

- + Pregnancy and Spinal Cord Injury:
Successful Outcome
- + Quality of Life in Spinal Cord Injury
Patients with Pressure Ulcers
- + Preparing the RN for the Constantly
Changing Nurse Leadership Role
- + Vibrostimulation Device (VSD):
New Advance for People with SCI



SCI NURSING



AMERICAN ASSOCIATION
OF SPINAL CORD
INJURY NURSES

AASCIN PHILOSOPHY STATEMENT

The American Association of Spinal Cord Injury Nurses (AASCIN) believes that spinal cord impairments (SCI) and related disorders (D) are multifaceted, catastrophic events with implications not only for those who are injured, but for families, significant others, and society as a whole. SCI/D nursing, as an art and science, has a primary role in assisting individuals with SCI/D to achieve and maintain an optimum level of physical and psychological well being. Nurses who specialize in the care of the individual with SCI/D are skilled practitioners with current knowledge of the pathophysiological and psychosocial implications of SCI/D, and possess the expertise to deal with the impact of SCI/D on the individual, family, and society.

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SCI NURSING JOURNAL

American Association of Spinal Cord Injury Nurses

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AMERICAN ASSOCIATION
OF SPINAL CORD
INJURY NURSES

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PRESIDENT'S MESSAGE

Mary Ann Reilly, MSN, RN



The 2009 Annual Conference is fast approaching. The Joint Program Committee met in late February and constructed a fabulous program. As you know the Congress of Spinal Medicine and Rehabilitation will be held at the Dallas Hilton, September 23rd -26th. It is being presented in partnership with ASIA. This will be a fantastic opportunity for AASCIN to participate in what will be the most comprehensive Spinal Cord conference presented. PVA will be offering \$425.00 scholarships to members who wish to attend the conference. Watch for the application to be posted on the AASCIN web site. Register early to assure yourself an opportunity for a scholarship. Once again, AASCIN Boot Camp will be a pre-conference option. The Psychologists and Social Workers will be also holding a pre-conference Boot Camp.

The AASCIN Board of Directors chose to forgo their 2009 mid year meeting. They did so because the Strategic Planning Counsel (SPC) comprised of 4 members of each association (Psychologists and Social Workers, Physicians, Nurses and the newly forming Therapy association) were meeting to continue the formulation of the Academy of Spinal Cord Professionals. The meeting include 16 hours of intense discussions and sound decision making. I would like to share with you the meeting highlights. The SPC is working with pro-bono attorneys who are helping us through the merger process formulating the new non profit organization and the developing the Academy bylaws. The Academy's Governing Board will consist of 3 elected representatives from each association. This newly formed Governing Board will elect their officers who will consist of a President, President-elect, and a Secretary/Treasurer. These board members will hold 1, 2 and 3 year terms. The bylaws will define how the sections formerly known as associations will articulate with the Governing Board. There will be 6 committees each consisting of 2 members representing each section. These members will be appointed for the 2010 board and elected by their respective sections beginning in 2011. The term of office for the committee members will be 2 and 3 years. These joint committees will be membership, finance, research, web, journal and program. There was a great deal of discussion about the web site, the abstract submission process and the membership renewal process. It is the Governing Bodies plan that the web site will be an ever-evolving tool.

The AASCIN Board is keenly aware that all of the hospitals we work for are tightening their belts and looking for a new cost effective approach to maintaining their quality of care. The 3 associations, AASCIN, APS and APSW, are doing the same thing. To survive these economic changes we needed to rethink how we have provided our members with the highest quality, most current and cutting edge information on the care of the spinal cord disabled. In June the 3 associations, AASCIN, APS and APSW, are planning on sending out a ballot asking our membership to ratify the merger. I invite any member who has questions or concerns to contact me. I can be reached at ma-reilly@sbcglobal.net.

Mary Ann Reilly, MSN, RN

Mary Ann is a Rehabilitation Nurse Manager at Santa Clara Valley Medical Center in San Jose, California and is the current President of AASCIN.

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EDITORIAL

Publish in SCI Nursing: Recognize the Opportunity

Deanna Persaud, MSN, RN

Greetings!

I hope you enjoyed the new look of SCI Nursing. Volume 26, Number 1 was the first issue produced by the Paralyzed Veterans of America (PVA). It offers not only a fresh new format but also allows the user to take advantage of online technology. Users can move easily through the issue using hot links directly from the Table of Contents or the text box located at the top of each page. I am very pleased with the addition of this new feature and I hope you are too. Kudos to Jim Angelo, Associate Director of Publications at PVA and his production crew!

One of my responsibilities, as the editor of SCI Nursing, is to solicit manuscripts for feature presentations. As you may have noticed, many articles that are published in nursing journals are written by nurse educators or graduate students, required to conduct research, write and to publish their work. Their contributions to professional literature has assisted our professional knowledge base to grow by leaps and bounds. To further increase our nursing knowledge base, contributions from nurses in all nursing roles are needed. Whether you are a staff nurse, educator, advanced practice nurse, nurse manager, or nurse administrator, each of you has important material that you can share about your nursing role, your patient care, and your workplace innovations. Did you know that there are close to 200 nursing journals available to nursing professionals? Just think of how many manuscripts are required to fill all those journals.

Are you interested in writing an article and not sure about how to get started? Publishing is a rewarding accomplishment. If you have an interest in this area, I advise you to start by jotting down your ideas. Choose a compelling topic that you are passionate about and intensely interested in. Do a review of the literature over the past few years and find out what others are saying about your topic and how it is being approached. Do you have a unique idea or slant? If so, that may be just the information another nurse is looking for. Why not share it?

Once you have selected a topic and picked a focus, begin to outline your content. Each nursing publication has its own purpose and audience, so make sure your desired topic lines up with the journal you're targeting. Please consider SCI Nursing!

SCI Nursing is dedicated to informing nurses about clinical, educational, research, legislative, and professional practice issues, and other aspects of caring for persons with SCI. SCI Nursing welcomes manuscripts from authors of all professional disciplines; however, the manuscript must include content relevant and meaningful to SCI nursing practice. (www.aascn.org)

Surf the AASCIN web site and study the writers' guidelines. Also, look at how that journal's articles are formatted. Paying close attention to issues like headings and subheadings will help you structure your article to the journal's style. The guidelines will also tell you how/where a journal wants manuscripts submitted.

Most authors write multiple rough drafts before they start to polish their manuscript into a piece they are ready to submit for publication consideration. Before submitting your manuscript, it is wise to have a trusted friend or colleague critique it. If you don't get much feedback from the "proof-reader," you may not have the right person doing the job. Remember, constructive criticism is designed to improve the overall quality of a manuscript.

When you are ready to submit your manuscript, rest assured that the members of the SCI Nursing Editorial Board are here to advise and guide you to your goal of becoming a published author. Feature articles are sent out for blind peer review. The review process assures that manuscripts are well written and reflect best practice. Following the review, the editor compiles the reviewer comments and authors receive written feedback regarding any changes that are required prior to publication.

I hope you will consider submitting a manuscript for publication consideration. You can enrich the world of SCI nursing by sharing your knowledge with your colleagues.

All the Best!

Deana Persaud MSN, RN

Deanna Persaud is a Professor of Nursing at CSU, Chico, in Chico, Ca. and the Editor of SCI Nursing.



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FEATURE ONE

Pregnancy and Spinal Cord Injury: Successful Outcome

Lisa Beck MSN, RN and Tamara Vos-Draper OT

Abstract

Pregnancies in women with spinal cord injury present unique and rare clinical challenges. These women are usually considered to be “high risk” secondary to complications that can arise during the course of pregnancy. Many complications can be prevented and treated through collaboration between an interdisciplinary outpatient rehabilitation team and a sophisticated obstetric team. This case study discusses the innovations, interventions, and unique practices of an outpatient spinal cord injury team in collaboration with an obstetrics team in accomplishing the successful full term pregnancy, delivery and post partum care of a 28 year old woman with C 5/6 tetraplegia.

Key Words: spinal cord injury, pregnancy, complications

Introduction

It is uncommon for a Physical Medicine & Rehabilitation (PM&R) consult to occur on the obstetrical unit, but very important when the patient’s history includes a spinal cord injury (SCI). The consult indication was a 28 year old pregnant woman with tetraplegia experiencing difficulty with labile blood pressure. Miss M sustained a C6 ASIA A spinal cord injury secondary to a motor vehicle accident in 1997. At the time of consult she was 15 weeks pregnant. Her medical history following her spinal cord injury included: pulmonary embolism, cholelithiasis, left ischial pressure ulcer requiring flap closure, right stage two pressure ulcer and episodes of depression. She was admitted to the obstetrical unit with complaints of chest heaviness, shortness of breath, headache and piloerection. Her symptoms were suspicious for autonomic dysreflexia. A thorough review of systems could not identify the cause of autonomic dysreflexia; however the patient was discharged to home with labetalol as needed.

Miss M was next seen in the SCI clinic, by the SCI Clinical Nurse Specialist (CNS) at 21 weeks gestation. Her pregnancy thus far was without complications, however, numerous spinal cord issues needed to be addressed. She was having difficulty

with breathing when sitting in her chair. Her spasticity was slightly increased as she was weaned off of her baclofen, but she was being stretched twice daily. She had managed her bladder with an indwelling catheter and Detrol. Her Detrol was discontinued, resulting in bladder spasms and leaking around the catheter. She had an every other day bowel program, using a suppository then transferring to the commode. In 2001, she developed a left ischial ulcer requiring surgical repair; she was very worried of risk of skin breakdown. She had a gel pressure reducing cushion, along with a power wheel chair that has both tilt and recline functions and utilized both frequently to change position. She did not maintain an exercise program and felt that she had become increasingly weak over the years, with worsening shoulder pain, right greater than left. This was also a significant concern as she intended to be active and interactive with her baby. She requested enrollment into a therapy program that would help her with the following goals: safely hold and care for the baby, adapt her equipment for close safe interaction with the baby, practice strategies for feeding, playing, dressing, bathing and changing baby with limited hand function, and to improve her strength and endurance especially in her shoulders and biceps. The collaborative practice of the Outpatient Spinal Cord Injury Rehabilitation Program would best assist Miss M in achieving her goals, provide support and reduce incidence of secondary complications through her pregnancy.

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Overview of Pregnancy with SCI

There appears to be a social stigma of poor outcomes regarding women with spinal cord injury being pregnant and becoming parents. Certainly these women need to take extra care of themselves while pregnant to reduce the incidence of secondary complications. A collaborative rehabilitation and obstetrics team can help achieve a successful, low complication pregnancy and delivery by being aware of risk factors throughout the pregnancy and postpartum. Common complications during pregnancy must be assessed and monitored. For example, the Center for Research on Women with Disability (2004) report a 38% risk of pre-eclampsia in women with spinal cord injury, compared to a 13% risk of pre-eclampsia in women without disabilities. Also the risk of spinal cord related complications, such as autonomic dysreflexia, increases with each trimester and the higher the level of spinal cord injury.

The First Trimester

During the first trimester, medications such as antispasmodics, anticholinergics and anticonvulsants should be weaned as they may compromise fetal growth. The risk to the fetus from these medications must be considered against the benefits to the mothers. Pregnancy and anemia may complicate a previously effective bowel program. Iron supplements must also be used cautiously to avoid worsening constipation. The pregnant woman with spinal cord injury may need to alter her dietary and fluid intake as well as frequency of bowel care. If this is not effective, stool softeners and stimulants may need to be added to her program to re-establish an effective bowel program. Topical anesthetic gels before and during bowel care may be needed to reduce the risk of autonomic dysreflexia during bowel care. Headaches are common in the first trimester of pregnancy, however, autonomic dysreflexia must also be ruled out for those with spinal cord injury at or above T6.

The Second Trimester

Bladder management may need to change during the pregnancy as the baby puts pressure on the bladder causing decreased capacity and increased bladder spasms. Women

have an increased excretion of bicarbonates and glucose during pregnancy, which becomes a culture medium for bacteria. There is clinical controversy of empirical treatment of urinary tract infections, again risk to the fetus must first be considered. Occurrence rates of urinary tract infection are reported at 35% for pregnant women with spinal cord injury, and 50% rate for those women using indwelling catheters (Jackson, 1996, Atterbury & Groome, 1998). Use of indwelling catheters can give rise to more difficulties (Burns and Jackson 2001). These women experience increased bladder spasms that can cause leakage around the catheter. Severe bladder spasms may also cause expulsion of the catheter. Effectiveness of bladder management and urine continence must be evaluated and options considered on a monthly basis. Jackson and Wadley (1999) surveyed 66 women, with a total of 101 pregnancies. They noted that a quarter of the women in their study had to change their method of bladder management during pregnancy. Methods to reduce the above complications include: aseptic technique with intermittent catheterization or cleansing of the indwelling catheter, more frequent bladder emptying, increased size of indwelling catheter and maintaining adequate fluid intake.

Impaired mobility, limited sensation, changes in posture (scoliosis, kyphosis) alters pressure distribution in persons with spinal cord injuries. Pregnant women with spinal cord injury have a 6-30% increased risk secondary to weight gain, edema and anatomic changes (Atterbury and Groome, 1998; Jackson and Wadley, 1999; Foote, 2002). Throughout pregnancy, proper pressure relieving techniques and transfers become more difficult. Skin inspection should be performed daily. Seating systems and cushions should be evaluated throughout the pregnancy. Pregnant women with spinal cord injury may require different seating systems and pressure relieving cushions through the phases of pregnancy; therefore, should also be followed by seating clinic specialists.

Twelve to 70 percent of pregnant women with upper motor lesions experience an increase in spasticity (Jackson and Wadley, 1999; Atterbury and Groom 1998). Stretching program at home twice daily can help reduce spasticity for mothers that have weaned off their antispasmodics. A case study by Robert et al. (2003) has documented implantation

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Unattended labor should be avoided as much as possible for women with spinal cord injuries at and above T6, as the risk of autonomic dysreflexia increases during labor.

of an intrathecal baclofen (ITB) pump during pregnancy on a 23 year old woman with incomplete T7 spinal cord injury. Her spasticity increased as the pregnancy progressed. Robert et al., conclude the use of ITB to be considered for treatment options of severe spasticity during pregnancy.

As the baby grows in the second and third trimester, pregnant woman with spinal cord injury may notice changes in their functional abilities. Fatigue and body changes can cause difficulty with activities of daily living, transfers, and ability to propel their wheelchair. Also the growing abdomen can become a barrier in driving and sitting behind the driver’s wheel of a car. Outpatient therapy program is beneficial to increase endurance, strength, and learn new techniques to compensate for changes in function.

The Third Trimester

Respiratory compromise occurs with decreased diaphragm movement as the fetus grows. Women with spinal cord injury at and above T-10 are at risk for atelectasis and pneumonia. Those with cervical and high thoracic lesions have potential need for ventilatory support due to decreased respiratory reserve and vital capacity (Atterbury and Groom, 1998). The growing uterus can also compress the pelvic veins, placing the pregnant women at risk for thrombophlebitis and bilateral lower extremity edema.

Labor and Delivery

Thirty to forty percent of women with spinal cord injury deliver at 37 weeks (Atterbury and Groom, 1998; Foote, 2002). Signs and symptoms of labor may present differently such as pain above the level of injury, increased spasticity, increased autonomic dysreflexia, change in breathing, and anxiety. Unattended labor should be avoided as much as possible for women with spinal cord injuries at and above T6, as the risk of autonomic dysreflexia increases during labor. Increased blood pressure during labor must be differentiated between autonomic dysreflexia and pre-eclampsia. Autonomic dysreflexia symptoms peak during contractions and abate after the contraction ends. Pre- anesthesia planning of epidural or spinal anesthesia will block afferent impulses,

reducing autonomic dysreflexia episodes. Anti-hypertensive medication use must be monitored to avoid rebound hypotension, which can cause a reduction in placental perfusion (Atterbury and Groome, 1998).

Post Partum

Orthostatic hypotension is common when first sitting after delivery, slow acclimation to sitting with compression stockings and abdominal binder may be necessary. Autonomic dysreflexia can result from pain and while breast feeding, thus continued pain medications or epidural should be considered. Breast feeding may pose difficulties secondary to proper positioning, decreased nipple sensation and decreased milk production. Other post partum problems include bowel and bladder difficulties, thrombophlebitis, fatigue, spasticity and headaches (Charlifue, Gerhart, Menter, Whiteneck, and Scott, 1992). Postural changes may have occurred during the pregnancy causing difficulty in seating and functional activities.

Back to our story

Miss M enrolled into the Outpatient Spinal Cord Injury Rehabilitation Program of which she interacted with seating specialists, occupational therapy and was followed on a monthly basis and as needed by the SCI CNS. Miss M found sacral sitting most comfortable for breathing, however, she also experienced shoulder pain and scoliosis as her weight increased. Miss M had used a Jay™ cushion since flap surgery in 2001 and had little difficulty with pressure from sitting. When mapped with XSensor™ pressure imaging equipment during the second trimester, areas of higher pressure were noted at right ischial tuberosity (IT) and sacral area. The lower cushion in combination with the weight gain caused her to sit out from the back of her chair, thus increasing her tendency to sit with a C-shaped spine and shortening trunk extension, resulting in the difficulty breathing. She tended to lean to the left side, which is the hand she drives her chair with to gain support from the armrest. Her hips shifted to the right side, allowing her pelvis to tip downward on the left and have more contact with the seating surface. She was placed on

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a high profile dry floatation cushion for pressure relief, her chair back was opened a bit, allowing her to sit and breathe more comfortably, and protect her skin during her pregnancy. Shoulder harnesses were attempted, however, she felt too restricted. A new wheelchair with custom molded seating would be assessed after the baby was born.



custom baby carrier

Miss M had many goals for occupational therapy related to preparing and caring for her baby. She wanted to improve strength and endurance of her shoulder group and biceps in order to safely hold and care for the baby. Creative adaptive equipment was

necessary for mother-baby interaction. Finally, she desired to practice strategies for feeding, playing, dressing, bathing and changing diapers with limited hand function. She worked with occupational therapy three times a week, for 45-60 minute sessions. Interventions to achieve her goals included: biofeedback to reduce strain on her shoulders while working on table top tasks, strengthening with weighted cuffs and a weighted doll, resistive fine motor tasks for wrist extensor and left hand pinch strength, aerobic conditioning, and review of adaptive equipment. Miss M and the occupational therapist also worked collaboratively with the Department of Engineering to develop unique baby care items. A custom padded lap table that attached to her wheelchair arm rests was developed so Miss M could interact and care for the baby in the infant stages and was designed to facilitate breast feeding as Miss M was interested in attempting that. A custom baby carrier was designed with an arm to attach the baby seat to Miss M's power wheelchair which allowed Miss M to safely interact and be mobile with the baby.

The equipment was finalized in her last months of pregnancy. Adapted bottle holders were discussed. She had tendon transfers in the past, thus her hand control on her left side was functional enough for her to hold bottles and use a

cloth to wipe spilled milk. She attempted to dress/undress the weighted doll but was not able to efficiently manage this activity. She was excited about the possibility of an adapted crib, but the cost was prohibitive.

One of Miss M's priorities was to be able to participate in her new role as a mother as much as possible. She indicated that while pregnant, she felt as though she was grieving the loss of function all over again as she imagined caring for a child. She has a medical history of recurring depression and also a remote history of alcohol abuse. She expressed concern regarding this history and possibility of post-partum depression. Miss M. was frequently asked how things were going for her in regards to symptoms of depression. The O.T. monitored her for symptoms of depression, and was prepared to make a referral for additional services as needed. O.T. assisted Miss M in identifying areas of parenting that she would feel comfortable and competent in participating in and these were focused on instead of the tasks she was not able to do. Miss M identified educating her daughter, reading and singing to her, and close physical contact as important to her. The baby car seat project was initiated in response to Miss M's goals and priorities.

The SCI CNS saw Miss M monthly to review spinal cord injury issues and potential complications. Urinary tract infections and a cold were the only complications Miss M experienced during her first two trimesters. During her third trimester, Miss M noted more frequent episodes of autonomic dysreflexia. These were usually related to her position in bed or sitting. Miss M became very astute to her signs and symptoms of autonomic dysreflexia and easily would find the trigger to resolve the symptoms. In preparation for delivery, the SCI CNS collaborated with the Obstetrical CNS, to educate the nursing staff regarding spinal cord injury secondary complications and prevention.

Two months before Miss M's due date, a family tour of the obstetrical unit and care conference was scheduled. Miss M was accompanied by her significant other, the SCI CNS, and occupational therapist for the tour. It was during the tour, issues of accessibility and prevention of secondary complications specific to the Labor and Delivery

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Family and Team Tour of Labor and Delivery Unit

unit were identified. These issues were then addressed during the care conference, which included Miss M, her significant other, the obstetrician, anesthesiologist, obstetrical CNS and staff nurse, social worker, SCI CNS, and occupational therapist. The major

concern with Miss M's delivery was unattended labor and reducing the risk of autonomic dysreflexia. The team discussed type of delivery, of which Miss M preferred vaginal delivery. But to avoid unattended labor, she would be admitted to the obstetrical nursing unit at 38 weeks gestation, with scheduled induction soon after admission. However, due to increased frequency of autonomic dysreflexia, mainly related to position, she was admitted at 36 weeks gestation.

While hospitalized on the obstetrics unit, her occupational therapist continued to see her 2-3 times a week to maintain Miss M's strength and continue with resistive fine motor activities. The SCI CNS and occupational therapist assisted the obstetric nurses in obtaining equipment; rehabilitation commode chair, Hoyer lift and adapted call light. The SCI CNS was a resource to the obstetric nurses regarding neurogenic bowel and bladder, autonomic dysreflexia, spasticity, and risk for impaired skin integrity.



Proud Father and the SCI Clinical Nurse Specialist

On the 6th hospital day, the obstetrics team noted that Miss M's baby turned breech. The usual procedure is to do a version and physically turn the baby. Version was discussed among the obstetric team with concerns from the SCI team. The

risk of autonomic dysreflexia due to the procedure would be significant, thus would need to be performed along with epidural pain control. Instead, at 37 weeks gestation, fetal lung maturity was assessed. Baby's lungs were mature, later that day, a team including the SCI CNS was called to deliver healthy baby T via low transverse cesarean section. An epidural provided control of spasticity and pain during the procedure, thus kept Miss M's blood pressure within baseline parameters. Spasticity and autonomic dysreflexia symptoms were monitored by the SCI CNS and anesthesiologist throughout the procedure.

Miss M was transferred to intensive care overnight for monitoring. The SCI CNS reviewed Miss M's SCI related care needs with the medical and nursing staff in the intensive care. The epidural remained in place for 2 days post partum, for pain management, thus to reduce the incidence of autonomic dysreflexia. Miss M's blood pressure remained stable post partum, her original bowel and bladder programs were re-established without difficulty. She voiced no issues with incisional pain. She and baby were dismissed to home 5 days after delivery. Miss M's care needs increased slightly upon return home, her public home health nurse re-evaluated her care needs resulting in increased personal care assistance time. She and her significant other were well supported by family members who assisted in the family transition to home.



Custom Seat

Miss M experienced post-partum depression. Her new maternal role brought forth new limitations that she had not fully considered. Breast feeding was unsuccessful, as she was not able to produce

enough milk for the baby. She was reliant on others in consoling and care for her daughter. She re-enrolled into the outpatient spinal cord injury rehabilitation program. She received support from her rehabilitation team as well as her mental health provider. She was able to become more

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She was able to become more involved in her daughter’s development with use of innovative equipment, developed by the occupational therapist and a member of the Division of Engineering.

involved in her daughter’s development with use of innovative equipment, developed by the occupational therapist and a member of the Division of Engineering. This equipment provided opportunity for the much needed mother-child interaction from her power wheelchair. Miss M developed worsening scoliosis during her pregnancy. She returned to seating clinic for fitting of a new wheelchair, which was planned early in her pregnancy, and custom molded seating system to accommodate and correct the postural changes that occurred.

Conclusion



The Happy Family

Miss M and her team felt that her pregnancy and delivery were uncomplicated. She and her significant other were very astute to the health of Miss M and baby. They worked diligently with both the spinal cord injury team and obstetric team to reduce the risk of complications. Successful outcomes, as experienced by Miss M, are possible with the interdisciplinary team thoroughness and knowledge described in Miss M case.

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FEATURE TWO

From the Archives... Quality of Life in Spinal Cord Injury Patients with Pressure Ulcers

Sarah Lyons, M.S., RN and Matthew Sorenson, PhD, RN



Editors Note:

The SCI Nursing Editorial Board is pleased to reprint this study on quality of life in spinal cord injury patients with pressure ulcers. Since online archiving of our past issues is a slow process, we are selecting outstanding articles we have previously published to share again with our readers. This article is a reprint of a feature published in SCI Nursing 24.3.

Abstract

Pressure ulcers can have a major impact on quality of life in those with spinal cord injury. The purpose of this mixed methods study was to describe subject perceptions related to the presence of a pressure ulcer, and compare quality of life scores among SCI individuals with a pressure ulcer with those without a pressure ulcer. All subjects (N = 36) had a grade 3 or 4 pressure ulcer, with at least one year between occurrence of injury and study participation. Data were collected through online surveys using a standardized quality of life instrument and four open-ended questions which addressed pressure ulcer perceptions. Quantitative findings found significant reductions in quality of life for SCI patients with a pressure ulcer as compared to SCI patients without such an ulcer. Qualitative findings reflected negative emotionality, loss of independence, and social isolation. These findings highlight the need for aggressive skin maintenance programs in individuals with SCI, and demonstrate a potential need for psychosocial support and counseling.

Key Words: spinal cord injury, pressure ulcers, quality of life

Introduction

Spinal cord injury is one of the most traumatic events capable of shattering someone’s view of their quality of life (QoL). There are “approximately 450,000 people in the United States (that) have sustained traumatic spinal cord injuries, with more than 10,000 new cases of SCI emerging in the U.S. every year” (Christopher and Dana Reeve Paralysis Resource Center, 2005). According to the Stockholm Spinal Cord Injury, those with a SCI demonstrate lower quality of life scores than does a general population of individuals without a spinal cord injury. Within the spinal cord population, that study found an even lower QoL “among individuals with medical problems, neurogenic pain, problematic spasticity and bladder problems” (Westgren, p. 1435). The resultant lack of sensation and changes in the skin at the molecular

level, with these individuals places them at risk for the development of pressure ulcers. It is estimated that between 50 to 80 percent of SCI patients will develop a pressure ulcer at some time in their life (Christopher and Dana Reeve Paralysis Resource Center, 2005). It has been stated that “the presence of pressure sores was associated with a lower QL” (Westgren, p. 1435). These wounds can play a large part in the overall health of the patient; affecting both physical and psychosocial health. They have a negative effect on self image and decrease independence in a population where independence has already been compromised. These effects can be devastating. Medication adherence, diet, exercise and pressure relief can help prevent these wounds, but even the most diligent patients can acquire them. Treatment is often self limiting, painful and disruptive to daily life, which makes adherence difficult and results in an adverse effect on quality of life.

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Medication adherence, diet, exercise and pressure relief can help prevent these wounds, but even the most diligent patients can acquire them.

QoL is defined as “a person’s sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her” (Ferrans, n.d.). There are many things that can affect the perception of these patients’ quality of life; lack of mobility, self independence, body perception and chronic pressure ulcers. Studying quality of life provides insight which enables the attainment of a more comprehensive view of how health care providers can adapt care to promote an individual patient’s QoL. The purpose of this study was twofold, (1) to describe the perceptions of SCI individuals with a pressure ulcer and (2) to compare quality of life between participants with a pressure ulcer and previous findings from SCI populations without a pressure ulcer.

Specific research questions were:

- Do pressure ulcers have an adverse affect on quality of life in individuals with a spinal cord injury?
- What is the SCI patients’ perception of living with a pressure ulcer?

Method

A sample of 36 spinal cord injury patients was recruited from three spinal cord injury internet sites and an outpatient clinic located within an urban rehabilitation institution. Participants were requested to complete the Ferrans and Powers Quality of Life Index along with six demographic questions including: age, gender, date of spinal cord injury, level of spinal cord injury, stage of pressure ulcer, and location of pressure ulcer. After the survey, participants had the option to answer four open ended questions about living with pressure ulcers. A total of 25 participants completed the 82 item QLI, with 22 completing the four open-end questions. Participants were required to have been over the age of 18, English speaking, post-SCI injury greater than one year with a pressure ulcer of a stage 3 or 4. The reason for these inclusionary criteria was to insure that participants were capable of distinguishing between the adjustments of life to a SCI versus the adjustment to a pressure ulcer. Stage 3 and 4 pressure ulcers require more extreme interventions than earlier stage pressure ulcers and therefore carry a greater possibility of interference with daily life. All surveys were completed online

using SurveyMonkey to insure privacy: no identifying data was obtained from participants.

Quality of life was measured using the Ferrans and Powers Quality of Life Index Spinal Cord Injury Version-III. (QLI) This survey consists of two parts, the first addresses satisfaction with daily life and the second covers the importance of activities of daily living. Each of the two parts consists of 37 items, combining for a total of 74. Responses are ranked from 1 to 6; with 1 representing very dissatisfied or unimportant and 6 representing very satisfied or important. Scores range from 0-30, with higher scores viewed as indicative of higher quality of life. The QLI has been used in over 200 studies and in 2002, May and Warren concluded there was support for the external validity of the survey in spinal cord populations. Approximately 48 other studies also provide support for homogeneity reliability with Cronbach’s alpha scores of .73 to .99 (Ferrans). Further information on reliability and validity may be obtained directly from the developer’s webpage (<http://www.uic.edu/orgs/qli/>).

Quality of life results were analyzed in SPSS (Version 14) using specifications provided by Ferran’s website. In order to calculate the QLI from the results of the survey, five scores were used: Overall Quality of Life (QLI) and four subscales: Health and Functioning, Social and Economic, Psychological/Spiritual, and Family. These scores were compared to those calculated from both a general population of healthy individuals and a general population of spinal cord injury participants using the same Quality of Life Index by Ferrans and Powers.

At the end of the survey four open-ended questions were posted. These questions included: What is your perception of your pressure ulcer? How does living with a pressure ulcer change your life? What could be done to assist you in managing your pressure ulcer? Do you think that a group therapy session would help you deal with the changes the pressure ulcer has had on your life? The responses to these open-ended questions were analyzed using content analysis and emerging themes extracted. A mixed methods study was used to elaborate on the perception of pressure ulcers in the SCI community, and to determine the need for further

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research. The open-ended questions were used to assist in understanding the magnitude and frustration associated with pressure ulcers and what could be done to promote healing in this population.

Results

Sample Characteristics

Of 36 participants, 27 were male and 9 female with a mean age of 42 years (range 21-71). The level of spinal cord injury varied with 47.1% having cervical spinal cord injuries, 47.1% having thoracic spinal cord injuries, and one participant reporting a lumbar injury accounting for 2.8% of the sample population. One subject did not provide information regarding level of injury (2.8%). The time with spinal cord injury ranged from 2 years to 46 years. The mean grade of pressure ulcer was 3.49 with 18 participants reporting grade 3 and 17 reporting grade 4. There was no significant difference in the quality of life scores in regards to gender, level of injury or stage of ulcer.

Data Analysis

Results from the quality of life index include an overall quality of life score (QLI) and four subscale scores; Health and Function (HFSUBa), Social and Economic (SOCSUBb), Psychological/Spiritual (PSPSUBc), and Family (FAMSUBd). These scores were obtained using specifications provided by Ferrans. Twenty-five participants completed the entire survey allowing their results to be analyzed and included. Means, standard deviation and range were calculated and results are depicted in Table 1.

The results of this survey were compared with results from both a study of a general population of healthy individuals using the Ferrans and Powers Quality of Life Index- Generic Version and a general population of SCI patients using the Ferrans and Powers Quality of Life Index Spinal Cord Version-III. General population data was received from Dr. Ferrans through personal communication, while the general spinal cord results were obtained from a previously published study by May and Warren (2002). When compared with the general

TABLE 1: SAMPLE MEANS AND STANDARD DEVIATIONS

QOL Scores	Mean	Std. Deviation	Range
QLI	17.50	6.46	4.32-28.08
HFSUBa	15.53	7.29	2.27-26.07
SOCSUBb	19.31	6.11	4.86-30
PSPSUBc	16.48	8.47	1.79-30
FAMSUBd	21.16	6.26	9-30

Note. n =25. HFSUBa (Health and functioning), SOCSUBb (Social and economic), PSPSUBc (Psychological/spiritual) FAMSUBd (Family)

population data the participants with pressure ulcers scored significantly lower in all areas of quality of life measurement. The overall quality of life for a general population was 23 out of 30; whereas the overall quality of life of the spinal cord injury population with pressure ulcers resulted in a score of 17.5. T-tests were performed on all variable means with a pre-determined level of significance set at < .05 using a 95% confidence interval (See Table 2).

TABLE 2: T-TEST COMPARISONS OF SAMPLE MEANS WITH GENERAL POPULATION MEANS

QOL Scores	General Population	SCI with Pressure Ulcers	P value
QLI	23.00	17.50	.0001
HFSUBa	23.19	15.53	.0001
SOCSUBb	21.83	19.31	.0047
PSPSUBc	22.95	16.48	.0001
FAMSUBd	25.6	21.16	.0001

Note: p < .05

These results were also compared with the previous study done by May and Warren in 2002 and there was a significant difference in overall quality of life ($p = .0014$). Upon

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Some of the participants responded that they had all they needed or that the only thing that would be helpful would be a “time machine.”

comparison of the subscales the most significant difference was in the Psychological and Spiritual results which included questions regarding peace of mind, faith in god, achievement of personal goals, happiness, personal appearance and self importance or satisfaction. The only area where there was no significant difference between the two populations was in the family subscale (See Table 3).

TABLE 3: T-TEST COMPARISONS OF SAMPLE MEANS WITH ANOTHER SCI POPULATION

QOL Scores	General SCI Population	SCI with Pressure Ulcers	P value
QLI	21.01	17.50	.0014
HFSUBa	19.92	15.53	.0004
SOCSUBb	21.56	19.31	.0341
PSPSUBc	21.74	16.48	.0002
FAMSUBd	22.94	21.16	.1675

Note: $p < .05$

Responses to the four open-ended questions were analyzed using content analysis with emerging themes extracted. All responses were initiated analyzed by the first author, with the second author providing independent analysis of the data. The authors then met to discuss the themes and agree upon category naming. Upon analysis of the responses to each question, there was an emergence of common, reoccurring themes being expressed throughout: (1) Loss of Independence, (2) Fear and Frustration, (3) Pain and Discomfort (4) Decreased Social Interaction. The first question that was asked was: What does having a pressure ulcer mean? Responses to this question ranged from straight forward definitions such as, “an open sore in the skin that is on a pressure point” to abstract and insightful responses such as, “Not being able to sit for long in my chair; not being able to go out; bandages; nurses; hospital stays; being away from my family; not being able to care for myself; not being independent; having to be taken care of.” This first question

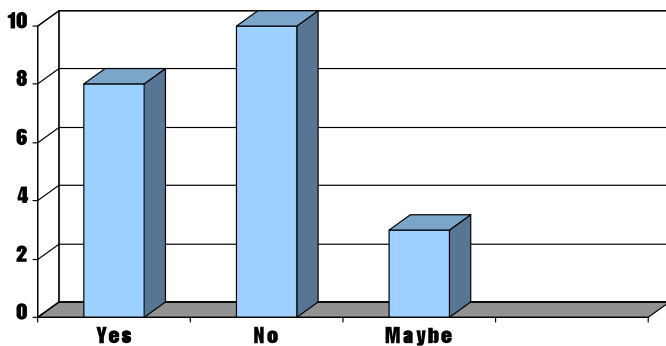
expresses the common theme of a loss of independence which also reappears in other responses to questions as well. Fear was also expressed throughout the responses as evidenced by this quote; “fear of infection and complications and the inconveniences of being limited to bed or less time up.” One other response simply stated that pressure ulcers meant “a lot of pain every day.”

The second question was: How does living with a pressure ulcer change your life? Participants wrote about their loss of independence and confinement to bed in order for the ulcer to heal properly. One participant wrote “(it) changes your life and the fact (that) you can’t go out and go where (you want to and) enjoy things that you used to do. You pretty much have to stay in bed and stay off of it all the time. It makes you go stir crazy, it impacts and everybody around you.” Feelings of stress and fear are visible in many responses including: “I am very stressed out all the time because I don’t know if this time will be the time it gets out of control as far as infection and will cause my death. I get depressed because I can’t do very much. Having a pressure ulcer is always a very low point in my life.” These responses also reflect a reduction in ability to interact with others.

Question three was: What could assist you in managing your pressure ulcer? There was little variance in the responses with participants stating that more caretakers or assistance, more money, and support and knowledge from the medical community would be helpful. A quote that summed up most of the responses is; “Someone available to help with dressings whenever needed, information about the best way to help it heal, qualified or experienced medical care.” Some of the participants responded that they had all they needed or that the only thing that would be helpful would be a “time machine.” The responses for whether or not group therapy would be helpful were that 47% said no, it would not be helpful, and 38% stated that it would definitely be helpful or of interest to them and 14% answered that it may be helpful (Table 4). Responses ranged from straight yes, no, or maybe to more in depth responses. “I definitely think that group therapy would help tremendously, the effects that a pressure sore has on a person is very traumatic. The absolute fear

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TABLE 4:
Responses to the question: Do you think that a group therapy session would help you deal with the changes the pressure ulcer has had on your life?



that I have has taken over my life. I believe talking with others that have gone through this would help.” A simple response such as the need for more “patience” indicates that there is a psychosocial aspect that needs to be addressed. All responses were analyzed by two authors to insure validity and consistency.

Discussion

The results of this study strongly support the hypothesis that quality of life in spinal cord patients with pressure ulcers is significantly lower than quality of life in a population of spinal cord injury patients without a pressure ulcer. Further loss of mobility and social isolation in a population already adapting to a debilitating situation may produce a compounding effect on daily life. The burden of these ulcers is clearly expressed in the qualitative results, which supports the reasoning for the mixed methods study; to elaborate on the quantitative data in order to further understand the implications of these ulcers.

Level of injury in the SCI patient was not a significant determinant of QoL; which has been a relatively consistent finding across previous studies (Brillhart, 2004; May & Warren, 2002, Westgren & Levi, 1998). The levels were separated by cervical, thoracic and lumbar. Gender is a variable that has gained more attention over the past years, especially with the up rise in depression among women, however the effect of gender on QoL has varied among

studies (May & Warren, Westgren and Levi). No significant differences between genders were found in this study.

Previous studies have shown higher QoL scores in spinal cord patients that had greater independence and were able to work, and participate in daily activities outside the home (Brillhart, 2004). Due to the intensive treatment that these wounds require, the effect on mobility and independence further isolates these sufferers from participating in their normal daily activities; and contributes to the significant difference in quality of life. This population faces constant challenges and when a compounding event such as a pressure ulcer is introduced, it adds additional stress to an individual who may already be significantly taxed. The medical community has not addressed the psychosocial aspects that pressure ulcers may have on the life of the SCI person. Focusing on the physical healing of the patient instead of healing them holistically causes the medical field to lose sight of the importance of emotional healing.

Qualitative findings demonstrate themes reflecting of negative emotionality with feelings of stress, depression, frustration concomitant with a loss of independence. From a situational context, these feelings are being experienced in individuals already facing physical limitations from a SCI along with possible emotional adjustment issues. The pressure ulcer then produces additional additive stress and contributes to even further limitation and loss of independence.

Previous studies have looked at the impact of wounds on quality of life and they focused on diabetic foot ulcers and venous leg ulcers. Emergent themes from a study done in 2005 on diabetic foot ulcers were consistent with themes from spinal cord injury patients with pressure ulcers. “Both ulcer and treatment affected mobility, independence and social life, and these experiences often led to anger, fear, depression, helplessness, boredom and loss of self-esteem” (Searle, Campbell, Talon, Fitzgerald, & Vedhara, 2005, p. 9). Venous leg ulcers have been studied extensively and their impact on quality of life is consistent with other studies with participants suffering from “emotional consequences of altered body image, living a restricted daily life, achievement of well-being in connection with a painful wound and bandage

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As these patients are trying to recover physically, they are deteriorating mentally.

discomfort, and a struggle between hope and despair with regard to a lengthy healing process” (Ebbeskog & Ekman, 2001, p. 238). Results are consistent in that there is a dramatic effect on the lives of sufferers of chronic wounds.

When looking at the individual responses to the open-ended questions it is evident that these pressure ulcers are causing much more than just physical problems. The first and second questions gathered responses that expressed the loneliness and fear that these ulcers have on their lives. Fear of death was expressed in more than one response. As these patients are trying to recover physically, they are deteriorating mentally. The third question brought about responses directed at frustration with the medical community. Although there were slightly more no responses for the question inquiring about group therapy being helpful, there was a stated desire to talk with others who are experiencing the same problem.

Limitations of Study and Further Research

A small convenience sample makes it difficult to generalize the results of this study; however the overwhelming difference in overall quality of life scores between both baseline populations and the pressure ulcer population can not be ignored. Results were compared with two previous data sets, rather than a control population. These data sets may not have been fully equivalent. Stages 1 and 2 pressure ulcers were not looked at in this study, and they may also elicit significant changes in activities of daily living. There is a definite need for further exploration on how to help these spinal cord injured patients deal with the affects that the pressure ulcers have enforced on their lives. Action needs to be taken to address the psychological issues that these wounds inflict.

Summary

Spinal Cord Injury patients with pressure ulcers are imprisoned by their wounds; they disrupt daily life and deteriorate not only the skin but also the mind. Attention needs to not only be focused on the physical healing of these wounds but the emotional healing as well. These patients have a choice to make on whether they are going to let the

pressure ulcer take control of their lives, as expressed by a participant in this study “its (pressure ulcers) made me choose to be depressed, lonely and weak.” SCI nurses can play a major role in helping individuals with a pressure ulcer talk about their experience and provide emotional support along with education in the future prevention of wound progression or development. Further research on appropriate psychosocial interventions during the experience of a pressure ulcer is strongly encouraged with an aim towards improving the quality of life in individuals with such a wound. Additionally, the evidence that a pressure ulcer can negatively impact quality of life highlights the need to provide education regarding ulcer prevention to all care providers and individuals with SCI.

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LEADERSHIP CIRCLE

Preparing the RN for the Constantly Changing Nurse Leadership Role

Tamara King, RN, MSN, CCM, CRRN

“Leadership is ultimately about creating a way for people to contribute to making something extraordinary happen.” This quotation extracted from Wikipedia is attributed to Alan Keith while serving in management at Genentech. It seemed an appropriate definition for this article because I feel that in healthcare, extraordinary things are happening everyday, generated and influenced by the actions of nurses.

From my perspective of a lifetime of nursing, the elements of nursing leadership have changed dramatically over the past 20 years. This has led me to believe that we might need to think differently about what constitutes a nurse leader and, consequently, how we might seek to develop nurses in the role. Due to rapid advances in medical science and technology there have been tremendous changes in what are considered necessary qualities for the effective nurse. The bedside nurse is now required to make more decisions based upon technological data and a wider base of medical knowledge; this role expansion in the decision making process may have created a first line manager in the bedside nurse. As an integral member of the care team, assessments and decisions made by the patient care nurse are often the basis for care plans designed to optimize patient outcomes. Thus, it could be argued that effective care delivery is greatly determined by the decisions of the patient care nurse, as his/her critical decision making

skills and performance may impact the decisions of physicians and other team members. The bedside nurse could therefore be considered first in a line of leaders, up through the charge nurse, nurse manager, and chief nurse. While the chief nurse may define and set the vision for the nursing department, success of care delivery also hinges on the effectiveness of all nurses from bedside practitioner through charge nurse and unit manager.

So how do we develop nurse leaders in today’s environment? Recently graduated nurses may have more advanced technological acumen than older nurses, yet may have less developed decision making skills; however, these nurses are expected to enter the nursing profession with the care coordinating skills necessary to adequately serve the needs of patients. Even though recently graduated nurses might have a better grasp of technology than many



Too often the nurse who has become adept at performing well at the bedside is then promoted out of her level of competence to the position of nurse manager.

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mature nurses the experience gap between knowledge and application of knowledge makes exercising and demonstrating leadership skills initially difficult. Veteran nurses have more experience in correlating patient data to lead the patient’s care plan to optimum outcomes. Nurse managers must somehow bridge the disparity gap to find a balance and develop leadership programs for nurses that promote the mental and practical skills necessary for the complete nurse of today. To achieve this, existing nurse leaders need to harness the expertise of the more experienced nurse to meld with the knowledge of the new nurse and produce a professional who develops well-honed skills to perform expertly at the bedside. The goal would be to create a confident skilled nurse in preparation for the more advanced levels of leadership.

The modern nurse is often and unrealistically expected to be a mental superwoman that somehow intuitively absorbs the rapidly expanding medical knowledge, at the same time developing the leadership skills necessary to take her career to the next level. Typically, nurses have not seen themselves as leaders and neither have they been recognized as such by other professionals in the industry or by the public. The problem of recognizing nurses as leaders is complicated by the confusing nature of the activities on the average nursing unit in which nurses are ubiquitous, multitasking at

everything while developing customized and individualized patient care plans. The very fact that they can serve many roles in this setting may render them virtually invisible and probably underestimated and undervalued. These nurses therefore rarely have the confidence or the will to advance in leadership roles though they may accidentally find themselves plummeted to the next level.

Too often the nurse who has become adept at performing well at the bedside is then promoted out of her level of competence to the position of nurse manager. Most non-healthcare corporations have leadership development programs that are mandatory for their managers. Within the healthcare industry there are many programs designed to develop the skills of managers in the administrative tract, yet, there are far fewer programs dedicated to developing nurse leaders. Until fairly recently advanced nursing practice has focused on developing clinical nurse specialists and nurse practitioners while neglecting the very important area of developing leaders for nursing administration. In essence, one size does not fit all when trying to develop the nursing leaders of tomorrow. Nursing management and nursing leadership are two highly specialized areas that deal with managing workforce and clients, and merely promoting an efficient nurse from the bedside does not produce a good nurse leader.

In this environment where nurse leaders may be under recognized for the extent of contribution, how can nurses be transfused with the desire and qualities they must have in order to be effective and efficient caregivers at any level of the leadership hierarchy? It is my belief that a good nurse leader evolves from the solid base of a bedside nurse who has become a good patient care manager, having grown under the guidance of her more experienced peer as well as using the knowledge she brings from didactic learning. That means that the expertise of the more proficient nurse needs to be harnessed through mentoring relationships with the novice nurse. Yet there is no ready path to this model, as the aging baby boomer population with attendant experience prepares to leave the arena. Due to the impending retirement of nurses who have developed leadership skills over time, lower enrollment in nursing schools, and lack of attention to the development of nursing leaders, there is presently a shortage of nurses ready for advancement.

Most persons know what he or she wants in a leader. They want a leader that has the ability to positively influence those around them, inspire confidence, make solid management decisions and yield consistent, verifiable and quality results. Good nurse leaders are thoroughly committed to positive patient outcomes, are patient advocates, believe they can,

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and do make a difference in the lives of those whom they lead and care for. Bedside nurses with leadership potential must somehow make the transition from care manager to workforce manager and effective leader. As such, the challenge is to create opportunities for nurses to be professional leaders, not just accidental leaders, who knowingly and willingly develop the skills necessary to become the best they can be.

A Swedish study of chief nurse and physician managers found that “as few as one-third of nurse managers investigated had participated in some sort of leadership programme” while most of their physician counterparts reported participation (Lindholm, 2006). It would be interesting to examine how we stand in the US where that is concerned; but for now, within the clinical environment, new nurses could be paired with those more experienced to develop necessary core skills. Coupled with that, focused leadership development modules could be introduced to teach the fundamentals of workforce and systems management. Ideally, nurses would be encouraged to pursue leadership studies at graduate level and supplement that learning with the training at organization level

where nurses with greater experience would be paired with nurses new to the profession to form leadership and knowledge synergy. There would be no conflict of old versus new; rather a situation would exist in which nurses, compatible because of a shared vision of the profession, mutually benefit from learning together.

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INNOVATION STATION

Vibrostimulation Device (VSD): New Advance for People with SCI

Marie Carlson, RN, BSN, CRN(C) and Kate McBride, RN, BSN, CRRN

Over the past two decades much has been written on sexuality and spinal cord injury (SCI). Research projects done at the Miami project and elsewhere have furthered our physiological understanding of the changes to sexuality for both males and females post SCI. Research is continuing in many areas of sexuality both nationally and internationally. One study, funded by the International Collaboration of Repair Discoveries (ICORD) coming out of a combined grant with the Sexual Health Rehabilitation Service (SHRS) and the BC Institute of Technology (BCIT) in Vancouver, Canada has focused on the development of a Vibrostimulation Device (VSD) more adapted to the needs of persons with SCI. The goal of the project was to ensure a high quality VSD design that is modular and adaptable and is developed at a respected research institute, in partnership with a respected clinical team

Although there are many vibrators on the market there are few devices suited for someone with altered mobility and sensation. With this in mind the partnership of the SHRS and BCIT teams developed, through focus groups and prototypes, a VSD specifically for men and women with SCI. BCIT's Applied Research Liaison Office (ARLO) was engaged. This project fit well within their mandate of:

- Medical and assistive device design and prototype development
- Evaluation of devices, technologies and products for persons with disabilities and older adults
- Commercialization of new health products, devices or technologies

As a result of this partnership a project plan was developed that included:

- Obtaining Yr 2 Ethics approval (both University of British Columbia & BCIT)

- Obtaining user feedback on device performance
- Usability feedback
- Design feature preference
- Reliability data
- Additional design feature input
- Costing model development

The BCIT ARLO took on the responsibility for commercialization activities as a part of their function, and a Patent was issued July 2008. An expert consultant, Cory Silverberg of Toronto, an AASECT certified sexuality educator, author, media contributor and researcher, engaged to assist the team in understanding the VSD industry needs, as the target was to market an adaptable, universal product appealing to able-bodied, disabled and senior populations in an affordable way.

The Sexual Health Rehabilitation Service was accountable for: recruiting patients for a male and female focus group, assisting BCIT staff in their

learning and understanding sexual function, as it pertains to SCI and needs of the population, facilitating focus groups for initial design priorities and organizing and implementing the clinical trials for Prototype use.

Focus Group Results

Sexuality post injury incorporates significantly more emotional aspects and mental concentration as compared to pre-injury. The focus groups revealed that partnered vs. solo sexual activities were by far preferred. Some of the participants were partnered, some were not, and some of the partnered participants trialed the VSD on their own. Therefore, depending on the person, the VSD either assisted this process (i.e. taught that there may be more potential or opportunity than previously thought), or hindered it (left them feeling a device did not add anything, was distracting or disappointing with respect to their

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Female with Q hand



Male solo

expectations). However, all participants empathically felt this was a positive project to pursue and requested the researchers to pursue further modifications to the VSD.

Clinical Trial Results

Some of the comments regarding the devices had to do with the actual shape and moulding of the device, such that it looked more “genitally adapted”, but the phallic implications were daunting to some of the women with SCI. Men with SCI found it acceptable but wished it had a more female appearance. In general both men and women wanted the VSD to be more accessible and user friendly on their own with poor hand function, or for a partner to use on them. The erotic aesthetics were also important, especially to get away

from the notion ‘yet another rehab adaptive device’, as this would make it more helpful for sexual arousal, and suggestions were made to make it more lifelike. There were also some difficulties managing the charging mechanism, even though the outlet plug was an innovative design for poor hand function.

Because of the power inherent in the vibrator, it was important to assess risks, including the promotion of autonomic dysreflexia (AD) and promotion of any other bladder, bowel or spasticity issues. No significant medical incidents, including AD, were noted. During the trials, because the protocol stated the device was prohibited from use on the partner, some partner affects were noted: if the partner was turned off or threatened by the device,

it was not as easily incorporated into sexual activity, as it was if the partner was enthusiastic and/or even saw the potential for mutual use back and forth.

In future studies it would be important to be able to incorporate the use by the participant and their partner.

Some of the more physiological effects were positive. The new device was instrumental for some in spotlighting the relevance of sexuality in the individual’s lives, especially if it had been put on the backburner, and added to a sense of valuing themselves as sexual beings post SCI. The trial was also a positive catalyst for sexual communication between some partners.

Lastly, as the researchers did not want to bias the exploration using the VSD, only general directions to its application on the genitalia were given, but it was found that a lack of sexual anatomy knowledge of some of the intelligent and well-informed subjects inhibited their experimentation. For the researchers, this need for better and clearer direction may result in a paradigm shift in sexual health education for persons with disability especially women, as most did not look for the sexual information themselves or feel that sex was a priority.

The VSD is now in the design feature input phase, and the teams are dedicated to bringing this product to market.

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The new device was instrumental for some in spotlighting the relevance of sexuality in the individual's lives, especially if it had been put on the backburner, and added to a sense of valuing themselves as sexual beings post SCI.

Marie Carlson RN, BSN, CRN(C) is a nurse clinician in the Sexual Health Service at Vancouver British Columbia and has been extensively involved in this project. For further information please contact Marie at marie.carlson@vch.ca

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Barb Lawrie RN, MSN, CRRN is the Director of Nursing Practice at Providence Health Care, Vancouver, British Columbia, Canada and a member of AASCIN Nursing editorial board. As column editor for the Innovation Station, Barb welcomes your comments, question, suggestions and manuscripts. You may email her at blawrie@providencehealth.bc.ca



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RESEARCH CORNER

How Do I Find a Good Questionnaire?

Matthew R. Sorenson, PhD, RN

When preparing a study, one of the most significant issues is selection of the measure used to evaluate the construct of interest. The questionnaire or scale needs to have demonstrated reliability and validity, and should also fit the conceptual model of the study. However, finding such a measure can be difficult. A graduate student approached me the other day with the very question that serves as the title of this column, how do I find a good questionnaire?

Several resources immediately came to mind, in terms of database searches and a review of the literature. However, sometimes a cursory search of the literature may not provide a sense of the number of tools that may exist. For example, a brief search of the stress literature could provide a restricted number of tools depending on the search terms used and even the perspective of stress that I have in mind. Several potentially valuable measures could be overlooked. Fortunately, there are the occasional review articles that address measurement and summarize some of the major tools available. There are also several texts available that may help start off a search.

Books and Textual References

There are a number of texts that have targeted measurement considerations within the field of nursing. One valuable resource is *Measurement in Nursing and Health Research* (Waltz, Strickland and Lenz, 2005). It is helpful

to review concepts of reliability and validity while searching for a research measure. A companion work would be the three volume *Measurement of Nursing Outcomes* (Waltz, Jenkins and Strickland, 2001) which provides valuable information on several tools and measures, providing illustrative examples of how select concepts have been investigated.

Also, several concepts have handbooks and measurement guides available. For example, the *Handbook of Neurologic Rating Scales* (Herndon, 2006) provides numerous scales and questionnaires specific to disease type and age group. This text also reviews measurement concerns and theoretical issues along with providing copies of each measure on a CD-ROM that accompanies the text. A similar offering is *Primary Care Tools for Clinicians* (Loretz, 2005) which while more focused on clinical assessment and history also has several useable rating scales. All measures are also included on an accompanying CD-ROM.

A good literature review is then a valuable starting point. Such a review not only helps identify measures in existence, but also can highlight the issues and problems that may be associated with a particular measure.

Internet Based Resources

Fortunately, there are several databases that are of value in searching for a research tool. Many of them can be accessed through hospital based systems, or a nearby library. The majority of these databases are not fully publically accessible and do require the library or hospital subscription.

A particularly interesting publically accessible site is one hosted by the Veterans Administration. *The Measurement Resource Archive* provides several search options, allowing for a search based on the instrument but also a section that reviews constructs and addresses relevant measurement considerations. The site is no longer actively updated, with the construct section last updated in 2005 and the

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instrument search in 2006. However, even though this information is a couple of years old, it provides a valuable resource, particularly for those struggling with a construct and trying to determine which measure to use.

Another valuable database is *Health and Psychosocial Instruments* that is available through OVID. This database provides a means of searching for a particular measure or using a keyword based approach to search using a construct. The results provide reference to an article that has used a particular measure and scrolling the detailed results page will reveal the original source for the questionnaire or measure. This is particularly helpful in getting a sense for how a tool was developed and the initial psychometric testing.

A resource that many are familiar with is the *Cumulative Index to Nursing and Allied Health Literature* (CINAHL). This resource is now incorporated into the EBSCO database. While many have used this resource to search for articles and other materials, it is possible to use CINAHL to search for research questionnaires and tools. A

keyword is typed into the search window and underneath the search options is a restriction in terms of publication type. Use this publication type selection and restrict the search to questionnaires. Using a keyword search in combination with this restriction provides a means of searching for research measures.

One other resource that is of value to researchers and clinicians is <http://www.medal.org>. This website provides numerous clinical calculators, medical algorithms along with scales and questionnaires. A particularly helpful element is the ability to download Excel spreadsheets that will provide immediate scores and calculations. This is a website that is well worth a look on the part of any healthcare provider or researcher.

Conclusion

Ultimately, when searching for a scale there are several options both in print and online. Yet, while there are extensive resources available; they are no replacement for a clear conceptualization of the construct and a thorough review of the literature.

Internet Links

Measurement Resource Archive/
Metric Archive

http://www.hsrdr.research.va.gov/for_researchers/measurement/instrument/

Medal.org

<http://www.medal.org>

Matthew Sorenson is an Assistant professor of Nursing at De Paul University and the editor of Research Corner. Matthew welcomes your comments, questions and suggestions. Please contact Matthew at msorenso@depaul.edu



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AGING WITH SPINAL CORD INJURY

Supplementing Health with Vitamins

Angela Starkweather, PhD, ACNP-BC, CNRN

Consumers are often bombarded with advertising about vitamins that promise health and longevity. Many of the participants in this multi-million dollar industry promise better visual acuity with vitamin A, a boost in energy from vitamin B-12, prevention or reduced symptom severity of the common cold with vitamin C, improved sex life and delayed aging from vitamin E, and reduced risk of diabetes with selenium; claims that have never been verified. The evidence for maintaining a healthy, well rounded diet in order to meet all of the body's requirements is compelling, and with the exception of calcium and vitamin D, other supplements are not usually required for older adults. However, a recent study by Walters, Buchholz, and Martin Ginis (2008) demonstrated that individuals with SCI may be especially prone to nutritional deficiencies.

Recommending supplements for aging individuals with SCI should be based on whether they are consuming the required amounts of daily nutrients, and often older adults experience a decreased appetite and thus, consume less. Although the body mass index provides information on whether enough calories are being delivered to the body, it does not decipher whether nutritional deficiencies are present, therefore, do not rely on the individual's weight alone when considering the need for a supplement. A 24-hour dietary recall can help provide a picture of whether the individual is taking in enough fruits and vegetables to meet the daily nutrient requirements. This evaluation can also help identify the need for assistance with meal preparation, use of assistive eating devices, and/or changes in meal patterns that may augment intake of specific nutrients.

In addition, individuals with kidney or liver problems need to be especially cautious with the use of vitamin supplements and require guidance from an experienced healthcare provider in order to plan their diet and tailor the use of supplements accordingly. For those having difficulty meeting the required amount of daily calories or with signs and symptoms consistent with a nutritional deficiency, a thorough nutritional assessment should ensue.

Supplements to Consider for Aging Individuals with SCI

Interventions focused on improving dietary intake of a well-balanced diet with lots of fresh fruits and vegetables may, in the long run, provide more benefit toward healthy aging. However, when individuals with SCI are unable to consume the daily recommended levels of key nutrients, a general, low-cost, multivitamin may suffice. However, it should be communicated that the multivitamin is used to supplement

and not replace usual dietary intake (Murphy, White, Park, & Sharma, 2007). If calories need to be increased along with vitamin intake, liquid supplements are available that may be helpful. Several of the common vitamin deficiencies found among older adults are as follows:

Vitamin deficiencies of calcium and vitamin D are the most common among older adults (Sebastian, Cleveland, Goldman, & Moshfegh, 2007). Both calcium and vitamin D are needed to keep bones strong, maintain posture, and prevent osteoporosis and devastating fractures. Three servings of low-fat or fat-free milk, cheese, and yogurt as well as leafy green vegetables, such as spinach, kale, or broccoli, are excellent sources to meet the daily requirement of 1,200 milligrams; for post-menopausal women it's increased to 1,500 milligrams/day. Those who cannot tolerate dairy products may consume calcium-fortified orange juice and cereals.

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A 24-hour dietary recall can help provide a picture of whether the individual is taking in enough fruits and vegetables to meet the daily nutrient requirements.

However, when individuals are at risk of not consuming enough calcium, calcium carbonate or calcium citrate supplements may be needed.

When the skin is exposed to sunlight, the skin produces the body's main source of vitamin D. However, as skin ages, its ability to synthesize vitamin D decreases. It is recommended that 400 IU (international units) be consumed daily for those less than 50 years old, and 800 IU for those over 50 years old. These recommendations assume regular sun exposure, thus older individuals who have limited sun exposure may require supplements to meet daily required amounts.

As no current guidelines exist for administering calcium and vitamin D supplements for persons with SCI, caution should be taken because excessive levels can increase the incidence of urinary stones. To decrease this risk, parathyroid hormone levels, and kidney and liver function should be evaluated prior to recommending regular supplements. In addition, measuring levels of calcium in the urine can help to identify if the individual is receiving too much calcium.

The B-12 vitamin is consumed primarily in meat or fortified cereal, and helps to maintain adequate levels of hemoglobin, red blood cells, and nervous system functioning (including memory). Older adults may be especially prone to B-12 deficiency, and

supplements may be needed to acquire the 2.4 micrograms suggested daily.

Another B vitamin, Folate, helps to reduce levels of Homocysteine, a molecule associated with increased risk of cardiovascular disease and stroke. Folate is generally consumed through dark green, yellow and orange fruits and vegetables, beans, nuts, seeds and fortified grain products such as pasta and flour. Foods with a high concentration of Folate include spinach, orange juice, and lentils. Some sources suggest that older adults receive 400 micrograms of Folate per day to supplement the amount consumed through dietary means.

Helping aging individuals with SCI determine the best routine for obtaining adequate amounts of key vitamins and minerals can play an instrumental role in their health and well-being. Because there is no 'magic pill' that provides the perfect amount of nutrients, and vitamin excess can be hazardous, individuals should be encouraged to consume a well-balanced diet including fresh fruits and vegetables daily. For those with known or possible risk factors for nutritional deficiencies, a referral to a nutritional healthcare professional can help to individualize the approach through more comprehensive assessment and planning, minimize the risks of excessive vitamin intake, and ensure that the individual with SCI has the vitamins required to supplement their health.

For more information, please see the following:

Dietetics in Physical Medicine and Rehabilitation, a dietetic practice group of the American Dietetic Association:

<http://www.dpmrdpg.org/index.cfm>

Find a local nutrition professional on the American Dietetic Association webpage by typing in your zip code at:

http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_fanp_consumer_ENU_HTML.htm

Angela Starkweather is an Assistant Professor at Virginia Commonwealth University School of Nursing. As a member of the SCI Nursing Editorial Board, she welcomes your comments or questions regarding the content of this article. She can be reached at astarkweathe@vcu.edu.



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Sebastian, R. S., Cleveland, L. E., Goldman, J. D., & Moshfegh, A. J. (2007). Older adults who use vitamin/mineral supplements differ from nonusers in nutrient intake adequacy and dietary attitudes. *Journal of the American Dietetic Association, 107*, 1322-1332.

Walters, J. L., Buchholz, A. C., & Martin Ginis, K. A. (2008). Evidence of dietary inadequacy in adults with chronic spinal cord injury. *Spinal Cord, November 11*, Article 6.

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BOOK REVIEW

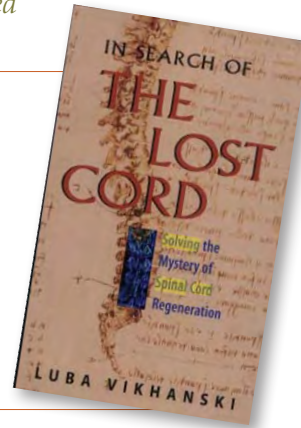
Vikhanski, Luba (2001). In Search of the Lost Cord: Solving the Mystery of Spinal Cord Regeneration. Washington, D.C.: The Dana Press and Joseph Henry Press Publishers

Reviewed by: Jessie Dickerson, RN, MSN, CWON-AP, CFCN; Retired

In Search of the Lost Cord: Solving the Mystery of Spinal Cord Regeneration

Vikhanski, Luba (2001).

Washington, D.C.: The Dana Press and Joseph Henry Press Publishers, ISBN: 0-309-07437-1
 269 pages, \$27.95



The award winning science writer Luba Vikhanski takes you on a fascinating journey around the world as she expertly set forth a chronicle of the international research involved in the quest for a cure for spinal cord injury. The author interviewed talented researchers looking to solve the mystery of spinal cord regeneration at laboratories in such countries as Spain, Sweden, Israel, Canada and the United States, just to name a few. The author was able to masterfully articulate how a small number of dedicated scientists were able to share their struggles, successes and failures with each other and to learn from each other in order to finally make hope a reality for thousands of individuals with spinal cord injury.

Vikhanski’s compelling story of the resulting international effort to restore function to the severely injured spinal cord could well be on the verge of a scientific breakthrough. In Search of the Lost Cord is an interesting and compelling story of science history in the making. Based on the progress that has already been made, one can venture to say that perhaps, some day in the not so distant future, those suffering with spinal cord injury may walk again.

This book is truly an inspiration and captures the ongoing excitement about the field of spinal cord regeneration as one follows the accelerated progress of the research that has taken place in the field. It is therefore, understandably how this ongoing research provides hope for what seemed impossible a

few years ago for people with spinal cord injuries. The future is, indeed, promising for a cure in the not too distant future. This book is a great resource to help keep hope alive.

Column Editor and Reviewer: Jessie L. Dickerson, RN, MSN, CWON-AP, CFCN



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ABSTRACTS FROM SELECTED LITERATURE

Perceptions of the Nursing Role in Spinal Cord Injury Rehabilitation

Reviewed by: Jamie Hannafin, BSN RN

Perceptions of the Nursing Role in Spinal Cord Injury Rehabilitation.

Pelleat, Glynis Collis. (2003). British Journal of Nursing 12(5), 292-299.

In the rehabilitation setting, patients with spinal cord injury are treated by a multidisciplinary team. This team typically includes doctors, nurses, physical therapists, occupational therapists, therapeutic recreation specialists, case managers, counselors, and many other varied healthcare professionals. This study focused on the way the nurse's role, in particular, is viewed by patients and nurses in a large rehabilitation unit.

The author interviewed both nurses and patients to learn about how each group perceived the role of nurses on the unit. The author detailed how efforts were made to eliminate or lessen extraneous factors that could skew the findings. The responses were coded, and themes were identified. The author

noted that this study only sampled from a single hospital unit located in Southern England, and therefore has limited generalizability.

The study findings suggested that the nurse's role appears to be multifaceted and requires a wide variety of physical skills and the ability to empower patients with spinal cord injury. Furthermore, the study findings suggest that nurses feel their skills are not valued by patients or by other healthcare professionals on the team. However, the study results reveal that the patients who were interviewed felt otherwise, reporting that they recognized and valued the skills and abilities of their nurses.

The role of a nurse has changed greatly over the years, and this study offers a glimpse into how this role is

perceived by both patients and the nurses themselves. While this study was limited by a small sample in one geographical location, the topic is significant to all nurses working in the rehab setting, and especially a rehabilitation setting with a focus on Spinal Cord Injury. It would be beneficial to use broader sampling methods to see if the views reported apply in other hospitals, both in England and in other countries.

John Morwaski, BSN, RN, CRRN is an SCI Nurse Educator at Shepherd Center in Atlanta, Ga. and the editor of the journal reviews column. Please contact John at john-morwaski@shepherd.org if you are interested in writing journal reviews.



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GUEST COLUMN

Power for the Patient in the Rehabilitation Setting

Terry Chase, MA, ND, RN



I work in a healthcare setting where rehabilitating the patient in the areas of physical function, mental focus and attitudinal shifts are all part of the process of returning to life after a catastrophic spinal cord injury. I see Dialogue Education™ (DE) as a well-formed process to support the shifting of power back to the patient and family who find themselves in a situation where power and self-determination can be altered by circumstance.

I see Dialogue Education™ (DE) as a well-formed process to support the shifting of power back to the patient and family...

As a person enters the healthcare system, power is subverted from the patient by the stripping away of personal clothing, pre-determined

food choices and treatments aimed at healing yet oftentimes done in the HC provider’s time frame. As Arthur Frank relates in his book, “At The Will of The Body” (1991) about the loss of personal power while dealing with the healthcare system: life turns to beige. It is difficult to accept the realities of what physicians can do for you without subordinating yourself to their power. The power is real, but it need not be total. You can find the places for yourself in the cracks. To me, Dialogue Education™ is one of the ways to expose the cracks and invite the power of the person to come forward while going through the rigors of the rehabilitation process. The use of Dialogue Education™ in 1:1 teaching, group experiences and the teachable moment offer an opportunity for dialogue in the moment. This dialogue provides the opportunity for the patient to have a voice and to hear their own power and experience their contribution to the situation just by being present and acknowledged as a human being.

Spinal cord injury can leave a person with little or no use of limbs, an inability or reduced ability to breathe without mechanical support and altered elimination systems requiring attendant care for even life’s most basic and private functions. In essence these patients are learning to deal with a body that no longer works like before injury. The use of one’s body in the world is altered on levels never

imagined or considered. A person’s sense of self can be rocked to very core and shake even the highest levels of self-confidence. Through the process of rehabilitation and the opportunity to learn new ways of moving about in the world through one’s own power or with specialized equipment, the person with this injury can make great gains and find their way in the world again.

Specifically I use the principles of Dialogue Education™ in my group classes for patients who have experienced a spinal cord injury. The most valuable tools of Dialogue Education™ I have learned and utilize on a daily basis are the Four A’s: Anchor, Add, Apply, and Away.

The most valuable tools of Dialogue Education™ I have learned and utilize on a daily basis are the Four A’s: Anchor, Add, Apply and Away.

At the beginning of each class “Anchor” by asking about what they know, what have they thought about so far about the topic? This acknowledges their presence, their ability to learn through daily experience and to anchor that they know something already. “Add” some information by chunking new information into small pieces and avoiding bowling them over with too many facts. I use many visual aids and props, to illuminate concepts that are difficult to grasp only through words. “Apply” is through what is happening

Spinal cord injury can leave a person with little or no use of limbs, an inability or reduced ability to breathe without mechanical support and altered elimination systems requiring attendant care for even life's most basic and private functions.

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now for them. How can they put this information to work in the moment or make a plan for use in the very near future, like at lunchtime or during evening personal care routines?

The patients leave the class with a sense of "Away" that they can use this information or practices in their directing care or performing personal care routines that are scheduled everyday.

I see the value and benefits of Dialogue Education™ to shift the balance of power back to the patients as an important step in their progress through rehabilitation. The goal of rehab is get patient back to life, to work, to family, and to full functioning as a contributing member of society. Through day-to-day attention of opening a space for dialogue and acknowledging the patient as a person this goal will be achieved.

Terry Chase, MA, ND, RN is the Patient & Family Education Coordinator at Craig Hospital in Englewood, Colorado.

Reprint with Permission from Global Learning Partners' e-journal Voices in Dialogue, Winter 2006, Issue No 8: <http://www.globalearning.com/voices/2006winter/rehab.htm>. "Dialogue Education™ is a learning-centered, change-focused system for successful adult learning: learning that has an immediate impact on the job, at home and across organizations. Dialogue Education™ models proven principles and practices developed over decades by Jane Vella, noted academic and founder of Global Learning Partners, Inc. To learn more about Dialogue Education™, please visit www.globalearning.com.

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Supplemental Nursing Intervention Documentation in a Multi-site Study Describes SCI Rehabilitation Details

Kelly M. Johnson, MSN, RN, CRRN, CNAA, BC

The SCIREHAB Project is a 5-year research effort designed to determine which SCI rehabilitation interventions are associated most strongly with positive outcomes at 1-year post injury. Outcome measures include functional independence, medical complications, rehospitalizations, social integration, and quality of life. 1,500 consecutive initial rehabilitation admissions of individuals with traumatic SCI from six centers are being enrolled. Nurse leaders from six centers collaborated over a 9-month period to identify important nursing contributions to the SCI rehabilitation process and describe how to capture data from nursing documentation. Resulting supplemental nursing documentation focuses on intensity of education, care management, and the nurse's perception of patient engagement in nursing care each shift. Data have been collected by all nurses at participating centers since October 2007. Preliminary data (first 3 months) show time spent in education and care management topics ranges from 1 to 4.5 hours per week; areas with substantial intensity include medication, bladder, and bowel education and psychosocial support, while relatively little time is devoted

to nutrition education. We will update data for presentation to include 9 months and approximately 500 patients: average hours per week (and per rehabilitation admission) spent in education/care management, variation among centers and between tetraplegic vs. paraplegic patients.

Get Published in a Peer-reviewed Journal

Joy E. Bailey, MSN, RN, CRRN, BC

As clinical and administrative nursing continue to evolve as more evidence-based models of care, it is important that the profession develops and nurtures clinicians to research, prepare, and publish in order to advance knowledge in the profession. This paper will introduce the aspiring nurse writer to ideas for research and publication, and suggest ways of preparing papers to target nursing and other clinical peer-reviewed journals.

Post Traumatic Syringomyelia: A Secondary Complication of SCI

Deanna Persaud, RN, MSN

To provide competent care, nurses working with persons who have sustained a SCI must be familiar with common secondary complications of injury. In this presentation, a case study approach will be used to explore a condition known as syringomyelia. Nursing assessment, to identify clinical

manifestations, will be described. The physiological basis of tethered spinal cord and syringomyelia will be discussed. Therapeutic interventions including cord untethering and surgical shunting procedures will be described.

Cardiovascular Complications After SCI

Mary Ann Reilly, MS, BSN, RN, CRRN

Santa Clara Valley Medical Center has a unique Acute SCI unit, the Rehab Trauma Center (RTC). The RTC accepts fresh injuries from the ER who are cardiovascularly stable and had not incurred multiple trauma along with SCI. In the past year the RTC has had several cervical cord injuries exhibit cardiac symptoms which caused a transfer to the ICU. This presentation will discuss the cardiovascular risk factors of the SCI along with parameters for early identification of CV instability.

Fever on the Spinal Cord Unit

Sandra K. Hunter, BBA, RN, CRRN

Fever on the spinal cord unit requires a different approach because the incidence of various etiologies and the etiologies are different from other medical environments. Further, the spinal injury itself often alters the presentation and behavior of fevers. The approach to this problem is presented.

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MS 101: Multiple Sclerosis for SCI Nurses

Richard A. Buhner, MN, RN, ARNP

Multiple sclerosis is a chronic, progressing, and disabling disease. Many spinal cord injury nurses are being asked to care for people with this condition. We will discuss the history, epidemiology, pathophysiology, and treatments for multiple sclerosis to provide an introduction to this tragic disease to support nursing practice with these people and families.

Multiple Sclerosis Overlaid on Spinal Cord Injury

Richard Buhner, MN, RN, ARNP

This is a case study of a spinal cord injured person who developed multiple sclerosis after his injury. It describes the diagnostic processes that were used to confirm this diagnosis, the treatment that was offered and implemented and the functional implications of the diagnosis. It also explores the course of the disease in this patient. The differential diagnoses will be discussed. The conflicting answers to the question: "Does trauma predispose to multiple sclerosis?" will be examined.

Having What it Takes to Care for the SCI Bariatric Patient

Joycelyn Craig, BSN, RN, CRRN; Donna Loupus, MN

Ever increasing bariatric admissions precipitated implementation of a bariatric task force at our facility. There are many aspects related to caring for the bariatric patient beyond patient handling equipment. Preparing the environment and the staff to safely accommodate this population can be a complex endeavor. Equipment and supply availability is essential prior to transfer to a facility. Evaluating admissions to determine their medical issues and the ability to offer diagnostic services must be considered in an admission criteria. Training and competency of the staff is necessary for all equipment, lifting and use of accessory items. Resource materials defining various equipment weight limits should be available to all units.

Pregnancy and Parenting with SCI

Lisa A. Beck, MS, RN, CNS, CRRN; Tammy Vos, MS

Pregnancies in women with spinal cord injury present unique and rare clinical challenges. These women are usually considered to be "high risk" secondary to complications that can

arise during the course of pregnancy. Many complications can be prevented and treated through collaboration between an interdisciplinary outpatient rehabilitation team and a sophisticated obstetric team. This case study discusses the innovations, interventions, and unique practices of an outpatient spinal cord injury team in collaboration with an obstetrics team in accomplishing the successful term pregnancy, delivery and post partum care of a 28 year old woman with C 5/6 tetraplegia. The innovation, interventions, and unique practices can be replicated in the field to advance the treatment of patients with SCI and pregnancy.



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FILM FESTIVAL REVIEWS

Understanding SCI & Functional Goals

Survive, Thrive & Alive! Brain Injury Awareness & Prevention

The following films were shown at the 25th Annual Educational Conference of AASCIN in Orlando, FL. in August, 2008.

Reviewer: Susan S. Thomason, MN, RN, APRN-BC, CRRN shares an overview of the content presented.

Understanding SCI & Functional Goals

“Understanding SCI & Functional Goals” is Part I of the educational video series, “Managing Secondary Conditions of Spinal Cord Impairment” (2006). It is produced by the University of Alabama-Birmingham, Department of Physical Medicine & Rehabilitation, Spain Rehabilitation Center, and was supported by grant #532 of the Paralyzed Veterans of America Education Foundation. This 25 minute DVD is a patient education lecture by Phil Klebine, MA. Klebine initially provides a basic overview of anatomy of the spinal cord, and discusses movement, sensation, vertebral/neurological levels of injury (LOI), and etiology of SCI. Functional goals for reaching maximal independence are explored based upon the LOI and completeness. The lecturer addresses the potential and limitations of each LOI and relates these to specific functional goals. Goals include: bathing,

grooming, eating, mobility, transferring, driving, pressure reliefs, self-coughing, tenodesis, bowel, bladder, household activities, vocation, writing, balance, ambulating, and others. Klebine emphasizes that there are only general guidelines for functional return. Although it is patient-centered, the DVD would also provide an excellent overview for interdisciplinary team members who are orienting to SCI.

Survive, Thrive & Alive! Brain Injury Awareness & Prevention

“Survive, Thrive, and Alive!” is an exceptional 29-minute DVD that was produced in 2006 by the Office of Educational Programs, Defense and Veterans Brain Injury Center (DVBIC). It is a documentary that has chapters with key points and links. This DVD adeptly increases awareness by discussing aspects of etiology, management, community integration, and prevention of traumatic brain injury

(TBI). Mild to moderate TBI is portrayed as the silent epidemic, involving concussions due to motor vehicle accidents, falls, sports, and other etiologies. TBI often goes undetected as persons learn compensation techniques to overcome their deficits; for example, time management may be a significant but subtle deficit. Strategies for detecting and managing TBIs are explored. For example, the Sports as a Lab Assessment Model (SLAM) compares baseline cognition to post-concussion cognition following blast and vehicular injuries. Working in a bookstore may offer therapeutic benefits to persons with TBI; these include cultivating social skills, modifying behavior, enhancing cognition, and memory organization. The basic tenets of this informative DVBIC video are that people do better if they know what to expect post-TBI, and early intervention is a key to the success of TBI rehabilitation.



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AASCIN Committee News

Lynn Parsons, DNS, RN, CAN-BC

Clinical Practice Committee reports that the guide *Preservation of Upper Limb Function: What You Need to Know*. Other guides being developed are Metabolic Syndrome and Coping with Spinal Cord Injury. A major focus of this committee is supporting the 2nd Annual “Boot Camp.” Potential funding for this event will come from a grant written for PVA. A decision regarding funding may be made as early as April 1, 2009.

Editorial Board members are reviewing feature articles for the Best Article of the Year and Best Aging article of the Year. Discussion ensued regarding having one journal versus separate journals for each of the professional disciplines represented in the Academy of Spinal Cord Injury. Deanna Persuad, Editor of *SCI Nursing* and Lynn Parsons, Board of Director liaison to the Editorial Board will represent SCI nurses.

Web Board and Membership Committee reports there are currently 523 members in all groups; 223 of those represent the SCI Nurses. To date, \$1,390 has been contributed by members. It is anticipated that many members will pay dues prior to the annual conference. Richard Buhner is the SCI Web Master and is working on web guidelines.

Aging Committee has received a \$2,000.00 grant award to support web-based activities and consultation support. This technical assistance will include informational sessions, webinars on topics related to the web such as search engine optimization and marketing and strategies to increase traffic (hits) to your web site.

ConsultGerIRN.org has a page on AASCIN's activities. This page can be viewed at <http://www.consultgerirn.org/>

Program Committee is in receipt of 67 abstracts for both poster and platform presentations for the 2009 conference for SCI Nursing. A total of 300 abstracts across all organization in the Academy of Spinal Cord Injury Professionals (ASCIP) were received. The annual conference will include plenary session across the ASCIP Papers and poster abstract submitters will be contacted in March to acknowledge acceptance of their abstract.

Planning for Boot Camp 2 is underway and speakers for the event are being vetted. Funding the event was discussed and it was noted that a proposal sent by the SCI Financial Development Committee could help support this event.

Additionally, this committee is working on a “Special Recognition Award” to acknowledge members who provide service to the SCI population.

Financial Development committee has worked on proposals to obtain funding for the annual conference with an emphasis on supporting Boot Camp 2. The Mike Utley Foundation turned down on submittal in January 2009 to fund the annual conference, however, they added that the proposal met their mission/guidelines and encouraged a resubmission.

Another proposal was submitted on February 2, 2009 to the Paralyzed Veterans Association (PVA) for \$50,000. The title of the proposal, “Boot Camp 2 for Spinal Cord Injury Professionals” if funded, will help pay for speakers, room rental, provide refreshments and support other aspect of the entire annual conference.

Lynn Parsons, DNS, RN, CAN-BC is a Professor and Director of the MTSU School of Nursing in Murfreesboro, TN. She is a member of the AASCIN Board of Directors and serves as the Treasurer and Editorial Board Liaison. Contact Lynn at lparkers@mtsu.edu.



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SAVE THE DATE!

The 2009 Congress on Spinal Cord Medicine and Rehabilitation

Sheraton Dallas Hotel

September 23-26, 2009

The Congress on Spinal Medicine and Rehabilitation, the nation’s premiere conference for spinal cord injury professionals, is coming to Dallas, Texas, in 2009. And next year’s Congress promises to be a truly unique, must-attend meeting of minds.

For complete details on how to register visit www.spinalcordcongress.org.

Copresented for the first time by the American Spinal Injury Association (ASIA) and the American Association of Spinal Cord Injury Nurses (AASCIN), the American Association of Spinal Cord Injury Psychologists and Social Workers (AASCIPSW), the American Paraplegia Society (APS) and the Therapy Leadership Council in Spinal Cord Injury (TLCSCI) and supported by Paralyzed Veterans of America-the Congress is expected to bring together more than 750 leaders, the “best and the brightest,” in spinal cord injury/disease/dysfunction (SCI/D) healthcare and research.

This year’s Congress topics include: Pain Management, Secondary Complications Associated with Aging and Evidence-Based Practice.

ASIA and AASCIN, AASCIPSW, APS and TLCSCI have long track records respectively of providing excellent annual scientific meetings. By combining their resources, this year’s not to be missed Congress will be a world-class venue for SCI/D professionals to network, share ideas, and to integrate the disciplines of medicine, nursing, psychology, social work, behavioral health and rehabilitation therapy-leading to better treatments, therapies and cures for people who live with SCI/D.

The Consortium for Spinal Cord Medicine Clinical Practice Guidelines

The Consortium for Spinal Cord Medicine, in partnership with PVA’s research and education team, strives to improve care of persons with spinal cord injury by making their care more research and evidence based through publication of The Consortium for Spinal Cord Medicine Clinical Practice Guidelines. The Consortium also publishes companion consumer guides to provide information to consumers of SCI related health care.

Clinical Practice Guideline topics include:

- Bladder Management
- Preservation of Upper Limb Function
- Respiratory Management
- Thromboembolism
- Autonomic Dysreflexia
- Pressure Ulcers
- Expected Outcomes
- Depression
- Neurogenic Bowel

Consumer Guide topics include:

- Depression
- Expected outcomes
- Pressure Ulcers
- Autonomic Dysreflexia
- Neurogenic Bowel
- and more

Check the PVA website www.pva.org under “Publications.” Downloads are free. Select publications are available in print and in Spanish.

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Calling All Medical Musicians

The Medical Musical Group (MMG) seeks members for its symphony orchestra and chorus. Health care professionals and friends may apply.

For information:

Call: (202) 797-0700

Mail: 1700 17th Street, NW, Suite 508
Washington, DC 20009

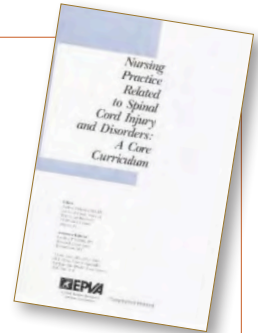
Email: vanmmg@hotmail.com

Visit our website: www.medicalmusical.com



“SCI Core Curriculum” Offer

Widely considered a “must-have” text for all SCI nurses and edited by longtime AASCIN members, Audrey Nelson, PhD, and Linda Love, MS, RN, CRRN, *Nursing Practice Related to Spinal Cord Injury and Disorders: A Core Curriculum*



A *Core Curriculum* is now available to AASCIN members at a significant discount. Thanks to an arrangement with Demos publishing, AASCIN members may order the book directly at a 35% discount, with free shipping. Go to www.demosmedpub.com and enter “AASCIN” as a discount code. Demos generously donated two copies for the book draw at the annual SCI Conference in Florida last year.

Bulletin Board

Submitted By Jessie Dickerson RN, MSN, CWON-AP, CFCN



Teamwork, Trends, And Technology: New Solutions In Multiple Sclerosis

Date: 23rd Annual Meeting
May 27-30, 2009
Location: Hyatt Regency Hotel
Atlanta, GA
Website: www.Mscare.org
Deadline: Register by May 15, 2009
Fax: (201) 678-2290 or (201) 678-2291

Howard H. Steel Conference: Pediatric Spinal Cord Injuries & Dysfunction

Date: December 3-5, 2009
Location: Hilton At The Walt Disney World® Resort
Lake Buena Vista, Florida
Website: www.Pedssci.com

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Conference Scholarships

Paralyzed Veterans of America Scholarship Announcement

2009 Congress on Spinal Cord Medicine and Rehabilitation

Sheraton Dallas Hotel

September 23-26, 2009

We are pleased to offer scholarships to attend the 2009 Congress on Spinal Cord Medicine and Rehabilitation. Scholarships are available on a first come, first served basis until funds have been exhausted. All scholarships **MUST** be submitted electronically. No fax or mailed applications will be accepted.

Eligibility

- Any current dues-paid member of:
- American Paraplegia Society (APS);
- American Association of Spinal Cord Injury Nurses (AASCIN);
- American Association of Spinal Cord Injury Psychologists & Social Workers (AASCIPSW); and,
- Select individuals connected with the Therapy Leadership Council on Spinal Cord Injury (TLC).*

* Since TLC does not have a membership, applicants will be reviewed and verified by the TLC planning group

Process

Complete and submit the scholarship application posted on the Congress on Spinal Cord Medicine and Rehabilitation website (www.spinalcordcongress.org).

Once your form has been submitted, you will receive a screen acknowledgment and an instant email receipt. Within 72 hours of the acknowledgement receipt, you will receive an approval or rejection notice.

If approved, you will receive a \$425 credit towards your hotel room and tax charges only at the Sheraton Dallas Hotel, the site of the 2009 Congress. **THE SCHOLARSHIP IS NOT A CASH AWARD.** Scholarship recipients are advised to register in the hotel under the same name used to apply for the scholarship.

Please note that an application for a scholarship does not register you for the actual congress or the hotel. You **MUST** register for the Congress (www.spinalcordcongress.org).

Questions

If you have any questions regarding this year's scholarship arrangements, please contact Brenda Finkel of Paralyzed Veterans of America at (202) 416-7704 or BrendaF@PVA.org.

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A Soldiers' Simple Request

SFC Geraldo N. Fournier Sr.

November 11, 2008

Veterans Day Message

The life of a Soldier is hard and misunderstood sometimes. People ask, "What makes a Soldier brave and face danger? What makes them suffer the pain of death?" I have seen death up close. I have watched a brave man die in front of me while serving in Iraq. I believe death is unpredictable and certain for us all, but I am not talking about an everyday death that will take us all, but the death of a Soldier who is willing to die to make others free, and help them live a life of peace.

Some people assume that when a Soldier is in war, they are comfortable in the battlefield with death because they are trained to fight or die. This is far from the truth! I agree that a Soldier is prepared to give his life, but he is never prepared to lose his family or his country because of war. The difference between everyday people and a Soldier is that they are willing to die for what they believe in without question or remorse. A Soldier fights to protect and defend the people whether helpless or not. He will fight to protect those he loves which include his family and his country. This is what drives him to face death; to build courage and to gain a brave heart, not for selfish gains. If a Soldier goes to war for self, then he is lost in a world of misconception and misunderstanding. This courage and bravery that rages within will never be well balanced in his soul if it is for selfish reasons.

Upon his return home, all he asks is a simple request of his country and his family and that is to be respected and loved. And if his life is lost in battle, all he asks of them both is to never be forgotten and to be buried with dignity and respect.

