DAY 1

2023 NurseCon at Sea

Miami

APRIL 24

	MAIN POOL DECK 11	ROYAL THEATER DECK 3 & 4	STUDIO B DECK 2	STAR LOUNGE DECK 5	PROMENADE DECK 5	OLIVE OR TWIST DECK 14	PLAYMAKERS DECK 4	BOLEROS DECK 4	SCHOONER BAR DECK 4	VINTAGES DECK 5	R BAR DECK 5	BULL & BEAR DECK 5	WINDJAMMER DECK 11
8:00AM													
9:00AM													
10:00AM													
11:00AM													
NOON													
1:00PM													
2:00PM					WELCOME RECEPTION & SIGNING WALL 2:00-4:00								
3:00PM						FRIENDS & FAMILY 3:00-3:30	VETERANS 3:00-3:30	PUBLIC/COMM HEALTH 3:00-3:30	NICU 3:00-3:30	PERINATAL 3:00-3:30	CARDIOLOGY 3:00-3:30	STUDENTS 3:00-3:30	TRAVEL NURSING 3:00-3:30
4:00PM						APRN 3:30-4:00	PSYCHIATRY 3:30-4:00	HOME HEALTH/HOSPICE 3:30-4:00	BIPOC 3:30-4:00	ONCOLOGY 3:30-4:00	LEADERSHIP 3:30-4:00	EDUCATORS 3:30-4:00	CORRECTIONS/SUB USE 3:30-4:00
						CRITICAL CARE/EMERGENCY 4:00-4:30	LGBTQ+ 4:00-4:30	ORTHO/SURGICAL/PERIOP 4:00-4:30	PEDIATRICS/SCHOOL NURSING 4:00-4:30	ALLIED HEALTH/HOLISTIC 4:00-4:30	INTL NURSING 4:00-4:30	MED/SURG 4:00-4:30	WOUND CARE/IV THERAPY 4:00-4:30
5:00PM						GERIATRIC 4:30-5:00	TRANSPLANT/FLIGHT NURSE 4:30-5:00	NEPHROLOGY/NEURO 4:30-5:00	TELENURSING/INFORMATICS 4:30-5:00	AMBULATORY/CLINIC 4:30-5:00	CASE MGMT/QUALITY 4:30-5:00	OTHER RN SPECIALTIES 4:30-5:00	REHAB/LONG TERM CARE 4:30-5:00
6:00PM	OPENING CEREMONIES GROUP PHOTO SAIL AWAY PARTY! 6:00-8:30												
7:00PM													
8:00PM			ICE SHOW 8:30-9:30										
9:00PM		NURSES GOT TALENT 9:00-10:00											
10:00PM				NURSECON ULTRA LOUNGE 10:00-LATE		SILENT DISCO 10:00-LATE							
11:00PM		DRAG BINGO 11:00-12:00	ICE SHOW 11:00-12:00										
LATE													

Meet Ups

DAY 2

TONIGHT'S THEME:
GREAT GATSBY

2023 NurseCon at Sea

CocoCay
APRIL 25

	MAIN POOL DECK 11 - MID	ROYAL THEATER DECK 3 & 4 - FWD	STUDIO B DECK 2 - MID	STAR LOUNGE DECK 5 - FWD	PROMENADE DECK 5 - MID	OTHER VENUES
8:00AM						
9:00AM						OASIS LAGOON TAKEOVER @ COCOCAY
10:00AM			OPEN SKATE 10:00-12:00			
11:00AM						
NOON						
1:00PM						
2:00PM						
3:00PM						
4:00PM						
5:00PM			TIK TOK DANCE CLINIC 5:00-6:00			
6:00PM						
7:00PM						
8:00PM		NURSE FEUD REGISTRATION 8:15-8:45				
9:00PM		NURSE FEUD 9:00-10:00				CASINO NIGHT @ CASINO DECK 4
10:00PM				KARAOKE 10:00-LATE	THE GREAT GATSBY BALLOON DROP PARTY 10:30-12:00	SILENT DISCO 10:00-LATE @ OLIVE OR TWIST DECK 14
11:00PM	MOVIE NIGHT: THE GREAT GATSBY 11:00-LATE					
LATE						

Enjoy CocoCay!
All Aboard at 4:30PM

DAY 3

TONIGHT'S THEME:

PAJAMA PARTY

2023 NurseCon at Sea

Day at Sea

APRIL 26

	MAIN POOL DECK 11 - MID	ROYAL THEATER DECK 3 & 4 - FWD	STUDIO B DECK 2 - MID	STAR LOUNGE DECK 5 - FWD	PROMENADE DECK 5 - MID	OTHER VENUES
8:00AM				CODE SEPSIS ESCAPE ROOM 8:00-9:50		
9:00AM		TELEHEALTH AND VIRTUAL PATIENT CARE 8:30-9:20	MEDICATIONS WITH ABUSE POTENTIAL 9:00-10:50			YOGA 9:00-10:00 @ SPORTS COURT DECK 13
10:00AM		NURSING PRACTICE IN A POST-PANDEMIC WORLD 9:30-10:20		OVERCOMING BARRIERS CAUSED BY WORKPLACE TRAUMA 10:00-11:50	NURSE BLAKE BOOK SIGNING 10:00-1:00 @ BOLEROS	
11:00AM		MENTORING RELATIONSHIPS IN NURSING 10:30-11:20	PAIN MANAGEMENT AND OPIOID USE ISSUES IN PRIMARY CARE 11:00-12:50	TRANSGENDER HEALTH IN THE PEDIATRIC POPULATION 12:00-1:50		
NOON		EXPLORING THE LEGAL ASPECTS OF NURSING WITH EXPERT PANEL DISCUSSION 11:30-1:20				
1:00PM	POOLSIDE GAMES		LONG-ACTING INJECTABLES 1:00-1:50			
2:00PM		ADVOCATING FOR PATIENT AUTONOMY 1:30-2:20	CANNABIS AND THE ENDOCANNABINOID SYSTEM 2:00-2:50	CARE OF THE LGBTQ+ GERIATRIC POPULATION 2:00-3:50		
3:00PM		EVOLUTION OF NURSING WITH EXPERT PANEL DISCUSSION 2:30-4:20	UNDERSTANDING NURSING REGULATION AND PUBLIC POLICY 3:00-4:50			
4:00PM		RECOGNIZING SUICIDE RISK IN NURSING 4:30-5:20		EMOTIONAL SAFETY & HEALTHY BOUNDARIES 4:00-5:50		
5:00PM			EMERGING TREATMENTS FOR POST TRAUMATIC STRESS DISORDER 5:00-5:50			
6:00PM				EDUCATOR MEET UP AND Q&A 6:00-6:50		NURSE TRIVIA 5:30-6:30 @ SCHOONER BAR DECK 4
7:00PM						
8:00PM		NURSE BLAKE LIVE! 8:00-9:00	ULTIMATE SKILLS CHECKOFF 8:00-9:00			
9:00PM						
10:00PM		NURSE BLAKE LIVE! 10:00-11:00	ULTIMATE SKILLS CHECKOFF 10:00-11:00			
11:00PM	PJ PARTY! 10:30-LATE			KARAOKE 10:30-LATE		NURSECON ULTRA LOUNGE 11:00-LATE @ OLIVE OR TWIST DECK 14
LATE		MOVIE NIGHT: MEAN GIRLS 12:00-LATE				

DAY 4

TONIGHT'S THEME: NURSECON GLOW

2023 NurseCon at Sea

Nassau, The Bahamas

APRIL 27

	MAIN POOL DECK 11 - MID	ROYAL THEATER DECK 3 & 4 - FWD	STUDIO B DECK 2 - MID	STAR LOUNGE DECK 5 - FWD	PROMENADE DECK 5 - MID	OTHER VENUES
8:00AM				RETHINKING THE TEAM NURSING MODEL 8:00-9:50		
9:00AM		CARE FOR THE PREGNANT PERSON IN URGENT CARE 9:00-10:50	LIPID LOWERING MEDICATIONS 8:30-9:20			YOGA 9:00-10:00 @ SPORTS COURT DECK 13
10:00AM			HEART FAILURE GUIDELINES 9:30-10:20	CARING FOR THE PREGNANT PERSON IN A CORRECTIONAL SETTING 10:00-11:50	NURSE BLAKE MEET AND GREET 10:00-1:00 @ BOLEROS	
11:00AM		ALCOHOL DISORDER 11:00-11:50	SAFE OPIOID PRESCRIBING IN PRIMARY CARE 10:30-12:20			
NOON		EXPLORING NURSING CAREERS WITH EXPERT PANEL DISCUSSION 12:00-1:50		PEDIATRIC FUNCTIONAL CONSTIPATION 12:00-1:50		
1:00PM			ANXIETY MEDICATIONS 12:30-1:20			
2:00PM		FLIPPING THE CLASSROOM 2:00-2:50	WARFARIN 1:30-2:20	SEXUAL ORIENTATION & GENDER IDENTITY LANGUAGE 2:00-3:50		
3:00PM	NAME THAT TUNE BINGO 2:30-4:00	NAVIGATING HEALTHCARE HIERARCHY WITH EXPERT PANEL DISCUSSION 3:00-4:50	BLOOD PRESSURE MEDICATIONS 2:30-3:20			
4:00PM				RACIAL DISPARITIES IN HEALTHCARE 4:00-5:50		
5:00PM	ALL ABOARD AT 5:30PM					
6:00PM						
7:00PM			CAMPFIRE 7:00-8:00			
8:00PM		DRAG SHOW 8:00-9:00				
9:00PM	GLOW ME AWAY! COSTUME CONTEST 9:00-10:00					
10:00PM	GLOW PARTY! 10:00-LATE	DRAG SHOW 10:30-11:30		KARAOKE 10:00-LATE		
11:00PM						SILENT DISCO 10:00-LATE @ OLIVE OR TWIST DECK 14
LATE						

NURSECON AT SEA

EDUCATION GUIDE

Course Title: Overcoming Barriers Caused by Workplace Trauma

Course Release Date: April 25-27, 2023

Description:
Nurses often experience traumatic events in the workplace. Unresolved trauma can lead to emotional exhaustion and moral injury or "burnout". This interactive workshop will provide you with the tools to identify these barriers, set emotional boundaries, and process workplace trauma. You will learn how to create a plan to reframe and manage the stress associated with workplace trauma. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Define Trauma and its sources
    - Trauma experiences, responses and manifestations that are unique to nursing
    - Discussion of Workplace Violence in Nursing
    - Identify the barriers you have created to protect yourself from getting hurt.
    - Pervasiveness and depths of unresolved traumas
- Learn how to use reframing to recognize and release the hold your trauma has on you.
- Create a plan to deal with the consequences of lowering your guard and to
- Handle the inevitable stresses of life.

Outline

I. Trauma
    A. What is trauma?
    B. 8 Dimensions of Wellness
    C. Moral distress
    D. Patient loss and death
    E. Indirect trauma
        1. 1 in 4 nurses are abused in the workplace
        2. Violent events against nurses are 3X greater than other occupations
        3. 68% nurses report verbal abuse and aggressive communications
    F. Past trauma + Workplace trauma + Present stress
        1. "...trauma is not just an event that took place sometime in the past; it is also the imprint left by that experience on mind, brain, and body."
    G. "The Body Keeps the Score"
    H. Barrier vs. Boundary

Course Title: Heart Failure Guideline Updates (Pharm)

Course Release Date: April 25-27, 2023

Description: As heart failure continues to have an elevated mortality rate across the nation and worldwide, it is paramount that nurses are knowledgeable about the updated guidelines for treatment, including ARNIs and PCSK9 inhibitors. Discussion will include the 2022 AHA/ACC/HFSA pharmacologic guidelines for the management of heart failure. This workshop will be geared toward APRNs, however nurses (RN & LPN) and nursing students are encouraged to attend!

Objectives

Upon completion of this course, the nurse should be able to:

- Discuss signs and symptoms of heart failure
- Discuss classes of heart failure
- Discuss the pharmacology of ARNIs: Entresto and its benefit to patients with HF
- Discuss the pharmacology of SGLT2 Inhibitors: empagliflozin & dapagliflozin and their
- benefit to patients with HF
- Discuss updated HF pharmacologic interventions, ARNIs (Entresto), SGLT2 Inhibitors (empagliflozin & dapagliflozin)

Outline

I. CDC Statistics
   A. 6.2 million adults in the US have HF
   B. In 2018, 13.4% of all death certificates were HF related; 379,800 individuals
   C. Estimated national cost per year: $30.7 billion in healthcare related costs d/t HF

II. Heart Failure
   A. Left sided failure
      1. Paroxysmal nocturnal dyspnea
      2. Elevated pulmonary capillary wedge pressure
      3. Pulmonary congestion
         a) Cough
         b) Crackles
         c) Wheezes
         d) Blood-tinged sputum
         e) tachypnea
      4. Restlessness
      5. Confusion
      6. Orthopnea

7. Tachycardia
8. Exertional dyspnea
9. Fatigue
10. Cyanosis

B. Right sided failure
1. Fatigue
2. Peripheral venous pressure
3. Ascites
4. Enlarged liver & spleen
5. May be secondary to chronic pulmonary problems
6. Distended jugular veins
7. Anorexia & complaints of GI distress
8. Weight gain
9. Dependent edema

III. HF Staging
A. Stage A - at risk for heart failure
B. Stage B - pre heart failure
C. Stage C - symptomatic heart failure
D. Stage D - advanced heart failure

IV. Sacubitril-Valsartan (Entresto) ARNI: Angiotensin receptor/neprilysin inhibitor
A. Use:
1. Improves LV function (EF)
2. Reduces risk of cardiovascular death & hospitalization for adult patients with HF
3. Most likely will require a prior authorization

B. Mechanism of Action:
1. Sacubitril inhibits neprilysin & Valsartan blocks angiotensin II type I receptors = reduced strain on the heart

C. Adverse Effects:
1. Angioedema, hypotension, AKI, hyperkalemia, cough, & dizziness

D. Contraindications:
1. Pregnancy/ breast feeding and if the Pt is on an ACE/ARB or lithium
2. If the Pt is switching from ACE inhibitor to Entresto, the ACE inhibitor must be held for a minimum of 36 hours prior to starting Entresto
3. Caution with elevated creatinine

E. Statistics:
1. Reduced risk of cardiovascular death by 20%
2. Reduced HF related hospital admissions by 21%
3. Reduced the risk of all cause mortality by 16%
4. Dosages: 24-26 mg BID, 49-51 mg BID, & 97-103 mg BID Titration is key!

V. SGLT-2 Inhibitors: Empagliflozin (Jardiance) & Dapagliflozin (Farxiga)
   A. Use:
      1. Reduce the risk for cardiovascular death and hospitalization for Pts with HF by decreasing sodium load & blood glucose by osmotic diuresis
      2. Pt does not have to have diabetes
   B. Mechanism of Action:
      1. Inhibiting the sodium-glucose co-transporter-2 found in the proximal tubules in the kidneys = excretes glucose in urine
   C. Side Effects:
      1. Bladder pain, cloudy urine, malodorous urine, dysuria, frequency, & anxiety
   D. Contraindications:
      1. Type 1 diabetics, frequent UTIs, & GFR below 30-45
   E. Statistics:
      1. Decreases risk for HF related hospital admission by 35%
      2. Reduced the risk of worsening HF by 26% in Pts without DM
      3. Reduced the risk for all-cause mortality
      4. Dosage: (empagliflozin) 10 mg, 25 mg (dapagliflozin) 5 mg, 10 mg
      5. About half of people with HF also have DM

Accreditation Statement

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To obtain credit for participating in this activity, the participant must:
1. Read the educational objectives and disclosure statements
2. Attend the course in its entirety
3. Complete and submit the course evaluation

Upon completion of the entire content, the learner may receive 1 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 1 hour to complete. Credits are given in 1-hour increments. Earn 1 pharmacology contact hour upon completion of the course.

Author: Andi Foley, DNP, RN, ACCNS-AG, EMT, CEN, FAEN

Dr. Andi L. Foley, DNP, APRN-CNS, EMT, CEN, FAEN, is the Clinical Nurse Specialist supporting nine EDs for St Luke's Health System in western Idaho. Experience over the last 20+ years has ranged across the country and spans EDs from 5-bed Critical Access to 25-bed academic to

90-bed community emergency departments. She is a Fellow in the Academy of Emergency Nursing and is the 2023 AEN Board Chairperson. Dr. Foley has a passion for helping to ignite a Spirit of Curiosity elevating evidence-based practice and high-quality care.

Disclaimer

The opinions expressed in this educational activity are those of the Author/Subject Matter Expert*. Please refer to any product's official label for approved indications, contraindications, and warnings. Further, participants should appraise the information presented critically and are encouraged to consult their current employers' policies and procedures. Please use manufacturer-provided directions and other resources for any product or device mentioned in this activity. All patient scenarios and stories are fictionalized based on an aggregate of nursing/SME experiences and are for education only. They do not represent a specific person or actual patient encounter.

* A "Subject Matter Expert" (SME) is a clinician with definitive knowledge sources to review, improve, guide, and teach others. Their knowledge is based on evidence-based practice, clinical research, and personal experience in their respective clinical settings. They meet the standard requirements of § 1456. Continuing Education Courses 16 CA ADC § 1456BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS § 1457. Instructor Qualifications

Faculty and Planners Disclosure Statement

None of the planners or presenters for this activity have relevant financial relationship(s) to disclose with ineligible companies.

Andi Foley, DNP, RN, ACCNS-AG, EMT, CEN, FAEN

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I. What barriers do you have that you previously thought were a boundary?
J. Japanese Knotweed
K. Trauma suppression
L. Mindfullness
M. Reframing
N. Self-care

Accreditation Statement

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California Board of Registered Nursing Contact Hours Provided by NurseCon, Provider approved by the California Board of Registered Nursing, Provider #CEP17493, for **2** Contact Hours.

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Upon completion of the entire content, the learner may receive 2 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 2 hours to complete. Credits are given in 2-hour increments.

Authors: Stephanie M. Hutchins, PhD & Jill McLellan Phelps, MS, BSN, BA, RN

Stephanie M. Hutchins, PhD, author of *Transformation After Trauma* and *Reclaim Your Life After Trauma*, helps individuals overcome trauma and cope with stress. She is a Certified Life Coach, Stress Management Coach, Advanced Wellness Coach, Neuro-Linguistic Programming Practitioner, and Yoga Instructor. She also owns Serotinous Life, a company that helps individuals harness the power of post-traumatic growth. Dr. Hutchins taught about the human body as a college professor for 12 years. She combines yoga principles, her knowledge of the human body, and her healing journey to empower others with tools to fuel massive personal and professional growth.

Jill fulfilled her lifelong dream of becoming a Registered Nurse at age 45! Her nursing career has been exclusively in long-term care, on a secure Memory Care Unit. Since her ADN graduation she completed her BSN and will obtain her MS in December, 2022. Jill wants all nurses to be empowered, challenged and work in settings that will maximize their personal and professional goals!

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Faculty and Planners Disclosure Statement

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Course Title: Lipid Lowering Medications (Pharm)

Course Release Date: April 25-27, 2023

Description: Coronary artery disease is the leading cause of mortality in the US and third leading cause in the entire world; it is undeniable that there is a correlation between hyperlipidemia and coronary artery disease. There is a need for nurses to be knowledgeable about lipid lowering agents to prevent CAD/ASCVD in our patients. This workshop will touch upon all of the different types of lipid lowering medications, such as ezetimibe (Zetia), statins, and injectables (alirocumab & evolocumab), as well as their uses, dosing, side effects, mechanism of action, and contraindications. This workshop will be geared toward APRNs, however nurses (RN & LPN)and nursing students are encouraged to attend!

Objectives

Upon completion of this course, the nurse should be able to:

- Discuss correlation between coronary artery disease (CAD) & hyperlipidemia
- Discuss the different types of medication that are used to decrease the risk/ manage of CAD
- Discuss statistical evidence of decreasing cholesterol levels by using lipid lowering medications
- Discuss safety of prescribing lipid lowering medications
- Discuss interventions to reduce the risk for CAD, Ezetimibe (Zetia), Statins, PCKS9 Inhibitors

Outline

I. CDC Statistics
   A. Heart disease is the leading cause of death in both men & women in the U.S.
   B. In 2020, Heart disease caused every 1 in 5 deaths, about 382,820 individuals
   C. 20.1 million adults ages 20+ have CAD
   D. 805,000 individuals in the U.S. have a myocardial infarction each year adults in the U.S. have HF
   E. In 2018, 13.4% of all death certificates were HF related; 379,800 individuals
   F. Estimated national cost per year: $30.7 billion in healthcare related costs d/t HF

II. Ezetimibe (Zetia)
   A. Use:
      1. Treat hyperlipidemia in conjunction with a low cholesterol diet
      2. Can be used in conjunction with statin medication and/or fenofibrate
      3. Lowers LDL and triglycerides
   B. Mechanism of Action:

1. Inhibits the small intestines from absorbing cholesterol = less cholesterol to the liver

C. Side Effects:
1. Muscle/joint pain, diarrhea, sinusitis, & elevated LFTs,

D. Contraindications:
1. Active hepatic disease, less than 10 years old, & pregnancy/breastfeeding

E. Statistics:
1. FDA approved: primary, mixed, and familial hypercholesterolemia
2. May take up to 2 weeks to see improvements
3. Lowers LDL by 13-20%
4. In combination w/ statin, Zetia will decrease risk for CAD by 2%

III. Statins

A. Use:
1. Lower cholesterol levels & protect against/ manage CAD

B. Mechanism of Action:
1. Inhibits hydroxymethylglutaryl-CoA reductase enzyme (Reduces hepatic cholesterol synthesis)

C. Side Effects:
1. Myopathy, rhabdomyolysis, hepatotoxicity, nausea, headaches, and increased blood sugar

D. Contraindications:
1. Active hepatic disease, and pregnancy/ breastfeeding
2. Caution with coadministration of 3A4 inhibitors (erythromycin, -azoles, & diltiazem)
3. No grapefruit juice (Increases risk for myopathies and rhabdomyolysis)

E. Statistics:
1. Stop the costly supplements!!!!
2. Fish oil, cinnamon, garlic, turmeric, plant sterols, and red yeast rice did not lower LDL levels when compared to a placebo
3. Rosuvastatin lowered LDL levels by 35.2% compared to a placebo

IV. PCSK9 Inhibitors: Alirocumab (Praluent) & Evolocumab (Repatha)

A. Use:
1. Lowering LDL cholesterol levels
2. Most likely will require prior authorization :w/ hx of CAD and maxing out statin therapy without desired effect or:
3. Statins are contraindicated
4. Familial hypercholesterolemia w/ pretreatment LDL >190 mg/dL in adults & 155 mg/dL in pediatrics less than 16 years old
5. Family history of premature CAD in first degree relative:: female <60 or male <50-55

B. Mechanism of Action:

1. By inhibiting PCSK9, the LDL binds to the LDL-R receptors on the hepatocyte surface, thus reducing the amount of plasma LDL-C levels

C. Dosage:
   1. Praluent: 75/150 mg q 2 weeks or 150/300 mg q 1 month
   2. Repatha is 140 mg q 2 weeks or 420 mg q 1 month

D. Side Effects:
   1. Myopathies, nausea, & soreness at injection site
   2. Does not affect LFTs (Can be used in liver cirrhosis, hepatic cancer, or NASH)

E. Contraindications:
   1. Hypersensitivity to either drug
   2. Caution is advised in patients with latex hypersensitivity
   3. There are no significant drug-drug interactions
   4. Knowledge deficit (aka: cannot be safely allowed needles, will not clean/ switch injection sites, or afraid of needles)

F. Statistics:
   1. Praluent lowers LDL by 36% in 4 months
   2. Praluent lowers LDL by 47% in 6 months in Pts with familial hypercholesterolemia when added to maximally tolerate statins
   3. Repatha: lowers LDL by 63% in 3 months & lowers the chance of Myocardial Infarction by 27%

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Course Title: Safe Opioid Prescribing using the National Standards Based on the FDA Blueprint

Course Release Date: April 25-27, 2023

Description: This program discussed the current CDC safe opioid prescribing recommendations for acute and chronic pain, describes prescribing methods and using abuse deterrent drugs and their mechanisms of action.

Objectives

Upon completion of this course, the nurse should be able to:

- Discuss CDC recommended pharmacological prescribing for acute pain management
- Discuss CDC recommended pharmacological prescribing for chronic pain management
- Describe prescribing methods for pain management in the opioid use disorder patient
- Identify and differentiate abuse-deterrent drug properties
- Summarize the impact of abuse-deterrent opioids on providers and on the opioid epidemic

Outline

I. PAIN TREATMENT CONCEPTS
   A. Historical over-prescribing, a massive and sustained exposure to opioids, and a gap in treatment availability have fueled the opioid overdose epidemic in the United States.
   B. When prescribed well, and used as prescribed, opioids can be valuable tools for effective pain management.
   C. Unintended consequences may occur from both under-prescribing (unmanaged pain) and over-prescribing (injudicious use of opioids).
   D. This presentation does not advocate for or against the use of opioids. We intend to help health-care providers manage pain without putting vulnerable patients at risk for misuse or opioid use disorder. The goal is to keep our patients, our communities, and ourselves SAFE

II. Types of Opioids
   A. NATURALLY OCCURRING OPIATES
      1. Codeine
      2. Morphine
   B. SEMI-SYNTHETIC OPIOIDS

1. Buprenorphine
2. Hydrocodone
3. Hydromorphone
4. Oxycodone
5. Oxymorphone

C. SYNTHETIC OPIOIDS
1. Alfentanil
2. Fentanyl
3. Methadone
4. Remifentanil
5. Tapentadol
6. Tramadol

D. AGONISTS
1. Codeine
2. Methadone
3. Morphine
4. Oxycodone

E. PARTIAL AGONISTS
1. Buprenorphine
2. Nalbuphine

F. ANTAGONISTS
1. Naloxone
2. Naltrexone

III. DEA Scheduled Drugs

A. Schedule I
1. Cannabis, ecstasy, heroin, LSD, peyote

B. Schedule II
1. Codeine, fentanyl, hydrocodone combination products, hydromorphone, meperidine, methadone, morphine, opium, oxycodone,

C. Schedule III
1. Products containing ≤ 90 mg codeine per dose, buprenorphine, benzphetamine, phendimetrazine, ketamine, anabolic steroids

D. Schedule IV
1. Alprazolam, carisoprodol, clonazepam, clorazepate, diazepam, lorazepam, midazolam, temazepam, tramadol

E. Schedule V
1. Cough preparations containing ≤ 200 mg codeine/100 ml

IV. RISKS VERSUS BENEFITS OF PRESCRIBED OPIOIDs

A. POTENTIAL RISKS
   1. Life-threatening respiratory depression/overdose
   2. Development of SUD/OUD
   3. Diversion
   4. Inadvertent exposure to family and pets
   5. Interactions with other meds and substances
   6. Neonatal abstinence syndrome
   7. Physiologic dependence and withdrawal

B. POTENTIAL BENEFITS
   1. Analgesia
   2. Option for patients with contraindications for non-opioid analgesics
   3. Relieves suffering
   4. May improve function and quality of life

V. THE NEUROMECHANISMS OF PAIN

A. Peripheral Pain Modulators:
   1. Histamines
   2. Prostaglandins
   3. Cytokines
   4. Bradykinin
   5. Substance P
   6. Others

B. Descending Neurotransmitters:
   1. Serotonin
   2. Norepinephrine
   3. Endogenous opiates
   4. Others

C. Feeling physical pain is vital for survival
   1. ACUTE
      a) Sudden onset, lasting weeks to months, self-limiting
      b) Ideally resolves with healing
      c) Triggered by tissue damage and inflammation
      d) Has protective value
      e) Inflammatory mediation
   2. CHRONIC
      a) Lasting three months or longer
      b) Generally steady-state or worsening
      c) Persists beyond normal healing period
      d) Serves no value
      e) Peripheral and central sensitization

3. NOCICEPTIVE/INFLAMMATORY
4. NOCIPLASTIC
5. NEUROPATHIC
6. MIXED TYPES (NOCICEPTIVE/NEUROPATHIC)
7. THE EXPERIENCE OF PAIN: A BIOPSYCHOSOCIAL MODEL
8. ADVERSE CHILDHOOD EXPERIENCES (ACEs)

VI. WORDS MATTER: LANGUAGE CHOICE CAN REDUCE STIGMA

A. Commonly used term
   1. Addiction
   2. Drug-seeking
   3. Addict
   4. Dirty urine
   5. Abuse
B. Preferred term
   1. Substance use disorder
   2. Using medication not prescribed
   3. Person with substance use disorder
   4. Testing positive
   5. Misuse

VII. PAIN ASSESSMENT

A. Query your state's Prescription Drug Monitoring Program (PDMP) to confirm patient report
B. Contact past providers and obtain prior medical records
C. For opioids currently prescribed, note the opioid, dose, regimen, and duration
D. Determine whether the patient is opioid-tolerant
E. PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)
F. PDMP DATABASES
   1. Reports on opioid prescriptions filled by patient
   2. Nearly all are available online 24/7
   3. 54 operational PDMPs in the U.S.
   4. In some states, prescribers are required to access; know your state laws
G. BENEFITS
   1. Lower rates of prescription opioid-related hospitalization and ED visits
   2. Reduction in "doctor shopping"
   3. Reduction in prescribing high doses and over-prescribing
   4. Identify drugs that increase overdose risk when taken together (such as benzodiazepines, gabapentinoids, opioids, and other sedatives)

H. SOCIAL & PSYCHOLOGICAL HISTORY
    1. Employment, cultural background, social network, relationship history, legal history, and other behavioral patterns
    2. Screen for:
    3. Mental health diagnoses, depression, anxiety, PTSD, current treatments
    4. Alcohol, tobacco, and other drug use
    5. History of Adverse Childhood Experiences (ACES)
    6. Family history of substance use disorder and psychiatric disorders
    7. Depression and anxiety can be predictors of chronic pain
I. PHYSICAL EXAM & ASSESSMENT
J. PAIN ASSESSMENT TOOLBOX
K. PAIN MANAGEMENT GOALS &TREATMENT OPTIONS: A MULTIMODAL APPROACH
    1. COGNITIVE BEHAVIORAL THERAPY
    2. PHYSICAL TREATMENTS
    3. INTERVENTIONAL TREATMENTS
    4. PHARMACOTHERAPY
L. EVIDENCE-BASED NONPHARMACOLOGIC TREATMENTS
    1. Tai Chi
    2. Yoga
    3. CBT and ACT
    4. Acupuncture
    5. PT/OT/aquatic
    6. Mindfulness meditation
    7. OMT
    8. Massage therapy
    9. Chiropractic
    10. Neuromodulation or surgical approaches (in some situations)
M. CONSIDER AN OPIOID ONLY WHEN:
    1. Potential benefits are likely to outweigh risks
    2. Patient has failed to adequately respond to non-opioid and nonpharmacological interventions
    3. Patient has moderate to severe nociceptive or neuropathic pain
N. OPIOID SIDE EFFECTS AND ADVERSE EVENTS
    1. SIDE EFFECTS
        a) Respiratory depression
        b) "Opioid-induced constipation (OIC) (most common)"
        c) Myoclonus (twitching or jerking)
        d) "Sedation, cognitive impairment"
        e) "Sweating, miosis, urinary retention"
        f) Allergic reactions
        g) Hypogonadism
        h) "Tolerance, physical dependence, hyperalgesia"

2. ADVERSE EVENTS
    a) Death
    b) Addiction
    c) Overdose
    d) Hospitalization
    e) Disability
    f) Falls or fractures
3. OPIOID-INDUCED RESPIRATORY DEPRESSION
    a) MORE LIKELY TO OCCUR:
        (1) In elderly, cachectic, or debilitated patients
        (2) If given concomitantly with other drugs that depress respiration (such as benzodiazepines*)
        (3) In patients who are opioid-naïve or have just had a dose increase
        (4) In patients with conditions causing respiratory compromise
    b) HOW TO REDUCE RISK:
        (1) Ensure proper dosing and titration
        (2) Do not overestimate dose when converting dosage from another opioid product
        (3) Can result in fatal overdose with first dose
        (4) Avoid co-prescribing benzodiazepines*
        (5) Instruct patients to swallow tablets/capsules whole
        (6) Dose from cut, crushed, dissolved, or chewed tablets/capsules may be fatal, particularly in opioid-naïve individuals
4. DRUG INTERACTIONS COMMON TO OPIOIDS
5. FOR SAFER USE: KNOW DRUG INTERACTIONS, PHARMACODYNAMICS, AND PHARMACOKINETICS
6. OPIOIDS AND CYP450 ENZYME INTERACTIONS
7. TRANSDERMAL/TRANSMUCOSAL DOSAGE FORMS

VIII. Special Populations

A. OLDER ADULTS
    1. RISK FOR RESPIRATORY DEPRESSION
        a) Monitor
        b) Initiation and titration
        c) Concomitant medications (polypharmacy)
        d) Falls risk, cognitive change, psychosocial status
        e) Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients

f) Start low, go slow, but GO
g) Routinely initiate a bowel regimen
h) Patient and caregiver reliability/risk of diversion

B. WOMEN OF CHILDBEARING POTENTIAL
1. Discuss family planning, contraceptives, breastfeeding plans with patients
2. Counsel women of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
3. Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
4. Refer to a qualified provider who will ensure appropriate treatment for the baby

C. CHILDREN & ADOLESCENTS
1. Pediatric analgesic trials pose challenges
2. Transdermal fentanyl approved in children ≥ 2 years
3. Oxycodone ER dosing changes for children ≥ 11 years

D. Others
1. Sleep disorders or sleep-disordered breathing (sleep apnea)
2. Dementia/nonverbal patients
3. Obesity
4. Renal/hepatic impairment
5. Psychiatric disorders
6. Life-limiting illness
7. Substance use disorder

IX. INITIATING OPIOIDS

A. Begin a therapeutic trial with an immediate release (IR) opioid
B. Prescribe the lowest effective dosage
C. Use caution at any dosage, but particularly when:
D. Increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day
E. Carefully justify a decision to titrate dosage to ≥ 90 MME/day
F. Always include dosing instructions, including daily maximum
G. Be aware of interindividual variability of response
H. Have PPA, baseline UDT, and informed consent in place
I. Co-prescribe naloxone and bowel regimen
J. Re-evaluate risks/benefits within 1–4 weeks (could be as soon as 3–5 days) of initiation or dose escalation
K. Re-evaluate risks/benefits every 1–3 months; if benefits do not outweigh harms, optimize other therapies and work to taper and discontinue
L. ONGOING AND LONG-TERM MANAGEMENT OF PATIENTS ON OPIOID ANALGESICS
1. Is the patient making progress toward functional goals?

2. Reset goals if required or indicated; develop reasonable expectations
3. Monitor for breakthrough pain
4. Review adverse events/side effects at each visit
5. Evaluate bowel function
6. Screen for endocrine function as needed
7. Report adverse events to the FDA website
8. Implement opioid rotation, as indicated
9. Check Prescription Drug Monitoring Program (PDMP)
10. Use urine drug testing (UDT)
11. Reassess risk of substance use disorder (SUD) and/or OUD
12. Monitor adherence to the treatment plan
13. Medication reconciliation
14. Evaluate for nonadherence

M. MONITORING PAIN AND SUBSTANCE USE DISORDER

N. WHEN TO MOVE FROM IR TO ER/LA OPIOIDS
1. Maintain stable blood levels (steady state plasma)
2. Longer duration of action
3. Multiple IR doses needed to achieve effective analgesia
4. Poor analgesic efficacy despite dose titration
5. Less sleep disruption
6. Patient desire or need to try a new formulation
7. Cost or insurance issues
8. Adherence issues
9. Change in clinical status requiring an opioid with different pharmacokinetics
10. Problematic drug-drug interactions

O. EMERGENCE OF OPIOID-INDUCED HYPERALGESIA
1. An increased sensitivity to pain
2. Usually occurs at high MME dosages and over long periods of time
3. A physiological phenomenon that can happen to anyone
4. Consider this explanation if:
    a) Pain increases despite dose increases
    b) Pain appears in new locations
    c) Patient becomes more sensitive to painful stimuli
    d) Patient is not improving in the absence of underlying cause or disease progression

P. OPIOID TOLERANCE
1. Patients considered opioid tolerant are taking at least
    a) 60 mg oral morphine/day
    b) 25 mcg transdermal fentanyl/hour
    c) 30 mg oral oxycodone/day
    d) 8 mg oral hydromorphone/day
    e) 25 mg oral oxymorphone/day

f) An equianalgesic dose of another opioid
g) Also use caution when rotating a patient on an IR opioid to a different ER/LA opioid

Q. OPIOID TOLERANCE VERSUS PHYSICAL DEPENDENCE
1. TOLERANCE
a) Occurs when increased dose is needed to maintain the functional status no longer achieved by current dose
b) Remember CNS and respiratory depression can develop with dose increase
2. PHYSICAL DEPENDENCE
a) Occurs when an individual only functions normally in the presence of the substance
b) Abrupt discontinuation or dosage decrease causes uncomfortable symptoms of withdrawal

R. OPIOID ROTATION
1. A change from an existing opioid regimen to another opioid with the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug

S. EQUIANALGESIC DOSING TABLES (EDTs)

X. GUIDELINES FOR OPIOID ROTATION

A. IF PATIENT…
1. Is receiving a relatively high dose of current opioid regimen
2. Is elderly or medically frail
3. Does not have these characteristics
4. Is changing route of administration

B. IF SWITCHING TO METHADONE:
1. Standard equianalgesic dosing tables are less helpful in opioid rotation to methadone
2. For opioid tolerant patients, methadone doses should not exceed
3. 30–40 mg/day upon rotation
4. Consider inpatient monitoring, including serial EKG monitoring
5. For opioid-naïve patients, do not give methadone as an initial drug

C. IF SWITCHING TO TRANSDERMAL:
1. Fentanyl: calculate dose conversion based on equianalgesic dose ratios included in the drug package insert

D. GUIDELINES FOR OPIOID ROTATION: SUMMARY
1. Frequently assess initial response
2. Titrate dose of new opioid to optimize outcomes
3. Calculate supplemental rescue dose used for titration at 5%–15% of total daily dose‡

E. BREAKTHROUGH PAIN (BTP)
    1. PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP
        a) Due to disease progression or a new or unrelated pain
        b) Target cause or precipitating factors
        c) Dose for BTP: Using an IR, 5%–15% of total daily opioid dose, administered at an appropriate interval
        d) Never use ER/LA for BTP
    2. CONSIDER ADDING
        a) PRN IR opioid trial based on analysis of benefit versus risk
        b) There is a risk for problematic drug-related behaviors
        c) High-risk: Add only in conjunction with frequent monitoring and follow-up
        d) Low-risk: Add with routine follow-up and monitoring
        e) Consider non-opioid drug therapies and nonpharmacologic treatments
F. ABUSE-DETERRENT FORMULATION (ADF) OPIOIDS
    1. Drug formulations designed to discourage misuse
        a) An ER/LA opioid with properties to meaningfully deter misuse (less likely to be crushed, injected, or snorted)
        b) Consider as one part of an overall strategy
        c) Mixed evidence on the impact of ADF on misuse
        d) Overdose is still possible if taken orally in excessive amounts
        e) These products are expensive with no generic equivalents
G. URINE DRUG TESTING (UDT)
    1. Urine testing is done FOR the patient, not TO the patient
    2. Helps to identify drug misuse/addiction
    3. Assists in assessing and documenting adherence
H. CONSIDERATIONS FOR RE-EVALUATING OPIOID USE
    1. One or two episodes of increasing dose without prescriber knowledge
    2. Sharing medications
    3. Unapproved opioid use to treat another symptom (e.g., insomnia)
    4. Use of illicit drugs or unprescribed opioids
    5. Repeatedly obtaining opioids from multiple outside sources
    6. Prescription forgery
    7. Multiple episodes of prescription loss
    8. Diversion
I. TOOLS TO REASSESS OUD/SUD RISK
    1. SBIRT Screening, Brief Intervention, and Referral to Treatment
    2. TAPS Tobacco, Alcohol, Rx, and Other Substances
    3. PDUQ Prescription Drug Use Questionnaire
    4. PMQ Pain Medication Questionnaire
    5. COMM Current Opioid Misuse Measure
J. CONSULTING A PAIN SPECIALIST

1. Appropriate when you feel you cannot provide the level of care needed
2. First ensure you have a reliable specialist to refer to
3. To find a pain specialist in your area:
4. Consult with state boards
5. Consult with colleagues
6. Use online resources
7. Consult payment source
8. Prior to referral, contact the specialist and ask what is needed for referral
9. Adequately DOCUMENT all patient interactions, assessments, test results, treatment plans, and expectations.

K. COUNSEL PATIENTS ABOUT PROPER USE
1. Take opioid as prescribed
2. Use least amount of medication necessary for shortest time
3. Use caution with long-term opioid use patients; avoid abrupt discontinuation or dose reduction; taper safely to avoid withdrawal symptoms
4. Notify HCP if pain is uncontrolled
5. Report side effects to HCP
6. Inform HCP of ALL meds and supplements being taken
7. Never share or sell opioids: can lead to others' deaths, against the law
8. Use caution when operating heavy machinery and driving

L. PROVIDE ANTICIPATORY GUIDANCE ON OPIOID SIDE EFFECTS AND ADVERSE EVENTS
1. Overdose and death: respiratory depression
2. Opioid-induced constipation (OIC): most common
3. Nausea, vomiting, GERD
4. Sexual dysfunction and other endocrine abnormalities (hypogonadism)
5. Tolerance, physical dependence
6. Hyperalgesia
7. Allergic reactions
8. Sedation, cognitive impairment
9. Falls and fractures
10. Sweating, miosis, urinary retention
11. Myoclonus (twitching or jerking)
12. Opioid use disorder (OUD)

M. OPIOID-INDUCED RESPIRATORY DEPRESSION
1. If not immediately recognized and treated, may lead to respiratory arrest and death
2. More likely to occur in opioid-naïve patients during initiation or after dose increase
3. Instruct patients/family members to:
   a) Screen for shallow or slowed breathing
   b) Deliver NALOXONE

c) CALL 911

N. SIGNS OF ACCIDENTAL OPIOID POISONING: CALL 911
   1. Person cannot be aroused or is unable to talk
   2. Any trouble with breathing, heavy snoring is warning sign
   3. Gurgling noises coming from mouth or throat
   4. Body is limp, seems lifeless; face is pale, clammy
   5. Fingernails or lips turn blue/purple
   6. Slow, unusual heartbeat or stopped heartbeat

O. NALOXONE
   1. An opioid antagonist administered intranasally (most common) or parenterally
   2. Reverses acute opioid-induced respiratory depression but will also reverse analgesia; may precipitate acute opioid withdrawal
   3. No misuse potential
   4. Discuss an overdose plan with patients; involve family/caregivers
   5. Ensure family/caregivers have access to naloxone; some states require co-prescribing
   6. Involve and train family, friends, partners, and/or caregivers in the proper administration of naloxone
   7. Know your local naloxone resources (e.g., the library, community centers)
   8. Check expiration dates and replace expired naloxone
   9. In the event of known or suspected overdose, call 911 and administer naloxone

P. SAFE OPIOID STORAGE AND DISPOSAL

Q. WHERE & HOW TO DISPOSE OF UNUSED OPIOIDS

R. WHAT IS ADDICTION?
   1. Addiction is the continued use of drugs or activities, despite knowledge of continued harm to one's self or others.

S. HOW TO IDENTIFY RISK FOR MY PATIENTS
   1. 10%–26% of patients on chronic opioid therapy (COT) for chronic noncancer pain (CNCP) may develop an OUD
   2. What to look for:
   3. High dosages
   4. Prolonged use
   5. Low hedonic tone
   6. Mental health disorders
   7. Past history of substance use disorder

T. Medication for Opioid Use Disorder (MOUD)
   1. Important and evidence-based medication that saves lives
   2. You can start from your office, as an outpatient
   3. Patients with OUD have decreased mortality when treated
   4. There are three medication options:
      a) Buprenorphine (Schedule III)

(1) The most commonly prescribed pharmacotherapy for the treatment of OUD
(2) Partial mu-agonist with “plateau effect” for respiratory depression
(3) Good efficacy and safety profile
(4) FDA-approved bup products for pain:
(5) Butrans: 7-day transdermal patch
(6) Belbuca: buccal mucosal film; BID dosing

b) Methadone (Schedule II)
c) Naltrexone (not a controlled substance)

5. AVOID OTHER SUBSTANCES THAT COULD CONTRIBUTE TO AN ACCIDENTAL OVERDOSE
   a) Benzodiazepines (BZDs), sedatives, muscle relaxants; they are CNS depressants
   b) More than 30% of opioid overdoses involve benzodiazepines (BZDs)
   c) Use a comprehensive SUD evaluation to support recovery efforts for all substances
6. Key Takeaways
   a) There is a place for opioids, but use caution
   b) Use multimodal therapies as part of the pain management care plan
   c) Screen for OUD risk with a validated instrument
   d) Continually reassess patients using opioids
   e) Patient and family/caregiver education is essential
   f) If you suspect an OUD, begin treatment

Accreditation Statement

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California Board of Registered Nursing Contact Hours Provided by NurseCon, Provider approved by the California Board of Registered Nursing, Provider #CEP17493, for **2** Contact Hour.

Method of Participation to Earn CNE Credit(s)

To obtain credit for participating in this activity, the participant must:

1. Read the educational objectives and disclosure statements
2. Attend the course in its entirety
3. Complete and submit the course evaluation

Upon completion of the entire content, the learner may receive 2 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This

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Course Title: Understanding Nursing Regulation and Public Policy

Course Release Date: April 25-27, 2023

Description: This presentation discusses the four functions of nursing regulation, how they impact public policy and nursing practice and how to mitigate issues when practice fails to meet national standards.

Objectives

Upon completion of this course, the nurse should be able to:

- Understand the basis for regulation
- Understand the role of Boards of Nursing
- Discuss society impact on public policy
- Discuss current issues
- Discuss nursing's political influence
- Understand mechanisms of political engagement

Outline

I. Basis for regulation
   A. United State Constitution—10th Amendment
      1. Separation of Powers
         a) Legislature enacts statutes and rules (laws)
         b) Executive approves and signs
         c) Judicial interprets the constitution and laws
         d) States Rights
         e) Founders wrote in concepts to allow states the right to choose
      2. Constitution History
         a) 7 Articles
            (1) Article 5 serves to amend the constitution
         b) 26 Amendments
            (1) One Amendment was repealed- the 21st Amendment repealed the 18th (prohibition)
         c) Over 11,000 attempts to amend failed
            (1) Examples: ERA, Flag desecration, abortion, English as national language, gun control, marriage other than man and woman
   B. Individual State Constitutions
   C. United States Administrative & Regulatory Code
   D. Individual State Administrative & Regulatory Code
   E. Statute in form of Practice Acts
   F. Administrative Rules

G. Board of Nursing Policy
H. Board Position Papers
I. Amendments That Impact Regulation
    1. 1st Amendment—freedoms (religion, political expression, speech, press, peaceable assembly)
    2. 5th Amendment—due process
    3. 6th Amendment—right to speedy trial, public trial, jury of peers, witnesses, counsel, confront witnesses
    4. 7th Amendment—jury trial for civil actions
    5. 8th Amendment—no excessive bail or fines
    6. 10th Amendment—rights reserved by states, such as determine scopes of practice
    7. 14th Amendment—made the first 10 apply to the states (Bill of Rights)
J. Administrative and Regulatory Law
    1. Federal and State
        a) Supremacy laws dictate that federal law rules over state law.
        b) Placed when issues started involving more than one state
    2. Congress and Legislatures given power to regulate
        a) Numerous Federal Agencies with authority to regulate (USDE, Medicare)
K. Administrative Procedures Acts (APA)
    1. Federal and State
        a) Federal system only adopted in 1950s
        b) States followed within 10 years
        c) Boards of Nursing expanded scopes of authority in 1950s
L. State APA
    1. Established rules and standards for organizations
    2. Promotes equal and fair treatment
    3. Avoids arbitrary decisions by boards
    4. Sets standards for:
        a) Educations
        b) Exams
        c) Licensure
        d) Discipline
M. State Systems
    1. May contract with other states
    2. Nurse Licensure Compact
    3. Drivers licenses
    4. PDMP access
    5. Waivers for disasters (Katrina waived nurse licenses)
N. Role of the Board of Nursing
    1. Approve educational programs leading to the licensure of people qualified to be nurses

2. License nurses using psychometrically sound and legally defensible tests
3. Monitor nursing practice
4. Take action on violations of the Nurse Practice Act using the disciplinary process and remove from practice those who do not meet the standards

O. Issues of Education
1. Approval of new programs, LPN, RN, APRN
2. Monitor faculty, curriculum, NCLEX pass rates
3. Monitor accreditation process
4. Monitor student activities, application numbers and enrollment

P. Issues of Licensure
1. Screen qualified applicants for NCLEX
2. Criminal background checks
3. Fingerprinting
4. Licensure renewal process
5. Maintain an inventory of qualified and practicing nurses within the state
6. Endorse nurses to other states
7. Recognize multi-state license for practice

Q. Practice Issues of Nursing
1. Monitor national standards
2. Issue position papers
3. Modify scopes of practice
4. Provide resources to nurses, patients and employers regarding practice guidelines

R. Issues of Discipline Based on NPA Violations
1. Drug Diversion
2. Boundary Issues
3. Scope of Practice
4. Falsification of information
5. Patient Safety Impairment or Harm
6. Other non-practice related issues
   a) Misdemeanor and Felony

II. Scope of Practice

A. What the public good says that you can do as a professional
1. Within state's rights, determined by legislatures
2. Delegated to regulatory boards that are composed of representative professionals with knowledge of the profession who are in good standing

B. What Impacts Nursing Politics?
1. WWII - 1941-1944
2. 81,145 RNs volunteered for duty in the Army and Navy Nurse Corps
3. Bolton Act, 1943
4. January 1945:

        a) 235,000 nurses had been classified according to their availability for military service
    5. ANA's testimony identified 4 fold problem:
        a) Needs of military
        b) Needs of veterans
        c) Needs of civilians
        d) 2 types of education & training needed: basic + advanced to secure teachers, supervisors and administrators
    6. The VietNam War
        a) MASH
        b) 10 nurse's names appear on the
        c) VietNam Memorial Wall
C. Shortage
    1. 800,000 short by 2020
    2. Easier work in other areas, even for RNs
    3. Perceived bad hours, lack of incentive even with high pay
    4. Leaving faster than they can be replaced
D. Nursing Shortages Throughout History
    1. World War I
    2. The first staffing ratio: one million men, ten thousand nurses
    3. 22,000 nurses actually served = 25% of the graduate nurses in the United States

III. Current National and State Issues Impacting Nursing
A. Federal Administration Healthcare Priorities
    1. Healthcare Coverage Reform
    2. IT- electronic health record development
    3. Increase Security of Medicare Trust Fund
B. Top 10 Political Issues from Nursing Perspective
    1. Scope of Practice
    2. Competency Measurement
    3. Globalization
    4. Compact Licensure
    5. Educational Standards
    6. Shortage
    7. Mandated Staffing Ratios
    8. Faculty Issues
    9. Access to Care
    10. Emerging roles for nursing
C. SOP and Current Political Issues - National Focus
    1. AMA established a broad SOP first
    2. Carve outs by other professions
    3. Financial implications with third party reimbursements

4. Meeting the overall public healthcare needs

D. Competency Measurement
   1. No common method
   2. No national standard
   3. Who is to determine?
      a) self, employer, regulators, educators?

E. Globalization
   1. Internet promotes easy access to information
   2. Distance Learning
   3. International Recruitment and Ethical standards due to shortage
   4. Movement toward national licensure
   5. Professional associations are going international
   6. NCLEX used in other countries as a basis for licensure
   7. European nursing shortage

F. Compact Licensure
   1. Method of mutual recognition of license to practice between jurisdictions
   2. Currently 23 states meet the standards and have compact language in statute to support mutual recognition
   3. Benefits:
      a) Supports common standards
      b) Easy for licensee
      c) Promoted mobility
      d) Cheaper for licensee
      e) Supports national database
      f) Promotes communication between jurisdictions
   4. Issues:
      a) Perceived as anti-union
      b) Some states report loss of license revenue
      c) Not a big issues for legislators
      d) Hesitant to open Nurse Practice Acts

G. Educational Standards
   1. AACN-American Association Colleges of Nursing
   2. Essentials for Baccalaureate Education
   3. Essentials for Masters Education
   4. Distance Learned Programs
   5. Qualified faculty who teach
   6. Quality of precepting
   7. Who certifies programs?

H. Threats of Shortages
   1. New concepts like Institutional Licensure
   2. Imposters—FITS program
   3. Negative impact on care
   4. Unsafe Practice

5. Someone has to do your job, and if not nurses then who?

I. Positive Outcomes of Shortages
   1. Funding for education
   2. New Programs developed
   3. Cadet Corps in WWII challenged 3 year education and within 10 years Associate Degree Education emerged
   4. Nurse Practitioners emerged
   5. Expanded Scopes of Practice

J. Mandated Staffing Ratios
   1. Gaining support among patient advocacy group
   2. Hard to maintain 100%
   3. Unknown implications for regulatory boards and discipline of those who do not meet

K. Faculty Issues
   1. Age
   2. Salaries
   3. Programs leading to graduate preparation are increasingly advanced practice focused
   4. Conflict between teaching and remaining competent in clinical setting

L. Access to Care
   1. Growing number of uninsured, underinsured and people without PCP
   2. Increasing numbers of children without health insurance
   3. Mal-distribution of healthcare providers
   4. Impact of the “niche” business
   5. Rural care needs
      a) Access to Care Issues
         (1) Reimbursement to NP, CNM, CNS, CRNA (some movement to reimburse for direct RN care)
         (2) Impact on provider role of RN within the RN scope of practice
         (3) Telehealth applications
         (4) Legal impediments needing change
         (5) NP and nursing home/hospice admits-clarify provider definition with Medicare
         (6) ANP recognized as PCP in statute language

M. Emerging Roles
   1. Private Business
   2. Owners of Assisted Living, Hospice and Home Care
   3. FPA allows for NP provider clinics
   4. Consultants, healthcare designers, subspecialty practice, group practice

N. Public Policy Development
   1. Means using data, other information and community values to address community health problems or build community capacity, weighing the

costs and benefits of policy options, choosing a desired option, and recommending programs and services to carry out that policy.

2. Tools of Public Policy
    a) Coercion
    b) Taxation
    c) Regulation
    d) Purchasing
    e) Resources Allocation
    f) Public programs
    g) Information and leadership
    h) Government choices and appropriation
    i) Financial support
    j) Political office

O. Who are the national groups that influence nursing?
1. American Nurses Association
2. National Council of State Boards of Nursing
3. American Academy of Colleges of Nursing
4. Specialty Nursing Organizations
    a) ANCC—Critical Care
    b) AORN—Operating Room
    c) EDNA—Emergency Nurses
    d) AONL—Nurse Executives
5. How???
    a) PAC funds—Political Action Coalitions
    b) Lobbying
    c) Presence in Washington DC and at State Legislatures
    d) Networking
    e) Holding office
    f) Holding a high profile positions in work or community
    g) Nurses on Boards Coalition

P. Current Trends
1. Common national standards accepted
2. Compact nurse licensure
3. Uniform practice standards
4. Uniform educational standards
5. Nationally vetted ethical standards of conduct

Q. Trends in APRN Practice
1. Education meeting Essentials of Graduate Education document written by AACN
2. Three P's are required:
    a) Advanced Pathophysiology
    b) Advanced Pharmacology
    c) Advanced Physical Assessment

3. Credit creep
4. Uncommon scope of practice compared to RN scope

R. Historic CNS Issues
1. Incorrect accounting of national numbers
2. No specialty exams that are psychometrically sound or legally defensible
3. Required 120 test takers annually
4. Programs lack pharmacology component
5. Practice settings not requiring prescriptive authority
6. Many states do not specifically license, identify or title protect the CNS
7. CNS practices under the RN scope of practice
8. CNS not consistently recognized in national legislation as providers

S. Questions to Ponder
1. Can you work to promote the needs of an organization while at the same time protect the public's interest?
2. Are Boards of Nursing the only nursing entities that care about the needs and interests of the public?

IV. Organizational Missions

A. Boards of Nursing:
1. The Mission of the Board of Nursing is to regulate nursing practice and education for the purpose of safeguarding the public health, safety and welfare

B. American Academy of Nurse Practitioners:
1. Promote excellence in NP practice, education and research
2. Shape the future of healthcare through advancing health policy
3. Serve as the source of information for NPs, the healthcare community and consumers
4. Build a positive image of the NP role as a leader in the national and global healthcare community

C. American Association of Nurse Executives-AONE:
1. To represent nurse leaders who improve health care. AONE members are leaders in collaboration and catalysts for innovation

D. National Association of Clinical Nurse Specialists:
1. Promote the contribution of Clinical Nurse Specialists to safe, quality, cost-effective health care outcomes
2. Increase national visibility and influence of CNSs
3. Promote the growth and development of NACNS
4. Provide a national forum for Clinical Nurse Specialists
5. Establish NACNS as the national authority for CNS practice, education, and research
6. Promote Clinical Nurse Specialist as a career of choice

E. Linking Outcomes of Association Board Member Actions
1. Boards of Nursing Role:

   a) Fiduciary responsibility.
   b) Protect the health and safety of the public
   c) Promote the integrity of the profession
   d) Ensure the rights of the individual member of the profession as guaranteed under the U.S. constitution
2. American Associations Role:
   a) Fiduciary responsibility
   b) Support programs that meet a need
   c) Promote and guide professional activities of the membership
   d) Association integrity
   e) Support member benefits as outlined in charter
3. Benefits of Organizational Board Participation
   a) Exposure to trends in practice
   b) Having a voice in the decision that can guide practice and the profession
   c) Resource links to help understand or clarify practice issues
   d) Understand various aspects of how organization consensus was achieved for specific issues
4. Keys to Success for Dual Board Participation
   a) Understand the missions of each
   b) Know who will be impacted by your decisions
   c) Listen and think before you decide
   d) Respect the purposes of each role
   e) Respect the viewpoints of others
   f) Understand that even small decisions can have huge outcomes
   g) Seek resolution to any conflicts of interest openly
5. Comparisons
   a) Board of Nursing:
      (1) Honor to serve
      (2) Learning opportunity
      (3) Network of Resources
      (4) Represent a perspective of practice
   b) Associations:
      (1) Honor to belong
      (2) Learning opportunity
      (3) Network of Resources
      (4) Represent a constituency

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Method of Participation to Earn CNE Credit(s)

To obtain credit for participating in this activity, the participant must:

1. Read the educational objectives and disclosure statements
2. Attend the course in its entirety
3. Complete and submit the course evaluation

Upon completion of the entire content, the learner may receive 1 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 1 hour to complete. Credits are given in 1-hour increments.

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Dr. Randall Hudspeth has been a NP since 1986. He has been an AANP member since it started and a Fellow since 2008. He served 2 terms as the APRN on the Idaho Board of Nursing and was board chairman. He served on the NCSBN board of directors and was on the APRN committee when the Consensus Model for APRN Regulation and Education was written. He is a fellow in both the American Institute of Regulatory Excellence (FRE) and the AANP (FAANP). He is board certified in pain management and was a test item writer for the ANCC certification exam in pain management. He formerly served on the editorial boards of the *Journal of Nurse Practitioners* and *Nursing Administration Quarterly* and has more than 160 peer reviewed publications, several textbook chapters and one book. He has been a regular AANP speaker for the past 11 years and was the AANP representative to the FDA endorsed CO*RE Opioid Use Provider Education Panel.

Disclaimer

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Faculty and Planners Disclosure Statement

None of the planners or presenters for this activity have relevant financial relationship(s) to disclose with ineligible companies.

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References

NCSBN 101, available at: Search | NCSBN

Course Title: Alcohol Disorder (Pharm)

Course Release Date: April 25-27, 2023

Description: This course will review the many disorders and disease states caused by or correlated to alcohol ingestion including withdrawal.

Objectives

Upon completion of this course, the nurse should be able to:

- Define Alcohol Addiction, Alcohol Use Disorder, and Alcohol Withdrawal
- Review Alcohol withdrawal including symptoms and treatment options
- Discuss other associated disorders and disease states such as Delirium Tremens and Wernicke-Korsakoff syndrome as well as managing these disease states
- Discuss treatment to options for AUD, explaining when to choose certain medications and expected possible adverse effects

Outline

I. Addiction
   A. Addiction is widely accepted as a DISEASE
      1. Terminology varies:
      2. American Psychiatric Association (APA)
      3. Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)
      4. Substance use disorders (alcohol use disorder [AUD], opioid use disorder [OUD], cannabis use disorder, etc.)
      5. National Institute of Drug Abuse (NIDA):
      6. A chronic, relapsing disease characterized by compulsive drug seeking and use despite harmful consequences as well as neurochemical and molecular changes in the brain
   B. Recommended Limits for Alcohol Consumption
      1. Men < 65 years
         a) < 2 drinks per day on average
         b) < 4 drinks in one day
         c) < 14 drinks per week
      2. Men > 65 or Women
         a) < 1 drink per day on average
         b) < 3 drinks in one day
         c) < 7 drinks per week
   C. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
      1. Screening:
         a) Assesses severity of substance use

        b) Identifies appropriate level of treatment
    2. Brief Intervention:
        a) Express concern and advise to abstain or decrease drinking
        b) Explain alcohol-related risks and links to health outcomes
    3. Referral to Treatment:
        a) Recommend specialty care or treatment options
D. Alcohol Use Disorders Identification Test (AUDIT)
    1. Developed by the World Health Organization (WHO)
    2. 10-question self- or clinician-administered survey
    3. Scores > 8 indicate harmful drinking (> 7 in elderly)
    4. Abbreviated version (AUDIT-C)
    5. Administer annually
E. Alcohol Intoxication (DSM-5)
    1. Recent ingestion of alcohol (EtOH)
    2. Significant problematic behavior or psychological changes developed during, or shortly after, ingestion
    3. Symptoms are not due to another medical condition or mental disorder
    4. > 1 of the following:
        a) Slurred speech
        b) Incoordination
        c) Unsteady gait
        d) Nystagmus
        e) Impairment in attention or memory
        f) Stupor or coma
F. Alcohol Withdrawal (DSM-5)
    1. Reduction in heavy and prolonged EtOH use
    2. Significant impairment in everyday functioning
    3. Not better explained by another medical or psychological condition
    4. > 2 symptoms, hours to days after cessation:
        a) Autonomic hyperactivity (e.g. HR/BP, sweating)
        b) Hand tremor
        c) Insomnia
        d) Nausea/vomiting
        e) Transient hallucinations (audio, visual, or tactile)
        f) Psychomotor agitation
        g) Anxiety
        h) Generalized tonic-clonic seizures
G. Monitoring Withdrawal
    1. Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A)
    2. Often use 10-item revised version (CIWA-Ar)
    3. Mainly objective measures:
        a) Quick administration (~ 2 mins)
        b) Measures withdrawal severity

c) Absent or Minimal < 8
d) Mild to Moderate 9 – 19
e) Severe > 20
f) NOT a diagnostic tool
g) Others (less common):
(1) Alcohol Withdrawal Scale (AWS)
(2) Short Alcohol Withdrawal Scale (SAWS)
(3) Alcohol Use Disorders Identification Test-Piccinelli
(4) Consumption (AUDIT-PC)
(5) Luebeck Alcohol Withdrawal Risk Scale-11 (LARS-11)
(6) Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

H. Inpatient Withdrawal Management
1. CIWA-Ar > 20 (severe)
2. History of delirium tremens or withdrawal seizures
3. Unable to tolerate oral medications
4. Co-occurring medical conditions posing risk if managed outpatient (e.g. pregnancy)
5. Co-occurring substance withdrawal (e.g., sedative-hypnotics)
6. CIWA-Ar > 10 (moderate) PLUS any of the following:
7. Recurrent unsuccessful outpatient attempts
8. Reasonable likelihood patient will not complete outpatient program (e.g., homelessness)
9. Active psychosis or severe cognitive impairment

I. Acute Withdrawal Pharmacotherapy Options
1. First Line:
a) Benzodiazepines (BZD)
(1) Benzodiazepines reduce:
(2) Withdrawal severity
(3) Incidence of delirium tremens
(4) Incidence of withdrawal seizures
(5) “LOT” (lorazepam, oxazepam, temazepam)
(6) Bypass phase I metabolism (i.e. bypass the liver)
(7) Ideal for elderly, over-sedated, or liver impairment
2. Second Line:
a) Mild-moderate withdrawal when BZD risk outweighs benefits
b) Less abuse potential
c) Outpatient withdrawal management
d) Adjunctive treatment
e) Efficacy comparable to BZDs
f) (Evidence limited to small single-site randomized trials)
g) Reduction of withdrawal symptoms
h) Time to withdrawal completion
i) Adverse effects

j) Phenytoin is NOT effective at preventing withdrawal seizures
    (1) Carbamazepines (CBZ)
    (2) Valproic Acid (VPA)
    (3) Gabapentin

3. Supportive Treatments:
    a) Supplements
    b) Antihypertensives
    c) Antipyretics
    d) Antipsychotics

J. Dosing Regimens
1. Fixed-Dose Taper
    a) Advantages:
        (1) Patient should receive adequate medication
        (2) Less monitoring / lower staff burden
    b) Disadvantages:
        (1) May receive more medication than necessary (↑ side effects)
        (2) Should not be used for delirium tremens management
    c) Examples:
        (1) Chlordiazepoxide 100 mg Q6H x 4 doses (with PRN), then
        (2) Chlordiazepoxide 50 mg Q8H x 8 doses (with PRN), then
        (3) Chlordiazepoxide 25–100 mg Q1H PRN CIWA-Ar > 10
2. Symptom Triggered
    a) Advantages:
        (1) Only give amount of drug needed to control symptoms
        (2) Less medication use
        (3) Shorter duration of treatment
    b) Disadvantages:
        (1) Requires trained staff to assess
    c) Examples:
        (1) Chlordiazepoxide 25–100 mg Q1H PRN CIWA-Ar > 10, or
        (2) Diazepam 5–20 mg Q1–4H PRN CIWA-Ar > 10, or
        (3) Lorazepam 4 mg every 10 mins until CIWA-Ar < 10 or sedation
3. Front Loading
    a) Slowly titrate dose upwards until one of the following:
        (1) Light sedation is reached (can be aroused with verbal stimulation)
        (2) CIWA-Ar < 10
        (3) Preferred treatment regimen for delirium tremens
        (4) Not favored in suspected head injury and liver dysfunction
    b) Example:

(1) Diazepam 10 mg→ 20 mg → 30 mg → 40 mg → 50 mg → 60 mg
(2) Repeat each strength dose once (10 mg, 10 mg, 20 mg, 20 mg…) 10 mins apart
(3) Continue administration until 320 mg total, light sedation, or CIWA-Ar < 8

II. Delirium Tremens (DT)
- A. Two distinct aspects: delirium & severe alcohol withdrawal
- B. Increases length of hospital stay, stay in the ICU, and mortality
- C. Overall mortality 1–4%
  1. Increases to 5–15% in those untreated
  2. Due to hyperthermia, cardiac arrhythmias, complications of withdrawal seizures, or concomitant medical disorders
- D. Risk Factors for DT
  1. History of DT
  2. Long history of DT
  3. History of withdrawal seizures
  4. Concurrent acute illness
     - a) Especially infection, respiratory, and cardiac disease
     - b) Early withdrawal symptoms
     - c) Severity of early withdrawal symptoms (SBP> 150, DBP> 100)
  5. Older age
  6. Structural brain lesion
  7. ↑[ALT], [GGT]
  8. ↓[Platelets]
  9. ↓[Mg], ↓[K]
  10. ↓[pyridoxine] (B6)
  11. ↑[Homocysteine]
- E. Treatment of DT
  1. The best treatment is prevention with long-acting BZDs, using a front-loading strategy
  2. Thiamine replacement (high rates of deficiency in DT)
  3. Will NOT treat DT or symptoms of DT
  4. Treatment refractory: phenobarbital, propofol (ICU), dexmedetomidine (ICU)

III. Wernicke-Korsakoff Syndrome
- A. Wernicke Encephalopathy:
  1. Caused by thiamine (Vit B1) deficiency
  2. Acute and reversible
  3. Caine's Criteria
     - a) Eye signs
     - b) Cerebellar dysfunction

c) Mild memory impairment or AMS
d) Signs of malnutrition
e) > 2 out of 4 is used to 'make a case'

B. Korsakoff Syndrome:
1. Long-term B1 deficiency leads to permanent neuronal damage
2. Mainly in the mamillary bodies
3. Chronic and irreversible
4. No diagnostic criteria
5. Severe memory problems
6. Confabulation
7. Normal cognition otherwise
8. Symptoms of Korsakoff's Syndrome
   a) Progression occurs in 56–84% of patients, regardless of thiamine replacement
   b) Prognosis:
      (1) Recover promptly: 25%
      (2) Improvement over time: 50%
      (3) Unchanged, permanently impaired, requiring LTC: 25%
      (4) Prevention is critical
      (5) No treatment for KS
   c) Symptoms:
      (1) Anterograde amnesia
         (a) Inability to form new memories
      (2) Confabulation
         (a) Replacing memory gaps with seemingly reasonable, but untrue, information
      (3) Retrograde amnesia
         (a) Episodic memory (events from the past) severely affected
         (b) Semantic memory (facts, concepts, language) is variably affected
         (c) Implicit memory (muscle memory) spared

C. Wernicke-Korsakoff Syndrome
1. Classical Triad:
   a) Mental status changes (82%)
   b) Confusion
   c) Memory disorder
   d) Anxiety / fear
   e) Coma / stupor
2. Ophthalmoplegia (29%)
   a) Nystagmus / retinal hemorrhages
   b) Ptosis / photophobia
   c) Diplopia / blurred vision

3. Ataxia (23%)
    a) Unsteady gait / dysarthria
4. Severity of Illness:
    a) Mild Disease:
        (1) Anorexia, followed by N/V, nystagmus, and subjective eye sx
    b) Moderate Disease:
        (1) Insomnia and emotional changes (anxiety, apathy, apprehension)
        (2) Progressive loss of recent memory occurs over 2–3 weeks
    c) Severe Disease:
        (1) Disorientation, confabulation, coma

D. Thiamine Deficiency
1. Reasons for deficiency in AUD:
    a) Poor diet
    b) ↓ absorption in the setting of EtOH
    c) ↑ thiamine loss in kidneys
    d) ↓ metabolism to active thiamine
    e) ↓ absorption of colonic bacterial thiamine
    f) ↓ Mg, which is a necessary cofactor in thiamine utilization
2. Treatment:
    a) Parenteral Thiamine
    b) Thiamine IV 200–500 mg TID x 3–5 days or until improvement
    c) Improvement occurs within 6 hours – 3 days
    d) NO ROLE for oral B1 during acute deficiency
    e) Oral thiamine and multivitamin can be given at discharge to prevent deficiency
    f) Patients shouldn't receive carbohydrates (PO / IV) before thiamine replacement

IV. Alcohol Use Disorder (AUD) DSM-5

A. Significant impairment or distress caused by a problematic pattern of alcohol use with > 2 of the following within a 12-month period:
1. Using ↑amounts over longer time periods
2. Difficulty cutting down
3. ↑ time spent seeking EtOH/ receiving
4. Craving EtOH
5. Failing to fulfill obligations
6. Continued use despite social problems
7. ↓ in other activities
8. Use in hazardous situations
9. Using despite knowledge of physical or psychological problems
10. Tolerance (one or both):

        a) ↑ amounts needed to produce desired effect
        b) ↓ effect with use of the same amount
    11. Withdrawal (one or both):
        a) Symptoms of withdrawal (slide 10)
        b) EtOH used to relieve or avoid symptoms

B. Alcohol Use Disorder (DSM-5)
    1. Most who consume EtOH do not meet AUD criteria
    2. Severity determined by number of symptoms displayed
        a) Mild: 2–3 symptoms
        b) Moderate: 4–5 symptoms
        c) Severe: > 6 symptoms
    3. Many individuals have a promising prognosis

C. Epidemiology
    1. 12-month prevalence (US)
        a) 12–17 y/o: 4.6%
        b) > 18 y/o: 8.5%
    2. Age of onset
        a) Late adolescence–early adulthood
    3. Costs US $223.5 billion yearly
        a) Lost productivity, crime, health
    4. Undertreated (< 20%)
    5. ↑ Mortality
        a) Comorbid conditions (e.g., liver disease, CVD, GI effects)
        b) EtOH accounts for 55% of fatal driving events
        c) Increased suicidal behavior and completion rate

D. Risk Factors for AUD
    1. Race:
        a) Native American/Alaskan: 12.1%
        b) White: 8.9%
    2. ↑ availability/peer use/stress
    3. Poor coping skills
    4. Comorbid psychiatric illness
        a) Schizophrenia, bipolar disorder
        b) 3–4x risk if close relative has AUD
    5. Genetics:
        a) 3–4x risk if close relative has AUD
        b) Children of AUD parents at risk, even if adopted at birth
    6. Age:
        a) 18–29 y/o: 16.2%
        b) > 65 y/o: 1.5%
    7. Gender:
        a) Males (12.4%) > females (4.9%)

E. Course of Illness

1. Characterized by periods of remission and relapse
2. Relapse does NOT mean treatment failure!
3. Common Scenario:
    a) Decision to stop drinking (often a response to a crisis)
    b) Period of abstinence (weeks or more)
    c) Limited periods of controlled, non-problematic drinking
    d) Consumption rapidly escalates to severe problems, again

F. Goals of Pharmacotherapy
1. Develop goals with the patient (goals may vary for each)
2. Achieve and sustain abstinence from alcohol
3. ↓ use, prevent long-term complications, etc.
4. Minimize and manage alcohol withdrawal symptoms
5. Prevent and/or manage the physical and social complications of continued alcohol use
6. Minimize or prevent relapses

G. Nonpharmacologic Therapy
1. Psychosocial interventions
2. Behavioral Couples Therapy (BCT)
3. Cognitive Behavioral Therapy (CBT)
4. Community Reinforcement Approach (CRA)
5. Motivational Enhancement Therapy (MET)
6. 12-Step Facilitation (TSF): Alcoholics Anonymous (AA), etc.
    a) "Ninety-day rule"
7. Medications may help patients be more receptive to therapy

H. Naltrexone (ReVia, Vivitrol)
1. Mechanism:
    a) Opioid antagonist
    b) May block reward signals
2. Dosing:
    a) ReVia: 50 mg PO every morning
    b) Vivitrol: 380 mg IM every 4 weeks(deep gluteal muscle)
3. Efficacy:
    a) Outcomes
        (1) ↓ relapses to dependence
        (2) ↓ returning to drinking
        (3) ↓ cravings
        (4) ↓ drinking days
        (5) ↓ relapse to heavy drinking
4. COMBINE (U.S.)
    a) Naltrexone > acamprosate
5. PREDICT (Germany)
    a) Naltrexone = acamprosate
6. Contraindications:

a) Opioid use within the past 7 days
b) Acute hepatitis or liver failure

7. Precaution:
    a) Hepatotoxicity (dose-dependent)
8. Adverse Effects:
    a) GI upset
    b) Dizziness / anxiety
    c) Injection site reaction (LAI)
9. Patient Education:
    a) Maintain abstinence for 5 days prior to initiation
    b) Not necessary, but improves outcomes
    c) Must be opioid-free for 7 days
    d) Lower dose may ↓ GI upset
    e) Medical bracelet / dog tags
    f) Alert paramedics to use non-opioids for pain relief
    g) Opioid tolerance will drastically decrease in OUD patients
    h) High risk of overdose

I. Acamprosate (Campral)
1. Mechanism:
    a) Unclear
    b) Glutamate modulator thought to counteract the GABA-glutamate imbalance associated with prolonged EtOH use
2. Dosing:
    a) Two 333 mg (666 mg/dose) DR tabs PO TID
3. Efficacy:
    a) Outcomes
    b) Reduced number of drinking days
    c) Increased abstinence
    d) Lengthens time to relapse
4. European Studies
    a) Positive Outcomes
5. US Studies
    a) No benefits
6. Contraindications:
    a) CrCl < 30 mL/min (severe renal impairment)
7. Precaution:
    a) CrCl 30–50 mL/min: reduce dose to 333 mg PO TID
8. Adverse Effects:
    a) Diarrhea (transient)
    b) HA, changes in libido, insomnia, anxiety, muscle weakness, dizziness, and suicidality
9. Patient Education:
    a) Swallow pill whole, do not crush/chew

b) Best results if taken 5 days after quitting (can start earlier if needed)
c) Full effect may take 5–8 days
d) Continue therapy even through relapse
e) Report any changes in mood or suicidal ideation
f) Can safely take with EtOH or opioids

J. Disulfiram (Antabuse)
1. Mechanism:
a) Irreversible inhibitor of acetaldehyde dehydrogenase
b) Acetaldehyde buildup causes flushing, N/V, ↑ HR, CV collapse, death
2. Dosing:
a) 500 mg PO daily x 1–2 weeks, then 250 mg PO daily
b) Significant ADRs: 125 mg daily
c) Inadequate response: 500 mg daily
3. Efficacy:
a) Ideal in highly motivated patients
b) Conflicting results in study data
c) High dropout rates within studies (i.e., poor adherence)
d) May be beneficial in patients court–ordered to take medication
4. Drug-Drug Interactions:
a) Foods/drinks/medications with EtOH
b) Elixirs, mouthwash, etc.
c) Metronidazole/ketoconazole
d) Produce similar effect
e) Inhibits CYP3A4
f) May interact with warfarin, phenytoin, rifampin, etc.
5. Contraindications:
a) Severe respiratory, CV, renal, or hepatic disease
b) Metronidazole/ketoconazole therapy
c) Produce disulfiram-like reaction
6. Patient Education:
a) Reaction lasts 30–60 mins to several hrs
b) Can use as PRN for difficult scenarios
c) Holidays, gatherings with EtOH, etc.
d) Consuming large amounts of EtOH can lead to coma/death
7. Adverse Effects:
a) Transient:
(1) Skin/acneiform eruptions/dermatitis
(2) HA, drowsiness/fatigue
(3) Impotence
(4) Metallic or garlic-like after taste
b) Serious (D/C disulfiram):

(1) Optic neuritis
(2) Peripheral neuritis, polyneuritis, peripheral neuropathy
(3) Hepatitis and hepatic failure

K. Topiramate (Topamax)
1. Mechanism:
   a) Believed to antagonize glutamate receptors, inhibiting dopamine release in the reward center
2. Dosing:
   a) Initial: 50 mg PO daily
   b) May need 100 mg PO BID
   c) Maximum: 300 mg daily
   d) Titrate over several weeks
3. Efficacy:
   a) Outcomes
      (1) Reduced drinks per drinking day
      (2) Reduced % of heavy drinking days
      (3) Reduced % of drinking days
4. NOT FDA-approved for AUD
5. Precautions:
   a) CrCl < 70 mL/min: reduce dose by 50% and titrate slowly
   b) Dose adjustment may be needed in hepatic impairment
6. Adverse Effects:
   a) CNS: Cognitive dulling, psychiatric disturbances, sedation, paresthesia, nervousness, ataxia, lack of concentration
   b) GI: abdominal pain, anorexia
7. Patient Education:
   a) Do not stop taking abruptly
   b) Gradually taper
   c) Topiramate may decrease efficacy of contraceptives
   d) Consider using back-up method while on this medication
   e) Crushing/chewing the tablet may produce a bitter taste

L. Gabapentin (Neurontin)
1. Mechanism:
   a) Unclear
   b) Likely through modulation of GABA activity in the amygdala
2. Dosing:
   a) Initiate at 300 mg PO daily
   b) ↑ by 300 mg daily, as tolerated
   c) Target dose: 1800 mg PO daily
   d) Three divided doses
3. Efficacy:
   a) Outcomes
   b) ↑ rates of abstinence

c) ↑ abstinence from heavy drinking
d) Possible useful in co-occurring neuropathic pain
e) Possible adjunct to naltrexone

4. NOT FDA-approved for AUD

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Course Title: Anxiety Medications (Pharm)

Course Release Date: April 25-27, 2023

Description: A course reviewing anxiety disorders, specifically Generalized Anxiety Disorder (GAD) and the management and treatment of the disorder.

Objectives

Upon completion of this course, the nurse should be able to:

- Review Diagnostic Criteria for GAD
- Review epidemiology and symptoms associated with GAD
- Discuss the management and treatment options for GAD, both non-pharmacological and pharmacological
- Discuss crisis management options

Outline

I. Anxiety Disorders
   A. Generalized Anxiety Disorder (GAD)
   B. Post-Traumatic Stress Disorder (PTSD)
   C. Panic Disorder
   D. Obsessive Compulsive Disorder (OCD)
   E. Social Anxiety Disorder (SAD)
   F. Agoraphobia

II. Generalized Anxiety Disorder (GAD)
   A. Epidemiology
      1. U.S. Prevalence (12-month)
      2. Adolescents: 0.9%
      3. Adults: 2.9%
      4. Lifetime risk: 9.0%
      5. Female-to-Male ratio: 2:1
      6. European descent > non-European
      7. Developed > non-developed countries
   B. Diagnostic Criteria
      1. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance) *Essential Feature
      2. The individual finds it difficult to control the worry
      3. The anxiety or worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days that not for the past six months):

a) Restlessness or feeling keyed up or on edge
b) Being easily fatigued
c) Difficulty concentrating or mind going blank
d) Irritability
e) Muscle tension
f) Sleep disturbance (difficulty falling or staying asleep,
g) or restless, unsatisfying sleep)

4. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
5. The disturbance is not attributable to the physiological effects of a substance (e.g.a drug of abuse, a medication) or another medical condition (e.g. hyperthyroidism)
6. The disturbance is not better explained by another mental disorder (e.g. anxiety or worry):
    a) Having panic attacks in panic disorder
    b) Negative evaluation in social anxiety disorder [social phobia]
    c) Contamination or other obsessions in obsessive-compulsive disorder
    d) Separation from attachment figures in separation anxiety disorder
    e) Reminders of traumatic events in posttraumatic stress disorder
    f) Gaining weight in anorexia nervosa
    g) Physical complaints in somatic symptom disorder
    h) Perceived appearance flaws in body dysmorphic disorder

C. Development & Course
1. Age of Onset (median): 30 years
    a) Broad range
    b) Rarely occurs prior to adolescence
    c) Peaks in middle age
    d) Declines across later years
2. Rates of full remission are very low
3. Course of Symptoms:
    a) Chronic
    b) Wax and wane throughout life
    c) Symptom severity
    d) Younger adults > older adults
    e) Content of worry tends to be age appropriate

D. Associated Features
1. Musculoskeletal symptoms:
    a) Muscle tension
    b) Trembling
    c) Twitching
    d) Feeling shaky

        e) Muscle aches
        f) Soreness
    2. Exaggerated startle response
    3. Other conditions associated with stress frequently accompany GAD:
        a) Irritable bowel syndrome
        b) Headaches
    4. Autonomic hyperarousal less prominent in GAD (than other anxiety disorders):
        a) Accelerated heart rate
        b) Shortness of breath
        c) Dizziness
E. Anxiety-Inducing Substances
    1. Stimulants:
        a) Caffeine
        b) Amphetamines
        c) Methylphenidate
        d) Pseudoephedrine
    2. Hormones & Steroids:
        a) Anabolic steroids
        b) Estrogen
        c) Progesterone
        d) Testosterone
    3. Illicit Substances:
        a) Cannabis
        b) Phencyclidine (PCP)
        c) Inhalants
        d) Cocaine
    4. Withdrawal:
        a) Alcohol
        b) Benzodiazepines
        c) Opioids
        d) Many other
F. GAD-7
G. Panic Attacks
    1. Palpitations, pounding heart, or accelerated heart rate
    2. Sweating, trembling or shaking
    3. Sensations of SOB or smothering
    4. Feelings of choking
    5. Chest pain or discomfort
    6. Nausea or abdominal distress
    7. Fear of dying
    8. Feeling dizzy, unsteady, light-headed, or faint
    9. Chills or heat sensations

10. Paresthesias (numbness or tingling)
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
12. Fear of losing control or "going crazy"

H. Non Pharmacological Treatment
1. Cognitive Behavioral Therapy (CBT)
   a) Most effective psychological therapy
   b) Underused, Cost, Time requirement
   c) Limited availability of trained therapists
   d) Sustained reductions 6 – 12 months
   e) Identifies negative thought patterns that provoke or worse anxiety

I. Pharmacotherapy
1. First-Line Drug Treatment
   a) Selective-Serotonin Reuptake Inhibitors (SSRI)
      (1) Any SSRI can be used; guidelines mention fluoxetine, sertraline, escitalopram, and paroxetine
      (2) All SSRIs can be dosed once daily
      (3) May cause increased anxiety upon initiation
      (4) Initiate at half of the minimum effective dose
         (a) SSRI Minimum-Maximum Effective Dose
            (i) Fluoxetine (Prozac®) 20 – 80 mg
            (ii) Paroxetine (Paxil®) 20 – 50 mg
            (iii) Sertraline (Zoloft®) 50 – 200 mg
            (iv) Citalopram (Celexa®) 20 – 40 mg
            (v) Escitalopram (Lexapro®) 10 – 20 mg
            (vi) Response time: 4-12 weeks
   b) Serotonin-Norepinephrine Reuptake Inhibitors (SNRI)
      (1) Any SNRI can be used; evidence supports extended-release venlafaxine and duloxetine
      (2) More likely to cause anxiety at initiation than SSRIs
      (3) Due to norepinephrine component
      (4) All SNRIs can be dosed once daily
      (5) Except immediate-release venlafaxine
         (a) SNRI Minimum-Maximum Effective Dose
            (i) Venlafaxine (Effexor®) 75 – 225 mg
            (ii) Duloxetine (Cymbalta®) 60 – 120 mg
            (iii) Desvenlafaxine (Pristiq®) 50 – 400 mg
            (iv) Levomilnacipran (Fetzima®) 40 – 120 mg
            (v) Response time: 4-12 weeks
   c) Pregabalin
      (1) Effective as short-term treatment
      (2) Rapid onset of efficacy (~1 week)

(3) May be a safe and effective way to discontinue long-term BZD therapy
(4) Controlled substance (Schedule V)
(a) Initiation:
(i) 50 mg TID, or 75 mg BID
(ii) Dosage Range: 150 – 600 mg/day Titrate by 150 mg/day weekly
(iii) Taper dose over one week upon discontinuation

2. Second-Line Drug Treatment
a) Buspirone (Buspar)
(1) Mechanism of Action:
(a) 5-HT1A partial agonist
(b) Delayed onset of action
(c) Full effect: 2 – 6 weeks
(d) Not to be used as PRN
(2) Efficacy:
(a) Decreased efficacy in prior BZD users
(b) Lacks evidence for concurrent depression
(3) Dosing Recommendations:
(a) Initiation: 7.5 mg BID
(i) Dosage range: 15 – 60 mg/day
(ii) Divided BID – TID
(b) Titrate in increments of 5 mg/day every 2-days to effect
(c) Very short half-life (~2.5 hours)
b) Hydroxyzine (Atarax®/ Vistaril®)
(1) Mechanism of Action:
(a) Histamine antagonist
(b) 5-HT2 antagonist
(2) Rapid onset of action:
(a) Sedative effect within 30 mins
(b) IM formulation
(3) Caution:
(a) Elderly
(b) Renal impairment
(4) Dosing Recommendations:
(a) Initiation: 25 mg BID (PRN)
(i) Dosage range: 50 – 100 mg QID (PRN)
(ii) Titrate 50 mg/day every week
(b) Adverse Effects:
(i) Anticholinergic effects
(ii) Impaired cognition, anti-SLUDG

            (iii) Antihistaminic effects
            (iv) Somnolence
    c) Second-Generation Antipsychotics
        (1) Evidence:
            (a) Monotherapy: sparse
            (b) Augmentation: some evidence
        (2) Mechanism of Action:
            (a) Anxiolysis thought to be mediated by 5-HT1A agonism
        (3) Major Concern: adverse effect profile
            (a) Metabolic effects
            (b) Tardive dyskinesia
            (c) Sudden cardiac death
        (4) Monotherapy:
            (a) Quetiapine XR
        (5) Augmentation in treatment-resistance
            (a) Olanzapine
            (b) Risperidone
            (c) Quetiapine
3. Crisis Management
    a) Benzodiazepines
        (1) Normally used short-term: 2 – 4 weeks (maximum: 4 weeks)
        (2) Rarely, can be used long-term for severely disabling anxiety
        (3) Used to treat anxiety that is severe, disabling, or that causes extreme distress
        (4) Provide quick symptomatic relief during acute episodes
        (5) Controlled substances (Schedule IV)
            (a) Abuse potential!
        (6) NICE guidelines recommend against use in panic disorder and with caution in
        (7) PTSD
        (8) Long-Acting (> 48 h):
            (a) Diazepam (Valium®): 20 – 70 h
            (b) Chlordiazepoxide (Librium®): 6 – 28 h
                (i) Both have desmethyldiazepam as an active metabolite (39 – 96 h)
        (9) Intermediate-Acting (24 – 48):
            (a) Clonazepam (Klonopin®): 30 – 40 h
            (b) Estazolam (Prosom®): 20 – 30 h
        (10) Short-Acting (< 24 h):
            (a) Lorazepam (Ativan®): 10 – 20 h
            (b) Temazepam (Restoril®): 8 – 20 h

(c) Alprazolam (Xanax®): 8 – 15 h
(d) Oxazepam (Serax®): 5 – 15 h

(11) Very Short-Acting (1 – 7 h):
(a) Triazolam (Halcion®): 1.5 – 5 h
(b) Midazolam (Versed®): 1 – 4 h

III. Key Takeaways
A. BZDs should only be used short-term for crisis management
B. Antidepressants are first-line and take time to work
C. Buspirone is only slightly better than a Tic-Tac® in prior BZD users
D. Hydroxyzine may be an effective alternative to BZD in an acute setting
E. SGAs should be last-line, if recommended at all

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Author: Andrew Babbage, PharmD

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Course Title: Long-Acting Injectables (Pharm)

Course Release Date: April 25-27,2023

Description: Discuss the place and purpose of long acting injectables, particularly in the behavioral health setting, as well as more about the medications and how they function and when they can be used.

Objectives

Upon completion of this course, the nurse should be able to:

- Review the pharmacokinetics of LAI and how they differ from oral medications
- Discuss best practices for LAI usage
- Review antipsychotic LAIs (FGAs and SGAs)
- Review non-antipsychotic LAIs (naltrexone and buprenorphine)

Outline

I. Long-Acting injectables (LAI)
   A. Medications injected IM or SC and are steadily absorbed over weeks
   B. Maintain stable plasma drug concentrations
   C. Reduced risk of adverse drug events
   D. Reduced risk of relapse and rehospitalization compared with oral medications
   E. Non-randomized, observational, 'real-world' data
   F. Display "flip-flop" kinetics
      1. IMMEDIATE-RELEASE ORAL (NORMAL) KINETICS
         a) Absorption rate >>> elimination rate
         b) Css determined by absorption rate, bioavailability, and dose
         c) Time to steady-state determined by elimination rate
      2. LAI (FLIP-FLOP) KINETICS
         a) Absorption rate <<< elimination rate
         b) Css determined by absorption rate, bioavailability, and dose
         c) Time to steady-state determined by absorption rate
         d) Once absorbed, distribution and elimination is the same as oral

II. LAI Pros vs Cons
   A. ADVANTAGES
      1. Ensure clinician awareness of nonadherence (missed appointments)
      2. Reduction in pill burden
      3. Reduced consequences of planned or unplanned treatment gaps
   B. CONCERNS
      1. Long time to complete elimination (hypersensitivity)

2. Medication absorption influenced by drug properties (e.g. water solubility, delivery vehicle) and patient factors (e.g. body weight, blood flow to injection site)

C. Injection site
1. Deltoid Muscle
a) Injection volume: up to ~1 mL
b) Greater blood flow than gluteal muscle
c) Increased rate of absorption (shorter Tmax) compared to gluteal
2. Gluteal Muscle
a) Injection volume: up to ~5 mL
b) Higher content of adipose tissue
c) Slower rates of absorption than deltoid administration
(1) This may lead to lower P-T ratios

D. Peak-to-trough Ratios
1. Peak concentration is an indicator of adverse effect severity
2. Slower absorption may reduce P-T ratio
3. Lower P-T ratios = greater tolerability (usually)
4. P-T ratios < 2.00 display balance between efficacy and tolerability

III. Dosing Strategies & Difficulties

A. Concentration at Steady-State (Css)
1. Maintenance dosing alone may take too long to achieve therapeutic concentrations
2. Loading doses can be used to help keep concentration near-therapeutic before steady-state is achieved

B. Dosing Scenarios
1. Initiation strategies vary between products
2. Loading dose vs oral overlap
3. Time to steady-state vary between products
4. Calculated using half-lives
5. Easy to “overshoot” or “undershoot” initiation
a) Overshoot:
(1) Increased risk for ADRs
(2) Common causes:
(3) Oral dose continued despite administration of loading dose
(4) Failure to decrease oral overlap dose over time
(5) Loading dose too high
(6) Will normalize at steady-state (~4 – 5 half-lives), if cause is corrected
b) Undershoot:
(1) Increased incidence of relapse
(2) Common causes:
(3) Oral overlap dose too low (or never started)

(4) Loading dose too low (or not given)
(5) Oral overlap duration too short
(6) Symptoms may be present until steady-state concentration reached (~4 – 5 half-lives)

C. Best Practices
1. Begin with lowest therapeutic dose
2. Lower doses may be as effective as higher doses, especially FGAs
3. Administer at the longest possible licensed interval
4. Highest risk of deterioration is immediately after LAI administration (due to slow absorption)
5. Relapse most often occurs 3 – 6 months after withdrawing LAI
6. Adjust doses only after an adequate period of assessment
7. May reduce dose in response to ADRs
8. Doses should be trialed for at least one month (preferably longer) before increasing
9. LAIs are not recommended for those who:
10. Are antipsychotic-naive (establish tolerance/efficacy using oral dose for 2 weeks)
11. Have a history of serious ADRs warranting immediate discontinuation (e.g. NMS)

IV. First-Generation Antipsychotics (FGAs)

A. Haloperidol Decanoate (Haldol®)
1. CHARACTERISTICS
a) Formulations: 50 mg/mL; 100 mg/mL
b) Gluteal or deltoid IM
2. PHARMACOKINETICS
a) Tmax: 7 days
b) Apparent half-life: 21 days
c) Time to steady state: ~14 weeks
d) May be achieved as early as third injection
e) Substrate of CYP2D6 and CYP3A4
f) Increased concentrations with inhibitors
g) Decreased concentrations with inducers
h) Initial dose 10 – 15x daily oral dose
(1) Elderly or debilitated patients
(2) Patients on low doses (< 10 mg/day) of oral haloperidol
(3) Requires oral overlap until steady state reached (~14 weeks), or as clinically tolerating
i) Initial dose 20x daily oral dose
(1) Long-term haloperidol use has led to tolerance
(2) Low-dose approach risks recurrence of psychiatric decompensation

(3) Loading dose strategy (does not require oral overlap)
(4) For haloperidol decanoate naive patients requiring >100 mg, give 100 mg IM, then remainder of the dose 3 – 7 days later

B. Fluphenazine Decanoate (Prolixin®)
1. CHARACTERISTICS
a) Formulations: 25 mg/mL
b) Gluteal IM or SC
2. PHARMACOKINETICS
a) Tmax: 8 – 12 days
b) First peak: ~24 hours
c) Second peak: ~8 days
d) Apparent half-life: 10 days
e) Time to steady-state: 8 weeks
f) Extensive “first-pass” metabolism
g) Increased concentration with CYP2D6 substrates and inhibitors
h) Initial LAI dose = 1.25x daily oral dose administered every 3 weeks
(1) Fluphenazine decanoate 25 mg every 3 weeks = 20 mg oral daily
(2) Recommended maintenance dose: 12.5 – 100 mg every 2 – 3 weeks
(3) Doses as low as 1.25 – 5 mg every 2 weeks have been effective in preventing relapse
(4) Lowest effective dose documented as 25 mg every 6 weeks
(5) Oral overlap until steady state reached (~8 weeks), or as clinically tolerating

C. General FGA LAI Characteristics
1. Indicated for schizophrenia
2. Requires Z-Track Technique
3. Require oral overlap (if not using load)
4. Recommended 21-gauge needle
5. Maximum volume per injection: 3 mL
6. Haloperidol: 300 mg
7. Fluphenazine: 75 mg
8. EPS - ExtraPyramidal Symptoms
9. Consider test dose
10. Haloperidol 25 mg
11. Fluphenazine 12.5 mg
12. Sesame oil delivery vehicle
13. Be mindful of allergies
14. Pain at injection site
15. Scar tissue may build-up over time

16. Higher rates of EPS vs. SGAs

V. Second-Generation Antipsychotics (SGAs)
- A. Aripiprazole lauroxil (Aristada® & Aristada Initio®)
  1. CHARACTERISTICS
     - a) Indications: Schizophrenia
     - b) Formulations:
       - (1) 441 mg/1.6 mL – gluteal/deltoid
       - (2) 662 mg/2.4 mL – gluteal
       - (3) 882 mg/3.2 mL – gluteal
       - (4) 1064 mg/3.9 mL – gluteal
       - (5) 675 mg/2.4 mL (Initio®) – gluteal/deltoid
  2. PHARMACOKINETICS
     - a) Tmax: 44 – 50 days
     - b) Apparent half-life: 30 days
     - c) Time to steady-state: 16 weeks
     - d) Metabolized by CYP2D6 and CYP3A4
     - e) Reduce dose in 2D6 poor metabolizers and those on
     - f) 2D6 or 3A4 inhibitors
     - g) Avoid in patients on 3A4 inducers
  3. INITIATION
     - a) Loading Dose
       - (1) Initio IM +
       - (2) 30 mg oral (regardless of daily dose) +
       - (3) Maintenance dose IM (within 10 days)
       - (4) Give in different location than Initio
     - b) Oral Overlap
       - (1) Maintenance dose IM +
       - (2) Daily oral dose x 21 days
  4. MAINTENANCE
     - a) 10 mg oral daily
       - (1) 441 mg IM every 4 weeks
     - b) 15 mg oral daily
       - (1) 662 mg IM every 4 weeks
       - (2) 882 mg IM every 6 weeks
       - (3) 1064 mg IM every 8 weeks
     - c) > 20 mg oral daily
       - (1) 882 mg IM every 4 weeks
- B. Paliperidone palmitate (Invega Sustenna®)
  1. CHARACTERISTICS
     - a) Indications:
       - (1) Schizophrenia

(2) Monotherapy or adjunct to mood stabilizers or antidepressants for Schizoaffective Disorder

b) Formulations:

(1) 234 mg/1.5 mL – gluteal/deltoid
(2) 156 mg/mL – gluteal/deltoid
(3) 117 mg/0.75 mL – gluteal/deltoid
(4) 78 mg/0.5 mL – gluteal/deltoid
(5) 39 mg/0.25 mL – gluteal/deltoid

(a) Not studied for schizoaffective disorder long-term

2. PHARMACOKINETICS

a) Tmax: 13 days
b) Apparent half-life: 29 – 45 days
c) Time to steady-state: 20 weeks
d) Dose Adjustments

(1) Avoid in patients with CrCl < 50 mL/min and/or on strong 3A4 and/or P-gp inducers
(2) Reduce dose in patients on P-gp inhibitors or with
(3) CrCl 50 – 80 mL/min

3. INITIATION

a) Loading Dose

(1) 234 mg IM on day 1 +
(2) 156 mg IM on day 8 (+ 4 days)
(3) Use 156 mg and 117 mg doses if CrCl is between 50 – 80 mL/min

b) Loading doses must be administered IM in separate deltoids

4. MAINTENANCE

a) Sustenna 78 mg IM every 4 weeks

(1) Paliperidone 3 mg oral daily
(2) Risperidone 1 mg oral daily

b) Sustenna 117 mg IM every 4 weeks

(1) Paliperidone 6 mg oral daily
(2) Risperidone 2 – 3 mg oral daily

c) Sustenna 156 mg IM every 4 weeks

(1) Paliperidone 9 mg oral daily
(2) Risperidone 4 – 5 mg oral daily

d) Sustenna 234 mg IM every 4 weeks

(1) Paliperidone 12 mg oral daily
(2) Risperidone 6 – 8 mg oral daily

C. Risperidone microspheres (Risperdal Consta®)

1. CHARACTERISTICS

a) Indications:

(1) Schizophrenia
(2) Monotherapy or adjunct to Lithium or

(3) Valproate for Bipolar I Disorder
b) Formulations:
(1) 12.5 mg/2 mL – gluteal/deltoid
(a) Not studied in clinical trials
(2) 25 mg/2 mL – gluteal/deltoid
(3) 37.5 mg/2 mL – gluteal/deltoid
(4) 50 mg/2 mL – gluteal/deltoid
2. PHARMACOKINETICS
a) Tmax: 30 days
b) Apparent half-life: 4 days
(1) Doesn't follow "flip-flop" kinetics
c) Time to steady-state: 8 weeks
d) Dose Adjustments
(1) Reduce dose in patients on strong 2D6 inhibitors
(2) Increase dose in patients on 3A4 inducers
3. INITIATION
a) Consta 25 mg IM
(1) Risperidone 2 – 3 mg oral daily
b) Consta 37.5 mg IM
(1) Risperidone 4 – 5 mg oral daily
c) Consta 50 mg IM
(1) Risperidone 6 mg oral daily
4. MAINTENANCE
a) Same as initiation dose
b) Administer dose every 2 weeks
c) Oral overlap must occur for > 21 days
(1) Should be 4 – 6 weeks based on timing of release

VI. Other SGAs
A. Aripiprazole monohydrate (Abilify Maintenna®)
1. Similar to Aristada with less flexible dosing
2. Must complete 14 days of oral overlap (no loading strategy available)
B. Olanzapine pamoate (Zyprexa Relprevv®)
1. Monitor for post-injection delirium/sedation syndrome (PDSS) x 3 hours after each dose (REMS)
C. Paliperidone palmitate (Invega Trinza®)
1. Patient must have received at least four doses of Invega Sustenna before transitioning
2. Last two doses received must have been the same
D. Paliperidone palmitate (Invega Hafyera®)
E. Risperidone (Perseris®)
1. Monthly SC injection
2. Only covers 3 – 4 mg of daily oral risperidone

VII. Non-Psychotic LAIs

A. Naltrexone (Vivitrol®)

1. CHARACTERISTICS
   a) Indications:
      (1) Alcohol Use Disorder
      (2) Opioid Use Disorder
   b) Formulations:
      (1) Vivitrol 380 mg/3.4 mL – gluteal
   c) Contraindications:
      (1) Patients in acute opioid withdrawal
      (2) Patient who have failed the Naloxone challenge test
2. PHARMACOKINETICS
   a) Tmax:
      (1) First peak: 2 hours
      (2) Second peak: 2 – 3 days
   b) Apparent half-life: 5 – 10 days
   c) Time to steady-state: 28 days
3. DOSING
   a) Store in refrigerator; can be unrefrigerated (< 77°F) up to 7 days prior to administration
   b) Initiation & Maintenance Dose: Vivitrol 380 mg IM every 28 days
   c) Patient must be opioid-free for 7 – 10 days before administration
      (1) Short-acting opioids: 7 days (IR formulations, heroin)
      (2) Given high rates of fentanyl-laced heroin, may consider longer opioid-free interval
      (3) Long-acting opioids: 10+ days (ER formulations, methadone, fentanyl)
4. ADVERSE REACTIONS
   a) Accidental opioid overdose
      (1) Large amounts of opioids needed to overcome receptor blockade
      (2) Significantly decreased tolerance
   b) Injection site reactions
      (1) Occasional discomfort at site
      (2) SC administration increases incidence of severe injection site reactions
   c) Precipitated opioid withdrawal
      (1) Significantly worse than natural withdrawal
      (2) Often requires hospitalization (rarely ICU)
   d) Hepatotoxicity
      (1) Acute hepatitis and liver injury seen 3- to 5-fold increase exposure than oral

e) Depression & Suicidality
    (1) Relatively small incidence
    (2) Suicidality: 1% vs 0%
    (3) Depression: 10% vs 5%
f) Eosinophilic Pneumonia
    (1) Extremely rare (1 – 2 cases in all trials)
    (2) Hypersensitivity Reactions

VIII. Other Non-Antipsychotic LAIs

A. Buprenorphine (Probuphine®)
    1. Biannual subdermal implant (80 - 320 mg) of Buprenorphine
    2. Must be on 8 mg or less of Buprenorphine daily
    3. Requires enrollment in REMS program and surgical procedure to place and remove implants
B. Buprenorphine (Sublocade®)
    1. Monthly (100 - 300 mg) SC injection of Buprenorphine for OUD
    2. Adults must tolerate at least 7 days of 8 - 24 mg Buprenorphine daily before administration
    3. Requires enrollment in REMS program
    4. Must refrigerate; can be kept at room temperature for up to 7 days before administration
C. Buprenorphine (Brixadi®)
    1. Weekly (8 - 32 mg) or Monthly (64 - 128 mg) SC injection of Buprenorphine for OUD
    2. Must have tolerated at least one single dose of transmucosal Buprenorphine before administration
    3. Does not require refrigeration
D. All extended-release formulations of Buprenorphine require provider be DATA waived

IX. LAI Quick tips & Reference

A. Require Oral Overlap
    1. Fluphenazine decanoate
    2. Risperdal Consta
    3. Haloperidol decanoate (without load)
    4. Aristada (without Initio)
    5. Abilify Maintenna
    6. Zyprexa Relprevv
B. Deltoid Administration Allowed
    1. Invega Sustenna – required for loading doses (first two doses)
    2. Aristada Initio (675 mg) and Aristada 441 mg
    3. Risperdal Consta
    4. Abilify Maintenna

5. Zyprexa Relprevv

C. Must Be Stored in Refrigerator Before Use
    1. Risperdal Consta
    2. Vivitrol
    3. Sublocade

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Course Title: Warfarin and Its Many Uses

Course Release Date: April 25-27, 2023

Description: Warfarin is a staple in cardiac pharmacology. In this workshop, we will discuss warfarin and its clinical and historical use. This workshop will be geared toward APRNs, however nurses (RN & LPN), as well as nursing students are encouraged to attend! The topics to review include: Mechanism of action, side effects and adverse effects, contraindications, effects of co-administration of other medications on INR, and dosing of warfarin per INR levels.

Objectives

Upon completion of this course, the nurse should be able to:

- Learn about the history of the discovery of warfarin
- Discuss safety precautions for the prescribing and management of the patient on warfarin
- Learn how to adjust dosing of warfarin based on INR level

Outline

I. History
   A. 1920s
      1. Cattle and sheep were eating sweet clover hay that had been infected with mold, which was used d/t financial hardships
         a) Farmers noted multiple livestock deaths
         b) Hemorrhagic disease = Sweet Clover Disease
      2. Frank Schofield and Lee Roderick (veterinarians) noted a plasma prothrombin defect
      3. Karl Link (biochemist) identified and isolated the active compound
   B. 1940s
      1. Coumarin was oxidized to produce 3,3'-methylene-bis(4-hydroxycoumarin) = Dicoumarol
   C. 1945s
      1. Dicoumarol (coumarin derivative) was considered as a rodenticide
         a) Too slowly acting to be a practical poison
      2. Karl Link & colleagues created 150 variation of coumarin
      3. Warfarin was number 42, which was found to be potent
   D. 1948
      1. Warfarin was a successfully rodenticide
   E. 1951
      1. US Army inductee attempted suicide with multiple doses of warfarin, but recovered when treated with vitamin K

2. Clinical studies approved for use in humans

F. 1954
   1. Trade name Coumadin was approved and marketed

G. 1955
   1. President Dwight Eisenhower was prescribed Coumadin after having a myocardial infarction

H. 1978
   1. John Suttie & colleagues discovered the mechanism of action of warfarin = disruption in vitamin K metabolism, which inhibits epoxide reductase (enzyme)

II. Uses
   A. Venous Thromboembolism Prophylaxis/ Management
   B. Recurrent Systemic Emboli
   C. Atrial Fibrillation (Valvular & Non-Valvular)
   D. Post Myocardial Infarction Intracardiac Thrombus
   E. Mechanical Valves

III. Mechanism of action
   A. Inhibits vitamin K epoxide reductase
      1. Occurs in the liver
      2. Vitamin K is a cofactor in gamma carboxylation
   B. No gamma carboxylation = Clotting factors: II (prothrombin), VII, IX, and X cannot function
   C. Factor II has a half life of 3 days (Clinical relevance) = desired effect of anticoagulation
   D. Factor VII has a half life of 4-6 hours (Clinical relevance) = may cause initial prolongation of PT

IV. Side effects
   A. Bleeding longer than usual from injuries
   B. Heavier and longer menstrual cycles
   C. Epistaxis
   D. Bleeding gum (trauma from brushing teeth)
   E. Hemoptysis
   F. Hematuria/ blood in stool
   G. Contusion
   H. Hematoma
   I. Petechiae
      1. Danger Signs:
         a) Hemorrhagic Stroke
         b) Headache (severe) – “Worst headache of my life”
         c) Blurred vision

d) Confusion/ Altered Mental Status
e) Paralysis
f) Seizure
g) Nausea & Vomiting
h) Photophobia
i) Facial Droop
j) Unequal pupils
k) Dizziness

V. Contraindications
   A. Large esophageal varices
   B. Thrombocytopenia with platelet count less than 50,000
   C. Significant bleeding condition; can be reassessed after 3 months (GI bleed)
   D. Pregnancy (Especially in first trimester, 2-4 week prior to delivery, and within 48 hours of delivery)
      1. Risk for spontaneous abortion
      2. Teratogenic
      3. Fetal/perinatal bleeding
   E. Coagulation disorders with baseline INR over 1.5
   F. Decompensated liver disease
   G. Use caution in:
      1. Previous intracranial hemorrhage
      2. Previous GI bleed
      3. Hx of peptic ulcer disease
      4. Repeated falls
      5. Alcoholism
      6. Untreated or poorly controlled HTN

VI. Medication Considerations
   A. Increase INR:
      1. Acetaminophen
      2. Allopurinol
      3. Amiodarone
      4. Androgens: Testosterone, oxandrolone, methyltestosterone
      5. ABX: Cephalosporins, doxycycline, fluoroquinolones, macrolides, metronidazole, penicillins, Trimethoprim-sulfamethoxazole (Bactrim)
      6. Azole antifungals
      7. Cancer therapies: Capecitabine, fluorouracil, imatinib, tamoxifen
      8. Lipid lowering agents: Fenofibrate, Fluvastatin, gemfibrozil, lovastatin, rosuvastatin, simvastatin
      9. Cimetidine
      10. Glucocorticoids: methylprednisolone & prednisone
      11. Omeprazole
      12. SSRIs: Duloxetine, fluoxetine, fluvoxamine, venlafaxine

13. Tramadol

B. Decrease INR:
    1. ABX: Dicloxacillin, griseofulvin, nafcillin, rifampin
    2. Azathioprine
    3. Cholestyramine
    4. Anti Seizure meds: carbamazepine, phenobarbital, phenytoin
    5. Ritonavir
    6. St. John's wort
    7. Sucralfate
    8. Vitamin K

VII. Clinical takeaways
    A. Anticoagulation therapy
    B. Diet education is very important
    C. Increases the risk for bleeding
    D. INR monitoring at least 1x per month: 2-3 or 2.5-3.5; don't guess, there is a chart
    E. Check prior medical and surgical hx
    F. Monitor medication use, especially during acute infections
    G. Hold warfarin 5 days prior to surgery, does not include avascular surgeries (cataracts)

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* A "Subject Matter Expert" (SME) is a clinician with definitive knowledge sources to review, improve, guide, and teach others. Their knowledge is based on evidence-based practice, clinical research, and personal experience in their respective clinical settings. They meet the standard requirements of § 1456. Continuing Education Courses 16 CA ADC § 1456BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS § 1457. Instructor Qualifications

Faculty and Planners Disclosure Statement

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Course Title: Blood Pressure Medications (Pharm)

Course Release Date: April 25-27, 2023

Description: Hypertension or "The Silent Killer" effects almost half the population of adults in the US. This course will discuss anti-hypertensive medication including: Diuretics, ACE/ARBs, beta blockers, calcium channel blockers, and alpha blockers. Further discussion will entail mechanism of action, side effects, contraindications, prescribing information, and statistics. This course will be presented for APRNs, however nurses (RN & LPN), as well as nursing students are encouraged to attend!

Objectives

Upon completion of this course, the nurse should be able to:

- Differentiate the uses of each class of anti-hypertensive medications
- Discuss benefits and contraindications of anti-hypertensive medications by class
- Discuss side effects and adverse effects of anti-hypertensive medications by class

Outline

I. Hypertension Statistics
   A. The silent killer!!!
   B. 47% or 116 million adults have HTN in the U.S.
   C. Only about 24% of adults with HTN have their BP under control
   D. 45% of adults have uncontrolled HTN
   E. Costs the U.S. about $131 billion each year

II. Complications of Hypertension
   A. Cerebral Vascular Accident (Stroke)
   B. Aneurysm
   C. Cardiomyopathy/ Heart Failure
   D. Chronic Kidney Disease
   E. Blindness
   F. Memory problems
   G. Dementia
   H. End organ damage

III. Diuretics
   A. Examples:
      1. Thiazide: hydrochlorothiazide, chlorthalidone, metolazone, & indapamide
      2. Loop: furosemide, torsemide, & bumetanide
      3. Potassium Sparing: spironolactone, triamterene, eplerenone, amiloride

B. Mechanism of Action:
    1. Thiazide: inhibits the reabsorption of sodium, potassium, and chloride in the distal convoluted tubule and thus not retaining water
    2. Loop: inhibits the reabsorption of sodium, potassium, and chloride in the loop of Henle
    3. Potassium Sparing: prevents sodium reabsorption by either inhibiting aldosterone receptors or binding to epithelial sodium channels in the kidney tubules
C. Side Effects:
    1. Dehydration, dizziness, orthostatic hypotension, electrolyte abnormalities, myopathies, & impotence
    2. Thiazides & loop: caution in use with Pts who have DM or gout
    3. Spironolactone: gynecomastia
D. Statistics:
    1. Thiazide: 9 mmHg systolic and 4 mmHg diastolic
    2. Loop: 8 mmHg systolic and 4 mmHg diastolic
    3. Potassium sparing: 16 mmHg systolic and 6 mmHg diastolic

IV. ACE Inhibitors/ ARBs
A. Examples:
    1. ACE Inhibitor: lisinopril, enalapril, captopril, quinapril
    2. ARB: losartan, valsartan, Olmesartan, telmisartan, irbesartan, candesartan
B. Mechanism of Action:
    1. ACE: Disrupts the renin-angiotensin-aldosterone system by inhibiting the conversion of angiotensin I to II
    2. Resulting in vasodilation because angiotensin II is a vasoconstrictor
    3. ARB: Antagonize receptor binding of angiotensin II to AT1 receptors
C. Benefits:
    1. BP control, stops the progression of LV remodeling, prevention of CVA & MI, and slows the progression of kidney failure
    2. Renal protection with individuals w/ DM
D. Side Effects:
    1. Dry cough, dizziness, hyperkalemia, & fatigue
    2. Angioedema!!!!
E. Contraindications:
    1. Hx of angioedema, pregnancy, allergy, already on an ACE/ARB, elevated potassium levels, AKI, & renal artery stenosis
F. Statistics:
    1. ACE: 8-11 mmHg systolic & 5-6 mmHg diastolic
    2. ARB: 5.5-8 mmHg systolic and 4-7.5 mmHg diastolic

V. Beta-Blockers
A. Examples:

1. Cardioselective: Metoprolol, nebivolol, atenolol, & esmolol
2. Non-cardioselective: Carvedilol, propranolol, timolol, nadolol, & sotalol

B. Mechanism of Action:
1. Cardioselective: Prevents epinephrine from binding to beta-adrenergic 1 receptors = decreased HR & contractility
2. Beta-1 receptors are abundant in the heart = Cardioselective
3. Non-cardioselective: Prevents epinephrine from binding to beta-adrenergic receptors 1, 2, & 3 = Decreased HR, contractility, BP, and oxygen demand by heart muscles
4. Beta receptors effect SNS including: HR, BP, RR, and pupil size

C. Benefits:
1. Rate control, BP control, decrease angina, migraine prophylaxis, anxiety, tremors, & glaucoma

D. Side Effects:
1. Fatigue, dizziness, sleep disturbances, cold fingers/toes, & SOB

E. Contraindications:
1. Bradycardia & heart blocks
2. USE CAUTION in Pt's with : Chronic lung disorders (COPD/Asthma), DM, HF, and PVD

F. Statistics:
1. Blood Pressure: 10 mmHg systolic and 8 mmHg diastolic
2. Heart Rate: 11 beats per minute

VI. Calcium Channel Blockers

A. Examples:
1. Dihydropyridines: Amlodipine, nicardipine, nifedipine
2. Non-dihydropyridines: Diltiazem & verapamil

B. Mechanism of Action:
1. Dihydropyridines: Blocks calcium from entering smooth muscle cells = vasodilation
2. Blood vessels are made of smooth muscles
3. Calcium entering cells causes contractions A.K.A vasoconstriction
4. Non-dihydropyridines: Decreases effects of the SA and AV nodes by blocking the influx of calcium into the cell = slowing cardiac conduction & slowing cardiac contractility
5. More effect on heart function rather than vasodilation

C. Benefits:
1. BP control, HR control, & decreased angina

D. Maximum benefits:
1. Elderly individuals, subarachnoid hemorrhages (CVA), artery stenosis, Raynaud phenomenon, SVD, & myocardial bridges

E. Side Effects:

1. HA, peripheral edema, dizziness, flushing, hypotension, decreased cardiac contractility, constipation, gingival hyperplasia
2. Start low and go slow!

F. Contraindications:
1. Hypotension
2. Dihydropyridines: Hx of reflex tachycardia and monotherapy in Pt's with ischemic heart disease
3. Non-dihydropyridines: HFrEF, 2nd or 3rd degree AV block, SSS, bradycardia
4. Use caution in Pt's with: GERD

G. Statistic:
1. Blood Pressure: 12-13 mmHg systolic and 6-9 mmHg diastolic

VII. Alpha blockers

A. Examples:
1. Terazosin, prazosin, doxazosin

B. Mechanism of Action:
1. Blocks alpha-1 (adrenergic) receptors causing inhibition of smooth muscle contraction = dilation of peripheral blood vessels, decreases peripheral resistance, thus reducing BP

C. Benefits:
1. BP control, BPH management, pheochromocytoma management, paraganglioma management

D. Side Effects:
1. Orthostatic hypotension, dizziness, priapism (sexual dysfunction), N/V/D, dry mouth
2. Watch out for the first dose effect: strongest effect on blood pressure

E. Contraindications:
1. Cataract surgery (pupil contraction), breastfeeding, hx of orthostatic hypotension, erectile dysfunction medications
2. Prostate Ca w/ prazosin & terazosin
3. Hepatic disease w/ doxazosin

F. Statistics:
1. Blood Pressure: 8 mmHg systolic & 5 mmHg systolic (study suggests this is likely an overestimate d/t short duration of clinical trials)

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Dr. Andi L. Foley, DNP, APRN-CNS, EMT, CEN, FAEN, is the Clinical Nurse Specialist supporting nine EDs for St Luke's Health System in western Idaho. Experience over the last 20+ years has ranged across the country and spans EDs from 5-bed Critical Access to 25-bed academic to 90-bed community emergency departments. She is a Fellow in the Academy of Emergency Nursing and is the 2023 AEN Board Chairperson. Dr. Foley has a passion for helping to ignite a Spirit of Curiosity elevating evidence-based practice and high-quality care.

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Course Title: **Transgender Health in the Pediatric Population**

Course Release Date: April 25-27, 2023

Description:
This underserved population faces numerous health disparities. We will review concepts that focus on promoting the health and positive development of youth who identify as transgender, while eliminating discrimination and stigma. This workshop is recommended for all nurses, students, healthcare workers, pediatrics, and emergency services.

Objectives

Upon completion of this course, the nurse should be able to:

- Understanding the psychosocial impact of gender dysphoria
- The mental health needs for those transitioning
- Options for surgical intervention

Outline

I. Understanding gender and sexual/romantic orientation
   A. Important terminology: https://www.genderhealthtraining.com/resources/ I would like to go over several terms from this resource and provide a printout of some definitions if possible.
      1. LGBTQ+ Terms for Professionals to Know
      2. Gender Terms of Identity
      3. Gender Affirming Social Terms
      4. Gender Identity Pronouns
      5. Terms Often Used by Health Providers
      6. Sexuality Terms of Identity
      7. Offensive Outdated Terms
   B. Gender Unicorn. https://www.hervagaboundroots.com/lgbtqia-resources

II. WPATH Standards of Care Version 8
   A. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
   B. Hormone Therapy
      1. Pubertal suppression vs. hormone therapy
      2. Statements of Recommendations
   C. Surgery and Postoperative Care
      1. Statements of Recommendations
      2. List of surgeries
   D. Voice and Communication

1. Statements of Recommendations

E. Primary care
    1. Statements of Recommendations
F. Reproductive Health
    1. Statements of Recommendations
G. Sexual Health
    1. Statements of Recommendations
H. Mental Health
    1. Statements of Recommendations
I. Gender affirming care in adolescence
    1. Gender identity development in adolescence
        a) Early childhood expression of gender diversity vs declaration with onset of pubertal changes
        b) Neuroimaging studies, genetic studies, and other hormone studies in intersex individuals demonstrate a biological contribution to the development of gender identity for some individuals whose gender identity does not match their assigned sex at birth
J. Unique issues in adolescence
K. Identity exploration
L. Consent and decision-making
M. Caregivers/parent involvement
N. Providing Gender affirming care for children
    1. Principles underlying standards
    2. Psychological literature and knowledge of the unique risks to gender diverse children
    3. Statements of Recommendations
O. Maslow's Hierarchy of Needs
P. Patient centered care

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Authors: Luna Hodges, DNP, AC/PC, CPNP, & Christine Young, BSN, RN

Luna Hodges is a pediatric nurse practitioner certified by the Pediatric Nursing Certification Board in acute and primary care. She has worked as a PNP in a pediatric endocrinology clinic since 11/2019 and specializes in diabetes mellitus, female puberty, short stature, polycystic ovary syndrome, hypothyroidism, and vitamin D deficiency. She also participates in a multidisciplinary clinic that provides care to pediatric transgender patients. Prior to becoming a PNP, she worked as a registered nurse in various areas including Labor and Delivery, Mother/Baby, and several children's specialty clinics including the pediatric endocrinology clinic that inspired her to become a PNP.

Christine Young, received her bachelor's degree in nursing from the University of Oklahoma (Boomer Sooner!) in 2002 and am is in a DNP FNP program at Baylor University with an expected graduation in August 2024. Christine began her nursing career in the NICU, but made the leap to ambulatory care after ten years. She found her passion whenshe started working for a pediatric plastic surgeon.

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Luna Hodges, DNP, AC/PC, CPNP

Christine Young, BSN, RN

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Russell R. Blair, DNP, MSN-Ed, RN

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Course Title: Caring for the Pregnant Person in a Correctional Setting

Course Release Date: April 25-27, 2023

Description:
It is essential to provide quality care to maintain, improve, and support health in the pregnant person who is incarcerated. We will address needs specific for the incarcerated pregnant individual along with mental health and substance use management. Corrections and correctional healthcare will be discussed. National standards, state and federal laws will be addressed for this vulnerable population.

Objectives

Upon completion of this course, the nurse should be able to:

- understand the practice of caring for the incarcerated, vulnerable patient population during pregnancy.
- describe unique situations and/or risk factors to this patient population.
- explain the differences in correctional settings and the levels of care available, to this patient population and others who are incarcerated.
- have knowledge regarding national standards and accreditation for healthcare, laws and provisions associated with caring for this patient population.

Outline

I. Introduction

II. Statistics and Data
   A. People who are incarcerated - female inmates
   B. Numbers of pregnant incarcerated people
   C. Trends of incarceration for females & pregnant people
   D. Typical offenses of this population

III. Realities of Caring for the pregnant incarcerated person
   A. Screening for Pregnancy
   B. Prenatal Healthcare Services
      1. Onsite
      2. Offsite (transporting patients)
      3. Alternative services - contracted services, agency/state programs, doulas, telehealth
   C. Labor & Delivery Care
   D. Perspective of a Correctional Staff/Nurses
      https://libraryguides.law.pace.edu/c.php?g=907784&p=6589570

E. Perspective of a Pregnant Incarcerated person

IV. Care and Considerations for Pregnant Incarcerated Populations
- A. Bias: Understanding & Acknowledging Potential Biases around Pregnant Incarcerated People (Care and Considerations for Pregnant Incarcerated Populations)
- B. Medically Complex - chronic conditions, high risk pregnancies
  1. Substance Use Treatment/ANA Position Statement
  2. Withdrawing in custody while pregnant
  3. Mental Health
  4. Trauma Informed Care: Special Considerations
- C. Educational Needs Regarding Pregnancy
  1. Stages of Pregnancy, Labor, Postpartum
  2. Nutrition & Physical Health
     a) Access to healthy foods and exercise
- D. Postpartum care https://www.pbs.org/wgbh/frontline/documentary/tutwiler/
- E. Understand potential complex behaviors in prison
- F. Other Population Considerations
  1. Neonatal Care - NICU, Placement
  2. Transgender
  3. Juvenile
- G. Patient Advocacy - Complex Situations

V. National Standards & Laws impacting Care
- A. Counseling and Care of the Pregnant person
  1. Prenatal care
  2. Active opioid use disorder
  3. Emergency delivery
  4. Custody restraints
     a) Safety: Best Practices- Shackling https://www.youtube.com/watch?v=baEOkTgI3v8
  5. Postpartum
- B. The Impact of State & Federal Laws
  1. Examples of States with Complex Laws
     a) Examples of States with Advance Pregnancy Support during incarceration.
     b) Sentencing Considerations
     c) Rooming in & Lactation Considerations

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Authors: Kristy Schmidt MN, RN, NEA-BC, CPXP, LSSGB & Russell Blair DNP, MSN-Ed, RN, CCHP

Ms. Schmidt's nursing career spans 18 years beginning as a RN in pediatric specialty care. Kristy has experience working in several care settings including medical-surgical, neurology, oncology, behavioral health, pediatrics, women's services, ICU and ED. Kristy's education includes a bachelor's degree from University of Alaska Anchorage, a Master of Nursing from Boise State University, and is currently enrolled in a DNP program through Boise State University. Kristy has served for 8 years in a leadership role including managing ambulatory clinics, quality and safety, vulnerable populations program management, and nursing and patient care services. This is Kristy's first year participating in NurseCon in addition to her current leadership and learning roles.

Dr. Russell (Russ) Blair's nursing career spans 4 decades beginning as an LPN in pediatric, newborn, and orthopedic units. Upon completion of his RN degree, he worked in emergency nursing, helped those with developmental disabilities, and correctional health care. Russ's academic career began in 2015, serving as a clinical instructor, assistant professor, and associate professor serving as clinical instructor and professor in mental health nursing. Russ served as Associate Dean of Nursing from 2018 until May 2020 when he joined the NurseCon team as an author. Russ continues to serve as an adjunct professor of nursing. Russ's primary role is as nurse planner and educator for NurseCon. Russ is a NurseCon at Sea 2022 educator.

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Faculty and Planners Disclosure Statement

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Russell R. Blair, DNP, MSN-Ed, RN, CCHP

Carrie Sue Sweet Lamb, DNP, APRN-CNS, RNC-OB, ACNS-BC

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Course Title: Rethinking the Team Nursing Model

Course Release Date: April 25-27, 2023

Description:
The Team Nursing model consists of professional and non-professional nursing personnel collaborating to provide comprehensive patient-centered care. In this workshop, we will define the roles and responsibilities of each member of the team and the implementation process. This workshop is recommended for all nurses, students, healthcare workers, managers, and nursing leaders.

Objectives

Upon completion of this course, the nurse should be able to:

- identify roles and responsibilities for each member of their team nursing model.
- develop a team nursing model for their current practice setting.
- assimilate team building strategies for their current practice setting.

Outline

I. The Team Nursing Model
   A. History of Team Nursing
      1. WWI (CNA)
      2. WWII beginning & the 1950s
      3. Word Collage activity - When you hear "team nursing", what do you think, feel? (group interaction/discussion)

III. Team Nursing Stories & Experiences (group interaction/discussion)
   A. What worked and why?
   B. What didn't work and why?
   C. What are our personal preferences, biases, etc. that influence success/failure?

IV. Collaboration Improves Patient Care
   A. Roles and responsibilities (RN, RN student, LPN/CNA) (group discussion)
   B. Interprofessional Team Collaboration
   C. Delegation: Do's and Don'ts
   D. Team Building Exercises

V. Team Nursing in Action - Moving from I to We

VI. Team Nursing Model (team design hypothetical team)

VII. Looking Ahead

A. Review hypothetical teams that have been developed (group presentations)
B. Where do we go from here? (group discussion)

VIII. Takeaways
A. The Challenge
B. Q & A

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Authors: Jason Williams DNP, RN & Russell Blair DNP, MSN-Ed, RN

Dr. Williams's nursing career began in 2000. He spent over 10 years in critical care in NY, CA, and ID. Academic highlights include 8 years as faculty at a private university and a public college in ID. He chaired or assisted their accreditation process. He also spent time as Associate Dean for a private college. He serves on the education committees for Nurse Leaders of Idaho and NurseCon. Presentations/posters include ANA-Idaho/NLI LEAP, Idaho Nurse Educators, and Western Institute for Nursing conferences. He owns a health and wellness company, teaches NCLEX® prep, and is an administrator for a community hospital.

Dr. Russell (Russ) Blair's nursing career spans 4 decades beginning as an LPN in pediatric, newborn, and orthopedic units. Upon completion of his RN degree, he worked in emergency nursing, helped those with developmental disabilities, and correctional health care. Russ's academic career began in 2015, serving as a clinical instructor, assistant professor, and associate professor serving as clinical instructor and professor in mental health nursing. Russ served as Associate Dean of Nursing from 2018 until May 2020 when he joined the NurseCon

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Jason Williams, DNP, RN

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Course Title: Implicit Bias and Healthcare Disparities

Course Release Date: April 25-27, 2023

Description:
This workshop will highlight the racial disparities that exist in healthcare and how implicit and explicit biases impact patient outcomes. Institutional racism has had a significant and long-lasting impact on the quality of health and life outcomes of underserved populations. Strategies for reducing racial disparities will be discussed and we will learn how to identify and mitigate our own biases. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Define implicit/explicit bias
- Demonstrate how biases can influence the workplace and healthcare outcomes/care
- Explain how to recognize personal biases
- Explore the relationship between unconscious bias, diversity and inclusion and preventing discrimination
- Explore ways to mitigate bias

Outline

I. Community Agreements & Housekeeping
   A. Activity One – self-reflect and group discussion
   B. Pt Handoff Report
   C. What comes to mind when you hear about these patients?

II. Define implicit bias
   A. Different types of bias in healthcare
   B. How bias affects healthcare and leads to disparities
   C. Why do we have bias?
   D. When does bias occur ?
   E. How do we assess our own bias

III. Reflection and groups discussion– sharing examples of our own implicit bias in nursing practice, or witnessing others expressing implicit bias in healthcare
   A. Activity Two – Case study – VBAC in Black pregnant woman
   B. Mitigating Implicit Bias: Within ourselves
   C. Mitigating Implicit Bias: In the workplace
   D. Mitigating Implicit Bias: Tips for Nurse Managers

E. Resources for continued learning (handout)

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Author: Erin Raiolo, M.Ed., BSN, RN, CNEcl, CEN, TCRN, Anna Quon, MBA HM, BSN, RN, AMB-BC, NEA-BC, & Yovaletta Scruggs, MBA, NEA-BC, RNC-OB

Erin has worked in healthcare for over 20 years. Erin began her healthcare career in EMS and pursued nursing as a second career in 2014. Erin worked as a GI/Endoscopy out of nursing school before moving back into Emergency Medicine where she has been a nurse for the past 7 years. Erin is also a full-time nurse educator with Northwood Technical College in New Richmond, Wisconsin where she teaches advanced nursing concepts to senior nursing students.

Anna is a dual board-certified nurse with over 16 years of acute and ambulatory nursing experience. As the Manager of Nursing Research at the Nursing & Patient Care Center of Excellence at St. Lukes' Health System (Idaho & Oregon), most of her days are spent training and mentoring staff in evidence-based practice, research, scholarly writing, and professional development. She is an active member and volunteer in numerous local and national professional organizations and is currently a doctoral student at Rush University in Chicago, IL, studying autism and health disparity research.

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Course Title: Care of the LGBTQ+ Geriatric Population

Course Release Date: April 25-27, 2023

Description:
This engaging workshop examines common healthcare issues and disparities that affect the LGBTQ+ community. Participants will practice tools and strategies for providing inclusive and compassionate care of the LGBTQ+ geriatric population. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Identify up to three historical events impacting the aging LBQTQ community.
- Describe the aging LGBTQ patient experience.
- List up to seven strategies that can be used to provide inclusive care.
- Develop awareness of the unique health challenges of the aging LGBTQ community

Outline

I. It is a Generational Thing
   A. 1910-1924 - The Greatest Generation
   B. 1925-1945 - The Silent Generation
   C. 1946-1964 - Baby Boomers
   D. 1965-1979 - Generation X
   E. 1980-1994 - Millennials
   F. 1995-2014 - Generation Z
   G. 2015-2030 - Generation Alpha

II. Significant Events
   A. 1917-1935 - The Harlem Renaissance
   B. 1950 - The Mattachine Society
   C. 1955 - The Daughter of Bilitis
   D. 1967 - 1st edition of The Advocate published
   E. 1969 - The Stonewall Riots
   F. 1981 - AIDS epidemic
   G. 2008 - Proposition 8 passes

III. The Aging LGBTQ+ Patient Experience
   A. Language matters
   B. CAMPERS
      1. C - clear purpose

2. A - attitudes & beliefs
3. M - mitigation plan
4. P - patient
5. E - emotions
6. R - reactions
7. S - strategy

IV. Health Promotion
- A. Lesbians
  1. Obesity
  2. Increased risk of cervical cancer
  3. Increased risk of breast cancer
- B. Gay Men
  1. HPV/Anal cancer
  2. Hepatitis B/C
  3. Increased risk of STDs
  4. Monkeypox
- C. Health promotion
  1. Injury due to violence
  2. Mental health/suicide
  3. Increased risk alcohol/substance abuse
  4. Housing instability
- D. Health promotion/Awareness: Transgender FTM
- E. Health promotion/Awareness: Transgender MTF

V. Aging with HIV
- A. Cardiovascular disease
- B. Lymphoma
- C. Diabetes mellitus II
- D. Osteoporosis
- E. Kidney failure
- F. Polypathology

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Course Title: Sexual Orientation and Gender Identity Language

Course Release Date: April 25-27, 2023

Description:
This workshop uses an interactive game to help participants understand the expanding language used to describe sexual orientation and gender identity. You will learn the difference between sex, gender, and sexual orientation, as well as the meaning of each letter in the LGBTQ+ acronym. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Describe the different gender identities
- Understand the difference between gender identity and sexual attraction
- Understand that patients with different gender identity may require different treatments
- Understand pronouns and how to use the correctly
- Understand different flags for the different gender identities

Outline

I. Breaking the binary
   A. Gender Identity
      1. How you think about yourself
   B. Gender Expression
      1. How you demonstrate your gender
   C. Biological Sex
      1. Organs, hormones, and chromosomes
   D. Sexual Orientation
      1. Physical, spiritual, and emotional attraction
   E. The Gender Unicorn
   F. Sex assigned at birth
      1. Female
      2. Other/intersex
      3. Male
   G. Gender Identity
      1. Female, woman, girl
      2. Other, gender(s)
      3. Male, man, boy
      4. Genderqueer
      5. Agender
      6. Cisgender

7. Gender fluid
8. Nonbinary
9. Transgender
10. Two spirit

H. Gender Expression
1. Masculine
2. Neither
3. Feminine
4. Androgynous

I. Attraction
1. Asexual
2. Aromantic
3. Demisexual
4. Heterosexual
5. Bisexual
6. Gay
7. Lesbian
8. Pansexual

J. Preferred Pronouns
1. he/him/his
2. she/her/hers
3. they/them/theirs
4. ey/em/eirs
5. zi/hir/hirs
6. xe/xem/xyrs

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Course Title: Care for the Pregnant Patient in the Urgent Care Setting (Pharm)

Course Release Date: April 25-27, 2023

Description: Pregnant women are not your average patient but will show up in your urgent care clinics on a daily basis. Understanding their unique needs and offering evidence-based, timely care can prevent complications for both the pregnant patient as well as the fetus.

Objectives

Upon completion of this course, the nurse should be able to:

- Identify and treat pregnant patients in an urgent care environment
- Avoid unnecessary treatments or treatments which can cause harm
- Use best practice to improve outcomes

Outline

I. Pregnancy Trimesters
   A. First trimester is from week 1 to the end of week 12
   B. Second trimester is from week 13 to the end of week 26
   C. Third trimester is from week 27 to the end of the pregnancy

II. FDA Pregnancy Categories
   A. Narrative sections for:
      1. Pregnancy
      2. Labor & Delivery
      3. Lactation
      4. Reproduction Risk in Men & Women
   B. Subcategories include:
      1. Risk Summary
      2. Pregnancy Exposure Registry
      3. Clinical Considerations
      4. Data
      5. Contraception
      6. Infertility
   C. Establish Pregnancy Status
      1. "How do you know you're not pregnant?"
      2. Don't forget those populations who are at risk of pregnancy
      3. Do urine HCG if unclear pregnancy status especially if treatment is impacted
      4. Don't Assume They're Pregnant!
         a) You'll always be wrong
         b) LGBTQI+

c) Obese patients
d) Body image issues hiding it

III. OTC Meds Safe Throughout Pregnancy
   A. Diphenhydramine
   B. Cetirizine
   C. Dextromethorphan
   D. Acetaminophen
   E. Docusate
   F. Polyethylene glycol
   G. Psyllium
   H. Neomycin/polymyxin
   I. Bacitracin
   J. Maalox
   K. Tums
   L. Mylanta
   M. Gaviscon
   N. Famotidine
   O. Hydrocortisone topical
   P. Miconazole

IV. Key Takeaways
   A. Pregnant patients aren't just for OB/GYNs
   B. Pregnant patients walk into urgent cares often
   C. They're not just a woman with a parasite
   D. Azithromycin should be used very sparingly
   E. Don't be afraid to adjust your practice, it's never too late

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Course Title: Medications with Abuse Potential (Pharm)

Course Release Date: April 25-27, 2023

Description: A discussion on non-controlled substances and medications that clinicians would not typically think of as having an abuse potential. Understanding a medication's mechanism of action and common side effects can help clinicians understand why and how people could misuse them.

Objectives

Upon completion of this course, the nurse should be able to:

- Define: abuse, dependance, addiction
- Identify Red flags and high risk patients
- Medication mechanism of action, how they're used & abused

Outline

I. Definitions
   A. Abuse
      1. Substances are used in a manner or amount inconsistent with the legitimate medical use
   B. Dependence
      1. Medications, especially controlled substances, are capable of producing dependence, either physical or psychological
         a) Examples: SSRIs, opiates, Afrin
   C. Addiction
      1. A compulsive behavior where acquiring and using a substance becomes the most important activity in the user's life
   D. Controlled Substances
      1. Narcotics
      2. Depressants
      3. Stimulants
      4. Hallucinogens
      5. Anabolic steroids
   E. Red flag behaviors that indicate potential trouble
      1. Male age 18-46
      2. Patient resists dose reduction and argues or negotiates for more
      3. More than one missed appointment, positive UDTs
      4. Early refills needed using multiple excuses or reasons why
      5. Lost or stolen prescriptions without police reports
      6. ER visits for pain complaints, especially if no accident is reported
      7. Resists referral to therapies or other evaluations

8. Patient self adjustment of pain medication doses
9. Making assumptions about patients without evidence
10. Patients cannot describe how they safeguard meds

F. Tricky Interactions
1. Just because it is said, doesn't make it medically necessary or real
2. "But" statements:
   a) "I'm not drug seeking"
   b) "I don't like taking pills"
   c) "Something has to change"
   d) "It's not my fault if I assault somebody"

II. The CDC Guidelines

A. Chronic Pain
1. Use a thorough pain specific assessment in addition to the traditional assessment methodology
2. Consider all possible treatment options and include the patient in the decision process of how to treat the issue
3. Establish functional outcome goals with the patient
4. Assess and monitor risks throughout the pain care continuum
5. Safely discontinue treatment, including a drug dose taper

B. Decision Making Process
1. Evaluation (Complaint, Examination, Assessment, Plan)
2. Based on medical opinion and training - not patient request/insistence
3. Treatments are often adhered to the best when in line with patient's desire/opinion
4. That doesn't mean you should recommend a treatment that isn't in line with the guiding principles
5. Might be that you order an appropriate treatment that the patient doesn't agree with
6. Not prescribing medications is a treatment

C. Assessment Components
1. HPI - describe the pain issue that you need to treat
2. Social & family history - a patient who lives in an abuse or drug using situation is a target/candidate for diversion/misuse, history of legal issues
3. History of pain med use, why taken, how it worked, what resolved the problem.
4. Obtain a complete/current medication list
5. Physical exam should also focus on the pain issue
6. Are there physical limitations evidenced
7. Use screening tools to assess risk, baseline UDT
8. Check the current PDMP

III. Seemingly Benign Medications Abused
- A. Any Sedative
  1. Trazodone
  2. Quetiapine
  3. Diphenhydramine
  4. Clonidine
- B. Hydroxyzine
- C. TCA (double danger)
- D. Antipsychotics
- E. Muscle relaxers
  1. Indicated for:
     a) Short-term MSK pain with muscle spasms (< 3 weeks of use)
  2. Off Label:
     a) Fibromyalgia
     b) Myofascial pain due to temporomandibular disorders
     c) PTSD, Sleep, Alcohol Withdrawal
  3. Adverse effects: somnolence, dry mucous membranes, dizziness, and confusion, xerostomia, ileus, tachycardia, mydriasis, confusion, urinary retention, hallucinations, reflex tachycardia, ALT elevation.
  4. Most Abused: Soma
  5. Antidote: None
- F. Remeron
- G. Stimulating
  1. Albuterol
  2. Pseudoephedrine
- H. Mood Altering
  1. Gabapentin
     a) Indicated for:
        (1) Partial seizures
        (2) Restless Leg Syndrome
        (3) Post Herpetic Neuralgia
     b) Off label uses:
        (1) Radiculopathy
        (2) Back pain
        (3) Anxiety
        (4) Insomnia
        (5) Seizure
        (6) Peripheral Neuropathy
     c) Antidote: None
     d) States where Gabapentin is classified as a controlled substance (AL, KY, MI, ND, TN, VA, and WV).
     e) States with mandated Gabapentin reporting (CT, DC, IN, KS, MA, MN, NE, NJ, OH, OR, UT, and WY).

        f) States deliberating mandated reporting of Gabapentin to controlled substances (DE, NY, and WI).
    2. Trazodone (higher doses)
    3. Venlafaxine
    4. Topiramate (weight loss)
    5. Carbamazepine

I. Cognition Altering
    1. First Generation Antihistamines
    2. Oxybutynin
    3. Dicyclomine

J. Non-psychoactive effects
    1. Psyllium Powder
    2. Fish Oil

K. “Holy Trinity” (Controlled)
    1. Oxycontin
    2. Xanax
    3. Soma

L. “Holy Trinity” (Non-controlled substances)
    1. Gabapentin
    2. Wellbutrin
    3. Seroquel

M. Cough Suppressants
    1. Active Ingredients: codeine, chlorpheniramine, codeine, phenylephrine, promethazine, hydrocodone, guaifenesin, hydrocodone, chlorpheniramine, pseudoephedrine
    2. Indicated for:
        a) Cough
    3. Off Label Uses:
        a) Cold symptoms
        b) Most Abused: Codeine/promethazine
    4. Antidote: Naloxone

N. Mental Health Medications
    1. Wellbutrin
    2. Trazodone
    3. Topiramate
    4. Buspirone
    5. Clonidine
    6. Vistaril (combined with other anticholinergics)

O. Weight Loss
    1. Laxatives
    2. Diuretics
    3. Topiramate
    4. OTC Supplements

P. Antibiotics
    1. Purchases in another country
    2. Takes only part and saves rest for rainy day
    3. Pressures provider
    4. “Zpacks always work well for me”
Q. Anti-diarrheals
    1. Loperamide
    2. OTC
    3. Binds to μ-opioid receptors
    4. High doses gives opiate-like effects
R. Miscellaneous OTC Medications
    1. Tylenol
    2. NSAIDs
    3. Afrin

IV. Key Takeaways
    A. Keep An Eye On Buprenorphine/Naloxone
    B. Not intended to get you to not prescribe medications
    C. Purpose of this is to keep aware, and consider alternatives in those patients who have use disorders, or at-risk for abuse.

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Before Brad became a nurse practitioner, he worked as a nurse for 6 years in orthopedics, telemetry and post anesthesia care unit (PACU). Brad graduated from Gonzaga University Family Nurse Practitioner program.
Brad has worked in a variety of settings as a nurse practitioner including a family practice/urgent care and in corrections. He started his own mobile urgent care practice in 2016, where he now works full time with a staff of 5 people.
Brad is married with two children. Brad's wife and co-owner, Nancy, has worked as a nurse for 14 years at a large local hospital. They enjoy traveling and doing activities with their very active children.

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Faculty and Planners Disclosure Statement

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Course Title: Navigating the Healthcare Hierarchy with expert panel discussion

Course Release Date: April 25-27, 2023

Description:
Navigating a healthcare organization's structure can be a complex venture. It is important to understand your healthcare structure to ensure team alignment and effective communication among nursing leadership and healthcare providers. This talk will highlight key elements for navigating the organizational hierarchy, influencing stakeholder groups, optimizing communication, and improving outcomes. The second hour will include an expert panel discussion and audience questions. This talk is recommended for all nurses, students, healthcare workers, managers, nursing leaders, and educators.

Objectives

Upon completion of this course, the nurse should be able to:

- Summarize the various hierarchies within differing healthcare systems.
- Identify best practices for communicating within the management structure.
- Define organizational impact of bypassing the chain of command.

Outline

I. Introduction
   A. History of Nursing Structures
   B. Roles & Responsibilities
   C. Types of Healthcare Hierarchies
   D. Functional vs Dysfunctional

II. Navigating Hierarchy
   A. Systems View of Healthcare
   B. Consequences for Bypassing Hierarchy
   C. Strategies for working within the healthcare hierarchy

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Author: Michelle Hamland, DNP, RN, RN-BC

Dr. Michelle Hamland is the co-founder and CTO of InvenTech Consulting and Director of Nursing Informatics at Marshfield Clinic Health System. Dr. Hamland has a Bachelor of Science in Nursing, Master of Science in Nursing Informatics, and Doctor of Nursing Practice in Healthcare Systems Leadership. She is an innovator, visionary, and health informatics expert. Dr. Hamland has years of experience in the development, deployment, and evaluation of healthcare technologies. She's passionate about improving the relationship between clinicians and technology. Dr. Hamland believes in implementing technologies that are practical and that can augment patient care, not disrupt it.

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Course Title: Code Sepsis Escape Room

Course Release Date: April 25-27, 2023

Description:
Sepsis is a leading cause of death in children and adults. Recognizing these severely ill patients can be difficult. Come learn about sepsis and see if you can escape the room! This workshop is recommended for all nurses, students, healthcare workers, critical care, emergency services, obstetrics, pediatrics, neonatal, medical/surgical, ambulatory, and geriatrics.

Objectives

Upon completion of this course, the nurse should be able to:

- Learn how to create an escape room and understand the value in this flipped classroom activity.
- Recognize sepsis symptoms, alterations in vital signs, and plan appropriate nursing interventions for a variety of patient populations (pediatrics, adults, maternity, etc).
- Work with a team to solve puzzles related to sepsis care so you can “escape the room”.

Outline

I. Introduction/overview
   A. What is sepsis?
   B. How does this impact my nursing role and patient care?

II. Motivation
   A. Sepsis facts
   B. Impact on health care

III. Comprehension
   A. Early recognition of SIRS criteria
   B. Critical assessments, diagnostic interpretation, etc.
   C. Activation of emergency response system/ protocols
   D. Prioritization of nursing interventions
   E. Sepsis management
   F. Practice
   G. Sepsis Escape Room
   H. What to expect
      1. Rules of the room
      2. Safe learning environment
      3. Hints if stuck

IV. Assess
   A. Escape Room Debrief Survey – Microsoft Forms
   B. Validation of skills performed

V. Apply
   A. What sepsis knowledge will I take into my nursing practice?
   B. How will this knowledge benefit my nursing practice?
   C. What is an escape room?
   D. How can this be implemented in my practice/role?

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Author: Erin Raiolo, M.Ed., BSN, RN, CNEcl, CEN, TCRN & Anna Steen, M.Ed., MSN, RN

Erin has worked in healthcare for over 20 years. Erin began her healthcare career in EMS and pursued nursing as a second career in 2014. Erin worked as a GI/Endoscopy out of nursing school before moving back into Emergency Medicine where she has been a nurse for the past 7 years. Erin is also a full-time nurse educator with Northwood Technical College in New Richmond, Wisconsin where she teaches advanced nursing concepts to senior nursing students.

Anna has been working as a nurse since 2013 and currently works at a critical access hospital in rural western Wisconsin. Not only do I work on the floor as a nurse, but I also am one of the Medical Surgical Department Nurse Educators. This role entails many avenues such as creating annual competencies for nurses, managing the preceptor program, and facilitating the nurse residency program. My background includes a bachelors and master's degree in education where I spent half of my previous career teaching in education. I also have a master's degree in

nursing with a focus on nursing education. Nursing and education have always been a passion of mine and nursing has allowed me to unite both.

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Faculty and Planners Disclosure Statement

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Course Title: Pediatric Functional Constipation

Course Release Date: April 25-27, 2023

Description:
Functional constipation is a common cause of hospital admission in the pediatric population. Learn about the pathophysiology, age-specific assessments, and treatments of this condition. Red flags for an organic cause for the constipation will also be discussed. This workshop is recommended for all nurses, students, healthcare workers, pediatrics, and emergency services.

Objectives

Upon completion of this course, the nurse should be able to:

- Define Constipation
- Identify physical examination norms, evaluation, and red flags
- Identify treatment options for constipation
- Define Voiding Dysfunction
- Learn the importance of mental health screening in the setting of voiding dysfunction
- Learn about treatment options for voiding dysfunction
- Identify situations that may impact the treatment of voiding dysfunction
- Learn physical assessment red flags and tests for voiding dysfunction

Outline

I. Introduction

II. Epidemiology

III. Contributing Factors

IV. Clinical Features
   A. Functional Constipation
      1. But what about IBS/IBD?
   B. Associated Symptoms

V. Diagnosis
   A. Criteria
   B. Exclusion of Organic Causes
      1. Red Flag Symptoms
   C. Recent Onset Constipation
   D. Chronic Constipation

VI. Differential Diagnosis
   A. Infant Dyschezia
   B. Hirschsprung Disease PHysi
   C. Slow Transit Constipation
   D. Cow's milk intolerance

VII. Physical examination

VIII. Treatment

IX. When to evaluate further?
   A. Laboratory Tests
   B. Motility Tests

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Author: Rachel Elledge, MSN, CPNP

Rachel Elledge, MSN, PNP-C is a board-certified pediatric nurse practitioner specializing in pediatric urology with interests in voiding dysfunction, dysfunctional voiding, neurogenic bladder, vesicoureteral reflux, and spina bifida. She manages the bowel and bladder clinic at the St. Luke's Children's Pavilion. Rachel is passionate about providing evidence-based practice and ensuring that both the child and their parents feel supported and heard. Rachel earned her master's degree as a nurse practitioner from the University of Missouri – Kansas City and completed her undergraduate studies at Jacksonville University and Goldfarb School of Nursing.

Prior to her work as a nurse practitioner, she has worked as a pediatric registered nurse (RN) in the ambulatory pediatric urology clinic as well as several other areas of pediatrics over the past 16 years. In her free time, Rachel enjoys cycling, hiking, and spending time with husband and their four children.

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Course Title: Overcoming Barriers Caused by Workplace Trauma

Course Release Date: April 25-27, 2023

Description:
Nurses often experience traumatic events in the workplace. Unresolved trauma can lead to emotional exhaustion and moral injury or "burnout". This interactive workshop will provide you with the tools to identify these barriers, set emotional boundaries, and process workplace trauma. You will learn how to create a plan to reframe and manage the stress associated with workplace trauma. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Define Trauma and its sources
    - Trauma experiences, responses and manifestations that are unique to nursing
    - Discussion of Workplace Violence in Nursing
    - Identify the barriers you have created to protect yourself from getting hurt.
    - Pervasiveness and depths of unresolved traumas
- Learn how to use reframing to recognize and release the hold your trauma has on you.
- Create a plan to deal with the consequences of lowering your guard and to
- Handle the inevitable stresses of life.

Outline

I. Trauma
    A. What is trauma?
    B. 8 Dimensions of Wellness
    C. Moral distress
    D. Patient loss and death
    E. Indirect trauma
        1. 1 in 4 nurses are abused in the workplace
        2. Violent events against nurses are 3X greater than other occupations
        3. 68% nurses report verbal abuse and aggressive communications
    F. Past trauma + Workplace trauma + Present stress
        1. "...trauma is not just an event that took place sometime in the past; it is also the imprint left by that experience on mind, brain, and body."
    G. "The Body Keeps the Score"
    H. Barrier vs. Boundary

I. What barriers do you have that you previously thought were a boundary?
J. Japanese Knotweed
K. Trauma suppression
L. Mindfullness
M. Reframing
N. Self-care

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Authors: Stephanie M. Hutchins, PhD & Jill McLellan Phelps, MS, BSN, BA, RN

Stephanie M. Hutchins, PhD, author of *Transformation After Trauma* and *Reclaim Your Life After Trauma*, helps individuals overcome trauma and cope with stress. She is a Certified Life Coach, Stress Management Coach, Advanced Wellness Coach, Neuro-Linguistic Programming Practitioner, and Yoga Instructor. She also owns Serotinous Life, a company that helps individuals harness the power of post-traumatic growth. Dr. Hutchins taught about the human body as a college professor for 12 years. She combines yoga principles, her knowledge of the human body, and her healing journey to empower others with tools to fuel massive personal and professional growth.

Jill fulfilled her lifelong dream of becoming a Registered Nurse at age 45! Her nursing career has been exclusively in long-term care, on a secure Memory Care Unit. Since her ADN graduation she completed her BSN and will obtain her MS in December, 2022. Jill wants all nurses to be empowered, challenged and work in settings that will maximize their personal and professional goals!

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Faculty and Planners Disclosure Statement

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Course Title: Emotional Safety and Healthy Boundaries

Course Release Date: April 25-27, 2023

Description:
How do we protect ourselves from moral injury or "burnout"? Healthy interpersonal relationships in the workplace can be difficult to establish. In this workshop, we will help you develop tools to protect yourself emotionally. You will learn to identify, assess, and develop a plan to thoughtfully say, Yes or No. This workshop is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Define boundaries and boundary types.
- Identify personal boundary needs.
- Demystify the perceived power of saying "No".
- Determine the true costs of "Yes".
- Identify, assess, and develop a plan to thoughtfully say, "Yes". Via utilization of the "Wheel of Life" tool.
- *Utilization of Maslow's Hierarchy of Needs and Nonviolent Communications Strategy in developing and maintaining boundaries.
- Build boundaries to reduce stress and prevent burnout.

Outline

I. Boundaries.
   A. What are boundaries?
   B. Why do boundaries get a bad rap?
   C. Life balance
   D. Stop overthinking
   E. Power of saying "no"
   F. Ladder of Inference
   G. "Set Boundaries, Find Peace"
   H. Wheel of Life
      a. Finances
      b. Career
      c. Relationships
      d. Contribution
      e. Health
      f. Personal growth
      g. Recreation

    h. Environment
I. “Reclaim Your LIfe After Trauma”
J. Develop a plan to thoughtfully say “yes” or “no”
K. Maslow’s Hierarchy of Needs
    a. Human needs never conflict...our strategies to obtain our needs can
    b. "Needs are never in conflict, only strategies are"
L. Perspective

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Author: Stephanie M. Hutchins, PhD & Jill McLellan Phelps, MS, BSN, RN

Stephanie M. Hutchins, PhD, author of *Transformation After Trauma* and *Reclaim Your Life After Trauma*, helps individuals overcome trauma and cope with stress. She is a Certified Life Coach, Stress Management Coach, Advanced Wellness Coach, Neuro-Linguistic Programming Practitioner, and Yoga Instructor. She also owns Serotinous Life, a company that helps individuals harness the power of post-traumatic growth. Dr. Hutchins taught about the human body as a college professor for 12 years. She combines yoga principles, her knowledge of the human body, and her healing journey to empower others with tools to fuel massive personal and professional growth.

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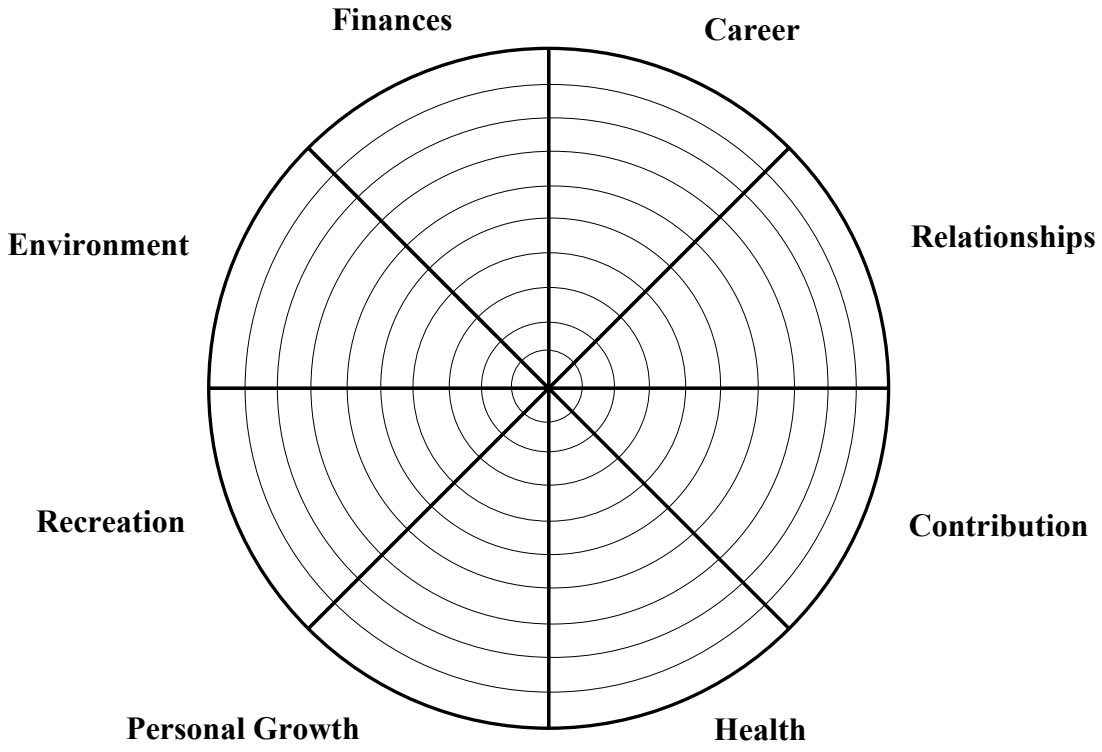
Emotional Safety and Healthy Boundaries Workshop

The Wheel of Life

Where are you on a scale from 0 – 10 in each of these areas of your life? The middle of the circle corresponds to '0' (very dissatisfied) and the outermost ring of the circle corresponds to '10' (very satisfied). Color in each section on the chart below, based on how you rate yourself in each area. You're rating yourself based on where you currently are in each area in comparison to where you really want to be. If you rate yourself a 7 in one area, you'll color in that area from 0 – 7, so you have 7 rows shaded in.



Finances includes your spending habits, debt, savings, investments, and retirement.
Career includes your job, business, and continuing education.
Relationships includes your relationship with your family, friends, and significant other.
Contribution includes giving time or money to your community and causes that are important to you.
Health includes your physical body, emotional health, diet, sleep, and exercise.
Personal Growth includes working through self-limiting thoughts, habits, and behaviors to make positive changes in your life and progress forward.
Recreation includes fun, hobbies, and creative expression.
Environment includes your home, the physical location of your home, and pets

Course Title: Cannabis and the Endocannabinoid System

Course Release Date: April 25-27, 2023

Description:
Recreational and medical use of cannabis has increased in recent years. We will explore the history of cannabis and how it is perceived in healthcare today. We will discuss what the endocannabinoid system is, its role in the body, and how it affects pain modulation and the immune system. This talk is recommended for all nurses, students, healthcare workers, APRNs, educators, and includes pharmacology credit.

Objectives

Upon completion of this course, the nurse should be able to:

- Discuss the history of cannabis and its place in society today.
- Visit terminology pertaining to the endocannabinoid system, what those terms mean, and examples for each.
- Discuss what the endocannabinoid system is, which receptors are involved, and how it relates to pain modulation and the immune system.

Outline

I. History of Cannabis
   A. Cannabis
   B. Medicinal Cannabis
   C. Cannabis-based Medicines
   D. Cannabinoids
   E. Phytocannabinoid
   F. Endocannabinoid
   G. Negative Allosteric Modulators
   H. Positive Allosteric Modulators
   I. CBD
   J. THC

II. FDA approved Cannabinoids
   A. Cesamet (nabilone) Synthetic cannabinoid similar to THC
   B. Epidiolex Plant-derived CBD
   C. Marinol (dronabinol) Synthetic THC
   D. Sativex Combination of THC and CBD in a 1:1 ratio

III. Endocannabinoid System
   A. Presynaptic

B. Postsynaptic

IV. Gastrointestinal System

V. Immune System

VI. Pain

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Author: Rudolph Pavlesich, DNP, FNP-BC, CRNA, APRN

Dr. Rudolph Pavlesich DNP, RN, PMH-BC earned his BSN from Purdue University on an Army ROTC scholarship. Dr. Pavlesich worked in all areas of Intensive Care for 12 years, 5 years as an Army Nurse Corps Officer, 7 as a civilian. He was deployed to Iraq for 1 year. Pavlesich earned his MSN from the University of North Florida's (UNF) Nurse Anesthesiology Program and then returned to UNF a year later to complete the DNP and FNP post-masters certification. He has been a practicing CRNA for 7 years, and is currently a partner in Blue Sky Anesthesia Associates based in New Hampshire providing mobile sedation in dental offices across New England.

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Course Title: Emerging Treatments for Post Traumatic Stress Disorder (Pharm)

Course Release Date: April 25-27, 2023

Description:
Post Traumatic Stress Disorder (PTSD) can manifest from a disruptive event that is shocking, scary, or dangerous. Nurses can be exposed to these triggering events in the workplace. We will discuss the warning signs, prevalence, and statistics surrounding the phenomena. Risk factors, behavioral interventions, and pharmacological treatments will be explored in this interactive discussion. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Discuss what PTSD is and some statistics surrounding the phenomena.
- Discuss the body systems that pharmacological treatments are aimed at to treat PTSD.
- Discuss three medications that have the most promise in the treatment of PTSD.

Outline

I. PTSD
   A. 3 in every 50 American Adults
   B. Up to 23% of Veterans
   C. 30% of First Responders

II. Diagnosis

III. Symptoms and Treatment
   A. Noradrenergic System
   B. HPA Axis
   C. Glutamate System
   D. Psychedelic-Assisted Psychotherapy
   E. Ketamine
   F. MDMA (Ecstasy)

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Course Title: Exploring the Legal Aspects of Nursing

Course Release Date: April 25-27, 2023

Description:
Malpractice and negligence impact nurses both professionally and personally. This talk will provide an overview of the legal principles which affect nursing practice. The litigation process, license complaints, and criminal liability will be reviewed. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Recognize the legal ramifications of a medical mistake and their personal liability
- The nurse will gain an understanding of how legal mistakes are reviewed and analyzed by a legal nurse consultants and attorneys.
- Discuss key differences between civil and criminal lawsuits and how they apply to charges against nurses.

Outline

I. Nursing Regulatory Bodies
   A. Boards of Nursing
      1. NCSBN: 59 BONs in the US
      2. BON structures
   B. Nursing Practice Act
      1. Qualifications for licensure
      2. Nursing titles that are allowed to be used
      3. Scope of practice (what the nurse is allowed to do)
      4. Actions that can or will happen if the nurse does not follow the nursing law
   C. Discipline
   D. Education
   E. Nurse Licensure Compact/APRN Compact
      1. NCL: 39 jurisdictions
      2. APRN: 3 jurisdictions

II. Protecting your practice
   A. Liability with License Protection
   B. Professional Boundaries
   C. Charting
   D. Speak Up

E. Competency
F. Social Media

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Author: Carrie Sweet, DNP, APRN-CNS, RNC-OB, ACNS-BC

Carrie Sweet currently serves as NurseCon's Vice President of Education and Accreditation. Prior to her current role, Dr. Sweet served as dean of nursing, opening a new campus for nursing students in LPN, BSN, and MSN programs. Dr. Sweet has worked in several states, in a variety of leadership and clinical roles, which have provided her with vast insight into nursing. In her 20+ years of healthcare experience, she has worked at the bedside, as a Perinatal CNS, educator, nursing manager, nursing practice director, professor, dean of nursing, medical director, consultant, author, and speaker. Dr. Sweet is passionate about mentoring nurses and advocating for underserved populations.

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Course Title: Recognizing Suicide Risk in Nursing

Course Release Date: April 25-27, 2023

Description:
Suicide is a difficult topic to discuss with patients and coworkers. Due to stressful workplace environments, nurses are at high risk for suicide. We will explore the prevalence and warning signs of suicide among healthcare workers. We will also learn what to do if you or someone you know has suicidal thoughts. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Increase suicide awareness among RNs
- Inform RNs about programs and resources surrounding suicide
- Dispel myths about suicide
- Educate how to talk about suicide

Outline

I. National Suicide Prevention Lifeline
   A. 1-800-273-TALK (8255)

II. Statistics and Data
   A. One person dies every 40 seconds by suicide
   B. 75 people will have killed themselves by the end of presentation (50 minutes)
   C. 2160 people will have killed themselves by midnight (24 hrs)
   D. H.R. 1319 American Rescue Plan Act of 2021
      1. Sec. 2703. Funding for mental health and substance use disorder training for health care professionals, paraprofessionals, and public safety officers.
      2. Sec. 2704. Funding for education and awareness campaign encouraging healthy work conditions and use of mental health and substance use disorder services by health care professionals.
      3. Sec. 2705. Funding for grants for health care providers to promote mental health among their health professional workforce.
      4. Sec. 2711. Funding for behavioral health workforce education and training.
      5. Sec. 2713. Funding for expansion grants for certified community behavioral health clinics.
   E. From 2007 and 2018, nurses were 18% more likely

to die from suicide than the general population.

F. Among female nurses, the risk of death by suicide was nearly twice the risk observed in the general population.
    1. Inadequate PPE
    2. Verbal and physical violence at work
    3. Incivility among staff
    4. Understaffed clinical areas
    5. Fear of exposing loved ones to infection
    6. Perfectionism
G. Nurses with suicidal ideation were less likely to report that they'd seek such help than nurses without suicidal ideation
    1. Fear of impacting one's career
    2. Doubt about confidentiality
    3. Difficulties taking time off work for treatment
    4. Difficulties scheduling appointment
H. HEAR (Healer Education, Assessment, Referral) 2016
    1. Education
    2. Presentations
    3. Confidential
    4. Anonymous survey
    5. Assessment
    6. Referral system

III. Common Myths about Suicide
    A. Talking about suicide increases the chance a person will act on it
    B. People who talk about suicide are just seeking attention
    C. Suicide can't be prevented
    D. People who take their own lives are selfish, cowards or weak
    E. Teenagers and college students are the most at risk for suicide
    F. Barriers to bridges, safe firearm storage and other actions to reduce access to lethal methods of suicide don't work
    G. Suicide always occurs without warning
    H. Talk therapy and medications don't work

IV. If someone you know or love is feelings suicidal
    A. Warning Signs
        1. Talking about
            a) Wanting to die
            b) Guilt
            c) Shame
            d) Being a burden to others
        2. Feeling
            a) Empty

b) Hopeless
c) Trapped
d) Full of rage
e) Unbearable emotional pain

3. Behaviors
    a) Withdrawing from friends
    b) Giving away important items
    c) Displaying extreme mood swings
    d) Eating or sleeping more or less
    e) Using drugs or alcohol more often

B. Ask the tough question: “Are you thinking about suicide?”
C. Listen to the person without judgment
D. Call 911 or 988
E. Stay with the person until professional help arrives
F. Try to remove any potentially harmful objects

V. What do you do if you are feeling suicidal?

A. Phone numbers
    1. SAMHSA Disaster Distress Helpline: 1-800-985-5990
    2. The Trevor Project LGBTQ+ youth: 1-866-488-7386
    3. IMAlive: 1-800-784-2433
    4. Crisis Text Line: Text HOME to 741741
    5. 988 Suicide & Crisis Line (call or text)
B. Websites
    1. Therapy Aid Coalition
    2. The Emotional PPE Project
    3. Healthy Nurse, Healthy Nation
    4. Give an Hour

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Method of Participation to Earn CNE Credit(s)

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1. Read the educational objectives and disclosure statements
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Upon completion of the entire content, the learner may receive 1 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 1 hour to complete. Credits are given in 1-hour increments.

Author: Elizabeth Pavlesich, DNP, RN, PMH-BC

Dr. Elizabeth Pavlesich, DNP, RN, PMH-BC has worked in mental health and substance abuse for over 25 years. After she earned her BS degree in Psychology from the University of Florida in 1999, she spent twelve years of her career as a Rehabilitation Therapist for a state hospital in Florida. During her time there, Dr. Pavelesich decided to apply to nursing school to broaden her reach and impact on patients and families suffering from mental illness and substance abuse issues. "Becoming a nurse seemed like a perfect fit for me because I truly enjoy talking to my patients, getting to know them, and assisting them with recovery and stability" she states. After getting her ADN, at a community college in Jacksonville, Florida, she began her nursing career in 2010. Pavlesich served as a bedside nurse for approximately six years in acute, emergency, and outpatient psychiatric settings before returning to school to get her Master's in Nursing Informatics in 2014. Shortly after earning her MSN, Elizabeth made her leap into leadership and became the first Psychiatric Safety Nurse at Johns Hopkins Bayview Medical Center. Always striving for growth, change, and an awesome challenge, she earned her DNP in 2021. Elizabeth most recently worked as a Clinical Educator for Behavioral Health and Substance Abuse in Annapolis, Maryland and Clinical Instructor for the University of Maryland and now is the Education Coordinator for NurseCon.

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Faculty and Planners Disclosure Statement

None of the planners or presenters for this activity have relevant financial relationship(s) to disclose with ineligible companies.

Elizabeth Pavlesich, DNP, RN, PMH-BC

Carrie Sue Sweet Lamb, DNP, APRN-CNS, RNC-OB, ACNS-BC

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Course Title: Mentoring Relationships in Nursing

Course Release Date: April 25-27, 2023

Description:
Preceptors and mentors are often viewed as having the same function. The mentor relationship has different dynamics and goals than a preceptor relationship. In this talk, you will learn how to establish mentoring relationships and the importance of informal and formal mentoring. This talk is recommended for all nurses, students, healthcare workers, mentors, preceptors, managers, and educators.

Objectives

Upon completion of this course, the nurse should be able to:

- Understand the importance of mentor/mentee relationships
- Identify components and characteristics of a mentor/mentee relationship
- Create a mentor/mentee relationship concept map

Outline

I. Nature vs Nurture
   A. Discussion: Knowledge - Intrinsic versus learned
      1. Bandura Social Cognitive Theory (learning through observation)
      2. How did things change from being children to being young adults
      3. What are some possible reasons for this change in perspective?

II. Selfless vs Selfish
   A. Discussion: Healthy versus unhealthy relationships and values
      1. Peplau Interpersonal Relations Theory (a need and an expert)
      2. Not all mentors consider the needs of the mentee over their own.
      3. Important to establish relationships that benefit both parties and are healthy.

III. Introduce Theories and authors; Understanding definitions
   A. Bandura: Social Cognitive Theory/Observational Learning Model
      1. We learn from observing those around and our surroundings
   B. Peplau: Interpersonal Relations Theory
      1. We learn from establishing relationships and serving one another
   C. Mentor: One who is experienced and trusted to advise, train, or counsel another
   D. Mentee: One who is advised, trained, or counseled by another

IV. Relationships are centered around me

A. Discussion: What do I need from others? Who can I help? Do I have the time? Can I afford not to? How many relationships should I establish at one time?

V. The reason for the relationship (Characteristic/skill)
   A. Activity: identify needed characteristics/skills for
      1. Personal
      2. Professional
   B. Activity: identify characteristics/skills I possess
      1. Personal
      2. Professional
   C. Activity: identify who I can get them from?
      1. Personal
      2. Professional

VI. Creating the concept map
   A. Discussion: What does your concept map look like?
      1. How many needs do you have to strengthen?
      2. How many strengths do you have to offer
      3. Which will you work on?
      4. How many values will I work on?
      5. Which value is my priority?
      6. Which do you have an identified potential mentor for:

VII. Managing the relationship
   A. Discussion: Considerations
      1. Entering: establishing the relationship
      2. Time: how long, how often, where, what format
      3. Ending: gracious thankfulness; pay it forward, honoring agreement

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Method of Participation to Earn CNE Credit(s)

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Upon completion of the entire content, the learner may receive 1 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 1 hour to complete. Credits are given in 1-hour increments.

Author: Jason Williams DNP, RN

Dr. Williams's nursing career began in 2000. He spent over 10 years in critical care in NY, CA, and ID. Academic highlights include 8 years as faculty at a private university and a public college in ID. He chaired or assisted their accreditation process. He also spent time as Associate Dean for a private college. He serves on the education committees for Nurse Leaders of Idaho and NurseCon. Presentations/posters include ANA-Idaho/NLI LEAP, Idaho Nurse Educators, and Western Institute for Nursing conferences. He owns a health and wellness company, teaches NCLEX® prep, and is an administrator for a community hospital.

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Faculty and Planners Disclosure Statement

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Course Title: Evolution of Nursing with Expert Panel Discussion

Course Release Date: April 25-27, 2023

Description:
Organizations often have "new" ideas of how nurses should practice. We will identify cyclic patterns of nursing practice and explore the evolution in practice, science, and autonomy. The second hour will include an expert panel discussion and audience questions. This talk is recommended for all nurses, students, healthcare workers, mentors, preceptors, managers, and educators.

Objectives

Upon completion of this course, the nurse should be able to:

- Examine nursing history and care over time
- Change is constant in nursing, explore how nursing has changed over time (Education, certification, dress code, personal presentation, etc)
- Understand where we are now, how has nursing evolved, what has come back to the forefront of importance, where are we going

Outline

I. Where it started
   A. Romans
   B. Crimean War
   C. Nightingale School of Nursing
   D. American Civil War

II. Nursing today
   A. United States Nursing Schools
   B. 3 million working nurses in the United States
   C. Accredited programs worldwide

III. What has changed?
   A. Education
      1. Education is lifelong
      2. Complexity of patients has increased
      3. 2010-2020 Institute of Medicine goals
   B. Responsibilities
      1. Bedside caretaking
      2. Nursing is an Art
      3. Nursing roles today

C. Specialization
    1. Clinical nurses
    2. APRNs
D. Safety & Quality
    1. Nurse's role in patient care
    2. Patient advocates
    3. Evidence-Based Practice
E. Clothing & Appearance
F. Technology
    1. Charting
    2. Virtual patients
    3. Virtual learning environments
    4. Telehealth
    5. Informatics
    6. Equipment
    7. Apps
    8. Patient Portals

IV. Where are we now?
    A. Education programs
    B. Nursing shortages
    C. Nurse leaders
    D. Diversity

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Author: Erin Raiolo, M.Ed., BSN, RN, CNEcl, CEN, TCRN

Erin has worked in healthcare for over 20 years. Erin began her healthcare career in EMS and pursued nursing as a second career in 2014. Erin worked as a GI/Endoscopy out of nursing school before moving back into Emergency Medicine where she has been a nurse for the past 7 years. Erin is also a full-time nurse educator with Northwood Technical College in New Richmond, Wisconsin where she teaches advanced nursing concepts to senior nursing students.

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Faculty and Planners Disclosure Statement

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Course Title: Telehealth and Virtual Patient Care

Course Release Date: April 25-27, 2023

Description:
Telehealth services improve patient access to medical information and engagement with clinicians. We will explore the rise in telehealth, telemedicine, e-visits, virtual care, and remote patient monitoring. Nurses have an increasing role in telehealth. We will discuss the opportunities of how we deliver care with the use of this technology. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Summarize clinical guidelines for Telehealth as it relates to current evidence, standards, and regulations.
- Identify implications for Telehealth approach to delivery of care.
- Differentiate the applications of Telehealth for enabling healthcare teams to effectively meet the needs of their patient population.

Outline

I. Introduction
   A. History & Models of Care
   B. Terminology
   C. Evidence, Legislation, & Regulations
   D. Types of Systems

II. Clinical Implications
   A. Access & Population Health
   B. Team-based care

III. Implementation
   A. Clinical & Technical Requirements
   B. Training
   C. Implementation & Evaluation

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Author: Michelle Hamland, DNP, RN, RN-BC

Dr. Michelle Hamland is the co-founder and CTO of InvenTech Consulting and Director of Nursing Informatics at Marshfield Clinic Health System. Dr. Hamland has a Bachelor of Science in Nursing, Master of Science in Nursing Informatics, and Doctor of Nursing Practice in Healthcare Systems Leadership. She is an innovator, visionary, and health informatics expert. Dr. Hamland has years of experience in the development, deployment, and evaluation of healthcare technologies. She's passionate about improving the relationship between clinicians and technology. Dr. Hamland believes in implementing technologies that are practical and that can augment patient care, not disrupt it.

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Faculty and Planners Disclosure Statement

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Course Title: Beyond the Bedside: Exploring Nursing Careers with Expert Panel Discussion

Course Release Date: April 25-27, 2023

Description:
Nurses have skill sets that are valuable and transferable to a variety of different career opportunities. Nurses can be caregivers, advocates, educators, and innovators, even when not working at the bedside or in a clinic. We will explore the alternative nursing opportunities that will take you beyond the bedside. The second hour will include an expert panel discussion and audience questions. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- Compare the skills and characteristics of the bedside versus the non-traditional nursing careers.
- Explore the pros and cons of non-traditional nursing careers.
- Identify requirements needed for the differing non-traditional nursing roles.

Outline

Introduction
A. History of Nursing
B. Traditional Roles of Nursing
C. Changes in Care Model
D. Transferable Skills in Nursing

II. Alternative Nursing Careers
A. Summary of different options
1. Technology
2. Content Writer
3. Health & Wellness
4. Legislative
5. Entrepreneur

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Dr. Michelle Hamland is the co-founder and CTO of InvenTech Consulting and Director of Nursing Informatics at Marshfield Clinic Health System. Dr. Hamland has a Bachelor of Science in Nursing, Master of Science in Nursing Informatics, and Doctor of Nursing Practice in Healthcare Systems Leadership. She is an innovator, visionary, and health informatics expert. Dr. Hamland has years of experience in the development, deployment, and evaluation of healthcare technologies. She's passionate about improving the relationship between clinicians and technology. Dr. Hamland believes in implementing technologies that are practical and that can augment patient care, not disrupt it.

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Faculty and Planners Disclosure Statement

None of the planners or presenters for this activity have relevant financial relationship(s) to

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Course Title: Flipping the Classroom

Course Release Date: April 25-27, 2023

Description:
Gone are the days of traditional soapbox-style instructor led lectures. A new generation of learners requires non-traditional methods of instruction to keep them deeply engaged with the material. Learn how to "flip the classroom" for adult learners. This approach prioritizes the learner in order to improve engagement and enhance active learning. This talk is recommended for all nurses, students, healthcare workers, educators, Clinical Nurse Specialists, preceptors, and managers.

Objectives

Upon completion of this course, the nurse should be able to:

- Learn about traditional vs non-traditional lecture methods.
- Understand why traditional methods of teaching don't work and learn how to engage a new generation of learners.
- Understand the role of the teacher and the learner in this flipped model.
- Participate in a variety of flipped classroom activities and learn how to utilize these methods of instruction for your classroom/nursing unit.

Outline

I. Traditional Lecture Methods
   A. Soapbox Style Lecture/Trainings
   B. Teacher directed
   C. Applications/settings used
   D. Why it's successful

II. Non-Traditional Lecture Methods
   A. Alternatives to Lecture/Trainings
   B. Learner centered
   C. Applications/settings used
   D. Why it's successful

III. Why Traditional Methods Don't Work
   A. New generation of students
   B. Integration of technology in learning environments
   C. Engagement levels

D. Lack of Retention of Information

IV. Flipping The Classroom
- A. What is it?
- B. 4 Pillars: FLIP
  1. Flexible Environment
  2. Learning Culture
  3. Intentional Content
  4. Professional Educator
- C. Bloom's Taxonomy
  1. Traditional
  2. Flipped Classroom- Lower level cognitive work is done before class, in class students engage in higher cognitive levels of learning while their peers and instructor are present to discuss high level ideas.
- D. Why is it preferred over traditional methods?
  1. Student engagement
  2. Instructor engagement
  3. Allows for authentic interactions
  4. Less infobesity
- E. What is expected of the teacher?
  1. Instructor vs Facilitator
  2. Creating activities
- F. What is expected of the student?
  1. Must take ownership of their learning by reviewing the material before class, so class can be spent on critical thinking activities to deep dive into the material, so class isn't the first time a student hears the material.
- G. Engaged Learning Strategies
  1. Jeopardy
  2. Peer Teaching
  3. Case study
  4. Ticket To Ride
  5. Who's the sickest
  6. Mind maps
  7. Escape rooms
  8. Stuck in an elevator
  9. Poll everywhere
  10. Twitter time
  11. Brain dump
  12. Muddy points

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Erin has worked in healthcare for over 20 years. Erin began her healthcare career in EMS and pursued nursing as a second career in 2014. Erin worked as a GI/Endoscopy out of nursing school before moving back into Emergency Medicine where she has been a nurse for the past 7 years. Erin is also a full-time nurse educator with Northwood Technical College in New Richmond, Wisconsin where she teaches advanced nursing concepts to senior nursing students.

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Flipped Classroom Activity Ideas

Brain Drain	This is a rapid-fire exercise where students shout out 5-10 concept-related terms that the instructor lists on a whiteboard. Then, as you work through and discuss each term, the instructor erases them one by one, enhancing students' recall capabilities.
Case Studies	Case studies can be pre-made (numerous books/websites with pre-made case studies on the market). You could also have the students create the case study as an added layer of learning. To make it more difficult, the students can do an unfolding case study where they only get more answers to the case if they chose the right diagnostics, labs, interventions, etc.
Clinical Puzzle	Write a component of patient care on a puzzle piece (Assessment, lab data, history, diagnostics, medications, surgeries/procedures, discharge issues, family issues, developmental assessment, psycho/emotional issues, etc.) • Give each student a puzzle piece • Have them all obtain data on the same patient • Have each student present that data in clinical post conference to put the "patient puzzle" together.
Compare & Contrast	Compare and contrast scenarios really fuel class discussion. Example, you could create two (or more) scenarios of patients with the same symptoms and conditions, and students must discuss how they would treat the patients differently or similarly.
Concept Maps	A visual representation of relationships between concepts. Ex: Diagnosis and treatments/outcomes/interventions/meds/orders, etc.
Discussion Board	Discussion board can be used to check the student's learning or dive deeper into a subject. • You can ask questions about subject matter • Provide case studies to enhance the learning • Ask for reflection • Nice way for students to interact with their peers outside of class- they can learn from each other • Great for ice breakers/ introductions before class begins (especially online classes) • Can be used anonymously to ask questions or discuss "muddy points"

Escape Room	Teams of 4-6 students work together using critical thinking to solve puzzles and find clues to "escape" Puzzles include: sx recognition, equipment set up, med dosages, etc It allows for different types of learners to be successful Improves teamwork and communication There is still required pre and post work as well as a debrief and evaluation
Find The Error	Present the students with an error: meds, labs, orders, etc that contradict a patient scenario and see if the students find the error. Ex: Pt was given Lasix for a pt with a K of 2.5. You could also set up a "room of errors" where the students need to find all the problems: ie – call light on the floor, bed in high position, IV tubing has bubbles, etc.
Games	• Jeopardy • Poll Everywhere Competitions • Bingo • Charades • Hangman • Puzzles • Pictionary
Grand Rounds	• Have team leader present on all patients • Discuss plans of care/orders/meds without reviewing chart • Review charts or plans/orders/meds to see if you were on the right track
Lunch & Learn Student Seminars	• Have the students present on a topic they came across in clinical. • Students present 10-15min seminar on a topic of their choice. • Student must also create a handout to support the information shared. • Can do all in one day or 1 per day (like when the student is team lead).

Mystery Patient/Diagnosis	Place boxes around the classroom with items and pictures related to that day's concept. Students will then use that to build a patient story and present it to the class. The class then brainstorms how a nurse might treat the hypothetical patient.
NCLEX Exam Item Writers	• Break students into pairs and have them write ten different NCLEX exam-style questions on a specific nursing concept or class topic. • Make sure students include a variety of wrong responses along with the correct answer. • Then have students present their questions and response options. • After classmates vote on which answer is correct, have the presenting pair reveal the correct answer and explain their rationales for both the right and wrong responses.
1 Minute Paper	Either present the info and students write a reflection OR give the students a topic, give them 5 min for research, and then they have 1 minute to write a paper on that topic.
Padlet	https://padlet.com/features Use padlet to collaborate with students on a topic or concept Students can add to the pad as a group or independently
Pass The Problem	Give students the medical problem. Have them pass the ball around and each student must answer a question: 1. Nursing diagnosis 2. Pathophysiology 3. Patient outcomes 4. Interventions 5. Orders/ Meds
Poll Everywhere	Create review quizzes, polls, competitions, word clouds, etc. https://www.polleverywhere.com/
Role Playing	Students can role play different people such as patients/family/staff etc. Have your nursing students act in a skit presentation that reveals a deeper learning point for the rest of the class. Example: The skit could reveal the importance of good and poor therapeutic communication.

Sticky Points vs Muddy Points	• Sticking Points: All students write 1 point that stuck out in their mind from the last lecture. Use in classroom (whiteboard) or online (padlet). • Muddy points are anonymous notes left by students on pieces of paper at the end of class that are then covered by the instructor next lecture.
Ticket To Ride	Study guide/outline to help students frame their studying TTR is given out to students, and they must have it completed be the 1st day we start a new lecture/learning plan. It includes definitions, concept mapping, fill in the blanks, pt scenarios, T/F, multiple choice, math, tables/grids, etc.
Twitter Time	Limits characters so students must focus on and write about what's important: main concepts Students can research a topic and share with their classmates, all the info combined can be a great way to study the basics Good way to share information such as a BB announcement

Course Title: Advocating for Patient Autonomy

Course Release Date: April 25-27, 2023

Description:
This talk will focus on identifying the decision-making needs of patients and families in healthcare and the nurse's role in supporting patient autonomy. We will address healthcare outcomes, nursing practice, evidence-based decision-making models, patient- and family-centered care, and patient and nursing advocacy. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- The participant will understand the definition of patient autonomy
- The participant will understand evidence that supports patient autonomy and decision making
- The participant will understand the nursing role in patient autonomy and advocacy
- The participant will understand the benefits to patient outcomes and to nursing practice through principles of patient autonomy

Outline

I. What does patient autonomy actually mean
   A. Why is it important
      1. Patient and family voice
   B. Data associated with Patient Autonomy/Decision Making
      1. Positive outcomes (example- impact of shared decision making model)
      2. Negative outcomes (example- lack of health literacy)
   C. Patient and Family-Centered Care
      1. What does it mean
      2. How does it related to patient autonomy

II. Care models/Nursing practices/Best practices that support patient autonomy
   A. Shared Decision Making
   B. Patient and Family Education
   C. Nursing/Clinical models/structures/practices (example- AskMeThree)

III. Benefits to nurses and clinical staff

IV. Impacts to patient outcomes

V. Intersection of Nursing and Patient Advocacy
   A. Legal implications
   B. Lobbying for and understanding laws, rules, regulations

VI. What can you do to support patient autonomy and advocacy
   A. How to apply what you have learned
   B. How to bring back ideas/information to your care setting/organization
   C. Simple practices (communication techniques)

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Ms. Schmidt's nursing career spans 18 years beginning as a RN in pediatric specialty care. Kristy has experience working in several care settings including medical-surgical, neurology, oncology, behavioral health, pediatrics, women's services, ICU and ED. Kristy's education includes a bachelor's degree from University of Alaska Anchorage, a Master of Nursing from Boise State University, and is currently enrolled in a DNP program through Boise State University. Kristy has served for 8 years in a leadership role including managing ambulatory clinics, quality and safety, vulnerable populations program management, and nursing and patient care services. This is Kristy's first year participating in NurseCon in addition to her current leadership and learning roles.

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Faculty and Planners Disclosure Statement

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References

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Course Title: Nursing Practice in a Post-Pandemic World

Course Release Date: April 25-27, 2023

Description:
Nursing practice and the healthcare environment have evolved since the COVID-19 pandemic. Together we will explore the landscape of nursing in the post-pandemic healthcare setting. Nursing models, innovations in practice, and understanding potential future changes and implications will be examined through a post-pandemic lens. This talk is recommended for all nurses, students, and healthcare workers.

Objectives

Upon completion of this course, the nurse should be able to:

- The participant will understand what it means to be in a post-pandemic time frame and stages of a pandemic
- The participant will understand changes to traditional/historic nursing practice and models
- The participant will understand drawbacks/limitations and benefits to changes in nursing practice
- The participant will understand innovative/creative approaches to solve for staffing/training/educational issues or challenges
- The participant will have a better understanding of what they may be able to do to prepare for changes during the post-pandemic timeframe

Outline

I. What does it mean to be post pandemic
   A. Stages of a pandemic
   B. Data associated with pandemic- lives lost, long-COVID, hospital/healthsystem COVID related data

II. What's changed in 'normal' nursing world
   A. Impacts of COVID-19 on nursing practice

III. What's the workforce actually look like (facts/data)
   A. median age, retirement, leaving the workforce, joining the workforce, nursing schools, open positions

IV. What changes will most likely endure (examples- financial issues, contract/travelers, LVN-LPN, recruitment)
   A. What are benefits to those changes

B. What are drawbacks to those changes

V. What are creative solutions or innovations in this space
   A. Recruiting strategies (guaranteed hours: salary-ing bedside staff, tuition reimbursement/loan forgiveness, train/grow your own, impact to long term staff, international nurses, student-school partnerships)

VI. What can you do to prepare
   A. What issues might you face
   B. What information can you apply or take back to your organization

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Method of Participation to Earn CNE Credit(s)

To obtain credit for participating in this activity, the participant must:

1. Read the educational objectives and disclosure statements
2. Attend the course in its entirety
3. Complete and submit the course evaluation

Upon completion of the entire content, the learner may receive 1 CNE credit(s). NurseCon will issue credit(s) evaluation. Once complete, you will be able to print out your certificate. This activity should take up to 1 hour to complete. Credits are given in 1-hour increments.

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Ms. Schmidt's nursing career spans 18 years beginning as a RN in pediatric specialty care. Kristy has experience working in several care settings including medical-surgical, neurology, oncology, behavioral health, pediatrics, women's services, ICU and ED. Kristy's education includes a bachelor's degree from University of Alaska Anchorage, a Master of Nursing from Boise State University, and is currently enrolled in a DNP program through Boise State University. Kristy has served for 8 years in a leadership role including managing ambulatory clinics, quality and safety, vulnerable populations program management, and nursing and patient care services. This is Kristy's first year participating in NurseCon in addition to her current leadership and learning roles.

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* A "Subject Matter Expert" (SME) is a clinician with definitive knowledge sources to review, improve, guide, and teach others. Their knowledge is based on evidence-based practice, clinical research, and personal experience in their respective clinical settings. They meet the standard requirements of § 1456. Continuing Education Courses 16 CA ADC § 1456BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS § 1457. Instructor Qualifications

Faculty and Planners Disclosure Statement

None of the planners or presenters for this activity have relevant financial relationship(s) to disclose with ineligible companies.

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