The New Hampshire Nurses Association is pleased to announce the appointment of Judith Joy, PhD, RN as interim Nurse Executive Director. The Association advocates for the health of all New Hampshire citizens and represents the interests of the State’s 22 thousand registered professional nurses.

Prior to this staff appointment Dr. Joy had a long history of volunteer service to the Association. She is a past president and served as chairperson of the Commission on Government Affairs. In addition, Dr. Joy has represented New Hampshire as an elected delegate to the American Nurses Association’s House of Delegates and Membership Assembly. While living in New York State, she served as president of District I of the New York State Nurses Association along with other elected and appointed positions in the State.

Dr. Joy’s work history includes her most recent position as Associate Professor of Nursing and Public Health at Colby-Sawyer College in New London, New Hampshire. Prior to her work as an educator she specialized in information systems, consulting with hospitals and the nurses of New Hampshire in this role. My priority and humbled by the opportunity to serve the Association to achieve our short and long term strategic goals.

Asked about her appointment Dr. Joy said: “I am honored and humbled by the opportunity to serve the Association and the nurses of New Hampshire in this role. My priority is to continue the efforts of the Association’s many volunteers to improve New Hampshire’s health and the practice of nurses throughout the State.”

Current association President Peggy Lambert commented: I am excited to make this announcement on behalf of the Board of Directors. We are extremely fortunate to have engaged a leader as talented as Dr. Judy Joy to be the interim Nurse Executive Director for NHNA. Not only is Dr. Joy a highly respected nurse leader, she has a deep appreciation for the issues facing nurses today. She brings a wealth of knowledge and understanding related not only to NHNA, but also the Northeast Multi State Division and ANA. In the recent past, Dr. Joy has spoken on behalf of NHNA at legislative hearings, advocating for the interests of nurses and patients. Dr. Joy will help lead New Hampshire Nurses Association to achieve our short and long term strategic goals. Please join me in congratulating Dr. Joy on her appointment.

-and involvement. Nominations are supported by recommendations from an instructor and from a peer with an exemplar(s) identifying evidence of caring, professionalism, advocacy, leadership and involvement.”

This year, the Commission on Nursing Practice is pleased to honor Dana Mott, a junior student in the Rivier University Nursing Program, as recipient of the Student Nurse of the Year award. Dana’s Nursing Instructor noted her enthusiasm and positive interactions in clinical post-conferences, where she shares her insight into patient care. She was described as an active learner, compassionate and well organized. Dana was recognized as a team leader and noted for her ability to “step up to challenges.” In her nursing student experiences on clinical units, she was noted to have developed professional rapport with patients, joining into unit activities and fostering therapeutic communication. An exemplar highlighted Dana assisting and guiding another student in the clinical setting, to increase her peer’s level of confidence in a new situation.

Dana was described as an exemplary peer mentor by her Program Coordinator for Rivier University’s Rivier Success and Visionary Project (RSVP). RSVP is supported by a grant from HRSA (Health Resources and Services Administration). Dana assists not one, but two international students from Spain and Cambodia in achieving their nursing education goals. Dana was described as being active on campus, where she balances her academics and athletics. She is an accomplished athlete on a university team, and is a member of the Student Athletic Advisory committee. Dana peer tutors in Anatomy and Physiology and mentors two students. She recently took part in a Christmas project at her university, where she helped collect and distribute gifts to the needy. She was described as caring, knowledgeable, well organized and an active learner who seeks out new opportunities. As well, she was noted to have a good work ethic and is a resource to her peers, offering them study tips. Dana’s scholastic achievements were recognized, as she is an honor student.
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Manuscript Format and Submission: Articles should be submitted as double spaced WORD documents (.doc format vs. .docx, please) in 12 pt. font without embedded photos. Photos should be attached separately in JPG format and include captions.

Submissions should include the article’s title plus author's name, credentials, organization / employer represented, and contact information. Authors should state any potential conflict of interest and identify any applicable commercial affiliation.

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EDITORIAL OFFICES
New Hampshire Nurses Association, 25 Hall St., Unit HE, Concord, NH 03301. Ph (603) 225-3783, FAX (603) 228-6672, E-mail office@NHNurses.org

EDITOR: Susan Fedter, RN, PhD

NHNA STAFF
Faith Wilson, Office Manager

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MISSION STATEMENT

NHNA, as a constituent member of the American Nurses Association, exists to promote the practice, development and well being of nurses through education, empowerment and healthcare advocacy.

Adopted 10-20-2010.

VISION STATEMENT

Cultivate the transformative power of nursing.

Adopted 10-20-2010.
My first order of business is to congratulate Dr. Judy Joy on her role as interim Nurse Executive Director for NHNA. Her activities on behalf of NHNA started February 28, 2016. NHNA has been searching for a Nurse Executive Director for over a year without being able to assemble slate of qualified applicants to interview. While the Board of Directors have worked diligently to keep our organization moving forward with the help of our very able Office Manager Faith Wilson it is clear that to accomplish all of our goals we needed to appoint an interim and will revisit our efforts to hire our next nurse executive director. NHNA is incredibly fortunate to have someone as talented and knowledgeable about NHNA and ANA step into this leadership role. Please welcome Dr. Joy into her role and feel free to contact her at NHNA.

New Hampshire voters have gone to the polls in record numbers to vote in the NH Primary. The votes are tabulated and the politicians have moved on to the next state. While we all tire of the phone calls and surveys we experience nonstop during the Primary we have unprecedented opportunities to attend town hall meetings with the candidates of our choice. The presidential primary in particular, allows us access to the candidates in small venues to determine which are aligned with the values that we personally hold.

As nurses, we must inform ourselves and others about legislative issues that impact nurses, nursing practice, our patients and the healthcare system. Equally important is the need for nurses to become involved in our legislative process, something I used to find a little daunting. Reflecting on why that was, I realized I was intimidated by the legislative process. It struck me that perhaps I was not always informed about the issues as I should have been. Often we believe someone else will do the work, watch over the bills being brought forth, take care of speaking to our representatives on behalf of the interest of nurses, but that is pretty naive thinking. So for all different reasons for me there was always another priority, until I became involved with NHNA.

Through our nursing organization I started to take time to educate myself on the issues, to ask, did we need a particular piece of legislation, where did the bill arise from, what good would it provide, what might be the unintended consequences, who would it help and who might it hurt, was it a special interest. Well, this is a good news story, the information we need is available and not that hard to find. Still, we must choose to make the time. NHNA and ANA can assist in keeping us current and help us learn to lobby to protect the title ‘nurse.’ We testified that there are those who want to represent themselves as nurses when they are not, for reasons of self-interest or simply lack of understanding. But it is not my intention to ‘rally the troops’ with threats of impending doom. Like crying wolf this strategy quickly ceases to be meaningful. However there are and will continue to be factions within our state who wish to limit and control the practice of nurses. NHNA recognizes that nurses must be able to define and control our own practice because nurse role satisfaction and compensation hinges upon autonomy and practice authority. This is not a ‘one and done’ as a popular TV ad suggests, this task requires ongoing attention and one I take seriously.

To be direct, defining, controlling and supporting practice to the full extent of our education and experience is the role of the professional organization. It is not a role that can be accomplished in isolation, however. Without engagement of nurses at all levels of practice and in all practice arenas we are simply less able.

It is with that in mind that I look forward to meeting many of you as I make visits across our state at your work places and specialty organization meetings. I am eager to hear from you how the New Hampshire Nurses Association can best act to meet your needs and share with you how you can be a part of that action.

Judy

Judith Joy, PhD, RN
Interim Executive Director, New Hampshire Nurse’s Association

I am honored and grateful for the opportunity to continue serving the nursing community in New Hampshire as its interim Nurse Executive Director. This organization has been successfully representing nurses for over a century and I am humbled to follow in the footsteps of so many nurse leaders.

I assume this position with both excitement and concerns. It is exciting and gratifying to be asked to appoint nursing representatives to State commissions as NHNA has been doing regularly over the past few years. When the Ebola crisis occurred NHNA was among the first to be asked for commentary. Just recently a popular radio journalist invited NHNA to represent nursing in a program on the future of the profession and health care in New Hampshire. Following a visit by NHNA to our congressional representatives in Washington this past year all were ‘signed on’ to a bill benefiting nurses. Many graduating student nurses are again attending our annual conference providing them with useful transition information. Being a member of NHNA, a credible and sought after source, is very exciting.

However, I am concerned that our organization is not as relevant as it needs to be with NH nurses. Not long ago the NH Nurse’s Association spoke in hearings to the legislature to protect the title ‘nurse.’ We testified that there are those who want to represent themselves as nurses when they are not, for reasons of self-interest or simply lack of understanding. But it is not my intent to ‘rally the troops’ with threats of impending doom. Like crying wolf this strategy quickly ceases to be meaningful. However there are and will continue to be factions within our state who wish to limit and control the practice of nurses. NHNA recognizes that nurses must be able to define and control our own practice because nurse role satisfaction and compensation hinges upon autonomy and practice authority. This is not a ‘one and done’ as a popular TV ad suggests, this task requires ongoing attention and one I take seriously.

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Judy
Focus on Specialty Groups 2016

Emergency Nurses Association: New Hampshire State Council

Holly Clayton RN, MSN

Emergency Nurses Host Regional Symposium

This year, it is the Emergency Nurse Association (ENA); NH State Council’s turn to host the New England Regional Symposium. The location rotates annually amongst regional member states. The 2016 symposium is entitled “Tapping Into Your Potential.” Chapter President Colin Richards noted “it’s kind of like” tapping a maple tree; fitting for a state that has a yearly production of about 90,000 gallons of maple syrup. With maple-sugaring season completing, this conference will be held on April 14 & 15 in North Conway, NH.

The symposium will offer Clinical and Leadership tracts. Members from the NH, CT, RI, ME and MA groups are expected to attend, as well as VT nurses. The conference features well known and national speakers, with the keynote speaker a past president of ENA. The White Mountains provide a beautiful setting, and discounted lodging is available. A certification class will be held the day before the conference starts, on April 13th.

Registration can take place online right up until the day of the conference, according to Richards. Participants do not need to be a member of ENA to attend. For further information on these events and online registration see the Splash page at http://NHENA.org.

Symposium Speakers:

- Ann Marie Papa – Yellow Brick Road
- Jean Proehl & Sue Barnard – Med Voluntourism
- Donna White – Compassion Fatigue
- Dr James Glazer – Orthopedic Injuries
- Dr Philip Chang – Pediatric Crush Injuries
- Dr. David Mooney – Pediatric Trauma
- Lu Mulla – Leadership
- Jess Wyman – Leading from the Front
- William Meehan – Concussion
- Trooper First Class Christopher S. Storm
- Jeffrey Stewart – Street Drugs
- Donna Hovey – Pediatric Disaster
- Judy West – RN Leadership

Online registration at NHENA.org

Chapter Overview

Richards said that the present NH chapter is actually three prior chapters merged into one. He noted that the 375 chapter members “have a passion for Emergency Room nursing.” He describes the group as being organized and welcoming of new members. The focus and mission of the NH chapter aligns with that of the national group: “to advocate for patient safety and excellence in emergency nursing practice” (ena.org). Richards also noted the importance of the educational component for members.

Monthly Meetings

The chapter board meets monthly in Concord, with Concord Hospital assisting in providing some meeting spaces. The meetings are live, with a one-hour educational offering with a new member invited to participate in the meetings remotely.

Chapter Projects

Past chapter projects have focused on psychiatric patient populations in the ED. Richards said the chapter has worked with the NH State Council of Nursing directors, the State of NH and Director of DHDHS on examining psychiatric issues in the state of New Hampshire and the Emergency Department (ED), with attention given to patient placement and patient flow. The work on solutions incorporated utilization of community resources. Some similar Federal issues have worked on by the chapter, as well.

Recent chapter projects have included:

- “Storm the Hill” – Richards explained that this is an opportunity each March for ED nurses to travel to Washington DC and meet with representatives of the House and Senate.
- Working with Kelly Ann Ayoette, New Hampshire Senator, on opiate issues across the state.
- Working with Safe Kids New Hampshire, in conjunction with the Children’s Hospital at Dartmouth-Hitchcock (CHHuDi), on pediatric safety initiatives (in progress).

National Conference

The national organization’s “Emergency Nursing 2016” conference is noted on ena.org as the largest conference dedicated to emergency nurses on several levels. The annual conference is scheduled for September 14 - 17, 2016 in Los Angeles, CA. Clinical, leadership and Advanced Practice tracts will be offered. Richards said many ED nurses and NPs from the NH chapter attend the conference each year. See ena.org for further information.

ENA Courses, Certifications and Advanced Practice

The NH chapter’s website offers information on chapter course offerings in their calendar. Information about ENA courses and Advanced Trauma Nursing (CATN) and the Emergency Nursing Pediatric Course (ENPC) are available on ena.org.

Nurses working in EDs have the opportunity to gain certification on several levels, including Advanced Practice Nursing. The Board of Certification of Emergency Nurses offers certifications including: Certified Emergency Nurse (CEN), Certified Flight Registered Nurse (CFRN), Certified Pediatric Emergency Nurse (CPEN), Certified Trauma Registered Nurse (CTR), and Trauma Certified Registered Nurse (TCRN). See www.becnecertification.org for more information.

When asked about Advanced Practice Nurses, Richards said several Nurse Practitioners are employed in EDs and belong to the NH chapter; and he noted a recent increase of NPs being hired into NH Emergency Departments.

New Members Welcome

Richards encourages new members interested in joining NH ENA to visit the chapter’s website www.NHENA.org. On a final note, he stated that nurses need not be ED nurses or from the NH chapter to attend the upcoming regional symposium in April; approximately 250 registrations are anticipated, and all nurses are welcome!
In My Opinion

What’s in a Name?

Susan Fetzer, PhD, RN
Editor, NH Nursing News

In ancient worlds, a name was believed to be very powerful. By evoking a name, you were summoning a powerful spirit who could help or destroy a person. In the Old Testament, your name was changed when your status changed. A name is often substituted for the proper name due to affection or to ridicule (e.g., Shorty for a tall person). Our parents and spouses often give us nicknames and we bestow nicknames on our children. Of course, when married the issue of taking the spouse’s last name arises. Some women hyphenate, some move their family or maiden name as a middle name and some just keep two names. I am one of the latter, having hyphenated for the first marriage and finding it difficult to de-hyphenate, I opted just to use two names, one professionally and one personally. It works.

The American Nurses Association was not the first name of the organization. In 1897, the name, Nurses’ Associated Alumni of the United States and Canada, was adopted by the founding ‘mothers’ of the organization. In 1901, incorporation of the organization in the United States required that ‘Canada’ be dropped and the name was changed to Nurses’ Associated Alumni. In 1911, the name changed again to the American Nurses Association. The ANA name has persisted over 105 years with a well-established brand and well recognized logo. However, some constituent associations, and state organizations have been forced to change their name.

In 1994, a takeover by pro-labor nurses of the California Nurses Association membership resulted in ANA removing the organization as an affiliate. It was a stressful and sad time for the California Nurses Association members who desired ANA affiliation. They banded together and began a new professional organization, ANA-California. In 2000, two more constituent associations are taken over by pro-labor nurses and disaffiliate from the ANA. In 2001, professional nurses from Massachusetts create the Massachusetts Association of Registered Nurses (MARN) as a constituent affiliate with ANA while in Maine, professional nurses join as ANA-Maine. In 2014 MARN changes its name to ANA-Massachusetts. In 2011, pro-labor nurses disaffiliated from ANA in Michigan and Minnesota. Quickly, professional nurses in both states reorganized with the Registered Nurses Association in Michigan (RN-AIM), becomes the 51st state nurses association to affiliate with ANA. Minnesota also reorganizes and becomes an affiliate as the Minnesota Organization of Registered Nurses. In 2013 RN-AIM became known as ANA-Michigan. In 2011 ANA disaffiliated from the New York State Nurses Association because of dual unionism and unfair labor practices by pro-labor members. However, in 2012, ANA-New York was launched and affiliated with ANA. Also in 2012, the Illinois Nurses Association split into two groups with the original organization existing solely for union nurses. ANA-Illinois was formed to serve all nurses in the state. To date professional nurses in 7 states have reorganized and reformed an affiliation with the ANA mainly due to hostile takeovers of the founding State Nurses Association by pro-labor factions. It was the reason for the name change.

In May, 1906 the New Hampshire Nurses Association became a constituent association to affiliate. Our name has been the same for 110 years. In the Northeast Multi State Division of ANA constituent states there are 6 member states, three have changed their name from their original charter, ANA-Maine, ANA-Massachusetts, ANA-Vermont. In my opinion, the name of NHNA does not need to change. The question arises, should we change? I imagine this discussion is similar to those of soon-to-be brides. Some brides want to keep their personal identity, some are less possessive. But after all, what IS in a name? Business refers to the brand-equity of a name. Brand equity is the estimated monetary value added to your name because people know who you are. The pro-labor takeovers kept the name of the parent organization for a good reason. On the other hand, if your local brand equity has grown greatly, a name change could end up costing more than it’s worth. Changing a name incurs costs from papers of incorporation, websites, and office supplies. The name of an organization is a lot like the cornerstone of a building. Once it’s in place, the entire foundation and structure is aligned to that original stone.

In my opinion, the name of NHNA does not need to change. The question arises, should we change? I imagine this discussion is similar to those of soon-to-be brides. Some brides want to keep their personal identity, some are less possessive. But after all, what IS in a name? What was not available in the Vermont announcement were the arguments against a name change. Placing the initials ANA, before the state, seems to fly in the face of state’s autonomy. The question is asked, is the state a member of ANA or does ANA create the state unit. At the present time, membership in ANA is optional for any nurse who wants to join. One wonders if NHNA membership would decline if the organizational name begins with ANA.

In conclusion, change a name should not be taken lightly. The reason behind the name change should be a good reason. If in doubt, keep it as it is.

Note: Editorial opinions do not necessarily reflect the opinions of the NHNA Board.
Five Nursing Jobs in the Top 100

Good jobs are those that pay well, challenge us, are a good match for our talents and skills, aren’t too stressful, offer room to advance and provide a satisfying work-life balance. Even though there is no one best job that suits each of us, U.S. News’ list of the 100 Best Jobs are ranked according to their ability to offer this mix of qualities. The rankings for 2016, announced in January, have five nursing jobs in the top 100.

1. Nurse practitioners earned a median salary of about $114,000 in 2014. The Bureau of Labor Statistics (BLS) predicts a 25 percent up tick in jobs for the field over the decade starting in 2014.

2. Registered nurses earned a median salary of about $67,000 in 2014. The RN field is expected to grow 16 percent by 2024, adding almost 440,000 new jobs.

3. Licensed practical nurses earned a median salary of about $42,000 in 2014, and we’re looking at a 16 percent growth by 2024.

4. Nurse anesthetists earned a median salary of about $154,000 in 2014. The Bureau of Labor Statistics (BLS) expects the profession to grow 19 percent from 2014 to 2024.

5. Nurse midwives earned a median salary of about $97,000 in 2014 and their numbers will grow by 25 percent in force over the next decade.

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TheEta Iota Sigma Theta Tau Chapter recently invited qualified undergraduate and graduate students to join the organization. New members will be inducted at The Elliott Alumni Center at UNH on April 9th at 1 pm. Nursing professionals not previously inducted as students can join STTI as Nurse Leaders. If you have not been inducted previously, please consider applying for membership and encourage friends and colleagues who you recognize as leaders to join. Those interested in applying for membership should review the Nurse Leader Membership Criteria (http://www.nursingsoceity.org/why-stti/stti-membership/application) and complete the printable Nurse Leader application (http://www.nursingsoceity.org/docs/default-source/Members/nl-application-pdf/nursingleadership.pdf?sfvrsn=0). Completed applications and required materials should be sent to Chapter President Joyce Cappiello at jecce@cappiello@unh.edu.

The Eta Iota Chapter continues to offer funding to members who are presenting their research at conferences and other events, and is accepting applications to support on-going research by active members. Please email Rosemary Taylor at rosemary.taylor@unh.edu for further information.

We are always looking for ways to actively engage the membership and support undergrad and graduate students in their research and transition to practice. All ideas are welcome! Please brainstorm and share! Also, some positions on the Board will be opening up in June as current officers complete their terms. If you are a member, please consider taking an active role in shaping the future of Eta Iota by serving on the Board. Send your ideas, and inquiries, as well as any news you would like to share with other members in this monthly newsletter, to rosemary.taylor@unh.edu.

The Eta Iota Chapter of Sigma Theta Tau recently was well attended by over 25 members. A session for members focused on Systematic Reviews and the Patient Engagement Handbook. We were fortunate (e-patient Dave), author of Let Patients Help: A Nurse Leader Membership Criteria

We continue our work to promote patient engagement (cost: $100.00) as a DVD with a discussion guide. The film is free through the NOND website (select “film” under “Resources”).

Holly Clayton RN, MSN

Marks: “NOND plays a critical role in transforming the lives of people with disabilities…. Only when we, as health professionals, embrace people with disabilities as our colleagues and not only as our clients and patients, will we create a more inclusive health care environment for all.”

Mcculloh: “My interest in helping to establish the National Organization of Nurses with Disabilities (NOND) was that I believed very strongly that it was time for nurses with disabilities to LEAD instead of having other people speak on our behalf or debate our worth.”

Marks: “Open the Door, Get ‘Em a Locker: Educating Nursing Students with Disabilities”

Holly Clayton RN, MSN

The film is free through the NOND website (select “film” on the right side of the homepage to link to the youtube offering) and may be of interest to nurses engaged in education and practice. As well, the film can be ordered (cost: $100.00) as a DVD with a discussion guide.
As nurses and educators, we often use metaphors and analogies to teach colleagues, students and patients. When teaching about the heart, we might start with William Harvey's metaphor “the heart is a pump” and go on from there. An example of an analogy could be “the structure of the heart is like the drawing of a box, divided into four squares. The top two squares are the right and left atrium, the bottom two squares are the right and left ventricles, etc.” ‘adding the vessels entering and exiting.

Before providing an example of analogy used for teaching patients in the late 1800’s, it is important to discuss its source. In 1895, Dr. R.V. Pierce published the seventh edition of a medical textbook “for the people,” entitled “The People’s Medical Advisor in Plain English: or Medicine Simplified.” He noted that the production of the numerous earlier editions had worn out and rendered useless the printing electrotypes. Pierce, with assistance from his faculty colleagues, revised the book to reflect recent advances in medicine.

Who was Dr. Pierce? Pierce was one of eighteen consulting physicians and surgeons at the Invalid’s Hotel and Surgical Institute, an institute dedicated to patients with chronic or lingering disease in Buffalo, NY. He was also the president of the World’s Dispensary Medical Student Association. The facility was endorsed by President Garfield and had its own pharmacy. Pierce (1895) wrote “we depend largely on solid and fluid extracts of native plants, roots, barks, and herbs, in prescribing for disease...” (p. 972).

Free consultations for the Invalid’s Hotel and Surgical Institute were offered through letters sent in the mail. Those who resided a distance away could be diagnosed and receive full treatment by written correspondence alone – with some reportedly amazing cures. However, for such patients, fees were determined at the time of consultation and needed to be paid in advance. According to the author, patients’ written description of their symptoms were requested, and with possible follow up by written correspondence (patients answered further questions by writing). Pierce stated this by mail might be more efficient than a face-to-face interview, where patients could become confused and provide inaccurate or incomplete information. Patients sought his professional care from homes throughout the American Union as well as Europe, Mexico, South America, the East and West Indies and other international locations, according to his statement dedicating the book to “my patients.”

As long as it was pre-paid, patients could send a urine sample to the institute for evaluation - “about a cupful will do.” The institute had a binocular microscope for urine analysis by a chemist on the premises. The examination and analysis of urine was requested, and with possible follow up by written correspondence (patients answered further questions by writing). Pierce stated this by mail might be more efficient than a face-to-face interview, where patients could become confused and provide inaccurate or incomplete information. Patients sought his professional care from homes throughout the American Union as well as Europe, Mexico, South America, the East and West Indies and other international locations, according to his statement dedicating the book to “my patients.”

Although the institute subscribed to the importance of urine microscopic examination and chemical analysis, the author noted “others fear that if they attach much importance to such examinations they will be ranked with ‘uroscopian’ or ‘water doctors’, a class of enthusiasts who claim to help diagnose chronic diseases of “the nervous system, blood, liver, kidneys, bladder, stomach, and all the other organs” (Pierce, p. 961). It was suggested that collected urine could be put in a hollowed out pine stick, packed in sawdust or paper, placed in a light wooden box and mailed with 2 cents postage for each ounce -- or sent by “express.” A large volume of samples was received in the mail daily – necessitating the evaluation - “about a cupful will do.” The institute had a binocular microscope for urine analysis by a chemist on the premises. The examination and analysis of urine was requested, and with possible follow up by written correspondence (patients answered further questions by writing). Pierce stated this by mail might be more efficient than a face-to-face interview, where patients could become confused and provide inaccurate or incomplete information. Patients sought his professional care from homes throughout the American Union as well as Europe, Mexico, South America, the East and West Indies and other international locations, according to his statement dedicating the book to “my patients.”

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Analogy: Nervous System and Telegraph System

As stated above, Pierce was one of the staff of 18 physicians and surgeons at the Invalid’s Hotel and Surgical Institute in Buffalo, and he published several editions of his medical textbook “for the patient.” The telegraph system had sent the first message in 1844, so it was well established as a means of communication by the time Pierce’s book was printed. Station to station, along wires, the telegraph system could transmit electrical signals. The Morse code was used for communication. Pierce used the structure of the telegraph wire system as an analogy to explain the nervous system to his text readers, “the people.” The following is excerpted from Pierce’s textbook (1895):

The Morse code was used for communicating. The telegraph wires were arranged in parallel, running in all directions, just as the nerves are distributed through out the body. Pierce explained that a telegraph wire system would be analogous to the nervous system, with the wires serving as conductive pathways for electrical signals.

The nervous system is composed of a vast network of nerve fibers that transmit signals throughout the body. Like the telegraph wires, these fibers are arranged in parallel, running in all directions. The telegraph wires transmit electrical signals, while the nerve fibers transmit chemical signals. The telegraph wires can be used to transmit a message over a long distance, just as the nerve fibers can be used to transmit a signal over a long distance.

In conclusion, the telegraph system served as a useful analogy for teaching about the nervous system, as it helped to explain the complex and intricate nature of the nervous system using familiar and accessible concepts. This approach allowed patients and students to better understand the nervous system by relating it to something they were already familiar with.
Organizing a journal club of your peers is a great way to begin to explore and evaluate the latest research and to discuss ways of integrating this evidence to guide current practice. The advantage of a journal club is that it provides an opportunity to keep current with new knowledge, to learn to evaluate research and to promote best practice implementation in the clinical area. Beginning a journal club is simple if you begin with a few easy principles.

For a practice or intervention to be evidence based it must be supported by sufficient evaluation to be valid. Remember that all that is published may not have the same scientific rigor. The purpose of the journal club should be to critically appraise published evidence for application to current practice. However, the group must have clear goals that will guide selection and appraisal of articles. For example a journal club may want to translate current research to answer a clinical practice problem, evaluate and revise policy or may want to begin to generate new knowledge through original research.

After you have made the decision to form a journal club you will want to cover the basics which would include: Who will lead the group? Where and when will the group meet? It is important that the group commit to the process. If the group is fairly inexperienced in reading and critiquing research a leader that is more experienced clinician such as a clinical education specialist or senior staff member should lead the discussion. As the group becomes more comfortable with critiquing the literature other members should take turns selecting the article to be discussed and leading the discussion.

Some groups find it more convenient to meet off site at a restaurant, while others will meet monthly during lunch at the clinical site. It is important however that there is commitment to meeting time and location for the group to form. There are some on line discussion forums that may be appropriate for a group to circulate and discuss articles such as email, chat rooms or blogs. The key is that articles are widely circulated, read and discussed. Members that are not able to attend may be able to submit their critique to the leader prior to the meeting.

An important step when forming a successful journal club is to provide the team with a research article and critique form. There are a number of well published templates that provide guidelines for critiquing the literature. The ANA has developed a toolkit with many valuable resources for appraising levels and quality of the evidence (http://www.nursingworld.org/Research-Toolkit/Appraising-the-Evidence). Table 1 summarizes some key points the group will want to discuss. These points follow a typical research manuscript format.

Table 1: Critical Appraisal Strategy

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the abstract representative of the article?</td>
</tr>
<tr>
<td>Is the purpose of the article clear in the introduction?</td>
</tr>
<tr>
<td>Is the literature review relevant and representative of recent research</td>
</tr>
<tr>
<td>in the field of interest?</td>
</tr>
<tr>
<td>Is the method selected appropriate for answering the research question?</td>
</tr>
<tr>
<td>Are the results valid?</td>
</tr>
<tr>
<td>Does the discussion connect the theoretical framework, the research</td>
</tr>
<tr>
<td>question and the meaning of the results?</td>
</tr>
<tr>
<td>Are there clear implications to practice?</td>
</tr>
<tr>
<td>Will you use new knowledge to improve your clinical outcomes?</td>
</tr>
</tbody>
</table>

After active discussion by the group and appraisal of the evidence, a summary of report findings should be created and disseminated. The group should prepare a summary that would include a review of the critique answering some of the following questions presented in Table 2.

Table 2: Research Summary

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the results valid?</td>
</tr>
<tr>
<td>Can the evidence be applied to your patient population?</td>
</tr>
<tr>
<td>Summarize the comments of the group, including conclusions</td>
</tr>
<tr>
<td>Does the group need to read additional articles about the topic?</td>
</tr>
<tr>
<td>Should the evidence be adopted to change practice or policy?</td>
</tr>
<tr>
<td>Does this topic generate clinical questions that we could answer with</td>
</tr>
<tr>
<td>additional research?</td>
</tr>
</tbody>
</table>

The biggest obstacle to forming a successful journal club is convincing colleagues that practice discussion is part of continuous quality improvement and is a process that can ensure inclusion of best practices. The journal club can be a valuable way to engage staff in evidence based practice, encourage a spirit of clinical inquiry and improve nursing practice. A final step for the journal club is to disseminate the information generated by the group. Post the article and research summary prominently on the unit. Develop action plans and next steps that keep the group relevant. Spread the excitement.

Pamela DiNapoli RN PhD is an associate professor of nursing at the University of New Hampshire and nurse researcher at Catholic Medical Center in Manchester.
In Memory of Our Colleagues

The New Hampshire Nurses Association honors the memory of and acknowledges the work of deceased nurses who have graduated from New Hampshire nursing schools or who have actively practiced in New Hampshire during their career. Sharing the names and information about these nurses is one way we honor their contribution to the profession. Brief submissions are welcome.

Notre Dame Grad
Irene Lillian (Pare) Cullerot, 86, died November 13, 2015. She was a graduate of Notre Dame De Lourdes School of Nursing and practiced as an RN and head nurse at Notre Dame Hospital.

Sacred Heart Grad
Lori M. Godbold, 78, died November 16, 2015, in Florida. Born in Concord, she attended Sacred Heart School of Nursing in Manchester and earned a Bachelor of Science in nursing degree from the University of Central Florida. She served in the United States Air Force, attaining the rank of Captain before her Honorable Discharge in 1970.

NH Hospital Grad
Gloria C. (Liberty) Berlin, 85, of Etna, died November 20, 2015. She attended the N.H. Hospital School of Nursing.

Office Nurse
Jane Withington, 67, of Hillsborough, passed away November 21, 2015, having been employed as an LPN, working at area Nursing Homes in greater Nashua, retiring in 2003 due to declining health.

CMC Nurse
Elizabeth “Betty” (Hughson) Richard, 68, of Manchester, passed away November 26, 2015. Born in Dundee, Scotland, she practiced as a registered nurse for more than 40 years, many of those at Catholic Medical Center.

50 years in Nursing
Annelle Frances (Green) Pielfa, 99, died November 28, 2015. A London native, she spent 50 years nursing in a variety of positions in the Concord area.

Sacred Heart Grad
Helen (Mizo) Byrne, 85, a lifelong resident of Nashua, died December 15, 2015. She worked as an licensed practical nurse.

Elliot Hospital of Keene Grad
Thelma “Sally” (Taylor) Beaucesne, 92, of Keene, died December 27, 2015. In 1944, she received her registered nurse degree from the former Elliot Community Hospital School of Nursing in Keene. She practiced at her alma mater and then was employed by the late Dr. John H. Meany as his office nurse.

School Nurse
Kathleen DeWitt Chase, 72, of Mason, passed away December 28, 2015. She obtained her nursing diploma in New York and then a BSN in Massachusetts. She practiced as a school nurse for the Mascenic School District for over 32 years (most of those at Boynton Middle School). Kathy was a very dedicated nurse and enjoyed nursing so much; she served as a camp nurse for 4H summer camps for over two decades.

Operating Room Position Available Immediately!
A progressive and well established medical team is looking for an RN Circulator to join our team!
The Operating Room has an average open for a full time, day shift with call. We offer the state of the art Surgical Suite the RN is responsible for the coordination of care for the patient undergoing surgery.
Located in beautiful Newport, Vermont, North Country Hospital and its surrounding towns have plenty of outdoor activities. North Country Hospital supports professional growth through certifications and continuing education.
Job Requirements:
Current Vermont RN License. Prefer OR experience however will consider the right candidate without experience and provide on-site AORN-Periop 101 course. Call response time 30 minutes or less.
Current ACLS within 1 year of hire. PALS within 2 years of hire. CCRN - national OR certification highly encouraged after 5 years of hire.
On-Call Housing Available
Interested candidates may apply online at www.northcountryhospital.org

For additional information contact: Troyer, Recruitment Coordinator, Human Resources, North Country Hospital, 189 Prouty Drive, Newport, VT 05855
403-254-2153 Ext 407 • Email: troyer@nchsi.org

nhhospitalnews.com • Page 9
New Hampshire Nursing News

Maternity Nurse
Mary Hitchcock Grad
Marion June Davis, USA Ret., 86, died January 7, 2016, in San Antonio, Texas. She was a 1951 graduate of the Mary Hitchcock Memorial Hospital School of Nursing and entered the Army Nurse Corps in 1953, becoming the first nurse from her hometown to become an Army Officer. She left active duty in 1957 to attend the University of San Francisco where she earned her BSN degree in 1961. Soon after she graduated, during the Berlin Crisis, she was recalled to active duty.

While on active duty the Army selected her for graduate school and she received her MSN in 1967. Marion remained on active duty until she retired in 1980.

During her career she served in various clinical positions which included bedside nursing at Brooke Army Medical Center, San Antonio, Madison General Hospital, Tacoma, Wash, and the 544th General Dispensary in Yokohama, Japan. She returned to nursing administration at Hays Army Hospital, Fort Ord, Calif., the 98th General Hospital, Nuremberg, Germany and at the 71st Evacuation Hospital in Pleikue, Vietnam. She had two assignments in staff work in the Enlisted Training Branch and in the Career Planning Branch of the Army Nurse Corps, both assignments in the Office of the Army Surgeon General, Washington, DC. Her last assignment before retiring was in the Training and Doctrine Command Headquarters at Fort Monroe, Va. This was the only time a nurse was assigned to that Command. Her medals included the Legion of Merit, the Bronze Star, Meritorious Service Medal with Oak Leaf Cluster, Army Commendation Medal with Oak Leaf Cluster, Vietnam Service Medal with 4 Bronze Service Stars, Vietnam Campaign Medal, Vietnam Cross of Gallantry with Palm, and Meritorious Unit Commendation.

In Memory continued on page 10

Carroll County Mountain View Community IS HIRING!
We are currently hiring Nurses to teach per diem, full time and part time. The right candidate without experience and provide on-site AORN-Periop 101 course. Call response time 30 minutes or less.
Expected: ACLS within 1 year of hire. PALS within 2 years of hire. CNOR - national OR certification.
Response time 30 minutes or less.
On-Call Housing Available
Interested candidates may apply online at www.northcountryhospital.org

For additional information contact: Troyer, Recruitment Coordinator, Human Resources, North Country Hospital, 189 Prouty Drive, Newport, VT 05855
403-254-2153 Ext 407 • Email: troyer@nchsi.org

Carroll County Mountain View Community is a Drug and alcohol free, Equal Opportunity Employer.
Notre Dame Grad

Lena (Miville) Landry, 81, of Manchester, died January 7, 2016. She obtained her nursing diploma from the Notre Dame Hospital Nursing School and practiced as a registered nurse at the former Notre Dame Hospital before retiring from the Catholic Medical Center.

ANRP

Denise Evelyn (Valeri) Hills, 65, of Farmington, passed away January 12, 2016 at her home. She obtained her nursing diploma in Massachusetts, an Associates’ from the N.H. Vocational Technical College in Stratham, and a degree from the University of Pennsylvania as a nurse practitioner. She was employed locally by Cindy Cooper, M.D., in Dover as an ANRP.

Wentworth-Douglass Grad

Thelma Victoria (Gamblin) Fay, 91, of Hooksett, died January 14, 2016. Born in New Brunswick, Canada she graduated from Wentworth-Douglass Hospital School of Nursing. Early in her career, Thelma was a registered nurse at several New Hampshire hospitals. Until her retirement, she was a phlebotomist with the American Red Cross in NH and VT.

VA Nurse

Dorothy T. (Gallagher) Davies, 89, of Manchester, passed away January 15, 2016. She obtained her nursing diploma in Massachusetts in the last class of cadet nurses. During her 41-year nursing career, she nursed veterans in a variety of locations including the U.S. Soldiers’ & Airmen’s Home in Washington, D.C., and the VA Hospital in Manchester.

Laconia Hospital Grad

Jane (Pesscott) Morin, 74, passed away January 22, 2016. She was a 1962 graduate of the Laconia School of Nursing. She obtained a bachelor’s degree in sociology and psychology from New England College in 1986 while she worked full time as a school nurse. Her nursing practice included operating room nursing, 4-H Spruce Pond Camp nurse, nurse at Camp Fatima, and 21 years as a school nurse for Concord School District in New Hampshire.

Cadet Corps Nurse

Cecile R. (LaFortune) Taylor, 95, of Franklin, died January 23, 2016. During World War II, she served in the U.S. Army Nurse Cadet Corps. Later, she practiced at Franklin Regional Hospital, Merrimack County Nursing Home, and the former Merrill Manor.

Pedi-Gero Nurse

Ruth Elizabeth (Cartier) Walsh, 76, passed away January 23, 2016, at her home. After obtaining a nursing diploma in Massachusetts she practiced at Frisbie Memorial Hospital, as the Director of Nurses at Langdon Place of Dover and Exeter, at Lilac City Pediatrics and the Rochester Manor. She retired in 2012.

Elliot Hospital Grad

Carline M. (Rayner) Murphy, 71, of Shelburne, passed away January 25, 2016. She was a 1965 graduate diploma of the Elliot Hospital School of Nursing. Upon graduating from nursing school, she had practiced as an RN at Weeks Hospital for two years and then at St. Vincent de Paul Nursing Home for 20 years.

NHTI Grad

Ellen (Souss) Broussard, 52, of Hampton, passed away unexpectedly January 25, 2016. She was a graduate the New Hampshire Technical Institute with an Associate’s Degree in Nursing. Ellen was employed as a nurse for over 30 years, practicing in assisted living facilities in the Nashua area.

St. Joes Grad

Ellen A. (Oddy) Loranger, 88, passed away, January 23, 2016. A New York native she relocated to Nashua and obtained her nursing diploma from the St. Joseph Hospital School of Nursing, graduating in 1953. She practiced at St. Joseph Hospital for 46 years until her retirement in 1999.

NVRH nurse

Ellen (Comtois) Lavigne, 78, of Littleton, died January 30, 2016. Born in County Cork, Ireland, she trained as a nurse in London. She practiced there during the Blitzkrieg, tending to the injured and the ill. After the war she immigrated to Boston and then moved to New Hampshire where she practiced as a private duty nurse, caring for permanently disabled patients or those with terminal illness. She was noted to her patients and worked well into her later years.

Gero Nurse

Anita (Bolleboux) Lahey, 74, passed January 31, 2016. She received her nursing diploma in Massachusetts and practiced as a geriatric nurse working at the former Odd Fellows Nursing Home in Concord.

Nurse Educator

Constance “Connie” Lorraine (Bosse) Broder, 83, of Amherst, died peacefully February 2, 2016. A 1953 graduate of the St. Joseph Hospital School of Nursing she received her Bachelor’s degree in Nursing from Boston College in 1954. She earned a Master’s degree in Education, with a minor in counseling, from Rivier College in 1978. She joined the faculty in 1978. She joined the faculty in 1978. She served as Director of Academic Affairs at St. Joseph Hospital from 1984 till her retirement in 1996. She served on Rivier College’s advisory board for healthcare and administration programs from 1984 till 1989. She served on the N.H. Board of Nursing. She was a member of Sigma Theta Tau, the national Nursing Honor Society, the American Nurse Association and the National League for Nursing, for which she worked as a site visitor as well as a member of its board of directors. She was also a member of the St. Joseph Alumni Association, serving as its president for several years. In 1984, Connie received the Sr. Madeleine of Jesus Award from the Rivier College Alumni Association. In 1996, Castle College of Windham, NH, honored her with the Catherine McAuley Award, named after the Irish foundress of the Sisters of Mercy, for her contribution to nursing and health science education.

NORTHERN VERMONT REGIONAL HOSPITAL

at Northeastern Vermont Regional Hospital, located in Vermont’s historic and rural Northeast Kingdom! NVRH is proud to offer a positive working community in which to grow, learn and excel in your profession.

Various Nursing and Nurse Practitioner positions are currently available in Med/Surg, Emergency Services, OR, Day Surgery and Physician Practices. New grads are welcome and encouraged to apply.

For a full listing of available positions and to complete the online application, visit the Employment Opportunities pages at www.NVRH.org.

NVRH offers competitive wages, shift differentials, per diem premiums and a generous benefits package for PT and FT employees working 20 or more hours per week. Benefits include medical, dental, vision, 401K retirement plan, tuition reimbursement, paid vacation days, membership to local gyms and more.

NVRH is an Equal Opportunity Employer.

Looking for strong RNs and LPNs to work in the home setting. Previous experience preferred but will train the right candidate.

PsyCh and bilingual candidates a plus.

Please send resume to Diane Radziwiez, RN, Clinical Director
**UNH Plans 50th Anniversary Gala**

Calling all UNH Department of Nursing alumni, faculty, friends and family! The Department is celebrating 50 Years of Excellence with a gala dinner and dancing event on Friday, April 29 at 6 pm. The event will take place at the Graphone Conference Center in Concord, NH. Please RSVP by April 22nd. Tickets are $50 per person. Further information is available at http://unhconnect.unh.edu/st/1518/index-tcl-social.aspx?sid=1518&gdid=2194&crn=06&calcid=063&kid=3741.

**School News**

**UNH DNP Program Visited by CCNE**

The UNH Department of Nursing hosted accreditation visitors from the American Association of Colleges of Nursing February 8-10, 2016. The visitors reviewed the standards for the Family Nurse Practitioner and Doctor of Nursing Practice programs. Activities included meeting with faculty, current students and past graduates. According to Chair Gene Harkless, “the reviewers found that our DNP and post-masters FNP certificate programs met all CCNE standards.” Formal notification about accreditation for these programs will not come until the Fall.

**National 2015 NCLEX Statistics**

BSN Programs 87.49% pass

AD Programs 82.00% pass

**NCLEX Report**

Two programs Plymouth State University (PSU) and Keene State College (KSC) were requested to submit and Educational Report to the Board of Nursing in February as consequence of low NCLEX past-tales of their graduates. The Board of Nursing has also expressed its concern to Harmony Health Care Institute (HHCI) regarding their continuing low NCLEX scores and lack of nursing accreditation candidacy.

**BON Program Approvals**

Lakes Region Community College’s nursing program was granted full approval status by the Board of Nursing in October 2015. Rivier University was granted full approval for their post-baccalaureate program and revised curriculum by the NH Board of Nursing during the November, 2015 meeting. The approval is in effect until their next accreditation visit in 2018.

**ED Note**: News from nursing schools, faculty, students or alumni are welcome. Please direct submissions to office@nhnurses.org with NHNN in the subject line.

**UNH Graduation Dates Announced**

Rivier University nursing students will be participating in a nursing pinning ceremony on May 4, 2016. Graduates will be in commencement attire as they graduate on May 7, 2016.

Franklin Pierce University will graduate RN to BSN and MSN nurses on April 20, 2016.

UNH will graduate over 150 BSN, MSN and DNP nurses on May 21, 2016.

**River Valley Close to National Accreditation**

River Valley Community College Nursing Program hosted a site review for initial accreditation of its Associate of Science in Nursing (ASN) program by the Accreditation Commission for Education in Nursing (ACEN) on February 11, 2016. RVCC was granted candidacy status in January 2015. The results of the accreditation application were not available at press time.

**NCLEX Reconsidered**

Ed Note: If it has been a year or years since you took the NCLEX (AKA “Boards”), how well would you do now?

1. A 16 year old high school student is diagnosed with cystitis. What assessment findings should the nurse expect?
   a. Fever and flank pain
   b. Leukocytosis and oliguria
   c. Chills, nausea, and vomiting
   d. Dysuria and foul-smelling urine

2. A patient with a diagnosis of major depression who has attempted suicide says to the nurse, “I should have died. I’ve always been a failure. Nothing ever goes right for me.” Which response demonstrates therapeutic communication?
   a. “You have everything to live for”
   b. “Why do you see yourself as a failure?”
   c. “Feeling like this is all part of being depressed.”
   d. “You’ve been feeling like a failure for a while?”

3. A patient admitted for a peripheral vascular disease of the left foot has just returned from a 4 hour dialysis treatment. What actions by the nurse are appropriate? (Select all that apply)
   a. Monitor blood pressure
   b. Notify provider of serum potassium = 3.3
   c. NPO for 4 hours after completion of treatment
   d. Instruct LNA to obtain dry weight
   e. Maintain bed rest for 4 hours after treatment

4. Dietary teaching for a patient with a diagnosis of GERD should include the avoidance of which foods? (Select all that apply)
   a. Acidic and pickled foods
   b. Milk and other dairy products
   c. Spicy and highly seasoned foods
   d. Coffee, tea and chocolate
   e. High carb and refined sugar foods

5. You are assigned the following patients to care for during your shift. The LNA reports the patients’ vital signs. Which would require your immediate attention and additional assessment?
   a. A 58 yo with hypothyroidism and regular heart rate of 52 bpm.
   b. A 38 yo patient with Graves disease and heart rate of 112 bpm.
   c. A 63 yo patient with r/o adrenal tumor and blood pressure of 140/100.
   d. A 49 yo patient with end stage COPD and respiratory rate of 24.

**Answers on page 12.**

**Memorial Hospital Nashua**

**Now is the time to become part of the Heart of Memorial Hospital!**

Memorial is now seeking the best nurses to expand our dynamic team. We need you in different specialties and we offer you . . .

* Critical Access Hospital caring for our community
* Responsive & Supportive Managers
* Evidence-Based Nursing Practices
* Clinical Ladders that celebrate all you accomplish
* Beside Support: Giving quality to your life, your work and your patients
* We offer Market-Leading Compensation with Extraordinary Benefits, Paid Time Off (PTO), Retirement Opportunities and Tuition Reimbursement

If you are interested, please contact Melanie, Tricia or Scott at (603) 356-5461 x2384.


Nurses Needed!

Are you ready to join our amazing nursing team? Are you ready to care for a patient, a family, a community? Are you ready to reach your full potential?

NURSES NEEDED!

Are you ready to join our amazing nursing team? Are you ready to care for a patient, a family, a community? Are you ready to reach your full potential?

Now is the time to become part of the Heart of Memorial Hospital! Memorial is now seeking the best nurses to expand our dynamic team. We need you in different specialties and we offer you . . .

* Critical Access Hospital caring for our community
* Responsive & Supportive Managers
* Evidence-Based Nursing Practices
* Clinical Ladders that celebrate all you accomplish
* Beside Support: Giving quality to your life, your work and your patients

We offer Market-Leading Compensation with Extraordinary Benefits, Paid Time Off (PTO), Retirement Opportunities and Tuition Reimbursement

If you are interested, please contact Melanie, Tricia or Scott at (603) 356-5461 x2384.


Registered Nurse to Work in the Greater Nashua Area

This is a Full-time position in Adult Med Surg units to care for adult patients with Medical/Surgical conditions at Nashua Hospital. Although duties include staffing four units on a rotating basis, as well as providing for round medical needs, patient care nursing responsibilities are day to day nursing needs of patients. Ability to work with diverse groups of people, including staff, families and patients. Patient care experience required. Must practice safe patient handling techniques. Must be able to work as a member of the health care team. Potential for night shifts.

Nashua Hospital is an Equal Opportunity Employer.

Please send resume to nfarrell@nashuacenter.org

**April, May, June 2016**

**New Hampshire Nursing News • Page 11**
NHNA Wants to See You…. IN THE NEWS

Do you have some news that you want to share with the nurses of New Hampshire? The NH Nursing News accepts short press releases or announcements of your accomplishments.

Did you present at a regional or national conference?
Did you publish in a newsletter or journal?
Did you get elected to a position in a state, regional or national professional organization?
Did you start a new program? Provide a new service?
Did you get an award for the best nurse?
Did you graduate with an advanced degree?
Did you get certified?
Did you get promoted?
Did you get an award for the best nurse?
Did you present at a regional or national conference?
Did you get elected to a position in a state, regional or national professional organization?
Did you start a new program? Provide a new service?

Deadline for the next issue is May 15, 2016.

Please send details and a photo if appropriate to office@nhnurses.org.

Welcome New and Returning NHNA Members
Thanks for Your Support of Nursing in New Hampshire!

NHNA welcomes these new and returning members. If you are not a member ask someone on this list why they joined! Go to nhnurses.org where joining is easy and one of the best professional values for your money!

Answers to NCLEX Reconsidered from page 11

1. D  
2. D  
3. A, D  
4. A, C, D  
5. D

maybe you don’t want to blow your own horn, but we do!!!

UNH Department of Nursing

50 Years of Excellence 1965 – 2015

GALA EVENT
Grappone Center, Concord, N.H. | April 29, 2016 | 6 p.m.
Tickets available at unh.edu search nursing50
Alumni please join the “UNH Nursing” group or email nursing50@unh.edu

Join 50 years of nursing alumni, faculty, friends and family for dinner and dancing!

Houlton Regional Hospital, is a progressive facility providing care with a personal touch to the communities we serve. We are presently seeking:

REGISTERED NURSES MEDICAL/SURGICAL/ACUTE CARE UNIT
36 HRS, 7P-7A $3.50 SHIFT DIFFERENTIALS EVERY THIRD WEEKEND SHARE OF HOLIDAYS
$5000.00 NET SIGN ON BONUS


Houlton Regional Hospital is located in Northern Maine where all four seasons are enjoyed. Visit our website at www2.houltonregional.org
Your generation says a lot about you to your nurse colleagues. Of course, you are ultimately responsible for your own reputation, but if your co-workers are interested in you, they will talk about you—what’s the world view—and you will find out more about the hallmarks of their generation, as well—it could make a difference in how everyone gets along.

~ Jennifer Larson, NurseZone.com

Much has been written and said about the generational differences in the nursing workforce. Some say the differences in ages, norms and values of the multi-generational nursing workforce, currently five to be exact, are causing major problems as the generations continue on a collision course with each other. The impact of this dimension of diversity in the nursing workforce has created an opportunity for organizations to become more flexible, accommodating and creative in finding ways to let every generation be heard. The important thing to remember is that if generational differences are not acknowledged and discussed, and solutions are not supported by top leadership, the resulting tensions may have a significant negative impact on patient care services.

Generation Z, the newest member of the nursing cohort, also known as “Gens,” “Zeds,” and “Zees” were born between 1992 and 2010 during the financial meltdown and don’t know a world without the Internet. The nursing professional development educators are only beginning to encounter the Generation in professional development activities, but may have witnessed members of this generation working or studying while also texting, surfing the Internet, or participating in an online social network. In addition to never knowing a world without technology, members of this generation have also never known a world without the specter of international terrorism and war. They watched disasters such as Hurricane Katrina and the earthquake in Haiti in real time on television and the Internet. The oldest were in high school, hoping for their first job when the global recession began in 2008. As a generation they are close to family, confident, and open to change (Rosen, Carrier, Cheever, 2010).

They are predicted to be the most entrepreneurial, conservative, diverse and educated generation in the world, and if that isn’t enough to impress you then take a look at other facts about this astonishingly promising generation who are making their way into the complex healthcare system:

• Gen Z respondents say they prefer in-person communications with managers (51%), as opposed to emailing (16%) or instant messaging (11%).
• 52% of Gen Z state that honesty is the most important quality for being a good leader.
• 34% are most motivated by opportunities for advancement, followed by more money (27%) and meaningful work (23%).
• 28% said balancing work and personal obligations was the top future career concern, due to wanting enough money (26%) and finding a stable job (23%).
• 32% believe they will be managing employees within the next 5 years.

At the organizational level, nursing leaders, from chief nurse executives to unit-level managers, need to anticipate generational differences and provide a positive environment for new nurses of all generations to develop and demonstrate their abilities. This environment can encourage staff nurses to understand and respect co-workers of all generational groups, recognizing not only areas of generational difference, but also a commitment to common goals, including the delivery of safe, high-quality patient care in a supportive and collegial environment (Keenews, Brewer, Kovner, Shin). While learning can occur between nurses of all age groups, particular attention should be paid to engaging the perspective of younger nurses. In the interaction of people from different generations in the workplace, members of the younger generation are always at a distinct disadvantage. Not only is the existing organizational structure based upon successful strategies used in the past rather than designed for the future, but also older nurses are positioned to establish both the formal and informal rules. Because of their longevity in the organization, the older generations often dominate in managerial and leadership positions of power. As a result, older nurses typically are more influential when changes are made to modify the existing structure and processes. Naturally, these nurses update processes and rewards in a way that makes sense from their generational perspective, not recognizing that they are biasing their decisions on historical assumptions that may not be held by younger nurses. Incorporating the perspective of younger generations forces an examination of generational assumptions and demands commons identification of practices that make sense for all nurses (Watson, 2006).

If your organization has just hired Generation Z new graduates and you haven’t re-designed and tailored your orientation program to meet their needs of wanting to be engaged, enthused and motivated, you might want to rethink your strategy. Why? Because they are multitaskers using a variety of forms of communication. They thrive on change and are seeking organizations on the cutting-edge of healthcare. Creativity is an important aspect of their education and they plan to use it. More importantly, organizations need to provide educators and managers with the tools and processes which allow them to reward and recognize, train, develop, and empower Generation Z more effectively.

Managing and leveraging generational diversity in the nursing workforce is not the sole responsibility of managers or human resources. Putting diversity to work in the workplace understanding each generational cohort and accommodating generational differences so as to capitalize on these differences in attitude, values, and behaviors must be a common goal of all nurses. According to Generations at Work, successful organizations build non-traditional workplaces, exhibit flexibility, emphasize respect and hold on to the relationships and focus on retaining talented employees. They recommend five ways to avoid any confusion and conflict: 1. Accommodate employee differences. Treat your employees as you do your customers. Learn all you can about them, work to meet their specific needs and serve them according to their unique preferences. Make an effort to accommodate personal scheduling needs, work/life balance issues and nontraditional lifestyles.

2. Create workplace choices. Allow the workplace to shape itself around the work being done, the customers being served and the people who work there. Shorten the chain of command and decrease bureaucracy.

3. Operate for a sophisticated management style. Give those who report to you the big picture, specific goals and measures. Then turn them loose. Give them feedback, rewards, and recognition as appropriate.

4. Respect competence and initiative. Treat everyone, from the newest recruit to the most seasoned employee, as if they have great things to offer and are motivated to do their best. Hire carefully to assure a good match between people and work.

5. Nourish retention. Keeping valuable employees is every bit as important in today’s economy as finding and retaining customers. Offer lots of training—from one-on-one coaching sessions, to interactive computer-based classes, to an extensive and varied classroom curriculum. Encourage lots of lateral movement.

Welcoming Generation Z are the other four generations of nurses. I like to think of them as the culture carriers passing on what it is to be a nurse, bridging the generation gap and guiding Generation Z into the nursing
Learn how you can strive for nursing excellence in providing patient-centered care. Why are nurses going back to school to get their BSN? You’ve heard “Nurses should be practicing to the full extent of their education and training” – but what does that mean for your practice? Why are nurses going back to school to get their BSN?

Nurses are talking about it.....and say they want more information....and further education. How can it be your guide as you encounter complex situations that arise in your daily practice? Learn about the Nursing Code of Ethics, newly revised in 2015 - “the Year of Ethics” - and find out how you can use it to guide your practice in delivering quality and ethical care.

IOM
Nurses are talking about it....and say they want more information.... What are the key points of the “Report of the Institute of Medicine (IOM) Committee on Quality Healthcare in America”? You’ve heard “Nurses should be practicing to the full extent of their education and training” – but what does that mean for your practice? Why are nurses going back to school to get their BSN?

Learn how this impacts patient’s quality of care and future nurse supply.

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Learn how this impacts patient’s quality of care and future nurse supply.

!”

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6 pm - 8 pm
Where: Granite State College
Concord, NH
Further information and registration: nhnurses.org

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Nursing Code of Ethics

Do you know The Code?

How can it be your guide as you encounter complex situations that arise in your daily practice?

Learn about the Nursing Code of Ethics, newly revised in 2015 - “the Year of Ethics” - and find out how you can use it to guide your practice in delivering quality and ethical care.

(Endnotes)


8 It’s critical that we recognize Generation Z’s differences and meet them where they are, rather than where we want them to be.

Priscilla Smith-Trudeau, MSM, RN, BSN, CRRN, CCM, HNB-BC is an author, speaker and healthcare leadership management consultant specializing in workforce diversity. Priscilla’s research and consulting has been focused on understanding nursing work group culture.

culture. The importance of each generation’s contributions to the evolution of the nursing culture cannot be underestimated. Each generation of nurses tends to see nursing practice through a unique lens that forms as a result of the events that were taking place in healthcare as they grew and developed from new graduates to seasoned professionals. While it is important not to generalize, take a look at what Generation Z can learn from generations that have preceded them:

Adjusting the workplace to bring the best out of a new and different generation is no easy undertaking. Spending time with Generation Z to understand how they live, what they value, and which ways they communicate can help set up your future workforce for success. Socializing the Generation Z nurse to the culture of the organization and individual units, including the vision, mission, values, behaviors, formal and informal practices can best be accomplished by tapping into the experience and wisdom of the culture carriers: Traditionalists, Baby Boomers, Generation X and Generation Y.

New nurses start to feel at home and committed to stay in an organization when they are empowered in practice, have a sense of belonging in a work group, and perceive that resources balance job stress. Before long, newly graduated nurses who commit to stay become the peer group for the next wave of new nurses, smoothing out wrinkles in the welcome mat and opening wide the door to a successful professional transition (Twibell, St.Pierre, Johnston, Barton, Davis, Kidd, Rook, 2012). It’s critical that we recognize Generation Z’s differences and meet them where they are, rather than where we want them to be.

Priscilla Smith-Trudeau, MSM, RN, BSN, CRRN, CCM, HNB-BC is an author, speaker and healthcare leadership management consultant specializing in workforce diversity. Priscilla’s research and consulting has been focused on understanding nursing work group culture.

(Endnotes)


Introduction to ICD-10

Sheryl LaCoursiere, PhD, FNP-BC, PMHNP-BC, APRN

On October 1, 2015, the Federal government has mandated that all claims for Medicare and Medicaid services, as well as anyone covered by HIPAA, use ICD-10 coding. This has forced private insurers to follow suit and required electronic medical records to adapt to allow for this new coding.

What is ICD-10?
ICD stands for the International Classification of Diseases. The ICD system has been developed and maintained by the World Health Organization (WHO). There have been eight major revisions, with ICD-9 being used since 1975. ICD-10 is much more robust, covering over 69,000 diagnostic codes, compared to ICD-9’s 13,000. The types of new codes vary. Some reflect a specific part of the body (for instance left, right, bilateral) or a location where an injury occurred (for instance land, sea).

All codes start with a letter, followed by 3 numbers. The first space is always a letter. The second and third spaces indicate the condition/illness. Codes can be up to 7 numbers. The fourth, fifth and sixth spaces indicate severity, etiology and location. Most of these spaces are taken up with increased severity or specificity of a problem. For instance, specificity of asthma is indicated by the 4th digit:

**Coding for Asthma - Severity**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.2</td>
<td>Mild intermittent asthma</td>
</tr>
<tr>
<td>J45.3</td>
<td>Mild persistent asthma</td>
</tr>
<tr>
<td>J45.4</td>
<td>Moderate persistent asthma</td>
</tr>
<tr>
<td>J45.5</td>
<td>Severe persistent asthma</td>
</tr>
</tbody>
</table>

The seventh digit is considered an extension that provides more information on the characteristics of an encounter. For instance, three possible values for the 7th digit are:

**7th Digit**

<table>
<thead>
<tr>
<th>Digit</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter</td>
</tr>
<tr>
<td>D</td>
<td>Subsequent encounter</td>
</tr>
<tr>
<td>S</td>
<td>Sequelae</td>
</tr>
</tbody>
</table>

One problematic aspect of ICD-10 is that many diagnoses have different codes depending on whether the encounter is initial or subsequent. Thus the code has to be manually changed between the first and second visit.

In the informatics class I teach at UMass Boston, this semester we are discussing the impact of ICD-10 on nursing practice. Some nurse practitioners in our DNP program have needed to learn this system very quickly, as they are expected to code their own patient visits. With up to 30 patients a day, and multiple diagnoses per patient, this can be a baptism by fire. Other nurse practitioners, usually those in larger hospital chains, have their coding done by their billing departments.

There are already quite a few apps available that “crosswalk” between ICD-9 and ICD-10. For instance, a hypertension code of 401.9 in ICD-9 is now 110 in ICD-10.

When trying to determine an ICD-10 code, think of the placeholders, and work from there to become more severe or specific.

**References:**
Center for Medicare and Medicaid Services web site http://www.cms.hhs.gov/ICD10

Coordinates can be up to 7 numbers. The fourth, fifth and six spaces indicate severity, etiology and location. Most of these spaces are taken up with increased severity or specificity of a problem. For instance, specificity of asthma is indicated by the 4th digit:

**Coding for Abdominal Pain - Specificity**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R10.31</td>
<td>Right lower quadrant pain</td>
</tr>
<tr>
<td>R10.32</td>
<td>Left lower quadrant pain</td>
</tr>
<tr>
<td>R10.33</td>
<td>Periumbilical pain</td>
</tr>
</tbody>
</table>

For abdomen pain, the specificity is indicated by the 7th digit. For instance, three possible values for the 7th digit are:

**7th Digit**

<table>
<thead>
<tr>
<th>Digit</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter</td>
</tr>
<tr>
<td>D</td>
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</tr>
<tr>
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When trying to determine an ICD-10 code, think of the placeholders, and work from there to become more severe or specific.

**References:**
Center for Medicare and Medicaid Services web site http://www.cms.hhs.gov/ICD10
Humor Me

Ed Note: Regularly exercising our sense of humor improves resilience, positivity, and balances the anti-negativity. Laughter may not solve problems but can change your chemistry allowing you to face them anew. “Humor Me” offers quips and stories to help you see things differently. Submissions are welcome.

6 Amazingly Simple Home Remedies
1. Avoid cutting yourself when slicing vegetables by getting someone else to hold the vegetables while you chop.
2. Avoid arguments with the females about lifting the toilet seat by using the sink.
3. A mouse trap placed on top of your alarm clock will prevent you from rolling over and going back to sleep after you hit the snooze button.
4. If you have a bad cough, take a large dose of laxatives. Then you’ll be afraid to cough.
5. You only need two tools in life – wd-40 and duct tape. If it doesn’t move and should, use the wd-40. If it shouldn’t move and does, use the duct tape.

15 Reasons Why It Is Good To Be A Woman – With Apology To Our Male Colleagues
1. We got off the Titanic first.
2. We can scare male bosses with the mysterious gynecological disorder excuses.
3. Taxis stop for us.
4. We don’t look like a frog in a blender when dancing.
5. We can make comments about how silly men are in all your problems.
6. We will never regret piercing our ears.
7. If we marry someone 20 years younger, we are make sure our privates are still there.
8. We don’t have to pass gas to amuse ourselves.
9. We don’t have to make our own mufflers.
10. We can always change our minds.
11. We can talk to the opposite sex without having to picture them naked.
12. If we marry someone 20 years younger, we are aware that we will look like an idiot.
13. We will never regret piercing our ears.
14. There are times when chocolate really can solve all your problems.
15. We can make comments about how silly men are in their presence because they aren’t listening anyway.

Vaccines Across the Lifespan
Audrey M. Stevenson PhD, MPH, MSN, FNP-BC

Although most individuals are aware of the need for childhood vaccines, a large number of teens and adults have not received all recommended vaccines. These vaccines are critically needed at all ages to prevent diseases and their sequelae including long-term illness, hospitalization, and even death. The percentage of adults that have received all recommended vaccines is well below the recommended levels needed to achieve herd immunity. The purpose of this article is to provide nurses with information on the importance of promoting vaccines to individuals across the lifespan.

Vaccines are an important protective mechanism in order to keep individuals themselves as well as others in the community healthy. According to the Center for Disease Control (CDC), vaccine preventable diseases are responsible each year for an average of 226,000 hospitalizations due to influenza with mortality between 3,000 and 49,000 people due to influenza and its complications, with the majority of these being adult. There were approximately 32,000 cases of invasive pneumococcal disease in 2012, with approximately 3,300 deaths. Currently, in the United States, between 800,000 and 1.4 million people suffer from chronic hepatitis B, which can lead to complications such as liver cancer. HPV is responsible for 17,000 cancers in women and 9,000 cancers in men in the U.S. each year, with 4,000 women losing their life each year from cervical cancer as a result of HPV infection.

The factors that influence the need for vaccines include: the age of the individual, personal health conditions, occupation, lifestyle, international travel and receipt of previous vaccines.

Why are Adult Vaccine Levels Low?
Older adults have traditionally had better vaccine rates for immunizations such as influenza and pneumococcal than younger adults and teens. Many younger adults assume that only children and teens need vaccine. In many cases young adults aren’t aware that they may be missing vaccines that they didn’t receive in childhood such as vaccines against Hepatitis A and B. They may also not be aware that some vaccines, such as Tetanus and Diphtheria booster doses every 10 years to continue to provide protection as the vaccine’s efficacy begins to wane.

Another reason that many adults don’t receive vaccines is that they are unaware of the seriousness of particular diseases and do not feel susceptible to contracting the disease. Few adults today have ever personally experienced or known anyone who has had many of the diseases that vaccines prevent, leading to a false perception of safety that actually harms the entire community. Adults are also susceptible to misinformation about the need for or safety of particular vaccines.

How to Determine if You are Missing Needed Vaccine?
Individuals are often unsure of the vaccines needed for themselves or their family members. The Centers for Disease Control and Prevention has a number of resources to provide both individuals healthcare professional information on vaccine topics. One tool that is particularly helpful is a quiz on required vaccines for adults and adolescents. (http://www2.cdc.gov/nip/adultimmsched/)

Adult Vaccines (19 and older)
Although many adults may have received some or all of the recommended vaccines in childhood it is important for each individual to review their vaccine record to ensure that they are fully protected. The following are the vaccines recommended for individuals 18 and older:

- Influenza (yearly)
- Tetanus, diphtheria, pertussis (Td/Tdap)
- Varicella
- Zoster
- Human papillomavirus (HPV) for both Females and Males
- Measles, mumps, rubella (MMR)
- Pneumococcal 13-valent conjugate (PCV13)
- Pneumococcal polysaccharide (PPSV23)
- Meningococcal
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae type B ( Hib)

Access Points
Historically the only place that an individual could receive a vaccine was at the individual’s healthcare provider’s office, which has changed in recent years. In addition to receiving vaccines at your healthcare provider’s office, individuals can receive most the recommended vaccines at pharmacies, Urgent Care Centers and other community locations. In addition, many employers recognize the importance of vaccinating employees and provide flu and other vaccines at the workplace.

Implications for Nurses
- Become a vaccine champion
- Be familiar with and recommend all of the vaccines needed by your patients
- Set the example by ensuring that you have received all of the recommended and required vaccines to protect your health and the health of others.

For more information and helpful vaccine tools go to:
http://www.cdc.gov/vaccines
For a vaccine app: http://www.cdc.gov/nip/vaccineschedules/hcp/schedule-app.html
**Figure 1. Recommended adult immunization schedule, by vaccine and age group**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age Group</th>
<th>Doses</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1 dose annually</td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)</td>
<td>19-21 yrs</td>
<td>1</td>
<td>Substitute 1-time dose of Tdap forTd boosters then boost with Td every 10 yrs</td>
</tr>
<tr>
<td>Varicella</td>
<td>19-21 yrs</td>
<td>2</td>
<td>2 doses</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1 dose</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>19-21 yrs</td>
<td>3</td>
<td>3 doses</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td>19-21 yrs</td>
<td>3</td>
<td>3 doses</td>
</tr>
<tr>
<td>Zoster</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1 or 2 doses</td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13)</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1-time dose</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1 dose</td>
</tr>
<tr>
<td>Meningococcal B</td>
<td>19-21 yrs</td>
<td>1</td>
<td>1 or more doses</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>19-21 yrs</td>
<td>2</td>
<td>2 doses</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>19-21 yrs</td>
<td>3</td>
<td>3 doses</td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

No recommendation

---

**Figure 2. Vaccines that might be indicated for adults based on medical and other indications**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>INDICATION</th>
<th>Pregnancy</th>
<th>Immunocompromising conditions (including human immunodeficiency virus (HIV))</th>
<th>HIV Infections (CD4+ T lymphocyte count)</th>
<th>Men who have sex with men (HSM)</th>
<th>Kidney failure, end-stage renal disease, receipt of transplanted organ</th>
<th>Heart disease, chronic lung disease, chronic obstruction</th>
<th>Apneas (including sleep respiratory and persistent complement component deficiencies)</th>
<th>Chronic liver diseases</th>
<th>Diabetes</th>
<th>Healthcare Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 dose annually</td>
<td>&lt; 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 dose annually</td>
<td>&lt; 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Varicella</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>3 doses through age 26 yrs</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>3 doses through age 26 yrs</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Zoster</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 dose</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 or 2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13)</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 or 2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 or 2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Meningococcal B</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>1 or 2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>2 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>3 doses</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis E</td>
<td>Contraindicated</td>
<td>No contraindicated</td>
<td>postcrisis recipients only</td>
<td>≥ 200 cells/ml</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

---

**Additional Information**

- Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or by telephone, 800-822-7967.
- Information on how to file a Vaccine Injury Compensation Program claim is available at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or by telephone, 800-338-2182. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20001; telephone, 202-357-6400.
- Additional information about the vaccines in this schedule, extent of availability data, and contraindications for vaccination is also available at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines) or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. – 8:00 p.m. Eastern Time, Monday – Friday, excluding holidays.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

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The nursing shortage in the 1970s and 1980s brought about changes in staffing patterns including the incorporation of 12-hour shifts. This trend continues as employers find 12-hour shifts more cost effective, decrease handoff errors and increase continuity of patient care. Some nurses prefer 12-hour shifts because they are able to work fewer days per week decreasing travel time and childcare costs. They enjoy more work-life balance and have the opportunity to seek additional employment on their days off.

Proponents of 12-hour shifts argue that 12-hour shifts lead to consistency and continuity of care because there is a reduction from three hand-offs to two hand-offs between nurses every 24-hours. Less hand-offs may also decrease the incidence of errors and sentinel events. Stone et al. (2006) found that 12-hour shifts led to greater job satisfaction, less absenteeism, and decreased turnover rates in staff. Medication errors, patient falls, and the incidence of decubitus ulcers measure of quality were similar in all shift lengths.

Despite the advantages of 12-hour shifts, concern has been expressed about nurses’ health and patient safety when nurses work for long periods of time. There are many other service related professions that work shifts greater than eight hours. The U.S. military has guidelines for tours of duty, as do aviation, railroad, and over-the-road (OTR) truck driving industries. Each group has regulatory bodies that document and regulate the shifts or hours individuals work. The Department of Transportation (DOT) and the Federal Aviation Administration (FAA) each regulate the duty schedules for pilots, air traffic controllers, engineers, Flight attendants, airline mechanics, and other employees in order to maintain airline safety standards and protect the crew and passengers. To protect the public, the number of consecutive hours in a day that truck drivers may work is regulated by the DOT and the Federal Motor Carrier Safety Administration. There is no state or federal regulation of the hours that a nurse may work, although some states have passed legislation prohibiting mandatory overtime.

The attractiveness of the 12-hour shift is that it allows nurses to seek employment of a second job. It is possible that one nurse could work full time in two different facilities at the same time.

Employers continue to offer, and some demand 12-hour shifts, even though the literature indicates negative patient outcomes related to nurses working 12-hour shifts. In 2011, the Georgia Nurses Association (GNO) issued a statement encouraging employers to offer a variety of shifts to accommodate nurses who are unable to work 12-hour shifts. The GNO encouraged facilities to limit the number of consecutive 12-hour shifts and offer appropriate break times (“Georgia Nurses Association,” 2011). The GNO also offered education for nurses regarding the impact of 12-hour shifts, lifestyle, unit culture, and organization policies contribute to work-related fatigue and errors among acute care nurses. Nelson suggests mandated breaks, leaving 12 hour shifts are not likely to change and plans should be implemented to decrease harm to nurses and patients. Nelson suggests mandated breaks, leaving work on time, and napping for the night shift workers.

Multiple studies and organizations recognize the correlation between nurse fatigue and patient safety. They also report that nurses and employers do not appreciate the risks associated with fatigue and have no guidelines or policies in place to address the possible consequences associated with 12-hour shifts. Nurses need to take the responsibility to employ evidence-based practice to reduce less than optimum outcomes (Caruso & Hitchcock, 2010). Smith-Miller, Shaw-Kokot, Curro, and Jones (2014) found that 12-hour shifts, lifestyle, unit culture, and organization policies contribute to work-related fatigue and errors among acute care nurses. Nelson writes that 12 hour shifts are not likely to change and plans should be implemented to decrease harm to nurses and patients. Nelson suggests mandated breaks, leaving work on time, and napping for the night shift workers.

The American Nurses Association (ANA) recognizes that nurse fatigue contributes to errors resulting in less than optimum patient outcomes. The ANA takes the position that employers offer work schedules that provide flexibility and rest between shifts, appropriate staffing, and compensation such that nurses do not seek additional employment (American Nurses Association, 2006b).

Stimpfel, Sloane, and Aiken (2012) found that in the hospital, with nurses working 12-hour shifts, more than 13 hours, patients reported decreased communication between nurses and between nurses and patients. These patients also reported poor pain control and delayed assistance when the call light was activated. Trinkoff et al. (2011) conducted a study, funded by the National Council of State Boards of Nursing, of work schedules for full-time RNs in the hospital to determine if nurses working longer work hours and lack of time away from the workplace, increased the incidence of morbidity and mortality in patients with pneumonia, abdominal aortic aneurysm, and acute myocardial infarction. Similar results were reported when nurses worked overtime or multiple consecutive days (Trinkoff et al., 2011).

Reese (2011) writes that it is time to take a critical look at staffing and formulate an evidence-based plan to provide safe, optimum care to patients while keeping nurses healthy and satisfied. Reese recommends decreasing the use of 12-hour shifts and overtime, assist nurses in leaving on time, protect vulnerable staff from the stress of long shifts and overtime, utilize the appropriate skill mix, encourage adequate rest time between shifts, develop practice safety guidelines when nurses are fatigued, and monitor staffing and scheduling trends. Caruso and Hitchcock (2010) looked at data that showed increased incidents of nurses’ performance, personal injury, patient care outcomes, and automobile accidents during the commute to and from work. They also report that nurses and employers do not appreciate the risks associated with fatigue and have no guidelines or policies in place to address the possible consequences associated with 12-hour shifts. Nurses need to take the responsibility to employ evidence-based practice to reduce less than optimum outcomes (Caruso & Hitchcock, 2010). Smith-Miller, Shaw-Kokot, Curro, and Jones (2014) found that 12-hour shifts, lifestyle, unit culture, and organization policies contribute to work-related fatigue and errors among acute care nurses. Nelson writes that 12 hour shifts are not likely to change and plans should be implemented to decrease harm to nurses and patients. Nelson suggests mandated breaks, leaving work on time, and napping for the night shift workers.

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Mitchell, G. (2013). Selecting the best theory to implement planned change (Master's thesis, Queen's University, Belfast).


Stimpfel, A. W., Sloane, D. M., & Aiken, L. H. (2012). The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs, 31*, 2509-2519.


12-Hour Shifts and Fatigue

Provide varying shifts to accommodate those who cannot work extended shifts.

**Resolutions:**

1. Encourage health care facilities to offer both 12-hour and 8-hour shifts for nurses.
2. Recommend to health care facilities the importance of limiting no more than two, consecutive 12-hour shifts.
3. Educate nurses about the acute and chronic health risks associated with fatigue and sleep deprivation documented with working 12-hour shifts.
4. Educate nurses about the increased patient care errors that are associated with working 12-hour shifts in comparison to working eight hour shifts.
5. Educate healthcare facilities on the importance of completely relieved breaks for nursing staff.

ANS/NHNA Membership Application

For assistance with your membership application, contact ANA Membership Billing Department at (800) 929-7709 or e-mail us at membership@ana.org

**Essential Information**

First Name/Middle Name

Date of Birth

Gender: Male/Female

Mailing Address Line 1

Credentialed

Mailing Address Line 2

Phone Number

Check preference:

City/State/Zip

Home: Work:

Email address

County

Current Employment Status: (ie. Full-time nurse)

Professional Information

Current Position Title: (ie. Staff nurse)

RN License #: State

Membership Fees

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Authorization Signature

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