MAssachusetts Report on Nursing

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March 2009

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MARN Announces 2009 Nursing Living Legends

Barbara Blakeney, MS RN

by Karen Daly

Barbara Blakeney has had an exceptional career in nursing. Her longstanding passion and commitment on behalf of patients and the profession has been evident and recognized publicly throughout her nursing career.

Barbara's passion and commitment to nursing have been exemplified throughout her longstanding career of service and leadership. As a visible and vocal leader at both the state and national level, Barbara has represented the profession with a clarity and sense of purpose that have engendered respect and recognition from both peers and policy makers nationally and internationally. She cares deeply about nurses and the patients we serve. Her life's work as a nurse and patient advocate has helped shape and advance the health care system and makes her extremely deserving of this special honor and recognition.

Mary Ellen Doona, Ed.D, RN

When you read the **MA**ssachusetts **R**eport on **N**ursing, one of the highlights is *Clio's Corner,* authored by Mary Ellen Doona. Each issue provides a doorway to the history of nursing and health care. Her vivid stories provide insight and knowledge about pioneers in nursing that is not usually known by nurses.

Mary Ellen has made many contributions to nursing and nursing history. She has enlightened nurses with numerous informative publications and presentations about historical nursing leaders in nursing history. Without her commitment to the profession as an historian, writer, teacher and practitioner, we would have less knowledge and insight into our past and present.

Joan Vitello, RN

by Gaby Cohen

Do you believe in soul mates? I do. I have always thought of Joan as my "Professional Nursing Soul Mate". I always feel this way when I talk with Joan about the Nursing profession and her attitude toward her nurses and nursing as a whole. Joan recognizes nurses for who they are; she knows about their commitment to safe, high quality patient care, their dedication to their workplace, their colleagues and their patients and families.

Because Joan *knows* nurses she goes the extra mile to support, protect, and appreciate them at all times. Joan *knows* that nurses are the most valuable assets of health care institutions. Joan's efforts ensure that nurses under her wing, wherever that may be, will love and advocate for their profession and will continue to give their hearts and souls to caring for others in need.

Marjorie Gordon

Read about Marjorie Gordon in the next issue of the **MA**ssachusetts **R**eport on **N**ursing due in July

Call for Posters to the 2009 Spring Conference

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2009 Awards for Excellence in Nursing

Excellence in Nursing Research
Dorothy Jones

Excellence in Nursing Education
Susan Emery, CRNA, MS

Excellence in Nursing Practice
Denise Braddock RN, CPON

Ruth Lang Fitzgerald Scholarship
Georgia Ameia Yen Patton RN, MS, GNP-BC

President's Award
Sandra Reissour
Jeanne Gibbs

Mary A. Manning Mentoring Award
Edward Coakley

*Look for articles about these great nurses in the Summer Edition of the **MA**ssachusetts **R**eport on **N**ursing*

8th Annual Spring Convention

8th Annual Spring Convention

Living Legends and Excellence in Nursing Awards Dinner
Friday, April 3, 2009
6:00 pm-9:30 pm

The Ethics Imperative in Nursing
Saturday, April 4, 2009
7:30 am-2:45 pm

Featuring
Keynote Speaker
Christine Mitchell
RN, MS, MTS, FAAN
Associate Director, Clinical Ethics, Harvard Medical School, Director, Office of Ethics, Children's Hospital

Dedham Hilton Hotel

MARN is a Constituent Member Association of the American Nurses Association

ANCC contact hours pending.

www.MARNonline.org

2009 Living Legends and Excellence in Nursing Awards Dinner

Friday, April 3. 2009 ~ 6:00 pm-9:30 pm

Join MARN as we celebrate the 2009 BEST in Nursing in Massachusetts as well as MARN's successes for the past 8 years!

Cocktail Reception
6:00 pm – 7:00 pm

Dinner and Awards Ceremony
7:00 pm – 9:30 pm

2009 Living Legends in Massachusetts Nursing

2009 President's Award

Excellence in Nursing Awards

Ruth Lang Fitzgerald Memorial Scholarship

Arthur L. Davis Publishing Agency, Inc. Scholarship

Mary A. Manning Nurse Mentoring Award

8th Annual Spring Convention

This convention is designed for students, nurses, nurse administrators and nurse educators interested in improving their knowledge of nursing ethics. The convention will focus on ethical issues in current clinical practice. You will hear from experts and nurses in different practice areas—from the neonatal ICU to home care—who will share their experiences and give you an opportunity to participate in the discussions and decisions.

The Ethics Imperative in Nursing
Saturday, April 4, 2009

7:30 am–8:30 am
Continental Breakfast, Exhibits and Registration

8:30 am–9:30 am
The Evolution of Moral Responsibility in Clinical Practice
Christine Mitchell, RN, MS, MTS, FAAN

9:30 am–10:00 am
Break, Exhibits, and Raffle

10:00 am–11:15 am
Listening for the Gray: Shared Reflections on Ethics Narratives
Panel Presentation

11:30 am–12:30 pm
MARN Business Meeting

11:30 am–12:30 pm
MASNA Student Forum

12:30 pm–1:30 pm
Exhibits and Buffet Lunch

1:30 pm–2:30 pm
Demystifying the Ethical Issues in Genetic Testing
Pamela J. Grace, PhD, APRN

2:30 pm–2:45 pm
Wrap-up and Evaluation

Speakers

Keynote Speaker
Christine Mitchell, RN, MS, MTS, FAAN
Associate Director, Clinical Ethics, Harvard Medical School, Director, Office of Ethics, Children's Hospital

Carol Bourne, RN, BSN
Patient Service Manager
Visiting Nurse Association, Boston

Sharon Brackett, RN, BS, CCRN
Staff Nurse
Surgical Trauma Intensive Care Unit
Massachusetts General Hospital

Pamela J. Grace, PhD, APRN
Associate Professor of Nursing and Ethics
William F. Connell School of Nursing
Boston College

Susan Young, RNC, MS
Clinical Nurse Specialist
Neonatal Intensive Care Unit
Beth Israel Deaconess Medical Center

Registration Information

Please include check or money order made out to MARN for the exact amount or you may choose to register and pay by credit card ***online*** at www.MARNonline.org.

Return registration form and check to MARN, PO Box 285, Milton, MA 02186. Registrations MUST BE postmarked no later than ***March 21, 2009***.

❑ $65 Awards Dinner ONLY

MARN Members
❑ $85 Convention Only 4/4/09
❑ $150 Awards Dinner 4/3/09 and Convention 4/4/09

Non-Members
❑ $115 Convention Only 4/4/09
❑ $180 Awards Dinner 4/3/09 and Convention 4/4/09

MASNA and Full Time Students
❑ $55 Convention Only 4/4/09

Part Time Students and New Grads*
❑ $75 Convention Only 4/4/09

Sponsor a Student Member or a New Grad Member*
***New Grad Member = Nurse in practice less than 12 months**
❑ $125 Member and FT Student—Convention Only 4/4/09
❑ $150 Member and PT Student/New Grad* Convention Only 4/4/09

Name: _____

Address: _____

_____
City State Zip

Email: _____

Phone: (___)_____

Fees are non-refundable.

Checks returned for insufficient funds will be subject to an administrative fee.

CALL FOR POSTERS at the MARN Spring Conference

All convention participants attending the Spring 2009 conference *The Ethics Imperative in Nursing* are welcome to contribute posters. Posters will be displayed near the exhibitors so that all who attend will have an opportunity to see them.

Go to **www.MARNonline.org** and fill out the poster submission form by **March 20, 2009.** Guidelines for poster submission are also available online.

Seeking Sponsors for Nursing Students or New Graduate Nurses to attend the MARN Spring Conference

Sponsor a nursing student or a new graduate to attend the 2009 MARN Spring Convention. Your sponsorship will provide the opportunity for novice future nurses to hear nurse experts; attend a special forum with MASNA students and network with nurses who share their passion for the profession. The full convention rate for MASNA and full time students has been reduced to $55.00. The part-time student and new graduate rate has also been reduced to $75.00.

The names of all sponsors will be listed in the MARN Newsletter. See conference registration form or email MARN at info@MARNonline.org or call 617-990-2856

PO Box 285
Milton, MA 02186
617-990-2856
newsletter@MARNonline.org

Representatives Christine E. Canavan, RN, BSN (10th Plymouth District: Easton, Brocton, & West Bridgewater), Mary Grant, RN, MS (Essex 6th District: Beverly), Kay Khan, RN, MS (Middlesex 11th District: Newton)

Nurse Legislators Share Their Stories and Strategies

January was the beginning of a new state legislative session. Although this starts in very difficult times, such situations often present new opportunities for change. On Friday, February 6, the MARN Health Policy Committee presented an outstanding health policy program *"Advocacy beyond the Bedside: Nurses Influencing the Political Process."* The keynote presentation featured the four nurse legislators, Representatives Christine Canavan, Jennifer Callahan, Mary Grant, and Kay Kahn who participated in a panel presentation. They discussed their reasons for running for state legislator, their role as health care advocates and their focus for this upcoming legislative session. They encouraged the nurses and the many students from around the state who attended to get active in the political process. They shared strategies that nurses can use to impact health care policy in Massachusetts.

The program marks the beginning of this year's work for the Health Policy Committee. The Committee is ready to review bills submitted to the legislature. The committee will select ten or twelve bills that are high priority to nurses in the Commonwealth and to MARN. The Committee will track these bills, and keep you informed of their progress through this column and the MARN website. The Heath Care Policy welcomes MARN members to volunteer for the Health Policy Committee. You will learn much and you will help to make a difference for health care in Massachusetts. Visit the MARN website for more Information: **www.MARNonline.org**

So stay tuned for more information about changes coming to health care in the Commonwealth.

MARN Vision Statement

MARN is committed to the advancement of nursing standards and practice, and to continuing professional development of registered nurses across the Commonwealth who share the belief that greater achievement occurs in an environment that embraces mutual respect of diverse perspectives, a spirit of collegiality, and the advocacy role of the nurse to individually and collectively shape quality health care.

This contemporary organization provides a virtual home for the nurturing and development of its membership. As a constituent member of ANA, the membership proactively responds to regional and national issues in ways that produce rippling outcomes in larger communities of professional nurses, health care decision makers, and citizens. Membership initiatives serve to strengthen enduring partnerships with other stakeholders in health care.

MARN Welcomes Mentoring Program Coordinator A. Lynne Wagner, EdD, RN, MSN, LCCE, FACCE

A. Lynne Wagner

Dr. Wagner's nursing career has spanned 40 years. She has worked as a medical-surgical staff nurse, in-service staff educator, certified Lamaze childbirth education instructor, family nurse practitioner, and for 20 years, a nursing professor at Fitchburg State College, which has honored her with Professor Emeritus. Presently, Dr. Wagner works as a Nurse Consultant facilitating the development of mentor programs and doing workshops on reflective practice, qualitative research, mentoring, and application of the Watson Human Caring Theory/Caring Science. Her research and model-building focuses on reflective practice, how nurses develop caring-self and practice, and the nurse/patient's perception of the healing role of caring during illness and life transitions. Dr. Wagner is also a poet and uses interpretive aesthetic inquiry in her research. She has published her work and has presented nationally and internationally.

Lynne's activities are not limited to nursing. She works with her church in social ministry with a focus on immigrant issues; is a Worship Assistant; and choir member. In her community she works with pregnant teenagers; volunteers with the Medical Reserve Corps; and participates in poetry writing group. She even has time for hobbies (reading, gardening, poetry-writing, painting) and she loves to travel.

Welcome Lynne!!

A Mentoring Opportunity for Novice RNs

"Mentoring Matters" Program, a grant-supported statewide opportunity is seeking novice nurses to be mentored by an experienced nurse. Mentoring does make a difference. One mentee stated, "My mentor has become a great support person and a friend in my life in nursing and beyond." Another said, "My mentor has made such a big difference in how I look at nursing and my future plans. She is always there for me……We share so much." If you would like support and a shared experience in nursing beyond your preceptorship, apply at www.MARNonline.org by March 27, 2009.

A Mentoring Opportunity for Experienced RNs

Apply to be a mentor for a new graduate nurse in the MARN "Mentoring Matters" Program, a grant-supported statewide opportunity for experienced nurses to mentor a novice nurse and make a difference in his/her career and life. Mentoring does make a difference for mentees and mentors. One mentors stated: "I know that having a 'mentor' in your life to support and value your opinion, to believe in you when you are having trouble believing in yourself, can help you achieve your goals…….I love seeing my mentee grow and begin to have confidence." Another said, "Not only did I feel I was helpful to my 'mentee,' it has made me more enthusiastic about being a nurse." A third reported, "We share our stories and learn more about life together." If you would like to make a difference in a new nurse's life and your own, apply at www.MARNonline.org by March 27, 2009.

Men in Nursing

Christopher J. O'Rourke-Friel, RN, CPON®

"The rationale for women to be admitted to previously male dominated professions posits that half the world's talent was wasted when women were excluded. The same holds true for men in nursing."

Eleanor J. Sullivan, PhD, RN, FAAN,
Former Dean, University of
Kansas School of Nursing
Past President, Sigma Theta Tau International
From *Men in Nursing: History, Challenges, and Opportunities.*

****

Why are there so few men in nursing? In the United States, less than 8% of nurses are male. Why in an age where women are increasingly making inroads into previously male dominated professions, is the care of the sick is still regarded as the domain of women? Can the paradigm of nursing as "women's work" be shifted?

Men were nurses long before the modernization of the profession. However, the efforts of the most influential nurse of all time are still being felt today. While it would be foolish to criticize the woman whose reforms in nursing helped save the lives and ease the suffering of countless millions, Florence Nightingale was very open about her intentions to take the power over nursing out of the hands of men, and put it in the hands of women. The success of Nightingale's "women only" nurse training schools is legendary, but this revolution had no place on its agenda for men. Scholars reflect that the documented history of nursing is almost exclusively about women's accomplishments, despite the fact that men have worked as nurses since the pre-Christian era, because women make up the majority of current nurses in most countries, and because most nurse historians have been female.

How do we go about reversing the attitude of 180 years? Unless we can affect some change in

Men in Nursing continued on page 11

ANA President Attends Gathering for Summit Conversations: Exploring the Emerging Consensus on American Health Care for the 21st Century

President of the American Nurses Association (ANA), Rebecca M. Patton, MSN, RN, CNOR attended the first of a series of "Summit Conversations" to highlight the emerging national consensus on key components of a reformed 21st century health care system on January 28, 2009, at the University of Miami.

ANA has long been a supporter of a restructured health care system that assures universal access to a standard package of essential health care services for all people within U.S. borders. ANA favors a restructured health care system that:

- Enhances consumer access to services by delivering primary health care in community-based settings.
- Fosters consumer responsibility for personal health, self care, and informed decision-making in selecting health care services.
- Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.

Sponsored by *America's Agenda: Health Care Education Fund*, Summit Conversations will be held in cities throughout the country over the next 12 months. They will bring together 100 of America's leaders in business, labor, government and the health care sector and will be hosted by University of Miami President Donna E. Shalala and moderated by Emmy-award winning political commentator Bill Press. In addition to Shalala, participants will include Dick Gephardt, former Majority Leader of the U.S. House of Representatives; Billy Tauzin, president and CEO of PhRMA; Jim Hagedorn, CEO and chairman of Scotts Miracle-Gro Company; Terry O'Sullivan, general president of the Laborers' International Union of North America; John R. Seffrin, Ph.D., CEO of the American Cancer Society; Rebecca M. Patton, President of the American Nurses Association; Pedro Jose Greer, Jr., M.D., assistant dean for Academic Affairs, School of Medicine, Florida International University; and Dr. C. Martin Harris, chairman, IT Division, Cleveland Clinic.

For more information on The Summit, please visit http://www.summitconversations.org.

President's Message

Toni Abraham MSN, APRN-C

Toni Abraham

As I complete my first year as MARN President I want to thank all the great people who have worked so hard this year to do the work of nursing in all areas. I especially want to thank all the student nurses who contributed to the MAssachusetts Report on Nursing during the last year. Faculty feedback after reading their students' insightful articles was positive and rewarding to them. In her January editorial Pamela F. Cipriano, PhD, RN, FAAN, NEA-BC, Editor-in-Chief of American Nurse Today, re-affirmed that nurses need to tell their stories about patient advocacy. Nurses need to "go public" so that the every day miracles that happen behind the scenes can be shared with others for affirmation and education. I applaud the students and hope they will continue to speak out, not only to their colleagues but in the public sector. I encourage them to be active in the Massachusetts Student Nurses Association so they can learn the skills necessary to lead the next generation of nurse advocates and innovators in health care.

January was National Blood Donor Month. When we think the many opportunities there are to volunteer and help our community, what better way is there than to give someone the gift of our blood? My father-in-law was a regular blood donor, being of service to others unknown to him gave him a feeling of satisfaction he remembered even when health prohibited him to continue giving.

I came across an interesting article about children in Louisiana schools being taught the importance of blood donation. The educational materials and presentations of the "Be A Hero" program first teaches them about platelets, plasma, the function of red blood cells, and how blood donations help save lives. The children are encouraged to talk about typical heroes and then expand their thinking to help them realize that blood donors save lives everyday by donating blood and can also be heroes. The children's part is to encourage their parents or other members of their community to become blood donors. What a wonderful way to teach children the art of giving!

Every day in our country, approximately 39,000 units of blood are required in hospitals and emergency treatment facilities for patients with cancer and other diseases, for organ transplant recipients, and to help save the lives of accident victims. If you can't think of a way to volunteer or donate your time, remember the selfless act of blood donation. You, too, can be a hero.

I hope to see everybody at the MARN Annual Gala Awards Celebration and Convention on April 3, and 4, 2009.

Editorial

Time for MARN to STEP *Forward*

Myra F. Cacace, GNP-BC

Hopefully by the time you are reading this the days will be warmer and the roads much less icy… what a winter we have had!!! Now that we are firmly into 2009, our newsletter will focus on the concept and actual practice of Volunteer-ism. In these tough fiscal times, organizations must rely more heavily on volunteers to provide crucial services. It is time for nurses to STEP *Forward* and join the growing number of volunteers who help make a difference in the lives of others.

Strength in any organization derives from the willingness of people who share the same values to come together to make a contribution. Without the dedication of nurses from this Commonwealth, our organization would not exist. There is so much work to be done to enhance our workplace, to improve the way we care for vulnerable people who need our help, and to work with all members of the allied health care professions and those in the political arenas to remove barriers to access at an affordable cost. For the seventh straight year, the Annual Honesty and Ethics Gallop poll rates nurses at the top of a list of 21 professions, followed by pharmacists, high-school teachers, and medical doctors. The great reputation of the nursing profession is based on our work within various health care settings where we are employed as well as in so many ways that we are viewed while performing other volunteer activities.

Time to volunteer might seem unlikely for many nurses who are struggling to deal with the micro-traumas of daily living. But there are countless opportunities for you to contribute your time and talent right in your workplace. Can YOU be a member of a patient care committee? Can YOU volunteer to help plan a party for the nurses on your unit? The possibilities to do a little extra are endless; the work does NOT have to be hard and the satisfaction you derive from helping out is hard to beat! My husband often laments that if I spent as much time thinking up schemes to make money for our family as I did for the various organizations I've been involved with we'd be rich! (which would give me more time for my volunteer work).

Enhance your life by spending some of your free time as a volunteer. I feel like I have been doing volunteer work forever. From the first time I went trick-or-treating for UNICEF in second grade, throughout junior high, high school, college and into my adult life I learned that working for something other than money is satisfying and fun. I am also surprised how valuable my nursing experiences are in helping me be a better volunteer. Improving things and helping others comes naturally to nurses. When one of the girls in my Girl Scout troop accidentally cut her finger, I was able to step right up and perform first aid and used the "teaching moment" to help all the girls earn their First Aid badge. When my kids were in the band I was always the first one asked to be a chaperone, even on the trips to Disney World…what a way to experience the rewards of volunteering.

Participation is the key. Team MARN will be in First Aid Tent B at the Boston Marathon. This promises to be a fun filled and gratifying day. Join a MARN committee and be a vital member of a professional nursing organization working to improve all aspects of nursing care in the Commonwealth. Please be sure to read the featured articles in the "Step Forward: MARN Volunteers Help Change the World" on pages 12 & 13. I invite you to write articles about your experiences as a volunteer. I invite you to make us aware of volunteer opportunities to volunteer in your area where nurses can help make a difference. For inspiration, be sure to read about the incredible efforts made by nursing students at the University Of Massachusetts in Lowell to volunteer thousands of hours to form a campus organization called Nursing Students Without Borders and their visit to Ghana on page 12.

Tell your story! Take some pictures! Voice your opinions! We publish quarterly, and the deadline to submit article and pictures are May 1, September 1, November 1, and February 1. Contact me at newsletter@MARNonline.org or contact the MARN office at info@MARNonline.org or send mail to PO Box 285, Milton, MA 02186. Please remember that it is our stated policy that we welcome all opinions. The Newsletter Committee wants to let the voices of every nurse in the Commonwealth be heard. However we do require that letters to the editor be signed in full in order for them to be included in the newsletter. We look forward to hearing from you!

Clio's Corner

CARRIE M. HALL (1873-1963): Pioneer at the Peter Bent Brigham Hospital

Mary Ellen Doona RN EdD

On 25 June 1998, alumnae of the Peter Bent Brigham Hospital School of Nursing gathered with administrators of the Brigham and Women's Hospital for an exhibit in the Carrie M. Hall Building, named for the Brigham's first Superintendent of Nursing and Principal of its nurses training school. Leading into the Carrie M. Hall Conference Rooms were photographs and awards among which were the Florence Nightingale and Edith Cavell Medals that Hall received for her leadership in Europe during World War I.

The first of John and Caroline (Rogers) Hall's three children, Carrie May Hall (1873-1963) was born in Nashua, New Hampshire 5 July 1873. She began her life the same year as nursing's first diploma was awarded to Linda Richards (1841-1930). Thirty-one years later in 1904, Hall accepted her own nursing diploma from the Massachusetts General Hospital Training School for Nurses (MGHTSN). During the next nine years, Hall gained administrative experience at the MGH (1904), the Quincy Hospital (1905) and the Margaret Pillsbury Hospital in Concord, New Hampshire (1906-1911). Along with these early positions, Hall served as president of the New Hampshire State Nurses Association (1911). While at the Brigham (1912-1937) she was president of the Massachusetts States Nurses Association (1921-1925) and then, president of the National League for Nursing Education (NLNE-1926-1928).

But all that was still to come, as Hall returned from Teachers College in New York to Boston in 1912. There she found that Boston's medical community had anticipated the reforms of the Flexner Report (1910). In 1906 the Harvard

Carrie M. Hall Wearing the Peter Bent Brigham Hospital School of Nursing cap that she designed (American Journal of Nursing July 1926, p. 582)

Medical School had relocated from Boylston Street (now the site of the Boston Public Library's Johnson building) to Longwood Avenue on twenty-six acres of the Ebenezer Francis estate. (The name endures in the Brigham and Women's Francis Street address). The Boston Psychopathic Hospital had just opened on Fenwood Road bringing psychiatry back from rural hospitals to the center of medical education and research. Nearing completion was the Peter Bent Brigham Hospital on Huntington Avenue that restaurateur and real estate baron, Peter Bent Brigham (1807-1877), had funded for the care of "sick persons in indigent circumstances."

Hall agreed to assume the nursing leadership at the Brigham provided the nursing department could open six months before the hospital did. Lost to the shadows of nursing's history is how Hall considered the proposal. It is reasonable to assume that she consulted with Sara E. Parsons (1864-1949), an 1893 graduate of the MGHTSN and since 1910 the leader of nursing at the MGH. Hall and Parsons would have met during MGHTSN alumnae association meetings. Given their positions as leaders of the new profession, it is likely that both attended the Boston convention of the American Society of Superintendents of Training Schools for Nurses and the Associated Alumnae in Boston in 1911 when they became, respectively, the National League for Nursing Education and the American Nurses Association.

What is known for certain is that Hall opened the Peter Bent Brigham Hospital School of Nursing 7 November 1912 with five students and Sally Johnson (1880-1957) a 1910 MGHTSN graduate as her assistant. Hall believed that good nursing education derived from good nursing care. She used the power and prestige of her position to advance nursing. She urged the visiting team of the Rockefeller Foundation to include hospital nursing in its study of nursing. The Foundation's Goldmark Report (1923) incorporated Hall's concerns but for some time to come nursing education continued to be the servant of the hospital. By 1926 she had to conclude that the "needs and purposes of the hospital and the school of nursing do not always run in parallel lines" (1926). If nursing education suffered, nursing care was excellent then, as it continues to be in 2009, as Brigham's nursing department nears its centennial.

As a twenty year old, Hall was dazzled by the brilliance of the new electric lights at the 1893 World's Fair in Chicago. Thirty-three years later as president of the NLNE founded at that Fair, Hall called on colleagues to carry the "bright torch of their principles and ideals ever higher and higher" (1926). The economic crash of 1929 darkened nursing's path yet by the time Hall retired (1 July 1937), 729 women had graduated during her tenure. More would follow until 1985 when the School closed. Among the many gifted graduates were Martha Ruth Smith and Lillian Goodman, the first deans respectively, of the Boston University School of Nursing and the University of Massachusetts at Worcester. They pioneered nursing education at the university as Hall had once done at the Peter Bent Brigham Hospital.

Sources

Hall, Carrie M. (1926). "Taking Courage: The Presidential Address-1926," American Journal of Nursing 26: 547-550.

CE Unit

MARN expresses their appreciation to the Ohio Nurses Foundation for making CE Units available for the MAssachusetts Report on Nursing

Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal

INDEPENDENT STUDY

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

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

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

Expires 12/2009.

DIRECTIONS

1. Please read carefully the enclosed article "Identification and Treatment of Alcohol Abuse, Dependence and Withdrawal."
2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the Massachusetts Association of Registered Nurses, P. O. Box 285, Milton, MA 02186.
   A. The post-test;
   B. The completed registration form;
   C. The evaluation form; and
   D. A check made out to MARN for $25 MARN members & $35 non-MARN members.

PLEASE NOTE: ONLY CHECKS WILL BE ACCEPTED FOR CE SELECTIONS . . . NO CREDIT CARDS PLEASE.

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

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, 614-448-1027, or Sandy Swearingen, 614-448-1030, Ohio Nurses Foundation at (614) 237-5414.

OBJECTIVES

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

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

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

There is no commercial support for this independent study.

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

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

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

Definitions of Alcohol Abuse and Dependence

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

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

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

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

Prevalence

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

Withdrawal Syndrome and Screening Tools

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

All patients entering the health care system should be assessed, however briefly, for alcohol abuse and dependence. Early identification of the abusing or dependent patient will aid in timely treatment and

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management of the many complications that can emerge due to alcohol's impact on the body (Burns, 1994). Common examples of these complications are the need for additional anesthesia or more intense pain management strategies, prolonged recovery, altered wound healing, and possible untreated alcohol withdrawal. Undiagnosed and untreated alcohol withdrawal can result in the patient's death. Alcohol withdrawal is experienced by the patient as one of three stages or syndromes.

Stage I Withdrawal

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

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

Stage II Withdrawal

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

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

Stage III Withdrawal

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

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

Screening Tools

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

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

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

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

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

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

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

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

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

Health History

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

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

Assessment of the Neurological System

Alcohol affects the neurological in both the short and long term. It is a central nervous system depressant that is dose dependent, with specific signs and symptoms varying with the concentration of alcohol in the blood (Burns, 1994). Intoxication with

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alcohol alters the level of consciousness and behavior, and these changes are modulated by the amount of alcohol ingested, the individual's tolerance, and factors such as ingestion of food and rate of alcohol ingestion.

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

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

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

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

Assessment of the Gastrointestinal System

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

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

Assessment of the Cardiovascular System

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

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

Assessment of the Immune System

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

Laboratory Findings

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

An elevated GGT (y-glutamyl transpeptidase) level is the most specific liver function test for alcohol abuse (Burns, 1994). GGT is elevated in approximately 75 percent of heavy drinkers with no other evidence of alcoholic liver disease (Lieber, 1991). A variety of common medications such as anticonvulsants, anticoagulants, and oral contraceptives can elevate GGT levels. Some medical conditions, such as non-alcoholic liver disease, gallbladder inflammation, lipid disorders, and obesity can also raise GGT levels. Norma GGT values are 8-30 U/L in men and 5-29 U/L in women (Rosman & Lieber, 1990).

Less than half of alcoholic patients will have an elevated MCV, which is a measure of the size of red blood cells (Rosman & Lieber, 1990). Normal values are 86-98 µm3. Folic acid deficiency, B12 deficiency, hypothyroidism, non-alcoholic liver disease, and leukemia can also increase red cell size. The liver enzymes involved in amino acid metabolism, aspartate aminotransferase (formerly SGOT) and alanine aminotransferase (formerly SGPT), will be increased with heavy alcohol use. Normal aspartate aminotransferase in adults is 0-35 U/L, and normal alanine aminotransferase is 0-35 U/L (Burns, 1994).

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

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

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

Treating Withdrawal Syndrome

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

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

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

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

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

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

Conclusion

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

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"Identification and Treatment of Alcohol Abuse, Dependence, and Withdrawal"
ONF-07-37-I Post-Test

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

NAME _____

FINAL SCORE_____

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

Please circle the **ONE** correct answer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Evaluation

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

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

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

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

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

INDEPENDENT STUDY
Registration Form

Name: _____
(please print clearly)

Address: _____

Day phone number: ( ) _____ RN _____ LPN _____

ONA Member: ____ Yes ____ No ONA Member Number: _____

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

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

TO: MARN
P. O. Box 285
Milton, MA 02186

ONA OFFICE USE ONLY

Date Received:_____ Amount:_____ Check No: _____

Additional Amount Due: $_____

Checklists Work for Nursing Documentation Too!

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Checklists have been getting a lot of attention lately. The New Yorker article by Atul Gawande (1) sparked discussion at our institution about this simple tool. Checklists have been developed around surgical procedure timeouts, central line insertion, and for transferring patients from one department to another, to provide examples of our institutions use. However, related to nursing documentation there were no checklists utilized.

Nurse Managers must ensure that their nurses are engaging in quality initiatives. The nurse mangers also have to ensure that documentation for all of the patient care activities, nursing assessments, and interventions are being documented appropriately. Individual follow-up is justified and informative related to the audits that nurse managers complete. Justified, in that, it allows for accountability to be given to the individual registered nurse responsible for the documentation. Informative, in that, it allows a one-on-one conversation to understand the bedside nurse's struggles, educational needs, and systems integration deficits, but also to provide feedback to the professional registered nurse on individual circumstances surrounding pertinent audit results.

Therefore, our colleague Shirley Sargent MS, RN, was intrigued by our data from the audits we had been collecting. Considering that our institution uses an electronic medication administration record (E-MAR), the rate of undocumented medication administration was greater than to be expected. Shirley commented that before the E-MAR, paper records were used and it was unacceptable to receive hand-off or end of shift report for a patient who did not have their medication administration documented. Therefore, having an E-MAR seemingly would make it easier to document a nurse's work.

However, the automated medication management system (e.g. Pyxis) does not interface with the E-MAR. This leads to "double documentation" of the administration of the medication. The obvious solution would be to conduct the hand-off procedure with a computer visualizing the E-MAR. This is not timely or easily accomplished. Therefore, the E-MAR remains 'invisible' to the nurses accepting responsibility for the patient. If there are discrepancies between the E-MAR and Pyxis, then the nurse must reconcile the two documents. This is time consuming and non-productive activity.

Shirley asked Elizabeth Centanni BSN, RN, and me to proofread and provide feedback related to the check list she developed. We felt this would be an excellent tool for our critical care units as well. The basis for this checklist creation was to act primarily as a reminder to the staff to document appropriately the work they are doing. Being able to take credit for the nursing process is an important act in our profession. Remember the nursing-legal idiom, "if it isn't documented, it didn't happen", also remains important. Each of us tailored the checklist to the needs of our intensive care units from the results of the regular audits we completed.

The form itself was placed on a uniquely colored piece of paper. We chose periwinkle blue because no other form in our institution uses that color. It was decided that the checklist would be limited to only five items. This would allow for focus and a supposed better completion rate. The top of the form is titled "ICU Daily Checklist". The date, shift, patient's medical record number and registered nurses name were requested to be completed. To ensure the registered nurse had 'ownership' of this checklist the furthest right hand column was for their initials. The charge nurses signature was requested at the bottom of the page. The instructions stated, "Charge Nurse – at the end of your shift, please collect sheets and place on Nurse Managers' door." Having only one person each day on each shift, the charge nurse, collect and submit the forms ensured orderly delivery of the documents.

One of the unit's five objectives for the checklist included; restraint documentation, EKG orders corresponding with each completed EKG, urinary catheter clinical needs assessment, daily patient mobility activity, and timely E-MAR documentation (Table 1). Opportunity and space is provided on the checklist sheet for written comments and reasoning if an objective could not be met or general comment. This "ICU Daily Checklist" has improved our documentation audit results. All five areas of quality improvement surveyed with the checklist in each unit have dramatically improved appropriate documentation completion in each audit category.

References:

1) Gawande, A. "The Checklist: If something so simple can transform intensive care, what else can it do?" The New Yorker Magazine, December 10, 2007.

Men Nursing continued from page 4

the public's perception of what it means to be a nurse, it will remain difficult to recruit more males into the profession. As a profession, nurses must challenge perceptions about nursing which create barriers for men to become nurses and take the necessary steps to present a more balanced image of nursing to the public.

The American Assembly for Men in Nursing (AAMN) was formed over thirty years ago. The Assembly believes that it is important to invite men who are nurses to a forum in order to discuss issues that impact their work in nursing. Frank discussion and organization are the first steps needed to change the public profile of men in nursing. To that end, a group of nurses at Children's Hospital Boston have partnered with faculty from Boston College and Curry College, which also are board members of the national organization, to form the newly recognized New England Chapter of the AAMN.

The goals and objectives of the New England Chapter mirror the national organization. These are:

- To encourage men to become nurses and join together with all nurses in strengthening and humanizing health care.
- To support men who are nurses to grow professionally and demonstrate to each other and to society the increasing contributions being made by men within the nursing profession.
- To advocate for continued research, education and dissemination of information about men's health issues, men in nursing, and nursing knowledge at the local and national levels.
- To support members' full participation in the nursing profession and its organizations

If you are a male OR a female nurse and you would like more information on the new Chapter, please email Chris O'Rourke-Friel, Interim President of the NE AAMN at Christopher.ORourke-Friel@childrens.harvard.edu or go to the website at www.neaamn.org

Christopher J. O'Rourke-Friel is a Staff Nurse II, Children's Hospital Boston and is the interim President, New England Chapter of the American Assembly for Men in Nursing.

ICU Daily Checklist

Date: _____ Shift: 7AM-7PM ❑ 7PM-7AM ❑

Patient MRN#_____ RN Name_____

Please be sure to check ***each*** item for ***each*** patient on ***each*** shift.

		Staff Nurse Initials
Restraints All patients with restraints must have an active order. ***No*** patient should be restrained without an order!	Yes-Orders are active ❑ N/A-Patient does not have restraints ❑	
EKG If you are obtaining an EKG—first make sure to obtain an order	Yes-order obtained ❑ N/A-no EKG done ❑	
FOLEY CATHETER.	Is the catheter necessary ? Yes reason: No Is the catheter stabilized/ anchored? ❑	
Patient OOB today? All patients should be evaluated to get OOB. Patient can be either OOB to chair or placed in Bed to Chair position.	Yes-Pt. OOB today ❑ No-Pt. did not get OOB today ❑ Reason_____ _____ _____ _____ _____	
Red Cells on SCM **E-MAR completed?** All medications should be signed off in a timely manner.	Red Cells Signed off? Yes ❑ No ❑	

Charge Nurse:_____ RN

Charge Nurse—at the end of your shift, please collect sheets and place on Nurse Manager's door.

STEP Forward MARN Volunteers!

Grassroots Lobbying – Volunteers Needed!

by Craven & Ober Policy Strategists, LLC

For our democracy to flourish and survive, citizens must be willing and able to participate in local, state and national politics. Citizens who do participate must believe that their involvement matters. The November 2008 election of President Barack Obama, a historical event, may prove to be a landmark example of how American citizens have renewed their belief in a viable democratic political system. The world watched as Americans voted for change. The new President immediately encouraged all of us to perform some community service during the Martin Luther King holiday weekend before his inauguration. Together we can, and must, weather turbulent economic times. During President Obama's first term in office, we must not forget the importance of staying engaged in our democracy.

For many of us, learning the basics about the democratic process was part of an elementary or high school civics class. Gaining access to that system, especially when individual or group interests are at stake, is often an effective function of professional associations and non-profit organizations. There are two kinds of lobbyists in the state legislature: volunteers and professionals. Informal coalitions of volunteer citizen lobbyists do not have to register as lobbyists in Massachusetts because they spend only a modest amount of money producing educational materials abut their causes. However, the Commonwealth of Massachusetts does require paid lobbyists and their employers to register and file financial reports. Registered lobbyists coordinate the flow of information by getting the right information to the right person at the right time. Volunteer lobbyist groups who are passionate advocates for a compelling issue can be the most important and effective grassroots lobbying base. Grassroots' support and action can enhance professional lobbyists' clout with legislators.

A key component to a successful lobbying effort is to win legislators' confidence. Before legislators agree to support the bill, testify at a public hearing or write a letter to the committee to request a favorable release of the bill, they want to understand every aspect of proposed legislation: what it does, what it costs, and what members of their constituency are affected by it. They also want to know who opposes the legislation and their reasons. An organized grassroots campaign is essential, they need complete information about a proposed legislation. The most effective means to communicate this to legislators is in a single page fact sheet that they can read in 40 seconds. With this concrete information, they can proceed through the necessary steps that lead to a floor debate and vote.

The idea of calling or writing their legislator might seem intimidating at first. Reassuring volunteers that they can learn how to talk to legislators and providing them with timely accurate information will ease their concerns. Another means to building a volunteer lobbying network is to identify other stakeholders who care about your issue and invite them to work with you towards a targeted goal of affecting a prospective bill's outcome. If you haven't been part of a grassroots advocacy campaign, make this your year. The democratic process can be fun and very rewarding. As Margaret Mead once said, "A small group of thoughtful people could change the world. Indeed, it's the only thing that ever has."

Craven & Ober Policy Strategists, LLC is a full service Massachusetts-based government relations firm dedicated to credible, assertive advocacy and to the dissemination of reliable public policy information.

University of Massachusetts/ Lowell Nursing Students Travel to Ghana: Start Nursing Students Without Borders

Dr. Miki Patterson, Faculty Advisor

Brianna Norton, Junior nursing student thought she should do something for a country/population in need and had no trouble getting her student peers to become excited about going somewhere to help other people while enhancing their nursing skills. They looked into mission trips that mainly provided healthcare and could also accommodate 10-12 students. They considered three options and decided that Ghana was the least hostile and was an English speaking country so they did not have to learn another language.

They began by investigating the country's health needs, cultural norms, especially around health care attitudes, and then began planning the specifics. They worked with a man from a community in Kpando, where they would spend the bulk of their time, learning about the specific needs of the community. They obtained the Ghana government sponsored HIV aids teaching program, which they used as a basis to plan their health care activities.

Next they had to develop a fundraising plan. They worked for thousands and thousands of hours to raise money and still committed to spend $3000 of their own money each to make the trip. They sponsored information sessions, ran a BINGO night, held a raffle, and sold candy bars. You name it; they tried it, and the campus Student Activities Center really supported their efforts! They applied for grants and sent letters to alumnae, health care institutions, Merck and Costco and friends asking for donations of tooth brushes, IV fluids, dressing supplies, infant formula, cough medicine, other medications, and even flip flops.

They learned about and followed all the CDC recommendations for immunizations and the precautions needed to prevent sickness from specific foods and water. They obtained medications and other necessary equipment to prevent Malaria, including mosquito nets and insect repellant.

Before they left, they completed all the tasks required to become an official student organization – not an easy feat at the University of Massachusetts. President of the University, Marty Meehan and the Provost gave the students their 100% support which added strength and legitimacy to their efforts. Their trip took place in the middle of January, 2009 and visited an orphanage, clinic, and hospital and worked to help care for disabled children. Valerie King and Maura Norton, University of Massachusetts/ Lowell Nursing faculty accompanied the students. If you could meet them you would be so amazed at their energy and conviction to make the world better one corner at a time. An information slide show fund raiser is planned for sometime in March, and they plan to write another article for the **MA**ssachusetts **R**eport on **N**ursing for the next issue.

Help Change the World!

Nurses Needed! Consider Joining the Boston Medical Reserve Corps

by Peggy Andreas RN

What is the Boston MRC? The Boston MRC is a group of volunteers who are ready to respond in the event of a public health emergency. In an emergency, volunteers perform a wide range of tasks aimed at keeping the city safe and healthy, for example, nurse volunteers may be called upon to administer medication to city residents, or immunizations to prevent an epidemic. Volunteers also provide critical support at planned events like the Boston Marathon, and the July 4th celebration.

Who volunteers for the Boston MRC? Although you do not need to have a medical background, we are specifically looking to increase the number of nurse volunteers. In addition, the Boston MRC is always looking for:

- Multilingual volunteers
- Community leaders
- Health Care Professionals
- Mental Health clinicians
- Everyday citizens with a desire to help Boston during an emergency

Do I need special training to volunteer? Yes, once you register online at www.bostonmrc.org you will have the opportunity to complete an orientation online, or in person, if you prefer. After that, if you are interested in taking on a larger role free leadership training is offered monthly and Continuing Education Units (CEUs) are awarded. Trainings are held at the DelValle Institute for Emergency Preparedness on Northampton St. near the Boston Medical Center.

How do I sign-up? Nurses like you are needed to keep Boston safe. The time commitment is small-but the rewards are many: meet new friends, learn new skills, earn free CEUs . Joining is easy, simply:

1) Submit a volunteer application at www.bostonmrc.org
2) Complete the orientation either online or in person
3) That's it-you are ready to go!

Be sure to view the calendar of training events online.

I joined the BMRC in 2004 and have attended a number of worthwhile trainings, including the recently offered "Leadership Under and Pressure" and "Patient Tracking in Mass Casualty Events". On one memorable occasion I was called on to serve during an immunization clinic, after an incidence of Hepatitis A was reported, and linked to an area food stand. Clinics were set up at various locations throughout Boston and staffed with nurses and other BMRC volunteers (pharmacists, registration clerks, interpreters, etc.) In cases such as this, when large numbers of the public are believed to be at risk for exposure

Boston medical reserve corps
A program of the Boston Public Health Commission

(in this instance-taxicab drivers) a fast response by well-trained professionals is crucial. My experience that day was a most positive one. I gave a few hours of my time, administered a lot of injections, and met a great group of nursing colleagues-all there for the same reason: to make a difference in the community!

Please consider registering. To learn more about the Boston Medical Reserve Corps and upcoming trainings visit their website www.bostonmrc.org. If you have additional questions contact Steph Sharp, Project Manager for the Boston MRC at volunteer@bphc.org.

Bulletin Board

Members Only

RESEARCH STUDY ON SHARPS INJURIES

Registered nurse volunteers are being sought as participants in a study designed to provide a better understanding of the meanings associated with the experience of sharps injuries. Nurses who have sustained their injury within the previous 24 months are eligible for participation, which involves one or more face-to-face interviews.

For more information, contact the investigator Karen Daley, RN by phone at (617) 596-1381 or email: daleykg@bc.edu

Visit MARN Website www.MARNonline.org

Statutory Requirements Regarding Nurse Practitioners as Primary Care Providers

A new Massachusetts statute requires insurers to allow their members to select a Plan participating nurse practitioner (NP) as a primary care provider and to include participating NPs in all paper and electronic provider directories.

In response to the new requirements, Blue Cross Blue Shield of Massachusetts (BCBSMA*) is implementing a process to enable members to choose an NP as their primary care provider. BCBSMA already includes NPs in our online and paper directories and has contracted with NPs for all products since 2001. In our implementation of the statute, we are collaborating with the Massachusetts Coalition of Nurse Practitioners (including a representative from MARN) and will notify Plan participating NPs and Primary Care Physicians as this implementation proceeds.

Mark your Calendar

These programs has sought approval by the Massachusetts Association of Registered Nurses, an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

STRESS RESOURCES LLC

MINDFULNESS-BASED STRESS REDUCTION PROGRAM

The internationally recognized MBSR program will help you ***CREATE CALM WITHIN CRISIS***, something we can all use in these challenging times! The MBSR program consists of 8 weekly 2-hour classes, taught by stress management expert and board-certified holistic nurse, **Pamela Katz Ressler, RN, BSN, HN-BC**

Spring 2009 classes begin on April 2
in Concord, MA.
Thursday p.m. ***or*** Friday a.m. classes are available.

CE: 16 contact hours.

Tuition: $350 (includes CDs, manual, and text), BCBS discount available

Contact: Stress Resources (www.stressresources.com) or 978-369-5243

This continuing nursing education activity was approved by the Massachusetts Association of Registered Nurses, Inc., an accredited approver of by the American Nurses Credentialing Center's Commission on Accreditation.

Conflict Resolution Skills Training

This conflict resolution skills training program teaches nurses conflict theory and effective communication skills to help them work successfully with patients and their families. It is recommended for professionals who work with multiple family members who may disagree about difficult decisions they need to make.

Date: May 5, 2009

Time: 9:00 - 3:00

Location: Newton, MA (specific information will be sent upon registration)

Fee: $195 Early Registration (6 weeks prior to program), $225 Regular Registration

Contact Hours: 4.75

Registration Info:
www.ElderDecisions.com or email training@ElderDecisions.com, 617-621-7009

For more information, contact Blair Trippe,
Partner Agreement Resources, LLC
30 Walpole Street
Norwood, MA 02062
Main Number: (617) 621-7009
blair@AgreementResources.com

Announcements

MARN Welcomes the Newly Formed New England Chapter of the American Assembly for Men in Nursing

Demetrius J. Porche, DNS, PhD(c), APRN, President and the Board of Directors of the American Assembly for Men in Nursing (AAMN) is pleased to recognize the New England Chapter of AAMN's contributions to promoting men in nursing and men's health in the New England community. The AAMN Board of Directors is enthusiastic about the New England Chapter's active involvement in our national organization and as the voice for men in nursing in the New England area".

For more information about the New England Chapter of AAMN, please contact:
Chris O'Rourke-Friel, RN, CPON®
Interim President
New England Chapter
American Assembly for Men in Nursing
Christopher.ORourke-Friel@childrens.harvard.edu

Policy for Accepting Announcements for the Newsletter:

MARN encourages organizations of higher education to submit announcements about continuing education opportunities and upcoming events that are of interest to nurses. Fees must be included with submissions.

The Fee Schedule is as follows:
Non-MARN Approved Providers/Sponsors—$50
MARN Approved Providers/Sponsors—$25

Payment can be mailed to MARN, PO Box 285, Milton, MA 02186. Please include a copy of the announcement and contact information (name, address, telephone, Email) with the check. Please email copy to www.MARNonline.org.

Announcements are limited to 75 words.

ATTENTION POTENTIAL PROGRAM ADVERTISERS

Please be sure to clearly state if your educational program is approved by the MARN Approver Unit in all program submissions!

The MARN Approver Unit

The only Professional Nursing Organization ANCC Approver Unit in the Commonwealth
Program reviewers: available to review your nursing education programs any time.
For up to date information about how to become an approved provider (for a single activity or as an organization) please visit the MARN Website www.MARNonline.org

Bulletin Board

MEMBER BENEFITS
Your guide to the benefits of ANA/MARN membership...
It pays for itself

- **Dell Computers—MARN and ANA ANA are pleased to announce a new member benefit. MARN and ANA members can now receive 5%-10% off purchases of Dell Computers. To take advantage of this valuable offer, or for more details, call 1-800-695-8133 or Visit Dell's Web Site at www.Dell.com**
- Walt Disney World Swan and Dolphin Hotel
- GlobalFit Fitness Centers—Save up to 60% savings on regular monthly dues at GlobalFit Fitness Centers.
- Professional Liability Insurance—a must have for every nurse, offered at a special member price.
- Nurses Banking Center—free checking, online bill paying and high yield savings all available to you 24/7 to fit any shift or schedule at an affordable price - Liability/ Malpractice, Health Insurance, Dental and Vision.
- CBCA Life and Health Insurance Plans—Disability Income, Long Term Care, Medical Catastrophe, Medicare Supplement, Cancer Insurance and Life Insurance Plans provided by CBCA Insurance Services.
- Discounts on auto rental through Avis and Budget: Call Avis 1-800-331-2212 and give ID# B865000 Call Budget - 1-800-527-0700 and give ID# X359100
- Save on your hotel stays at Days Inn, Ramada Inn, Howard Johnson and more.
- Online discounts on all your floral needs through KaBloom.

Promote yourself: professional development tools and opportunities

- Members save up to $140 on certification through ANCC.
- Online continuing education available at a discount or free to members.
- Conferences and educational events at the national and local level offered at a discount to members.
- Member discounts on nursesbooks.org—ANA's publications arm.
- Up to 60% savings on regular monthly dues with GlobalFit Fitness program.
- Find a new job on Nurse's Career Center—developed in cooperation with Monster.com.

Stay informed: publications that keep you current

- Free subscription to The American Nurse—a $20 Value.
- Free online access to OJIN—the Online Journal of Issues in Nursing.
- Free subscription to the MAssachusetts Report on Nursing—a $20 value
- Free access to ANA's Informative listserves including—Capitol Update and Members Insider.
- Access to the new Members Only web site of NursingWorld.org.
- Free access to MARN's Member-Only Listserve

We also welcome any pictures that show MARN members in action…at work or at play. Interested persons, please contact Myra Cacace at myra@net1plus.com.

MARN News is an up to date information service about a variety of issues important to nurses in Massachusetts. You must be a MARN member to be included, so join today!

MARN member: Have you gotten your **MARN News** message? If not, then we don't have your correct email address. If you want to begin receiving this important information, just send an email to: info@marnonline.org with "ADD" and your name on the subject line.

Certified Nurses Day is March 19!

Board Certification of nurses plays an increasingly important role in the assurance of high standards of care for patients and their loved ones. Nursing, like health care in general has become increasingly complex. While a registered nurse (RN) license provides entry to general nursing practice, the knowledge-intensive requirements of modern nursing require extensive post-secondary and continuing education and a strong personal commitment to excellence by the nurse.

MARN encourages national board certification for all its nurses. Patients are encouraged to inquire whether there are certified nurses on staff when they visit a hospital or their primary care provider. There are many nursing certification specialties such as medical-surgical, pediatric, pain management, cardiac vascular, oncology, hospice, case management, emergency nursing, critical care and many others. Many nursing certification bodies exist to serve the full range of specialized nursing care offered in the contemporary health care system; national nurse-certifying bodies should be accredited by either the American Board of Nursing Specialties (ABNS) or the National Organization for Competence Assurance (NOCA), or both.

Please join MARN in honoring those hardworking, dedicated nurses for their professionalism, and a job well done!

Boston College Launches Advanced Practice Forensic Nursing Program

by Joshua J. Jensen

With violence filling the pages of our newspapers and television screens and an increased awareness of the physical and mental health impacts of violence, there is a mandate to act. For Angela Amar, associate professor of nursing at Boston College, that means developing an advanced practice forensic nursing program at Boston College's Connell School of Nursing. Amar sees a clear need for advanced practice nurses who are able to address the broad health needs of individuals who have experienced violence, as well as assist individuals throughout the legal process with evidence collection, forensic documentation, and court testimony. In short, Amar saw an emerging need for advanced practice forensic nurses. To fund development and startup costs of this effort, Amar applied for and was awarded a grant from the Health Resources and Services Administration (HRSA), part of the US Department of Health and Human Services. With courses available starting in 2009, Forensic Nursing is available as both a specialty in the master's program or as an additional specialty for nurses who have already obtained a master's degree.

Though nurses have been doing forensic work for decades, the professional identity of the forensic nurse is still developing. The first forensic nurses in clinical practice were sexual assault nurse examiners (SANEs). The role of the SANE came about in the mid to late 1970s to meet the unique needs of survivors of rape and sexual assault. Since the creation of early SANE programs the scope of forensic nursing practice has expanded to include all roles where nurses can combine healthcare expertise with a legal component. According to the International Association of Forensic Nurses, forensic nurses work with individuals experiencing a broad range of interpersonal violence, including domestic violence, sexual assault, child and elder abuse and neglect, physiological and psychological abuse, occult and religious violence, and human trafficking. Nurses trained in the area of forensics are equipped to work in a variety of settings and roles, including forensic mental health, correctional nursing, legal nurse consulting, emergency and trauma services, public health and safety, and death examination.

Advanced practice forensic nursing is an even more recent development. For the first time, in 2009, the American Nurses Credentialing Center (ANCC) will offer an Advanced Practice Forensic Nurse recognition specifically designed for nurses who have completed a graduate program in forensic nursing. Boston College is on the leading edge, with only a handful of these advanced practice programs offered in the United States. Advanced practice recognition promises to give forensic nurses the skills and tools to participate in clinical research, and to use existing research to impact their own practice.

As a newly recognized specialty, advanced practice forensic nursing may not be familiar to the broader public. Forensic nurses have a unique skill set that meets the needs of individuals and communities experiencing violence, but for many it is not yet second nature to turn to forensic nursing to find this expertise. To address this awareness challenge proactively, Amar approached an impressive list of community leaders, building an advisory committee that reads like a "who's who of forensic leaders" in the Boston area. Led by Lucia Zuniga, director of the Massachusetts Sexual Assault Nurse Examiner (SANE) Program, this community-based advisory committee addresses a number of program needs including program development, establishing clinical opportunities for students, and acting as a vehicle to integrate advanced practice nurses into the fabric of forensic science and practice. Organizations and agencies represented on the advisory committee include the Norfolk and Suffolk County District Attorney's offices, the Boston Police Department, the Massachusetts Executive Office of Public Safety and Security, the Victim Rights Law Center, the Massachusetts Department of Public Health, the Center for Community Health Education, Research, and Service (CCHERS), Harvard University, the Suffolk County Sheriff's Department, Massachusetts Office for Victim Assistance, and the Fenway Institute.

Although advanced practice forensic nursing is a new initiative, the study of forensic nursing at Boston College is well established, rooted in the work of Ann Burgess, a Connell School of Nursing professor since 2001. Burgess's relationship with Boston College goes back to 1972, when she completed early victimology research with Boston College sociologist, Professor Lynda Lytle Holmstrom. This work would lead Burgess down a path that eventually would form the scientific foundation of the field of forensic nursing.

Burgess has continued to lead research in forensic science. She is currently the co-primary investigator on a collaborative grant project with the Justice Resource Institute and Villanova University. This purpose of this two-year project is to advance empirical research related to combating online sexual victimization of children and adolescents and to improve Internet safety strategies.

Burgess has also been an innovator in the teaching forensic science, leading a number of popular undergraduate courses on the subject. Students from across the university give Burgess's courses high marks, in part due to her ability to bring difficult concepts to life through real-world examples drawn from her own experience. Recently featured on the ABC news program 20/20 for her work on the Riley Fox case, Burgess has also testified as an expert witness in the Duke Lacrosse case, as well as the infamous Menendez brothers' trial. In addition, Burgess has leveraged her work with the FBI, and often brings FBI agents into the classroom to discuss their forensics work.

Burgess is thrilled to see young faculty building off the foundation that she has created through her research and teaching. "When my work on rape trauma syndrome was published, I never dreamed that 35 years later there would be enough research to provide graduate students with an evidence-based curriculum in forensic nursing," she says. "Yet the time has come and the Connell School is ready for graduate students who will continue to advance forensic science and forensic nursing practice."

Amar agrees with Burgess' assessment. She comments, "I'm very excited about the thought of building a community of people who are going to work together to advance the science of forensic nursing."

This project is/was supported in part by funds from the Division of Nursing (DN), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under grant number 5001194 and title XXX for $877,000. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by the Division of Nursing, BHPr, DHHS or the U.S. Government. *Joshua Jensen is the Director of Marketing and External Relations at Boston College's William F. Connell School of Nursing. He can be reached at joshua.jensen@bc.edu.*

National Nurses Week Facts

Did you know...?

(Feel free to use the following information as you plan your events.)

There are nearly 2.9 million registered nurses in the United States. And, 2.4 million of them are actively employed.

National Nurses Week has a distinctive history.

The American Nurses Association was founded in 1896

Isabel Adams Hampton Robb was the first president of the American Nurses Association

According to projections released in February 2004 from the **Bureau of Labor Statistics,** RNs top the list of the 10 occupations with the largest projected job growth in the years 2002-2012. Although RNs have listed among the top 10 growth occupations in the past, this is the first time in recent history that RNs have ranked first. These 10-year projections are widely used in career guidance, in planning education and training programs and in studying long-range employment trends. According to the BLS report, more than 2.9 million RNs will be employed in the year 2012, up 623,000 from the nearly 2.3 million RNs employed in 2002. However, the total job openings, which include both job growth and the net replacement of nurses, will be more than 1.1 million. This growth, coupled with current trends of nurses retiring or leaving the profession and fewer new nurses, could lead to a shortage of more than one million nurses by the end of this decade. (For details, see www.bls.gov/emp/#outlook.)

The nation's registered nurse (RN) workforce is aging significantly and the number of full-time equivalent RNs per capita is forecast to peak around the year 2007 and decline steadily thereafter, according to Peter Buerhaus of Vanderbilt University's nursing school. Buerhaus also predicted that the number of RNs would fall 20 percent below the demand by 2010. *(Journal of the American Medical Association, June 14, 2000)*

Schools of nursing were forced to reject more than 147,000 qualified applications to nursing programs at all levels in 2005–an increase of 18 percent over 2004, according to a report by the National League for Nursing (NLN). The NLN Blamed the problem in part on a continuing shortage of nursing educators. Meanwhile, nursing colleges and universities denied 32,617 qualified applicants in 2005, also resulting primarily from a shortage of nurse educators, according to survey data released by the American Association of Colleges of Nursing (AACN). The AACN survey also reveals that enrollment in entry-level baccalaureate nursing programs increased by 13.0 percent from 2004 to 2005. According to AACN, this is the fifth consecutive year of enrollment increases with 14.1, 16.6, 8.1 and 3.7 percent increases in 2004, 2003, 2002 and 2001, respectively. Prior to the five-year upswing, baccalaureate nursing programs experienced six years of declining enrollments from 1995 through 2000.

There are over 240,400 advanced practice nurses in the United States. Of these, approximately 144,200 are nurse practitioners, 69,000 are clinical nurse specialists, 14,600 are both nurse practitioners and clinical nurse specialists, 13,700 are nurse midwives, and 32,500 are nurse anesthetists.

The Congressional Nursing Caucus–a bi-partisan initiative, co-chaired by U.S. Reps. Lois Capps (D-CA) and Steven LaTourette (R-OH), with 56 congressional members–was formed in March 2003. The purpose of the caucus is to educate Congress on all aspects of the nursing profession and how nursing issues impact the delivery of safe, quality care. The caucus was formed after consultation between congressional leaders and ANA.

Research indicates that advanced practice registered nurses can provide 60 to 80 percent of primary care services as well as or better than physicians and at a lesser cost.

49 states and the District of Columbia allow advanced practice nurses to prescribe medications.

The January 5, 2000, edition of the *Journal of the American Medical Association* (JAMA) reported the results of a study which revealed patients fared just as well when treated by nurse practitioners as they did when treated by physicians.

The nation's nurses rank first for their honesty and integrity, with 82 percent of Americans rating them "high" or "very high," according to a 2005 Gallup Poll. Nurses have consistently rated first every year but one after being added to the list in 1999.

The American Nurses Association consists of 54 state and territorial associations, whose mission is to work with ANA's Associate Organizational Members (AOMs) and Organizational Affiliates for the improvement of health standards and availability of health care services for all people, foster high standards for nursing, stimulate and promote the professional development of registered nurses, and advance their economic and general welfare.

A study published in the January/February 2006 journal *Health Affairs* provides new evidence that if hospitals invest in appropriate Registered Nurse (RN) staffing, thousands of lives and millions of dollars could be saved each year. Specifically, the study shows that if hospitals increased RN staffing and hours of nursing care per patient, more than 6,700 patient deaths and four million days of care in hospitals could be avoided each year. In addition to the immense societal benefits of adequate nurse staffing, the anticipated financial benefits of savings per avoided patient death or hospitalization may also be significant. This study is important because it highlights the fact that people suffer and die when nursing care is inadequate. It is the latest study in a growing body of evidence that clearly demonstrates that nurses make the critical, cost-effective difference in providing safe, high-quality patient care.

A study, published Sept. 23, 2003, in the *Journal of the American Medical Association* (JAMA) and conducted by Linda Aiken of the University of Pennsylvania, determined that the educational level of RNs working in hospitals has a significant impact on whether patients survive common surgeries. The study probed the impact not only of the numbers of RNs providing bedside care, but how the educational preparation of RNs impacts patient mortality. Among the study's most significant findings: that raising the percentage of RNs with bachelor's degrees from 20 percent to 60 percent would save four lives for every 1,000 patients undergoing common surgical procedures.

A study on the nursing shortage by Linda Aiken of the University of Pennsylvania School of Nursing found that an estimated 20,000 people die each year because they have checked into a hospital with overworked nurses. The study also found that Americans scheduled for routine surgeries run a 31 percent greater risk of dying if they are admitted to a hospital with a severe shortage of nurses. That's approximately one-fifth of the up to 98,000 deaths that occur each year as a result of medical errors. Nurses in the study cared for an average of four patients at a time, with the risk of death increasing by about 7 percent for each additional patient cared for over that baseline number. (Source: "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," study; *Journal of the American Medical Association,* Oct. 23-30, 2002.)

The link between adequate and appropriate nurse staffing and positive patient outcomes has been shown in several ANA publications and studies, including ANA's *Nurse Staffing and Patient Outcomes in Inpatient Hospital Settings.* This report, published in May 2000, found that shorter lengths of stay are strongly related to higher RN staffing per acuity-adjusted day and that patient morbidity indicators for preventable conditions are inversely related to RN skill mix.

A 2001 ANA Staffing Survey revealed that America's RNs feel that deteriorating working conditions have led to a decline in the quality of nursing care. Specifically, 75 percent of nurses surveyed felt the quality of nursing care at the facility in which they work has declined over the past two years, while 56 percent of nurses surveyed believe that the time they have available for patient care has decreased. In addition, over 40 percent said they would not feel comfortable having a family member or someone close to them be cared for in the facility in which they work, and over 54 percent would not recommend the profession to their children or their friends. These statistics reveal a disturbing trend.

America's registered nurses report that health and safety concerns play a major role in their decisions to remain in the profession, according to findings from a Health and Safety Survey released in 2001. In the survey, over 70 percent (70.5 percent) of nurses cited the acute and chronic effects of stress and overwork as one of their top three health and safety concerns. Yet nurses continue to be pushed harder–with more than two-thirds reporting that they work some type of unplanned overtime every month.

The American Nurses Credentialing Center Magnet Nursing Services Recognition Program offers guidelines designed to shift hospital administrators' focus from expensive, short-sighted recruitment efforts to meaningful retention strategies. Hospitals that have been designated as "magnets" have been found in studies to attract and retain professional nurses who experienced a high degree of professional and personal satisfaction through their practice. "Magnet" criteria can be used by nurses and administrators to assess their own facilities for improvements. For details regarding this program, see www.nursecredentialing.org/magnet.

An Invitation for MARN Members!
Become an active member—Join a MARN Committee today!

Mary A. Manning, MN.RN
Executive Director
Massachusetts Association of Registered Nurses
PO Box 285
Milton, Ma 02186
617-990-2856

Are you a MARN member who is looking for a way to become more involved in the organization? Do you have a special talent or interest? Can you find the time to work on a one time only project? If you are looking for the chance to become more active in the organization, then we are looking for you! Listed below are the descriptions of the various active committees for the Massachusetts Association of Registered Nurses.

MARN Awards Committee: Develops criteria for and selects winners for three annual nursing excellence awards, two scholarship awards and Living Legend awards. Meets quarterly by teleconference and email and once/year in person to prepare for Awards Luncheon/Dinner. Members expected to attend Annual Meeting and Awards Luncheon/Dinner during the Spring Convention. For more information, please contact MARN at info@MARNonline.org or 617-990-2856: Attention: Maura Fitzgerald, Chair.

MARN Bylaws Committee: Reviews MARN Bylaws annually to create and propose changes and additions as suggested by the membership and/or Board of Directors and to maintain compliance with ANA Bylaws. Meets in person as necessary (usually once per year) and by teleconference and email as necessary to prepare for Annual Meeting. Members expected to attend Annual Meeting held during Spring Convention. For more information, please contact Cammie Townsend at CTownsend@mghihp.edu or 617-990-2856.

MARN Continuing Education Committee: The Massachusetts Association of Registered Nurses, Inc. is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This committee plans and executes an Annual Provider Forum, writes quarterly newsletter articles, and functions as the MARN Approver Unit in reviewing provider and activity applications for continuing education credit. Meets monthly in Milton, MA on the first Wednesday morning of each month (9am–12pm). For more information, please contact Chairperson Sandra MJ Reissour at BerkshireRN@aol.com or 413-794-3402.

MARN Fall Clinical Conference Planning Committee: Plans and executes Annual Fall Conference focused on topics of clinical relevance. Responsibilities include site selection, speaker selection, developing contact hour application, assisting with marketing and on-site registration. Meets monthly by teleconference and/or email to plan. For more information, please contact MARN at info@MARNonline.org or 617-990-2856.

MARN Health Policy Committee: Reviews proposed legislation and health policy issues for recommendation to the Board of Directors. Provides analysis to the Board and the membership for recommendations; will also be meeting with legislators. Meets monthly on the first Tuesday evening of each month by teleconference (7-8pm) and plans to meet quarterly in person. For more information, please contact MARN: info@MARNonline.org or 617-990-2856.

MARN Membership Committee: Develops new membership initiatives, reviews membership statistics, and contacts new members to welcome them to the Association. Presents to schools and colleges of nursing, attends other professional organizational programs and meetings to promote MARN and the importance of professional organizational membership. Meetings are monthly by teleconference (5:30-6:30pm) and quarterly in person. For more information, please contact chairperson, Cidalia Vital at info@MARNonline.org or 617-990-2856..

MARN Newsletter Committee: Meets exclusively by email to review articles for publication, develop story lines, and create a quarterly newsletter circulated to every RN licensed by the Commonwealth. **ALL MARN MEMBERS ARE INVITED TO SUBMIT ARTICLES OF INTEREST.** For more information, please contact Editor Myra Cacace at newsletter@MARNonline.org or 978-433-6155.

MARN Spring Convention Planning Committee: Plans and executes Annual Spring Convention and Business Meeting. Responsibilities include site selection, speaker selection, business meeting execution, developing contact hour application, assisting with marketing and on-site registration. Meets monthly by teleconference and/or email to plan. For more information, please contact MARN at info@MARNonline.org or 617-990-2856: Attention Peggie Griffin Bretz.

MARN & ANA - A Partnership That Works For YOU!

The American Nurses Association and MARN are an influential and effective network of registered nurses who support nursing.

When you join MARN and ANA, you join with nurses around the country in speaking with one strong voice on behalf of your profession and health care. Together we can make a difference! As a full ANA/CMA member—you are a full voting member in the American Nurses Association and your state nurses association and entitled to valuable products and benefits that help you:

Be heard: advocating for nurses where it matters

- Federal lobbying on issues important to nursing and health care—issues such as safe staffing, nursing workforce development, overtime pay and access to care.
- State lobbying through our State Nurses Associations and nationwide state legislative agenda on issues vital to your scope of practice.
- Representing nursing where it matters, including the Environmental Protection Agency, Department of Labor, the U.S. Department of Health and Human Services and many others, right up to the White House.
- Speaking for nursing through the media including stories in the Wall Street Journal, Chicago Tribune, USA Today, 60 Minutes, NBC Nightly News, CNN, and NPR to name a few.
- Speaking for U.S. nurses as the only U.S.A. member of the International Council of Nurses and attending meetings of the World Health Organization.

Guide the Profession: ensuring nursing quality and safety

- Maintaining the Code of Ethics for Nurses which was first developed by ANA in 1926.
- ANA develops and publishes the Scope and Standards of practice for nursing and many of its specialties.
- Through the National Database on Nursing Quality Indicators, ANA is collecting data that link nurse staffing levels to quality nursing care.
- Addressing workplace hazards such as back injuries, latex allergies, safe needles and workplace violence.

Influence Decisions: becoming involved

- Join one of the many committees and boards at the national, state and local level that are shaping the direction of the association and the profession.
- Participate in member surveys that let you influence the association's agenda.

Save money: discounts and privileges for members.

For more information, visit the ANA website http://www.nursingworld.org/member2.htm

State Nurses Association Membership Application

8515 Georgia Avenue, Suite 400 • Silver Spring, MD 20910-3492 • Phone: (301) 628-5000 • Fax: (301) 628-5355

DATE _____

Last Name/First Name/Middle Initial | Home Phone Number | Social Security Number

Credentials | Work Phone Number | Basic School of Nursing

Preferred Contact: Home _____ Work _____ | Fax Number | Graduation (Month/Year)

Home Address | Date of Birth | RN License Number/State

Home Address | E-mail

City/State/Zip | County | _____ UAN member? _____ Not a Member of Collective Bargaining Unit

Employer Name | Member of Collective Bargaining Unit other than UAN? (Please specifiy)

Employer Address

Employer City/State/Zip Code

Membership Category (check one)

M Full Membership Dues
- ○ Employed - Full Time
- ○ Employed - Part Time

R Reduced Membership Dues
- ○ Not Employed
- ○ Full Time Student
- ○ New graduate from basic nursing education program, within six months after graduation (first membership year only)
- ○ 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues
- ○ 62 years of age or over and not employed
- ○ Totally Disabled

Please Note:

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the CMA is not deductible as a business expense. Please check with your CMA for the correct amount.

Choice of Payment (please check)

○ **E-Pay (Monthly Electronic Payment)**

This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize my Constituent Member Association (CMA)/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.

- ○ Checking: Please enclose a check for the first monthis payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.
- ○ Credit Card: Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

Monthly Electronic Deduction Authorization Signature

○ **Full Annual Payment**

Membership Investment _____
ANA-PAC (Optional – $20.04 suggested) _____
Total Dues and Contributions _____

Online: www.NursingWorld.org (Credit Card Only)

○ Check (payable to ANA) ○ VISA ○ MasterCard

CREDIT CARD INFORMATION

Bank Card Number and Expiration Date

Authorization Signature

Printed Name

Amount: $ _____

○ **Automated Annual Credit Card Payment**

This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize CMA/ANA to charge the credit card listed in the credit card information section for the annual dues on the 1st day of the month when the annual renewal is due.

Annual Credit Card Payment Authorization Signature

○ **Payroll Deduction**

This payment plan is available only where there is an agreement between your employer and the association to make such deduction.

Signature for Payroll Deduction

Please mail your completed application with payment to

AMERICAN NURSES ASSOCIATION
Customer and Member Billing
P.O. Box 17026
Baltimore, MD 21297-0405

* By signing the Monthly Electronic Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Abovesigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a $5 fee for any returned drafts or chargebacks.

Full Membership Dues: $249/year or E-Pay $20.75/month

Reduced Membership Dues: $124.50/year or E-Pay $10.38/month

Special Membership Dues: $62.25/year or E-Pay $5.19/month

Sponsor, if applicable _____

SNA membership #_____

MEMBERSHIP APPLICATION