Jr., CAE, Executive Director

PERSONNEL ISSUES: Reaffirmed the terms of Mr. Klein's employment contract.

TRI-COUNCIL: Discussed issues for the meeting of the Executive Committees of ISNA and the IN Organization of Nurse Executives, representatives from the Dean/Directors group and the IN State Board of Nursing on Friday, January 23, 2009 at 3:00PM at the Marriott North.

BOARD OF DIRECTORS MEETING

Friday, February 13, 2009
ISNA Headquarters

PRESENT: 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
Guests: Meredith Addison, member (morning); Liz Nacman, IUSON Student

ACTION ITEMS

- Accepted the Board Minutes of November 21, 2008 and the Executive Committee Minutes of January 19, 2009.
- Accepted the 2007-2008 Financial Statement presented by Mike Wolf, CPA, Ent & Imler CPA Group.
- Approved purchase of Certificates of Deposit at Bank of America and Wachovia.
- Reviewed the revised 2009 ISNA Budget with two scenarios: one with renewal of ISNAP contract August 1, 2009 and one without.
- Decided to hold 2009 Meeting of the Members on a Friday in September or October.

Healthcare Decision Day

ISNA will promote Healthcare Decision Day by placing a link to ANA on ISNA web site and a posting to the ISNA listserve.

State Trauma System

Tracie Pettit, IN State Trauma Registry Manager and Merry Addison, presented the ongoing work to establish a state-wide trauma system and asked for ISNA's support. The Board discussed Senate Bill 464 and House Bill 1215.

The ISNA Board recommends changes to the proposed composition of the Trauma Committee (SB 464) which include increasing the number of non-trauma and/or rural Emergency Department Physicians and registered nurses on the Committee. The ISNA Board also supports using fees collected from the Bureau of Motor Vehicles

and moving violations to support the funding of the Trauma System.

OR Circulators

Diana Sullivan and Rhonda Anders and Teresa Nosek AORN discussed HB 1593, Surgical Technologists and Circulators. The bill would require one RN Circulator in every room for the "duration of the surgical procedure". The bill currently has an exception for critical access hospitals. AORN would like to have the exception removed. ISNA supports HB 1593 with the exception to be removed.

REPORTS

- The board congratulated Judy Morgan on the designation of Good Samaritan Hospital, Vincennes, as a Magnet facility by the American Nurses Credentialing Center.
- Ernest Klein, Executive Director, reported that a special meeting of the American Nurses Constituent Assembly has been scheduled for May 3 and 4, 2009. He reviewed his written report and gave an update on current legislation. He also noted the registration for the Legislative conference on Feb. 18, 2009 had been closed. Vicki Csenar, who will be working at ISNA on a temporary basis to assist with support services and special projects, was introduced.

BOARD OF DIRECTORS

March 27, 2009
Conference Call

Present: Ella Harmeyer, President; Barbara Kelly, Vice-President; Paula McAfee, Treasurer; Judy

Barbeau, Secretary; Jennifer Embree; Eleanor Donnelly; Vicki Johnson, Judy Morgan, Directors; and Ernest Klein, Executive Director.

ACTION ITEMS

- Approved a Corporate Resolution authorizing the Executive Director to submit a proposal to the State to administer the Rehabilitation Monitoring Program for Nurses.
- Decided to move the Board meeting date of April 24 so that Board members could attend the workshop sponsored by the IN Nursing Workforce Development Coalition.
- Reviewed the January 2009 ISNA financial statement.

MEETING DATES

- Board Meeting, conference call May 8, 2009, 1:00-3:00pm
- ISNAP 3rd Annual Workshop, Indianapolis–October 16, 2009
- ISNA Annual Meeting of the Members, Indianapolis–October 23, 2009

Continuing Education Program



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 nursing education providers approved by the ISNA Committee on Approval:

For complete contact information go to:
www.indiananurses.org/providers.php

Bloomington Hosp & Healthcare System, Bloomington, IN
Clarian Health Partners, Inc., Indianapolis, IN
Clarian North Medical Center, Carmel, IN
Columbus Regional Hospital, Columbus, IN
Community Health Network, Indianapolis, IN
Deaconess Hospital, Evansville, IN
EHOB, Inc, Indianapolis, IN
Good Samaritan Hospital, Vincennes, IN
Health Care Education & Training, Inc., Carmel, IN

Health Care Excel, Inc., Terre Haute, IN
King's Daughters' Hosp & Health Services, Madison, IN
LaPorte Regional Health System, LaPorte, IN
Lutheran Health Network Fort Wayne, IN
Major Hospital, Shelbyville, IN
MCV & Associates Healthcare Inc., Indianapolis, IN
Memorial Hospital & Health Care Center, Jasper, IN
Memorial Hospital of South Bend, South Bend, IN
Methodist Hospitals, Gary, IN
Parkview Health System, Fort Wayne, IN
Porter Education and Rehabilitation Center, Valparaiso IN
Purdue University Continuing Nursing Education, West Lafayette, IN
R.L. Roudebush VA Medical Center, Indianapolis, IN
Reid Hospital & Health Care Services, Richmond, IN
Schneck Medical Center, Seymour, IN
Scott Memorial Hospital, Scottsburg, IN
St. Francis Hospital & Health Centers, Beech Grove, IN
St. Joseph Regional Medical Center, South Bend, IN
St. Margaret Mercy, Hammond, IN
St. Mary's Medical Center, Evansville, IN
St. Vincent Hospital & Health Care Center, Indianapolis, IN
The Community Hospital, Munster, IN
VA Northern Indiana Health Care System, Marion, IN
Valparaiso University College of Nursing, Valparaiso, IN
Wishard Health Services, Indianapolis, IN

CNE 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 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:

ERCP Workshop

Indiana University, Indianapolis
1/29-30, 2/5-6, 8/6-7, 11/5-6, 12/3-4
Erica Levi-Turner
550 University Blvd., Indianapolis, IN 46202
(317) 278-3088 (317) 278-0164
eleitur@iupui.edu
Approved for 14.0 contact hours

RN Champion Program

Indiana Organ Procurement Org.
2/19/09
Melissa Skalicky, RN, BA
7220 Engle Road, Fort Wayne, IN 46804
(260) 241-7629 (260) 436-4275
melissas@iopo.org
Approved for 3.0 contact hours

Pediatric Donation

Indiana Organ Procurement Org.
3/23/09
Melissa Skalicky, RN, BA
7220 Engle Road, Fort Wayne, IN 46804
(260) 436-6023 (260) 436-4275
melissas@iopo.org
Approved for 4.0 contact hours

Safeguard Their Tomorrows-A resource to help prevent infant abductions

Mead Johnson Nutrition
Karen Lundgren, MS, RD
5330 Whiting Avenue, Edina, MN 55439
(952) 829-0380 (952) 829-7420
karen.lundgren@bms.com
Approved for 2.0 contact hours

ISCVPR Annual Meeting & Conference

Indiana Society Cardiovascular & Pulmonary Rehabilitation
4/15-16/09
Susan Bauman, BSN, BC
Porter Hospital Cardiac Rehab
814 LaPorte Avenue, Valparaiso, IN 46383
(219) 263-4629 (219) 464-1215
susan.bauman@porterhealth.com
Approved for pre conference 2.0, conference 5.2 contact hours

SNAP Pharmacology Update for Advanced Practice Nurses 2009

Society of Nurses in Advanced Practice (SNAP)
4/4/09
Suzanne Ruiz, RN, MS, NP-C
1614 S. Cline Avenue, Schererville, IN 46375
(219) 934-8862 (219) 934-8870
sruiz@comhs.org
Approved 4.5 contact hours

Breast Cancer: Oncology Nursing Perspectives

Community Cancer Care, Inc.
3/11/09
Susan Walker, RN, BS
115 West 19th Street, Indianapolis, IN 46202
(317) 924-4022 (317) 924-4233
sswalker@cccounreach.com
Approved for 6.2 contact hours.

Certification Corner



by Sue Johnson, PhD, RN, NE-BC



Sue Johnson

The world is changing and yet much the same!

We have a new Administration in Washington and a lot of initiatives occurring nationally, regionally, and locally. Compliance with Core Measures is necessary for hospitals to ensure that patient care meets standards and to avoid loss of reimbursement for skin ulcers, patient falls,

and other conditions that CMS deems "hospital-acquired". Comprehensive documentation is essential if we are to be paid for our services. Lack of insurance is more prevalent in our hospitalized

patient population and lack of reimbursement for services is a concern for all healthcare facilities.

There is still a nursing shortage and a lack of qualified faculty to educate future nurses. We are still the most respected group of health care professionals and nursing care distinguishes one healthcare facility from another. These things have not changed.

There is a bright spot that is visible in the current turbulent healthcare climate. Certification is being sought by more direct-care nurses who see it as a valuable credential for their clinical practice and job mobility. Nurses know that they are the glue that makes health care facilities run. They are aware that they have to be the best at what they do for their facilities to deliver excellent patient care and remain economically viable. Certification validates nurses' skills in their chosen specialties and there is pride in achieving this distinction.

Some hospitals are also aware of the importance of certification to their care delivery and are now providing certification preparation courses in different specialties, reimbursing for examination fees, and even paying for re-certification costs. There are even celebrations for nurses who are newly certified and articles in annual nursing reports.

The world is changing and certification support is a positive change!

Good Samaritan Hospital Achieves Initial Magnet Status

COLUMBUS REGIONAL AND GOSHEN GENERAL HOSPITAL RECEIVE RE-DESIGNATION

Congratulations to the staff at Good Samaritan Hospital, Vincennes. The Commission on Magnet Recognition Program, American Nurses Credentialing Center, recently announced the granting of Magnet status for Excellence in Nursing Service. The Commission also re-designated Columbus Regional Hospital and Goshen General Hospital as Magnet Facilities.

Other facilities in Indiana that have achieved Magnet status are: Clarian Health Partners (Methodist Hospital, Indiana University Hospital and Riley Children's Hospital) Indianapolis, Goshen General Hospital, LaPorte Regional Health System, Lutheran Hospital of Indiana, Fort Wayne, Schneck Medical Center, Seymour.

EXCELLENCE IN NURSING SERVICE RECOGNITION PROGRAM

Purpose of the Recognition Program

The Magnet Nursing Services Recognition Program for Excellence in Nursing Service was established in 1993. It is the highest level of recognition that the American Nurses Credentialing Center, a subsidiary of the American Nurses Association, can accord to organized nursing services in health care organizations.

This program provides a framework to recognize excellence in:

- the management philosophy and practices of nursing services;
- adherence to standards for improving the quality of patient care;
- leadership of the chief nurse executive in supporting professional practice and continued competence of nursing personnel;
- and attention to the cultural and ethnic diversity of patients and their significant others, as well as the care providers in the system.

This recognition indicates excellence in nursing services, development of a professional milieu, and growth and development of nursing staff. The baseline for the program is the Scope and Standards for Nurse Administrators (ANA). The magnet recognition status is valid for a four-year period, after which the recipient must reapply.

Objectives

The objectives of this program are to:

- recognize nursing services that utilize the Scope and Standards for Nurse Administrators (ANA) to build programs of nursing excellence in the delivery of nursing care to patients;
- promote quality in a milieu that supports professional nursing practice;
- provide a vehicle for the dissemination of successful nursing practices and strategies among institutions utilizing the services of registered professional nurses.

Benefits

Recognition of excellence may be publicized by the recipient and used in its marketing strategies directed toward consumers and potential nursing personnel. It will enhance recruitment and retention of highly qualified professional nurses, thus facilitating consistent delivery of quality patient care. Since this recognition award indicates excellence in nursing services, the recipient is a model for other nursing service systems. In this aspect, excellent nursing service variables may be emulated by others, thus contributing to upgrading the quality of nursing service in the nation's health care delivery systems. Additionally, staff nurses within the recognized magnet nursing service system may also be contacted by other nurses for consultation services.

Further outcomes of the recognition may include:

- enhanced recognition within the community for nursing services and the agency;
- increased utilization of the agency by health care consumers and health care networks; and
- increased stability in patient care systems across the organization.

Call for ISNA Award Nominees

HONORARY RECOGNITION AWARD NOMINEES

Biennially the Indiana State Nurses Association confers on an individual who has rendered distinguished service or valuable assistance to the nursing profession the status of Honorary Recognition. Any ISNA member, constituent association, or structural unit may recommend to the ISNA Board of Directors the name(s) of any individual(s) deserving recognition.

If the nominee is a nurse, the individual must be a current member of ISNA and have held membership in ISNA for at least four (4) years. Selection shall not be made posthumously. The nominee approved by the ISNA Board of Directors will be invited to attend the ISNA Meeting of the Members for the presentation of the Award. If due to extenuating circumstances the nominee cannot be present, the presentation will be made in absentia. Names of individuals not receiving honorary recognition may be resubmitted for consideration at another time.

Previous recipients:

- 2007–Vicki Johnson
- 2005–Louise Neufelder
- 2003–Beverly Richards

Submit nominees deserving Honorary Recognition to the Indiana State Nurses Association by August 15, 2009. Send the name, biographical information, and details as to why the individual is deserving of the award to ISNA via mail at 2915 North High School Road, Indianapolis, IN 46224, by Fax 317/297-3525, or by E-mail to info@IndianaNurses.org.

GEORGIA B. NYLAND PUBLIC POLICY AWARD for Contributions to Health Policy

ISNA is seeking nominees for the biennial Georgia B. Nyland Public Policy Award. In 1999 the ISNA Board of Directors established an award in honor and memory of Georgia Nyland. Georgia was devoted to the advancement of the profession and to excellent health care. For many years she used her tireless energy and talents to influence legislators and others in the health policy arena to evoke positive changes that have benefited many.

Criteria: This award is presented to a registered nurse who is a member of the Indiana State Nurses Association for outstanding contributions to the development and implementation of health related policy at the local, state, and/or national level. The recipient is recognized for significantly influencing policy and legislation that positively affects the health and well being of citizens and the practice of professional nursing. The award will be presented biennially at the ISNA Meeting of the Members.

Previous recipients:

- 2007–Dianna K. Sullivan
- 2003–Pamella Jahnke
- 2001–N. Jean Macdonald

Nominations with supporting data must be received by ISNA no later than August 15, 2009. Send to ISNA at 2915 North High School Road, Indianapolis, IN 46224, fax to 317/297-3525 or email to info@IndianaNurses.org.

PSYCHIATRIC/MENTAL HEALTH AWARDS

The ISNA Psychiatric/Mental Health Chapter is seeking nominees for two awards to be presented at the 2009 ISNA Meeting of the Members on October 23, 2009.

Ruth Stanley Psychiatric Nurse of the Year Award for Clinical Practice in Psychiatric Nursing

Criteria: The candidate must be a member of the Indiana State Nurses Association who has demonstrated excellence in psychiatric practice through working directly with clients and families

and served as a clinical role model who inspires other nurses to improve the care of psychiatric clients.

Previous Recipients:

- 2007–Cynthia Wilson
- 2005–Karen O'Mara
- 2003–Frankie Whitesel

Beverly S. Richards Psychiatric Clinical Nurse Specialist of the Year

Criteria: The candidate must be a member of the Indiana State Nurses Association who actively practices as a clinical nurse specialist in working with clients, families, groups, or in consultation and serves as a leader who advocates for consumers and professionals while setting a standard through his/her practice which inspires other nurses to improve client care.

Previous Recipients:

- 2007–Diana Kemper
- 2005–Leslie Oleck
- 2003–Ellen Eichel Chesnut

To nominate a nurse for either of the above awards, submit as much information on the nominee as possible, including a curriculum vita if available. Document the nominee's involvement in each area listed in the above criteria. Information on the nominator should also be submitted including name, position, employer, address, and phone number. Also include information on your relationship with the nominee and how you became aware of his/her excellent practice. Information should be sent to the PMH Chapter, Indiana State Nurses Association, 2915 North High School Road, Indianapolis, IN 46224, no later than August 15, 2009.

Independent Study



Guidelines for Managers of Impaired Nurses

Introduction of the Problem

Chemical dependency is identified as one of the leading health problems in the United States. In the general population, it is estimated that one out of nine suffer from this disease. However, with health care professionals, this number increases to one out of five to seven.

Chemical dependency is a medical, treatable illness with certain recognizable signs and symptoms. It is characterized by physical and/or psychological dependence on mood-altering chemicals, tolerance and relapse. It is primary, progressive, chronic and fatal unless treated.

Causes of chemical dependency are multi-factorial. These factors include genetic predisposition, family and peer influences, sexual abuse in childhood, low self-esteem, and self-treatment of mental illness symptoms.

The cost of chemical dependency is significant. It affects the employer, co-workers, clients, family and community at large through absenteeism, accidents, injuries, stress-related illnesses, violence, etc.

It is essential for managers to understand the disease of chemical dependency. By understanding the disease, managers will be better able to recognize the problem earlier and to intervene more effectively. Early intervention has been proven to save lives, improve patient care and decrease costs to the organization.

Signs and Symptoms

Many nurses are addicted to more than one substance. The following list of symptoms is separated according to substance, but symptoms may in fact be mixed due to multiple dependencies. In addition, mental health issues associated with dependency are

not uncommon and may further complicate symptoms. Signs and symptoms of the impaired nursing professional with chemical dependency include the following:

Signs and Symptoms of the Drug Addicted Nurse

Marijuana (dope, weed, herb, grass, pot, reefer, mary jane, blunt, ganja, joints)

- Rapid loud talking
- Excessive laughter or inappropriate happiness
- Forgetfulness in a conversation (i.e., "What was I saying?")
- Inflammation in whites of eyes; pupils unlikely to be dilated
- Appearance of intoxication, but has no smell of alcohol
- Appearance of sleepiness or stupor in the latter stages
- Distorted sense of time passage, tendency to overestimate time intervals
- Tendency to drive vehicles slowly, below speed limit
- Increase in appetite especially after smoking marijuana
- Odor similar to burnt rope on clothing or breath
- Presence of roach clips (e.g., paper clips, bobby pins, hemostats or tweezers) and bongs or water pipes
- Slowed thinking and reaction time, confusion, impaired memory and learning
- Impaired balance and coordination
- Frequent respiratory infections; increased heart rate, anxiety, panic attacks

Phencyclidine (PCP, angel dust, boat, hog, love boat, peace pill)

- Pupils may appear dilated
- Mask-like facial appearance
- Rigid muscles, strange gait
- Irrational speech or behavior
- Symptoms of intoxication
- Hallucinations

- Violent or frightened reactions
- Subject to flashbacks
- Exaggerated physical and mental reactions to situations
- Disorientation; agitation and violence if exposed to excessive sensory stimulation.
- Deadened sensory perception (may experience severe injuries while not appearing to notice)

Amphetamines (speed, meth, hearts, pep pills, bennies, uppers, peaches, cartwheels, sky-rocket)

- Dilated pupils
- Dryness of mucous membranes (dry mouth and lips)
- Excessive sweating and shakiness; increased heart rate, metabolism, rapid or irregular heartbeat, heart failure
- Reduced or loss of appetite
- Lack of sleep, insomnia
- Talkativeness, but conversation often lacks continuity; changes subjects rapidly.
- Unusual energy, accelerated movements and activities, nervousness.

Cocaine (coke, crack, snow, blow, candy, Charlie, flake, toot, C, bump, rock)

- Dilated pupils
- Runny nose; reddened and sore nose; cold or chronic sinus/nasal problems; nosebleeds
- Respiratory problems
- Unexplained bursts of energy
- Restlessness or nervousness, panic attacks, irritability and anxiety
- Repetitive and non-purposeful behavior
- Long periods without sleeping or eating, likely to be emaciated & malnourished
- White powder in container and/or around nose
- Use or possession of paraphernalia including spoons, razor blades, mirrors, little bottles of white powder and straws.
- Increased temperature, chest pain, nausea, abdominal pain, strokes, seizures, headaches.

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Opiates (horse, smack, junk, H, morpho, dollies, heroin, opium, morphine, codeine, Fentanyl, Demerol, oxycodone, hydrocodone)

- Pinpoint pupils
- Respiratory depression and arrest
- Drowsiness, confusion, sedation.
- Nausea and vomiting, constipation
- Apathy and decreased physical activity
- Short lived euphoria or feeling good effects
- Changes in state of mind, going back and forth from feeling alert to drowsy
- Coma or death (result of overdose)
- Staggering gait (heroin)

Signs and Symptoms of the Alcoholic Nurse

- More irritable with patients and colleagues; withdrawn; mood swings.
- Isolated: wants to work night shift, lunches alone, avoids informal staff get-togethers.
- Elaborate excuses for behavior such as being late for work.
- Black-outs: complete memory loss for events, conversations, phone calls to colleagues; euphoric recall of events on the floor.
- Job shrinkage: does minimal work necessary.
- Difficulty meeting schedules and deadlines.
- Illogical or sloppy charting.
- Increasingly absent from duty with inadequate explanations; long lunch hours, sick leave after days off.
- Calls in to request compensatory time at the beginning of the shift.
- Change in physical appearance.

Ethical Considerations and Guidelines of Chemical Dependency Issues with Nurses

Misuse of prescribed medications, non-prescribed drugs and alcohol is a violation of the Nurse Practice Act and the ANA Code of Ethics for Nurses. Nurses impaired by drugs and/or alcohol pose a serious risk of harm to patients, colleagues and themselves. It is an expectation that employers have a duty to protect the patient as well as an ethical obligation to assist their employees. Therefore, it is a concern for an employer when an impaired nurse is giving or supervising nursing care. A manager should consider the following guidelines and/or ethical issues.

- Confidentiality related to information concerning a chemical dependency problem is required by federal law. Each facility should have a policy which includes: 1) identification of the person who will interact with the employee concerning their impaired practice, 2) a referral process for evaluation and treatment, and 3) the consequences associated with refusing treatment.
- It is the obligation of a colleague or manager to document and report an impaired colleague's behavior to the employer or designated supervisor. (ANA Code of Ethics for Nurses with Interpretative Statements, standard 3: "The nurse promotes, advocates for and strives to protect the health, safety and rights of the patient." Interpretation 3.5 & 3.6) An impaired nurse should not be allowed to give nursing care until she has been evaluated and received treatment.
- A nurse should be offered treatment in lieu of firing. In the long term, it is more cost effective to help the nurse get treatment and return her to the workplace than to replace her with a new employee. Valuable expertise and service history may be lost if the nurse's employment is preemptively terminated, especially given the current and projected nursing shortage.
- The suicide risk is great after a nurse with impaired behavior is confronted. It is necessary to assure that the nurse is not left alone after an intervention. (See section on Intervention for full description.)
- The nurse has the right to refuse treatment. Although nurses may put themselves in legal jeopardy if they refuse treatment, it is each person's right to make that decision. The employer needs to make it clear that if evaluation and treatment are rejected by the nurse, the nurse will be fired and reported to the appropriate authorities.

Enabling Behaviors

Often those individuals surrounding the impaired nurse (families, coworkers, and friends) engage in behaviors that attempt to rescue or enable the addictive behaviors of the addict. These individuals mistakenly believe they can help the individual by covering for them, making up excuses, or feeling sorry for them. Instead of allowing the individual to accept the consequences for her own behaviors, they will frequently intervene on her behalf. This type of enabling behavior only serves to allow the addict to continue longer in her addiction and to experience more severe consequences of her addiction. Nurses and other caregivers often assume the role of "rescuer." It is important to educate staff about appropriate limit/boundary setting and recognition of the signs and

symptoms of chemical dependency. It is also very important to educate them on the benefits of early intervention in addiction, and allow individuals to accept responsibility for their own actions and the consequences of these actions. (ANA Code of Ethics for Nurses with Interpretative Statements, standard 3: "The nurse promotes, advocates for and strives to protect the health, safety and rights of the patient." Interpretation 3.5 & 3.6).

What Should One Do When Suspecting an Impaired Employee?

Several steps should be followed when a manager suspects an employee has a problem with chemical dependency. The organization should have a policy addressing "fitness for duty." This policy should guide the manager in the steps to take if the manager suspects an employee is impaired, what data to collect, lines of communication, confidentiality, and legal issues. The policy should address what to report, when to report, and to whom to report.

Documentation

Documentation is essential to the process for potential future actions. Documentation includes, but is not limited to, trends in absenteeism and tardiness, incident reports, written complaints, charting reviews, opiate record discrepancies and evaluations. Documentation should be made at the time a problem or incident occurs. Over time, the manager may be able to see patterns from the documentation they have made. Caution: Please do not wait until a crisis occurs in order to look back over the problems/incidents that may have occurred during the past year.

The following tool may be of assistance in assessing absenteeism and tardiness: Print a calendar on 1-2 pages and use a color system to plot days of absenteeism and days of tardiness. Look for any patterns such as absenteeism after a scheduled weekend off, tardiness or leaving work early and habitual episodes of extended lunches or break times.

Month, year (A = absent; T = tardy)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1-off	2-A	3-T 1 hr	4-on	5-on	6-off	7-left early
8-A	9-T 2 hr	10-off	11-on	12-on	13-on	14-off
15-off	16-T ½ hr	17-on	18-off	19-on	20-on	21-on
22-T 1 hr	23-off	24-on	25-on	26-on	27-left early	28-off
29-off	30-on	31-on				

Summary: The above example shows a pattern of missing work following a weekend off consistent with alcohol abuse.

Incident reports and written complaints or write-ups

Employees should document problems on a day to day basis. Be as detailed as possible when writing these reports. Include:

- Specific timeframes and date
- Specific place
- Persons involved (participants and/or observers)
- Resources for additional information (chart documentation, lab data, x-ray, any additional reports)
- Actions taken
- Participants' responsiveness
- Outcomes

IF YOU SUSPECT A NURSE MAY HAVE A CHEMICAL DEPENDENCY PROBLEM, LOOK FOR PATTERNS WHEN REVIEWING THESE REPORTS. LOOK FOR THE FOLLOWING POSSIBLE SIGNS OF CHEMICAL DEPENDENCY IN THE REPORTS OR COMPLAINTS:

- Multiple complaints of appearance
- Liability of mood
- Interpersonal problems with or related to patients, staff, family
- Patient complaints
- Frequently absent from unit/workplace while on duty

Charting review

When reviewing the nurse's charts, look for:

- Accuracy
- Timeliness of entries (late entries)
- Coherence (incomplete thoughts/statements)
- Inappropriate terminology
- Unexplained changes in handwriting (illegible writing if usually neat)

Opiate and medication records

Look for discrepancies:

- Ordering medications from the pharmacy prior to the refill date
- Orders for patients who have died or been discharged
- Inaccurate opioid counts
- Increases in charted medication administration of mood-altering drugs without appropriate cause
- Unexplained changes in route of administration
- Non-compliance for observing wastage of opiates

- Frequent breakage or wastage of opiates
- Patient reports of decreased pain relief on specific shifts despite record of medications administered
- Patient comments regarding not receiving pain medication administration even though it was reported and/or charted.
- Review records of automated medication systems for discrepancies in the provision of mood altering chemicals.
- Discrepancies in the provision of mood altering chemicals via automated medication systems.

Performance evaluations

- Check employee file for changes in the evaluation of job performance over time with no apparent cause.
- Look at work history.
- How does the nurse deal with others?
- What is the ability of the nurse to take or provide feedback?

The Next Step

Once you've reviewed all the information, write down your findings. Is there a pattern of behaviors causing you to think that the nurse may have a problem with chemical dependency or some other issue? Patterns of chemical dependency vary depending on stage of diseases, substances used and the nurse. There may be only one sign and symptom or many signs and symptoms. If you suspect there is a problem, then talk to your immediate supervisor.

If chemical dependency is not the problem, then look for alternative explanations for behavior. For example, there may be stressors at home which are interfering with ability to work; lack of knowledge to carry out the job; physical or mental health problems. Deal with these as needed and appropriate.

Note: If the nurse appears to be obviously under the influence of mood altering chemicals in the work setting, the manager must deal with the issue. The

patients must be protected immediately. Remove the nurse from the unit/department, get a drug screen, and evaluate the need for emergency treatment (either medical and/or psychiatric). If immediate treatment is needed, transport the nurse to the emergency room. Once the immediate emergency is stabilized, then develop the plan of action to deal with the problem.

Develop a plan of action for an intervention to deal with the problem. Ideally the manager will have time to do this over several days. The plan should include:

- **When:** If the nurse is obviously impaired or at risk for harming others, take action immediately. Don't wait. Remove the nurse from the patient care area and get the nurse to a safe place. For example, does the nurse need emergency medical or psychiatric treatment? Or is the nurse able to provide a drug screen? If the nurse is not in immediate medical or psychiatric crisis, begin the intervention.
- If the nurse is not on site, then plan the best time to confront her. This might be the next time the nurse is scheduled to work or at a planned meeting. Interventions work most effectively when the nurse is unaware of the intent of the meeting. Note: An impaired nurse may not appear for a meeting if she suspects that she is to be confronted about her behavior.
- **Who:** Who will conduct the intervention? Ideally the most experienced and knowledgeable person in the disease of chemical dependency and intervention should be the leader of the intervention.
- Who will/needs to attend? Usually the manager, supervisor and other staff providing relevant data about behaviors. A union representative may be present if the nurse is in a collective bargaining unit, has been asked and requests representation. Sometimes, colleagues may provide information. In addition, human resources and/or employee health/EAP may be present. It is also possible that a representative of the pharmacy, pharmacy board, security department or the police may attend. (Please note that the latter groups may file or cause criminal charges to be filed against the nurse.) It is important for the nurse to know they have the right to ask for an attorney to be present and that they have the right to remain silent.
- **What:** What will the intervention include? An intervention provides the opportunity for the manager to present data to the nurse regarding the suspected substance abuse and for the nurse to

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explain her behavior.

To prevent potential retaliation by the impaired nurse, names of people who have contributed information about behaviors should be kept confidential and not released to the nurse. Information about evaluation and treatment options needs to be presented. Consequences of failure to follow through with evaluation and/or treatment need to be identified—such as loss of job, potential criminal charges. An agreement between the employer and employee to address the problem within a specific time frame should be completed.

Note: If the nurse goes to court, the attorney representing the impaired nurse may subpoena records regarding complaints about the nurse's performance or behavior. Similarly, a board of nursing may subpoena the records as part of its investigation.

- **Where:** Where will the intervention take place? A confidential but safe place needs to be identified and reserved.
- Make arrangements for a medical leave of absence and staff coverage during absence.
- In preparation for an intervention, safety is a prime consideration for the nurse and all members of the intervention team. The nurse is facing a crisis in her life. It includes the threat of loss of license and livelihood with possible loss of income, legal involvement, inpatient treatment, and family upheaval. Another significant loss is the mood altering chemicals the nurse has become dependent upon—her “best friend.” In order to protect all parties involved, the manager needs to find a secure area for the intervention such as an office or a conference room where they will not be interrupted but which provides some privacy for the nurse (to protect confidentiality). Someone not involved in the intervention but who is nearby should be informed so that if security needs to be called, they can do so. If the manager is aware that the nurse carries weapons such as a knife or gun, the manager needs to consider having security in the room during the intervention. Prior to beginning the intervention, the manager should also ask the nurse if she currently has anything in her possession that could harm anyone.
- In addition, the manager should consider the nurse's home status. Are there children who will need care and after school arrangements if the nurse goes directly to treatment or evaluation? Is there a spouse or family member who should be contacted after the intervention? Are there pets in the home which will need to be cared for if the nurse goes directly to treatment? These situations may interfere with the nurse's willingness or ability to go directly to treatment or evaluation.
- There is a high risk of suicide at this time. Create a plan to ensure that the employee is not left alone at any time during the intervention and post-intervention periods. There is a high risk of suicide at this time. The intervention, while supportive and with the nurse's well-being in mind, is still a confrontation. Because this is a time of crisis, family or a designated friend needs to know that the nurse should not be left alone until the nurse is admitted into a treatment facility.

Once you've developed your plan, you may wish to rehearse what needs to be said and how to best present the information.

Legal Rights

When planning the intervention process, the manager should be aware of the rights of the nurse. Most nurses do not know that they have any legal rights. If the nurse is apt to be accused of drug theft/diversion or impairment while on duty, the accused nurse should know that she has the right not to incriminate herself. The manager should make the nurse aware that legal action (criminal and administrative—nursing license) could occur. The nurse should also be advised to seek legal representation; preferably an attorney with experience in criminal law. The nurse needs to have a criminal attorney present when meeting with these types of officials so that she does not incriminate herself. If the attorney is not able to be present at this time, the nurse needs to obtain instruction from the attorney regarding what to say or not say. (An attorney familiar with administrative law would be used when dealing with a board of nursing re: the nurse's license.) In the event nursing or pharmacy board investigators or the police are present, the accused nurse should be aware that none of these agencies have the authority to offer “deals” with the law. The prosecutor can make recommendations to the court (judge) but cannot guarantee the judge will accept them.

Intervention

A commonly used intervention strategy is the Johnsonian model in which a counselor will prepare a group of people significant in the nurse's life to confront the nurse with their observations and concerns. The group may include colleagues, employers, spouse and friends. This is a rehearsed group that meets to determine goals, time and place of intervention and

how each person will respond if the nurse rejects the plans. Often the person with the least influence begins the process and the most influential person speaks last. Presenting the data in a calm, supportive and non-judgmental way is essential. The counselor facilitates this process.

Variations of the Johnsonian model can include using an employee assistance person as the facilitator with recovering employees confronting the nurse. In addition, some peer assistance programs can provide volunteer nurses who meet with the impaired nurse to educate about the disease and make treatment recommendations. Careful documentation of the events leading to the intervention is essential. It is common for the nurse to deny the problem and try to manipulate the confrontation. A one-to-one intervention is never recommended.

Post Intervention

It is not uncommon for participants in an intervention to feel exhausted after the session. Although there may be a feeling of relief that the “task” is accomplished, many angry feelings were undoubtedly expressed during the intervention. Those who helped with the intervention frequently feel ambivalent—was the intervention the best thing to do? Now my colleague will be without an income for an extended amount of time. What about the children, pets, husband/wife? Will the nurse ever trust me again?

Those who work directly with the impaired nurse may feel angry that they have put up with the negative behavior as long as they did. Or they may feel guilty for not doing something about the situation earlier. With the nursing shortage, the unit now may be understaffed until the nurse returns to work.

IT IS IMPORTANT THAT THOSE WHO TOOK PART IN THE INTERVENTION MAINTAIN CONFIDENTIALITY. There may be curious unit members who were not part of the intervention who ask questions related to what happened in the meeting. The manager should be prepared to respond to staff while maintaining confidentiality. Stating that the nurse is now on medical or family leave should be sufficient.

Debriefing may be of assistance in helping the participants of the intervention express their feelings and experience closure. It needs to be done in a location where confidentiality can be maintained.

The Human Resources department should send the appropriate leave of absence forms to the nurse.

Treatment

The purpose of treatment is the safe withdrawal from drugs and alcohol, to help the person honestly face the addiction, and to develop new attitudes that will help the nurse embrace a drug and alcohol free lifestyle.

For the nurse seeking help for chemical dependency, the most likely source will be a multidisciplinary treatment program that is recovery oriented, which has abstinence as a goal and that utilizes a 12-step program such as Alcoholics Anonymous and Narcotics Anonymous. The program needs a broad rehabilitation component which supports restoration of function and ongoing sobriety. Graduated levels of service provide the nurse individualized, specialized care. Following is a list of components of quality inpatient programs:

- Medically monitored detoxification from drugs and alcohol.
- Monitored abstinence from mood altering chemicals.
- Concurrent treatment of all medical diagnoses.
- Evaluation and treatment of psychiatric needs.
- Support of healthy self-care regarding diet, exercise and sleep.
- Active participation in facilitated groups.
- Comprehensive biopsychosocial evaluation.
- Family program/conferences.
- Mediation with referents (people who have referred the client), legal aspects, employer.
- Active participation in Alcoholics or Narcotics Anonymous.
- Individualized counseling.
- Education and guidance with recovery skills.
- Discharge planning.
- Intensive outpatient care and aftercare.

For those nurses who are recommended for outpatient treatment, the Intensive Outpatient Program can be modified to meet their individualized needs.

Length of treatment is best determined on an individual basis but at a minimum should include detoxification and stabilization. Extended treatment is occasionally necessary to deal with life circumstances. These may include a halfway house or a ¾ house or sober house accommodations. The person in a half way house is still in treatment. The person in a ¾ house is involved in 12 step meetings with a sponsor and undergoes urine screens. A sober house is not connected to a treatment center but is in the community. It includes residents with like diagnoses who are involved in 12-step meetings and a sponsor. It also has in-house meetings.

To access information about treatment programs, use the local telephone directory; access internet searches; contact your physician, Employee Assistance Program (EAP), insurance company or local mental health service agencies.

Return to Work

The recovering nurse who has completed treatment and is in an aftercare program must decide what and with whom information about the situation should be shared. It often works to have a short “conference” with the staff, recovering nurse and manager on the unit prior to the nurse returning to work. During that conference, the recovering nurse can share any restrictions they will have when returning to the unit. If there is a medication restriction, specifically a narcotics restriction, who will be responsible for passing the nurse's narcotics and what tasks will the recovering nurse assume in return?

A return to work contract usually mandates attendance at 12-step meetings such as Alcoholics Anonymous, etc., continued outpatient aftercare or other meetings, and drug screening. The returning nurse might need to work day shift for several months and not be mandated to work overtime in order to meet all of the required recovery obligations. This may seem unfair to the other staff and needs to be explained to employees affected by these restrictions. (See Appendix 2 for sample return to work contract.)

The returning nurse should make it clear to the other staff that it was not their fault that she was using drugs. It was not because the unit was understaffed and the stress was too much or because another nurse would not take on additional work – the nurse chose to take drugs or use alcohol as part of the disease.

The returning nurse needs to understand that some staff may continue to be angry about the drug use and for having to “put up” with the nurse's behavior in the past. The nurse also needs to recognize that she will be suspected in the future whenever medications come up missing. If this occurs, the nurse should insist on giving a urine specimen immediately so that her name and integrity can be preserved.

The recovering nurse needs to continue to work a relevant recovery program. This includes following the return to work and aftercare contracts signed with the employer, attending two to three 12-step meetings per week, and attending support groups or individual therapy if indicated. It took the nurse a long time to become ill to the point of treatment. It will take time to develop and maintain a good recovery program.

Relapse

Relapse is part of the disease of chemical dependency and does not occur suddenly. It is a process beginning with attitudinal change. Phase 1 includes minimizing problems, overconfidence, unrealistic goals, and expecting immediate life improvement. Phase 2 is emotional deterioration with the nurse easily angered and upset, dishonest with self, mood swings, resentment collecting, frequent complaints, etc. In Phase 3, there are situational changes including not staying with “clean” (alcohol and drug free) people in “clean” places, acting out, anger, infrequent or no attendance at AA or other self-help groups, creating a series of crises so the nurse has a “reason” to drink or use. Phase 4 involves returning to drinking or using drugs, hostility, and preoccupation with alcohol/drugs.

The goal should be intervention in any of the phases; earlier interventions being more effective. Treatment, support and 12- step programs all emphasize relapse prevention.

When the nurse returns to work, the manager should encourage the nurse to remain active in relapse prevention activities such as assessing high risk situations, learning coping skills, and changing attitudes. The manager should also be aware of what the symptoms of relapse are and what to do if the nurse shows signs of relapse. The manager must be aware of the facility's policy regarding relapse. Will the nurse be allowed to return to treatment or will the nurse be fired?

The nurse who relapses often feels a strong sense of shame, guilt and hopelessness. The nurse needs to re-enter treatment immediately and may need more emotional and psychiatric support during this time.

Drug and Alcohol Testing

Drug and alcohol testing should be done when a nurse is suspected of using mood altering chemicals. It should also be done immediately prior to the nurse returning to work after treatment and then on a random basis over the next 1-2 years. The frequency of testing may be dictated by the return to work contract, facility policy and/or other applicable contracts. Random tests should not be planned or announced ahead of time. In addition, the nurse in recovery should be able to request a drug and/or alcohol screen if there is any question that the nurse might be using (e.g., when narcotics are missing, etc.). Costs of drug testing may be paid by the facility, by the nurse, or a combination of both.

The manager needs to be aware of what the facility policy requires regarding testing and who to contact to get a test done based on observed behaviors. The policy should describe the types of tests done, when, by whom, who pays, cut off points for drugs tested, confidentiality, re-testing, etc. There are several agencies that can help provide information about what needs to be included in the policy. For example, the state Bureau of Workers'

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Compensation and the Department of Health and Human Services (federal agency) both have guidelines that are important for employers to be familiar with when developing policies. It is essential that chain of custody specimens be processed only through state approved labs.

Dual Diagnosis (Chemically dependency and psychiatric issues)

Treatment of addiction becomes more complicated when there are coexisting psychiatric conditions. It is estimated that over 50% of the persons struggling with a mental illness have an addiction problem as well. Because many of the addictive behaviors can produce anxiety, depression, disorientation, and delusions, the problem of separating psychiatric symptoms from physiological consequences of action can become very difficult. Failure to detect both illnesses can lead to inappropriate treatment, referral and follow-up. Some of the reasons that substance abuse may co-occur with mental illness include the following:

- Substances may be used to “self” medicate symptoms of the mental illness. For example, alcohol may be used to treat feelings of anxiety or depression.
- Substances may be used to treat the side effects of prescribed medications. Lethargy and lack of energy may be countered with a stimulant.
- Individuals may have a genetic predisposition to both mental illness and chemical dependency abuse.
- The misuse of substances may trigger a mental illness.

Referral to a treatment facility with the ability to treat clients with dual diagnosis is an important consideration in selection of the appropriate treatment facility. Treatment for both the mental illness and the chemical dependency problem must be done at the same time. It is difficult to manage the psychiatric problem when the individual is engaged in active addiction. Reasons for this approach include the following:

- The approach of chemical dependency treatment alone is to avoid all substances. If a mental illness such as depression or bipolar disorder exists, it is necessary to medicate the psychiatric disorder and therefore all medications cannot be discontinued.
- The approach of mental health professionals is often to treat the mental illness and expect that the chemical dependency problem will go away with effective treatment. Eliminating the substances of abuse is necessary or the psychiatric treatment will not be effective because of the continuing mind altering “self” medications.
- Generally it is most effective to treat co-occurring disorders with a combination of medications, psychosocial treatment and supportive community services.

Following initial treatment for chemical dependency, selection of a treatment provider knowledgeable of both mental illness and chemical dependency is a vital consideration for ongoing mental health treatment.

Nurses With Psychiatric Problems Only

The nurse who has “only” a psychiatric/mental health problem also needs appropriate treatment. It is essential that a treatment provider be selected who is knowledgeable of psychiatric problems and appropriate treatment including appropriate medication and usage. In addition, if a return to work is contemplated, it is necessary for the treatment provider to understand the skills, abilities, and thought processes essential to providing safe nursing care.

The following is a list of signs and symptoms of the most common mental health disorders for use as an educational tool. Please note that the nurse who is dual diagnosed may show mixed signs and symptoms depending upon the mood altering chemicals being used.

Affective Disorders**Major Depressive Episode:**

Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functions: at least one of the symptoms is either depressed mood or loss of interest and pleasure.

- depressed mood
- markedly diminished interest or pleasure in all, or most all, activities
- significant weight loss or gain when not dieting
- insomnia or hypersomnia
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of worthlessness or excessive guilt
- concentration difficulties or indecisiveness
- recurrent thoughts of death, suicidal plan or previous attempts

Manic Episode:

Consists of a distinct period of abnormally and persistent elevated, expansive mood lasting at least one week, and during the period of mood disturbance, three (or more) of the following symptoms have persisted to a

significant degree:

- inflated self-esteem or grandiosity
- decreased need for sleep
- hypertalkative
- flight of ideas or racing thoughts
- highly distractible
- increase in goal directed activity or psychomotor agitation
- excessive involvement in pleasurable activities
- Anxiety Disorders
- Excessive anxiety and worry for at least six months, about a number of events or activities
- Person finds it difficult to control the worry
- Anxiety and worry as associated with three (or more) of the following:
 - restlessness
 - easily fatigued/excessive fatigue
 - difficulty concentrating
 - irritability
 - muscle tension
 - sleep disorder
- Anxiety cause clinically significant distress in social, occupational or other important areas of function
- Anxiety is not due to physiological effects of a substance
- Obsessive/compulsive behaviors

Posttraumatic Stress Disorder:

- Person has been exposed to a traumatic event in which:
 - Person witnessed or experienced an event that involved actual or threatened death or serious injury of self or others.
 - Person's response involved intense fear, helplessness or horror.
- Traumatic event is persistently re-experienced by:
 - recurrent or intrusive recollections of event
 - recurrent dreams of event
 - acting or feeling as if event recurring
 - intense psychological distress when exposed to similar internal or external cues
 - Physiological reactivity on exposure to internal or external cues
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
- Persistent symptoms of increased arousal following the trauma
- Disturbance causes significant distress or impairment in social, occupational or other important areas of functioning

Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and demonstrating at least five of the following symptoms:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self damaging (spending, sex, substance abuse, reckless driving, or self-mutilating behavior)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability due to marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociative symptom

Considerations for Managers with Collective Bargaining Units (Unions) in Working With Chemically Dependent Nurses

A number of managers work in collective bargaining facilities. An understanding of the perspective and role of the union representative will be helpful for the manager who is dealing with an impaired nurse.

The following guidelines will be considered by local unit leaders when working with impaired nurses. The manager should be aware of these considerations. If a nurse is involved in a collective bargaining unit, the nurse should be offered local unit representation prior to or at the start of the intervention. If the nurse desires local unit representation, all action has to stop until the local unit representative is present.

- Remember that strict confidentiality is an absolute necessity.
- Advise the nurse as to your role as local unit leader. You are not an attorney, and your representation is only as a union representative under a collective bargaining agreement.
- Strongly advise the nurse to retain legal counsel—especially if criminal charges or administrative board proceedings are anticipated.
- Attorney referrals can be obtained through the

local bar association. The nurse should be sure to ask for an attorney who has experience in working with chemical dependency. An attorney with criminal expertise is needed if the nurse is facing criminal charges. An attorney with expertise in administrative board proceedings is needed if dealing with a board of nursing.

- Strongly advise the nurse against giving any statement to the employer, to investigators from the board of nursing and/or pharmacy board, or to any other person without first consulting legal counsel.
- Any statement or admission made by the nurse can later be used against her at a board of nursing disciplinary proceeding or at a criminal proceeding.
- Know your facility's policies regarding:
 - Search of employees' workspace, lockers, vehicles and person
 - Surveillance and monitoring of work areas
 - Drug free workplace policy and drug testing procedures
- Ask that a split specimen urine collection be taken as part of the drug testing process. Ensure that chain of custody process is followed. (A split specimen is one in which half of the specimen is put into a second container. This is done when there is any question regarding contamination of the first specimen).
- Ask about the availability of Employee Assistance Programs and/or other community resources and referrals.
- Ask about the specifics of health insurance coverage for chemical dependency treatment if the nurse has health insurance through her workplace.
- Request a Family Medical Leave Act application packet for the nurse to complete.
- Ask about the availability of paid and unpaid time—for example, PTO, vacation time, sick time, short-term disability, unpaid medical or personal leave of absence.
- Ask about employment consequences. If the employer intends to discharge the nurse, would the employer consider a “last chance agreement” instead? Or would the employer allow the nurse to resign in lieu of being terminated?
- Ask about the availability of alternative work assignments and other non-nursing job vacancies at the facility while the nurse is restricted from practicing as a registered nurse.
- Ask whether the employer intends to file a report with the Board of Nursing, the Pharmacy Board, and/or the local police department.

Boards of Nursing

Boards of nursing are charged with the responsibility for protecting the public. Each nursing board responds to the issue of nursing impairment differently. Some boards take the nurse through the disciplinary process, some have an alternative to discipline program, and others work with outside organizations to provide an alternative to the disciplinary process. Managers, local unit representatives and nurses should check with their state nursing board to see what is done when a nurse may be chemically dependent or psychiatrically impaired.

Look at the state nursing law and rules to see what actions the state may take. If there is an alternative program, what kinds of criteria must a nurse meet in order to enter the program? A nurse who has had treatment previously and then relapsed might not be eligible to enter the program. A nurse might not be eligible if the nurse substituted drugs (e.g., withdrew morphine and inserted saline). The law in each state will be different.

In addition, identify reporting requirements. Talk to the nurse administrator regarding what the facility's position has been in the past. Many employers work with impaired nurses so long as they don't relapse and are working on recovery. Others may choose to fire and then report the nurse immediately.

Why Keep the Recovering Nurse in Your Employ?

It is not unusual for managers to report that the nurse found to be impaired for chemical dependence was their “best nurse.” Often being the “best nurse” leads to greater denial in confrontation of the problem by managers and co-workers. Studies have found that being the “best nurse” is a label often given to impaired nurses who also often have graduated in the top of their classes, are perfectionists, and are highly motivated to be the “best.” They are the nurses the manager can count on to work overtime, come in on their day off, and to never say no. So when that nurse is no longer able to be the “best nurse,” how should the manager react?

One view is that it is not ethical to fire the impaired nurse. Many employers have found that although some careful planning must occur to return a nurse new to recovery to work, it can be successfully accomplished to the betterment of the patients, co-workers, the institution, and for the recovering nurse. It is essential that the recovering nurse be protected from access to substances in the form of mood altering drugs

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and narcotics; thus a medication restriction must be enforced. This may mean other staff members will need to assume these responsibilities. In return, the recovering nurse will assume other tasks to assist those who are administering her medications.

The nurse will still be the highly motivated, skillful person she was initially. As the recovering nurse's personal insight grows with participation in her treatment program, the nurse may exhibit increased compassion and understanding of others, demonstrate more effective communication and assertiveness skills, and be better able to handle personal stressors. The work unit will remain intact and the employer will not have the expense and downtime associated with the hiring and orientation of a new employee. The "best nurse" will not be lost to the profession.

For more information about the Indiana State Nurses Assistance Program go to www.IndianaNurses.org/isnapsite/ or call 1-800-638-6623.

Additional Resources

Note: This information is based on experiences by representatives of and materials from the Ohio Nurses Foundation's Peer Assistance Program for Nurses.

American Association of Nurse Anesthetists, www.aana.com/peer

American Nurses Association. (2001). Code of Ethics for Nurses with Interpretative Statements

Bissell, L., & P. Haberman. (1984). Alcoholism in the professions. New York: Oxford University Press.

Bissell, L., Sullivan, E. & E. Williams. (1988). Chemical Dependency in Nursing: The Deadly Diversion. Menlo Park, CA: Addison-Wesley Publishing Co.

Crosby, L. & L. Bissell. (1989). To care enough: Intervention with chemically dependent colleagues. Minneapolis: Johnson Institute Books.

DSM-IV-TR. (2006).

Gorski, T. (1989). Passages through recovery: An action plan for preventing relapse. Minnesota: Hazelden.

Gorski, T. (1989). The relapse/recovery grid. Minnesota: Hazelden.

Ohri, Z. & Leslie, R. (2006). Chemical Dependency (Chapter 15). In P. Dickerson (Ed.), *Women's Health: A Resource Guide for Nurses* (pp. 167-178). Pittsburgh, PA: Oncology Nursing Society.

For the most recent information including research, see the following websites or locations:

Al-anon.Alateen.org or check in the phone book in your community.

Alcoholics Anonymous, www.alcoholicsanonymous.org or check in the phone book in your community

Hazelden Publishing & Education, www.hazelden.org, 1-800-328-9000

Johnson, V.E. (1986). Intervention: How to help someone who doesn't want help. Minneapolis: Johnson Institute Books.

National Institute on Drug Addiction (NIDA), www.nida.nih.gov

National Institute on Alcohol Abuse and Alcoholism (NIAAA), www.niaaa.nih.gov, 1-301-443-3860

National Clearinghouse for Alcohol and Drug Information, info@prevline.health.org, 1-800-729-6686

Ohio Bureau of Workers' Compensation Drug-Free Workplace Program.

SAMSHA.

State Boards of Nursing. For example, Indiana's web site is www.in.gov/pla/nursing.htm

Guidelines for Managers Working with Impaired Nurses Ohio Nurses Foundation

ONF-08-50-I

This independent study has been developed for managers to better understand nurses who are chemically dependent and/or psychiatrically impaired. 1.29 contact hours 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 10/2010

DIRECTIONS

1. Please read carefully the enclosed article, "Guidelines for Managers Working with Impaired Nurses."

2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the Indiana State Nurses Association, 2915 North High School Rd., Indianapolis, IN 46224.
 - 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 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent 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 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, 614-448-1027 (zohri@ohnurses.org), or Sandy Swearingen, 614-448-1030 (sswearingen@ohnurses.org).

OBJECTIVES

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

1. Describe the signs and symptoms of chemical dependency.
2. Discuss the manager's role in identifying and managing the nurse who is chemically dependent and/or psychiatrically impaired.

The planners and authors have no conflict of interest. There is no commercial support for this independent study.

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Authors of these guidelines include:

Sharon Parker, MS, RN
Judith Anderson, PhD, APRN, BC
Susan Yoder, PhD, RN
Ruth Leslie, RN
Diane Matuska, RN
Deborah Napier, BSN, RN
Zandra Ohri, MA, MS, RN

Note: Because the majority of nurses are female, the word "her" is used as a primary reference pronoun in these guidelines. This does not mean that information does not or could not apply to men.

POST-TEST—Guidelines for Managers Working with Impaired Nurses

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

NAME _____

FINAL SCORE _____

Select true or false for the following questions.

1. When confronted at the workplace regarding theft and/or diversion/impairment, the nurse must confess at that time in order to lessen the consequences.
 - a. True
 - b. False
 2. The nurse should speak to an attorney before meeting with officials such as police, regulatory board, etc.
 - a. True
 - b. False
 3. Usually a one-to-one intervention of the nurse is best to make the nurse feel at ease.
 - a. True
 - b. False
 4. Careful documentation of the events leading to the intervention is essential.
 - a. True
 - b. False
 5. It's important for the unit manager to let the staff know about the happenings at the intervention to avoid the rumors that can occur.
 - a. True
 - b. False
 6. Debriefing may be of assistance in helping the participants of the intervention express their feelings and experience closure.
 - a. True
 - b. False
 7. Nurses with alcohol or drug addictions must go through intensive inpatient treatment.
 - a. True
 - b. False
 8. Nurses who have gone through an individualized inpatient program do not have to participate in Alcoholics or Narcotics Anonymous.
 - a. True
 - b. False
 9. Treatment for alcoholism should at a minimum include detoxification and stabilization.
 - a. True
 - b. False
 10. The recovering nurse should decide what and with whom information about the situation should be shared in the workplace.
 - a. True
 - b. False
 11. Initially the nurse returning to work may need to work day shift and refrain from mandated overtime as part of the nurse's return to work contract.
 - a. True
 - b. False
 12. The nurse needs to inform the staff that the understaffing and job stress led to the addiction problems.
 - a. True
 - b. False
 13. It took the nurse a long time to become chemically dependent to the point of treatment; therefore, it will take time to develop and maintain a good recovery program.
 - a. True
 - b. False
 14. Relapse comes quickly without warning and should not be considered part of the disease itself.
 - a. True
 - b. False
 15. In the event of relapse, the nurse needs to re-enter treatment immediately and may need emotional and psychiatric support at this time.
 - a. True
 - b. False
 16. If a nurse is a member of the facility's collective bargaining unit, the manager must ask if the nurse wants a bargaining unit representative present during the intervention.
 - a. True
 - b. False
 17. If the nurse states that she wants a collective bargaining unit representative with her during the intervention, the manager must stop everything until that representative arrives.
 - a. True
 - b. False
 18. Boards of nursing are responsible for protecting the nurse.
 - a. True
 - b. False
 19. Misuse of prescribed drugs is a violation of the nurse practice act?
 - a. True
 - b. False
 20. Documentation of work attendance is done to see a pattern of absenteeism and tardiness.
 - a. True
 - b. False
 21. Referral to a treatment facility with the ability to treat clients with dual diagnosis is an important consideration in selection of a treatment facility.
 - a. True
 - b. False
 22. Borderline personality disorder is a pattern of instability of interpersonal relationships, self-image and marked impulsivity beginning by early childhood.
 - a. True
 - b. False
- Select the one correct answer for the following questions.**
23. The nurse who relapses often feels which of the following:
 - a. Shame
 - b. Guilt
 - c. Hopelessness
 - d. All of the above.
 24. Who has the authority to offer the nurse "deals" with the law that are guaranteed to be accepted?
 - a. Pharmacy Board
 - b. Police
 - c. Prosecutor
 - d. Judge
 25. What is the best type of attorney that would be familiar with dealing with issues with a board of nursing?
 - a. Divorce attorney
 - b. Administrative Law attorney
 - c. Criminal attorney
 - d. Personal Injury attorney
 26. Using the Johnsonian model for intervention strategy, who may be included to confront the nurse?
 - a. Colleagues
 - b. Employer
 - c. Spouse/significant other
 - d. All of the above
 27. The purpose of treatment is:
 - a. The safe withdrawal from drugs and alcohol
 - b. To help the person honestly face addiction
 - c. To develop new attitudes that will help the nurse embrace a drug and alcohol free lifestyle
 - d. All of the above.
 28. The return to work contract may include the following mandates:
 - a. 12-step meetings such as AA/NA
 - b. Going to church each week
 - c. Never to take another pain medication again
 - d. All of the above
 29. Causes of chemical dependence include all of the following except:
 - a. Genetic predisposition
 - b. Sexual abuse in childhood
 - c. Low self-esteem
 - d. Appropriate self-medication of depression.
 30. Chemical dependence is a:
 - a. Treatable illness
 - b. Medical condition
 - c. Primary illness
 - d. All of the above
 31. The following is accurate concerning legal/ethical considerations of chemical abuse:
 - a. Confidentiality of information related to chemical dependency is not required by federal law.
 - b. An impaired nurse should be allowed to practice until she has been evaluated.
 - c. It is the obligation of a colleague to document and report impaired colleague's behavior.
 - d. It is the right of a nurse to refuse evaluation and treatment and leave employment without being reported to the appropriate authorities.
 32. Enabling behavior on the part of colleagues include:
 - a. Understanding the benefits of early treatment of chemical dependency
 - b. Making up excuses for an impaired colleague's mistakes
 - c. Allowing the impaired nurse to accept the consequences of her behavior
 - d. Allowing the impaired nurse's work to go undone
 33. Signs and symptoms of opiate abuse include all of the following except:
 - a. Distorted sense of time
 - b. Nausea and vomiting
 - c. Respiratory depression
 - d. Pinpoint pupils
 34. The alcoholic nurse exhibits the following characteristic(s):
 - a. Preference for working overtime
 - b. Elaborate excuses for being late to work
 - c. Offers to do more than is required at work
 - d. All of the above
 35. The following discrepancies may indicate that a nurse on the unit has a chemical dependency:
 - a. Orders of narcotics for patients who have been discharged
 - b. Patients' reports of increased pain relief during the suspected shift
 - c. No breakage or wastage of opiates
 - d. All of the above
 36. Any organization should have a policy addressing "fitness for duty" which includes:
 - a. Guidelines for a manager that address steps to take if an employee is suspected of having a chemical dependency
 - b. Legal issues related to substance abuse
 - c. Directions on who to report the suspected abuse to
 - d. All of the above
 37. Drug and alcohol testing should be done when:
 - a. A nurse is suspected of using mood altering chemicals
 - b. Prior to return to work after treatment
 - c. On a random basis over 1 to 2 years post treatment
 - d. All of the above
 38. Which of the following statements is false?
 - a. Over 50% of people with mental illness have an addiction diagnosis as well.
 - b. Treatment of addiction is less complicated when there is coexisting mental illness.
 - c. Individuals may have a genetic predisposition to both mental illness and chemical dependency.
 - d. None of the above

Post-Test continued on page 14

Post-Test continued from page 13

Evaluation

- 1. Were the following objectives met?
 - a. Describe the signs and symptoms of chemical dependency. _____ Yes? _____ No?
 - b. Discuss the manager's role in identifying and managing the nurse who is chemically dependent and/or psychiatrically impaired. _____ Yes? _____ No?
- 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?

**Guidelines for Managers Working
With Impaired Nurses
ONF-08-50-I**

Registration Form

Name: _____ (please print clearly)

Address: _____

Day phone number: _____

LPN_____ RN_____

ISNA Member: _____Yes _____No ISNA Member Number: _____

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

Please return:
Completed Post-test and Evaluation Form
Registration Form

TO: Indiana State Nurses Association
2915 North High School Road
Indianapolis, IN 46224

ISNA OFFICE USE ONLY		
Date Received: _____	Amount: _____	Check No: _____