



## Kentucky Board of Nursing

### Programs of Nursing Update

March 2006

Questions? Contact: Patty Spurr, Education Consultant @ 502-429-3333; Patricia.Spurr@ky.gov

## NCSBN Position Statements

A topic that I know you are faced with frequently is students with English as a second language. Enclosed are copies of position statements from the NCSBN related to:

- English Language Proficiency Standards-It would be interesting to see how these recommendations compare with your university/college policy.
- Information for Internationally Educated Nurses: Becoming licensed in the United States-This would be a great handout to use when you receive calls.

## Students Attending Board and Committee Meetings

Dr. Beason wanted to extend the invitation to Programs of Nursing to have students attend either Board or Committee meetings. Dates for meetings the remainder of 2006:

**Practice Committee** is to consider those matters related to the interpretation of the legal scope of nursing practice as defined by Kentucky Revised Statutes Chapter 314 and Board of Nursing administrative regulations. Committee deliberations may include review of other relevant statutes and regulations as necessary.

**Education Committee** is to consider those matters related to mandatory continuing education and prelicensure nursing education in the Commonwealth.

**Consumer Protection Committee** is to consider those matters relating to investigation and disciplinary processes and preparation of hearing panel members.

Board Meetings	Education/Practice Committee	Consumer Protection Committee
Meetings begin at 1 p.m. on Thursday & 9:00 a.m. on Fridays	Both meetings begin at 9:00 a.m.	Meets at 1 p.m.
<ul style="list-style-type: none"> <li>• Feb. 23-24</li> <li>• Apr. 20-21</li> <li>• Jun. 22-23</li> <li>• Aug. 10-11</li> <li>• Oct. 19-20</li> <li>• Dec. 14-15</li> </ul>	<ul style="list-style-type: none"> <li>• Mar. 16</li> <li>• May 25</li> <li>• Nov. 16</li> </ul>	<ul style="list-style-type: none"> <li>• Mar. 16</li> <li>• May 25</li> <li>• Nov. 16</li> </ul>
<p><i>All meetings are held at the Board Office.</i> 312 Whittington Parkway, Suite 300, Louisville, KY 40222</p>		

Our only request is that you let us know that you are coming, and the approximate number of students, so that we can be prepared to accommodate. Please RSVP at least one week prior to the meeting that students will be attending: Dea Cook at [Dea.Cook@ky.gov](mailto:Dea.Cook@ky.gov)

## Nurse/Physician Collegiality

Back in December, I sent you each an article written by Dr. Barry for the Jefferson County Medical Society newsletter about lack of nurses' preparation when calling a physician. The KHA has written a commentary that is being published in the February 2006 edition of the same newsletter. I am sending you a copy of both in case you cannot put your finger on the first copy. Thought you would find this of interest.

## KBN Annual Report 2004-2005

The Annual Report has been released for the last year; enclosed is a hard copy for you. Additional copies are available on the KBN Web page for your reference.

## Evidenced Based Practice Care Sheets: Available Through CINAHL

Okay, please bear with me if I have been out of the loop, or just have had a lack of observational skills. I was doing a lit search in CINAHL and saw the option of "Evidenced Based Care Sheets"—I clicked on it and what a find! There is a very extensive list of disease processes that have had a "Care Sheet" developed based on published research. So in the off chance that this would be new to even one person, I wanted to send to everyone for use with faculty and students. I am copying a sample of one of the sheets in case you have not seen them.

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**NCLEX REPORTS ARE ENCLOSED ONLY IF YOU HAVE HAD STUDENTS GRADUATE SINCE JULY 1, 2005 AND TAKE THE NCLEX.**

## **Position Statement**

December 2005

### **NCSBN Recommends English Language Proficiency Standards for Internationally-educated Nurses**

The National Council of State Boards of Nursing (NCSBN) urges state and federal policymakers to consider an immediate update to the standards they mandate for English language proficiency for internationally-educated nurses wanting to work in the United States (U.S.). Specifically, NCSBN asks that the federal Section 212.15 (g) (4), paragraphs (i) & (ii) of the Immigration and Nationality Act (which requires foreign health care workers who request certification for the purpose of performing labor as a health care worker in the U.S meet minimum set standard scores on federally-recognized English language proficiency tests) be updated to reflect NCSBN's latest recommendations for current standards.

NCSBN represents the 60 state and territorial boards of nursing who regulate nurses in the United States (U.S.). Boards of nursing know that sufficient English language proficiency is a crucial aspect of nursing practice in the United States. On behalf of its member boards, NCSBN has developed current and well-documented English language proficiency standards for all nurses coming to the U.S. to practice. These minimum standards reflect the minimum level of English language proficiency necessary for entry-level nurses to be able to perform both safely and effectively.

Passing scores for the International English Language Testing System (IELTS) and three different versions of the Test of English as a Foreign Language (TOEFL) have been adopted by NCSBN as follows:

<b>Test</b>	<b>Passing Standard</b>
IELTS	Overall score of 6.5 with a minimum of 6.0 all modules.
TOEFL written	Overall score of 560
TOEFL CBT	Overall score of 220
TOEFL iBT	Overall score of 83

In making its English proficiency recommendations to its member boards, NCSBN considered the results from a variety of industry-accepted standard setting procedures. It is recommended that internationally-educated nurses meet or exceed these standards before they are issued a license to practice nursing in the United States. NCSBN also recommends these standards for federal purposes of assessing nurse English language proficiency.

Recently, ETS has released a new internet version of the TOEFL (TOEFL-iBT) and is discontinuing the earlier computer based version, the TOEFL-CBT. Therefore, it will be extremely important for all states and the federal government to have a passing standard in place for the new TOEFL iBT that is specific to nurses. However, there will continue to be people who have taken the TOEFL CBT and written TOEFL who will continue to expect that their scores will still be able to used for certification.

The NCSBN recommended minimum scores for nurses taking these English language proficiency examinations were based upon a standard setting process specific to nurses. Please note that the NCSBN recommended English proficiency standard applies to licensed practical nurses (LPN) and vocational nurses (VN), as well as, registered nurses (RN).

**For additional information regarding NCSBN policies and position statements, contact Kristin Hellquist, NCSBN Director of Policy & Government Affairs at 312.525.3665 or [khellquist@ncsbn.org](mailto:khellquist@ncsbn.org). For questions related to the standards setting process please contact [nclexinfo@ncsbn.org](mailto:nclexinfo@ncsbn.org) or 866.293.9600.**

## Information for Internationally Educated Nurses: Becoming a Licensed Nurse in the U.S.

### FACTS TO KNOW BEFORE YOU WORK AS A NURSE IN THE U.S.:

- All registered (RN) and licensed practical or vocational (LPN/VN) nurses who work in the U.S. must have a nursing license in the state(s) where they will work. The National Council of State Boards of Nursing (NCSBN) has 60 state and territorial member boards of nursing that issue nursing licenses to both RNs and LPN/VNs who work in their state.
- The U.S. Federal government is the authority regarding immigration issues, not the states and territories. Nurses who want to work in the U.S. will need to obtain the proper work visa(s) before they will be allowed to move. For help with this process, please contact the

Department of Homeland Security (DHS), Office of U.S. Citizenship and Immigration Services (USCIS) at: [http://uscis.gov/graphics/how-doi/Health\\_Cert.htm](http://uscis.gov/graphics/how-doi/Health_Cert.htm).

- There are two types of licensure to become familiar with:
  1. *Licensure by NCLEX®.* Candidate applies for initial licensure in a U.S. state or territory and takes and passes the NCLEX nursing exam. The NCLEX-RN is the nurse licensure examination given for licensure as an RN. The NCLEX-PN is the licensure examination given for licensure as an LPN.
  2. *Licensure by Endorsement.* Used after a nurse has passed NCLEX and has at least one U.S.

state or territorial nursing license, and applies to another state for a nursing license.

### STEPS TO OBTAIN YOUR FIRST NURSE LICENSE IN A STATE OR TERRITORY:

- 1) Contact the board of nursing in the state where you will work as a nurse. Information on how to contact the boards of nursing can be found at: [www.ncsbn.org](http://www.ncsbn.org).
- 2) Inform the board of nursing that you were educated outside the U.S. and ask the board to send you an application to apply for a license by examination. Request an application specific to your qualifications for licensure as an RN or an LPN. The board of nursing in the state where you intend to work is the

best place to get information about your eligibility to become a licensed RN or LPN/VN.

- 3) In addition, ask the board of nursing about any other requirements needed for licensure in the state. States may request official copies of your education transcripts, criminal background checks or passage of specific English language proficiency examinations. Discuss with the board of nursing their individual requirements regarding the English proficiency examinations that they will accept, and the passing scores needed to be issued a nursing license in that state.

- 4) General licensure requirements include proof that you:

- Have comparable nursing education
- Safely practiced nursing in home country
- Proof that you passed an approved test that demonstrates that you can read, write, speak and understand the English language (if you were not educated in English).
- Passage of the NCLEX examination
- Application fee

Also, many boards of nursing require a CGFNS Certificate, CGFNS Credentials Evaluation Service or in some cases a *VisaScreen*™ certificate, before they will issue a nursing license. In some cases, candidates must have one of these certificates prior to being allowed to take the NCLEX examination. Information regarding obtaining a CGFNS Certificate can be found at [www.cgfns.org](http://www.cgfns.org). Additionally, some states perform their own credentials review or utilize other services for credential review services, please check with the individual state board of nursing for their requirements.

- 5) The licensure application will include information on how to register and take the NCLEX examination. Remember, the registration materials and NCLEX are only given in English. Follow the registration instructions. Contact the board of nursing or the testing department at NCSBN for assistance (e-mail [nclexinfo@ncsbn.org](mailto:nclexinfo@ncsbn.org) for assistance). Requirements may vary from state to state regarding eligibility to take the NCLEX, so please visit the board of nursing Web site or contact them with questions. Candidates should only apply to one state at a time to take the NCLEX.

- 6) Remember to ask for a copy of the Nursing Practice Act in the state in which you are licensed to practice nursing. It contains the state's regulations and all nurses are accountable to practice according to those regulations.

- 7) After licensure, read the paperwork carefully to see if there are additional requirements. Some states issue temporary permits, and therefore may require additional information, including a U.S. Social Security Number, to finalize your nursing license. Requirements and procedures vary, so it is important to be in contact with the board and to know when you can legally begin work as a nurse in the U.S.

- 8) Nurses should also be familiar with renewal procedures so you always remain current and legally authorized to practice. If you should move to practice in another state, repeat some of these steps to inquire about 'endorsing' (obtaining another license in a different state or territory).

# COMMENTARY

## A Call to Action:

### *Physician and Nurse Relationships Must Stop Putting Patients at Risk*

By Annalisa B. Benner RN, BSN, MBA

In the August addition of *Louisville Medicine (2005)*, Dr. Mary G. Barry wrote a commentary on a late night unproductive, frustrating phone conversation between herself and a nurse at a local hospital. Unfortunately, any number of physicians could probably identify with the described scenario. An unprepared nurse calling a physician to report a condition change is only one of many issues that contribute to the widening divide between nurses and physicians.

This ever-growing divide between nurses and physicians is threatening hospital risk management including employee verbal harassment, medication errors and patient safety. Additionally, it is further aggravating the current and forecasted increased nursing shortage. The critical point raised by Dr. Barry with the unproductive, frustrating conversation between herself and the nurse may be one that crops up as a daily stress among physicians and nurses alike, but it is also a reflection of a long term worsening condition involving problematic interpersonal communication between physicians and nurses that creates an unhealthy and high risk working environment. As organizations such as the Joint Commission and the Institute for Safe Medication Practice produce studies which validate these issues and resulting negative outcomes, additional organizations have developed plans for action. Therefore, it is past due time that we call for action and stop putting patients at risk!

#### Medication Errors

According to the 1995 – 2003 Joint Commission report, *Root Causes of Medication Errors*, problematic interpersonal communication resulted in 60 percent of medication errors. There is evidence recognizing that interpersonal communication between physicians and nurses is inherent when reducing the risk for medication errors. That is, communication between physicians and nurses creates either opportunity for accuracy when medicating patients or instigates dysfunction in that same setting that results in compromising patient safety. For example, The Institute for Safe Medication Practice (2004) reported 49 percent of respondents indicated that past intimidation from a physician altered the way they handled order clarifications or questions about medication orders in the present. Additionally, 40 percent of respondents who reported having concerns about a medication order either assumed it was correct or asked a co-worker to talk to the physician prescriber rather than inquiring about the medication from the physician themselves. Based on these findings, interpersonal communication has proven to be problematic between physicians and nurses and without a call to action, patient safety will continue to be compromised.

#### Nursing Shortage

On the brink of a nursing shortage, it is clear that nurse retention is an important issue for the future of healthcare. In an effort to reduce attrition rates among nurses it is essential that the interpersonal communication between physicians and nurses create a supportive work environment. In fact, in a national survey of nurses, Williams & Wilkins (2004) reported that nurses more likely to rate their work relationship with physicians, as excellent or very good were also more satisfied with their jobs. This finding suggests that promoting constructive communication and relationships between physicians and nurses is important for nurse retention. Additionally, when asked the question, "Physicians at this facility show respect for the skill and knowledge of the nursing staff." The Kentucky Hospital Association (2004) reported a statewide average positive score of 75 percent. This score may appear adequate, but to fully understand the impact, it is important to drill down to the range. The individual hospital scores ranged from as low as 43 percent to a high of 90 percent, with the majority of low scores found in rural hospitals.

As our baby boomer population ages and requires more nursing care, hospital nurses of this same generation will also age and retire, in conjunction with fewer Generation X nurses to replace them. These three factors outline a need to increase the attractiveness of hospital nursing to Generation X nurses. One of the definitive characteristic of the upcoming generation is their desire for a positive working environment. The nursing graduate is entering into a more competitive employment market and therefore able to seek out healthy work environments in which to practice. This further supports focusing on the improvement of physician and nurse relations to accommodate quality healthcare with adequate nursing staff in all Kentucky communities. The decrease in nurses in the rural hospitals will cause a "trickle down" affect to the urban areas, such as Louisville. For example, if there are not enough nurses working in small rural communities, hospital beds will close forcing the overflow of patients to the urban areas, stressing the staffing capacity levels of the urban facilities beyond the ability to deliver good, safe care. Therefore, maintaining equal access to quality healthcare in both rural and urban areas is paramount to the balance of Kentucky's medical system. Creating work environments that promote positive physician/nurse relations is necessary to attract and retain nurses in all Kentucky communities will support that balance.

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## Risk Management

With malpractice issues on the rise, reducing medical errors is essential. What better way for physicians to prevent malpractice issues than to communicate positively and build a good relationship with the people who are working with their patients. A strong nurse/physician relationship, gives the nurse a feeling of partnership with the physician, allows her or him to gain ownership in the treatment regime, and puts the physician in a stronger position if the course of treatment is challenged.

Taking time to develop good relations through careful communication with the nursing staff can only be advantageous to the physician, who is at the patients' side for only a limited amount of time during the course of a hospitalization. Physicians and nurses frequently work under different understandings, which can impact how they communicate. Therefore, it is helpful for nurses and physicians alike to understand some of their difference in order to relate and communicate with one another effectively. For example, according to Colon (2005), physicians tend to be entrepreneurial, task oriented, outcome driven, have a heretical, commanding leadership style and tend to be adversarial when conflict arises. On the contrary, nurses tend to be organizational, relationship-team orientated, process and outcome driven, with bridge-building democratic leadership styles, and are compromising or conflict avoidant. Although nurses and physicians tend to have differences in how they work, according to Cohon, it is important to recognize and capitalize on their common goals: to care for patients, have complimentary skills that impact patient health and safety and are both necessary and important for problem solving within the dynamic organization.

As evidence increases regarding the importance of the nurse/physician relationship and interpersonal communication, many healthcare entities are focusing on how to improve this environment. The Institute for Safe Medication Practices has outlined the following improvement process and more information regarding this process can be found at [www.ismp.org](http://www.ismp.org):

1. Establish a steering committee of physicians, trustees, senior leaders, middle managers, pharmacists, nurses and other diverse hospital staff
2. Create a code of conduct
3. Survey staff
4. Open the dialogue about workplace intimidation using frank discussions with objective moderators
5. Establish a standard, assertive communication process
6. Establish a conflict resolution process
7. Encourage confidential reporting of intimidating behavior
8. Enforce zero tolerance
9. Provide ongoing education
10. Lead by example
11. Reward outstanding examples

In addition, the American Association of Critical Care Nurses has written Standards for Establishing and Sustaining Healthy Work Environments, which can be downloaded from [www.aacn.org](http://www.aacn.org). These are guidelines to be used in the development of the six standards: skilled communication, true collaboration, effective

decision making, appropriate staffing, meaningful nurse recognition and authentic leadership. Critical elements of these standards are a mixture of hospital based management and physician influence. Hospitals would be prudent to use these guidelines as they partner with physicians and nurses in development of a healthy working environment. Standard two, true collaboration, states, "nearly 90 percent of the American Association of Critical-Care Nurses' members and constituents reported that collaboration with physicians and administrators is among the most important elements in creating a healthy work environment." Standard two goes on to state that "nurse-physician collaboration has been found to be one of the three strongest predictors of psychological empowerment of nurses." This being the case, it is clear that a physician who works to solve problems, educate nurses and, in general, work in a joint effort when treating patients will be working with a nurse of higher quality, competence and confidence. This combination puts the patient in an optimal healing environment as well as putting the physician and the nurse in a healthy working environment.

Finally, in an attempt to manage the situations similar to Dr. Barry's middle of the night phone conversation, to which I referred at the beginning of this article, The Institute for Healthcare Improvement has published a process developed by Kaiser Permanente of Colorado called SBAR. The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the healthcare team about a patient's condition. When a nurse calls a condition change to a physician he or she is to:

- ❑ **Situation:** Identify self, unit, patient room number and briefly state the problem, what is it, when it happened or started, and how severe.
- ❑ **Background:** Give pertinent background information related to the situation.
- ❑ **Assessment:** State an assessment of the situation.
- ❑ **Recommendation:** Make a recommendation or what does he or she want?

The process is simple and provides a standard way to approach a phone call to a physician regarding the condition of a patient. It is clear, concise and involves a two way conversation between the two care providers. Notice that the last two actions put the nurse into a collaborative roll with the physician. To use this method effectively, the physician will need to be open to listening to what the nurse is recommending and assess the information without prejudice or condescension.

For the sake of the patient, now is the time to stop pointing fingers at the other guy or expecting the nurse or hospital administrator to "fix" the problem. The problem is motivated by both the physician and the nurse and the responsibility for the solution must also be motivated by the physician and the nurse. The strategy for success must be a joint effort because the negative affects of not doing anything will be on the shoulders of all involved. Take this article to your favorite CEO or CNO and tell them you want to participate. You want to start the ball rolling toward a healthy work environment. **LM**

# Close Calls

In my dream I'm paddling down the Rio Grande, searching for the green kingfisher, a fancy, speedy, pretty bird who darts from branch to branch out over the water. There! – a glimpse of his little crest, and then an owl zooms past my ear, waking me up. I wouldn't see what kind of owl; the hospital was calling. It was all of two a.m.

"Dr. Barry?"

"Yes."

"This is the service, I have Norton's for you, put them through?"

"Yes."

*[What if I said no, I was dreaming?]*

Hi, this is 5B ICU, is this Dr. Barry?"

"This is Dr. Barry." *[No, it's Dr. Who.]*

"Please hold for Esmeralda."

*[Great. I try to remember the owl's wing . . . and that had to have been the kingfisher, his bill was as long as his tail. If only I'd heard him calling.]*

"Dr. Barry?"

"Yes."

"This is Esmeralda, in 5B ICU?"

"Yes, what's going on?" *[Yeah, yeah.]*

"You know Mrs. Bennifer?"

"Dr. Shaw's patient? Yeah, what's up?"

"Her urine output is low."

"How low?"

"Only two hundred cc's this shift."

*[Oh, for heaven's sake. It's only two hours into the shift.]*

"What's her total I and O for the day?"

"Uhh . . . I don't have that. Hold on."

*[Damn. Why doesn't she have that?]*

My cat wakes up and sits on my shoulder. I move the phone to the other hand.

"Dr. Barry?" *[Who else?]*

"What?"

"She's three thousand in and 4600 out."

"And she's on Lasix every twelve, right? At eight and eight?"

"Yes."

"Is she breathing worse? Are her stats lower?"

"She's congested."

*[The dreaded word, congested: It can mean anything from florid CHF to the common cold, from somebody just not being suctioned enough to some poor old lady aspirating herself to death. I cut to the chase.]*

"Is she in trouble?"

"What do you mean?"

"What's her heart rate?" *[Is she dying, you dodo.]*

"Umm . . . AMBER!" she shouts.

I flinch. My cat flinches.

"AMBER, can you see the monitor?"

She puts me on hold.

*[I grit my teeth.]*

"Dr. Barry?"

"What?"

"It's 80."

*[I choose my words carefully.]* "Is that up, or down, from when you came on?"

"Ummmm . . . I think it's down. The aide took it. CHARLOTTE!"

*Jeez!* My cat leaps off my shoulder.

"Dr. Barry?"

What?" *[If I yell, it will wake my husband.]*

"Charlotte's off the floor. But I think it's the same."

*[She thinks. It's so reassuring when ICU nurses leave the vital signs to the aides.]*

"Do you think you can tell me her blood pressure, or do you have to holler at somebody else?"

She sounds wounded. "No, I can tell you."

"AND???"

"You mean now, or when I came on?"

*[I grind my teeth.]* "Esmeralda! I would like to know her pulse NOW as opposed to then, and her B/P NOW as opposed to then" – my husband turns over, noisily—and I would like to know WHY you are upset about her urine output when nothing you have told me indicates that she's in trouble from it."

Silence.

"Well . . . It's just lower."

"I see."

Silence.

I say, dangerously, "So you call me about

a patient whose vital signs you don't know, whose O2 stats you don't know, and whose I & O you don't know, simply because six hours after her last Lasix her urine output quits pouring out."

Silence.

"And you put me on hold twice and yell in my ear, to boot."

"Now, Dr. Barry, I'm sorry, I don't know what you're upset about. Her urine output was just – LOWER, and I thought I ought to notify you."

"You did. I am notified. Listen, Esmeralda, how long is a dose of Lasix supposed to last?"

Silence.

*[At least she didn't yell for help.]*

"Lasix lasts six hours. See? La-six, lasts six hours?"

"Oh!"

"So her last dose would be wearing off about now. But she's negative overall, she is not tachycardic, so I am not going to do anything till one of us makes rounds in the morning. You got it?"

"OK."

*[I do not say, for God's sake, get your act together before you call the doctor. I do not say, for heaven's sake, examine the patient first! Know what they're allergic to. Know what meds they got recently. Know why, exactly, you are worried enough to call the doctor. If the only close call is whether we'll lose it, and wake our spouses, we can manage. But if the patient survives a close one because you, the nurse, failed to know and I, the doctor, failed to ask, it's due to luck. Patients should not have to depend on luck.]*

"Bye." I hang up. The kingfisher is long gone. <sup>LM</sup>



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# COMMENTS

## Crohn's Disease: Maintaining Remission with Medications

author

Darlene Strayer, RN, MBA

### What We Know

- ▶ Medical treatment of Crohn's disease (CD) involves lifetime surveillance and periodic changes in prescribed medication algorithms
- ▶ Treatment goals are achievement and maintenance of remission to decrease the risk of complications
- ▶ Individual drugs target different steps of the inflammatory cascade, but multiple drugs are required to achieve and maintain remission
- ▶ Medical treatment algorithms are coordinated with the stage of disease activity
  - Mild to moderate disease (MMD): patient is ambulatory, eating, with symptoms controlled
  - Moderate to severe disease (MSD): patient has pronounced symptoms of fever, weight loss >10%, dehydration, anemia, abdominal pain, or intermittent vomiting
  - Severe fulminant disease (SFD): patient has persistent symptoms despite corticosteroid therapy and/or a high fever, persistent vomiting, intestinal obstruction, abscess, rebound tenderness, or cachexia
  - Remission: patient is asymptomatic and without inflammatory sequelae

**Note:** Medications routinely used for treatment of CD can cause life-threatening complications and comorbid disease conditions; lab tests completed pre- and post-initiation of treatment, thorough patient assessment, and knowledge of the manufacturer's profile for each drug are essential. (See Quick Lesson About...Crohn's Disease, CINAHL Accession Number: 5000000244)

### What We Can Do

- ▶ Administer prescribed medications to affect various aspects of the disease
  - **Aminosalicylates (5-ASA)** exert an anti-inflammatory effect on intestinal mucosa. Specific drugs such as sulfasalazine and mesalamine act on specific areas of the intestinal tract
  - **Antibiotics** such as metronidazole and ciprofloxacin are used in all stages of disease activity for healing of inflammation, abscesses, fistulas, and perianal CD
  - **Corticosteroids** are short-term anti-inflammatory immunosuppressants used in all disease stages. They are effective in inducing, but not maintaining, clinical remission
  - **Immune modulators** such as azathioprine or methotrexate are second-line agents used in SFD to interrupt the immune response, reduce inflammation, and induce and maintain remission. They are also alternatives for patients who refuse or are dependent on corticosteroids
  - **Biologic therapies** induce remission by regulating the balance between pro- and anti-inflammatory effects; they are indicated for use in SFD, treatment-resistant disease, fistulizing disease, and as maintenance therapy to prolong remission. Infliximab, a genetically engineered antibody that exhibits a rapid, long-lasting response, is one such therapy
- ▶ Be well informed about medication protocols, interactions, and side effects
- ▶ Educate the patient on the importance of treatment plan adherence, prompt reporting of adverse responses, ongoing medical surveillance, and maintaining a healthy lifestyle

**Note:** Other medications currently being evaluated and/or in limited use for CD treatment include cyclosporin, CDP571, interleukin-10, natalizumab, ICAM-1, ISIS 2302, opreleukin rhIL-II, priliximab, and thalidomide

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## Coding Matrix

References are rated using the following codes, listed in order of strength:

- M** Published meta-analysis
- SR** Published systematic or integrative literature review
- RCT** Published research (randomized controlled trial)
- R** Published research (not randomized controlled trial)
- G** Published guidelines
- RV** Published review of the literature
- RU** Published research utilization report
- QI** Published quality improvement report
- PP** Policies, procedures, protocols
- X** Practice exemplars, stories, opinions
- GI** General or background information/texts/reports
- U** Unpublished research, reviews, poster presentations or other such materials
- CP** Conference proceedings, abstracts, presentations

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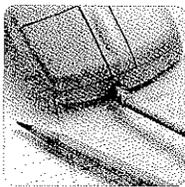


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### II. Major Routes of Administration

- A. Oral (P.O.)
- B. Intramuscular (IM) (illustration
- C. Subcutaneous (Subq)
- D. Intravenous (IV)

- 1. Methods of IV administration
- 2. IV piggyback or IV push (RN only)

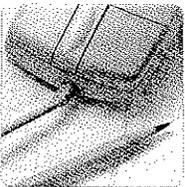
#### i. use

- for quicker response and effect
- replaces IM injections to increase client comfort
- for loading doses to rapidly increase serum levels

#### ii. nursing interventions

- check for five RIGHTS of administration
- check the patency of IV line

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- 2. For professional in standard, state board of nursing imposes penalties (in order of severity):

- A. On probation
- B. Censured
- C. Reprimanded
- D. License suspended
- E. License revoked

### VI. Standards of Nursing Practice and Standard of Care

- A. American Nurses Association publishes its Standards of Nursing Practice, which define the responsibilities of the nurse to all clients for quality of care.
- B. Each institution sets standards of care, both across the institution and for specific client populations.



Learn more about the Standards of Nursing Practice by visiting the American Nurses Association.

Visit the web site for the National Council of State Boards of Nursing to find the nurse practice acts for each state.

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