Cipriano Re-elected ANA President – Will Visit New Hampshire

The Membership Assembly of the American Nurses Association, attended by New Hampshire Nurses Association President Bobbi Bagley and Past President Peggy Lambert, re-elected Pamela Cipriano PhD, RN, NEA-BC, FAAN to a second two year term as President during the annual meeting June 23-25, 2016. Cipriano is the 33rd nurse to serve in the role of President in the organization’s 120 year history. Cipriano noted “I was honored to be elected to a second term as president and remain committed to our work to raise awareness so that nurses are “top of mind” to lead changes in health care. Our mission remains unchanged: Nurses advancing our professional to improve health for all. For the past two years, it has been with great pride that I have led ANA, a trusted voice that represents nurses in the halls of government, protects and promotes nursing practice, and influences healthcare policy,” said Cipriano, a member of the Virginia Nurses Association. “Registered nurses are on the frontlines of providing lifesaving health care to millions of people each day and it is an honor to advocate for nurses and to lead an association committed to improving health care for all.”

During her presidential remarks, Cipriano reviewed ANA’s core values: Service-Focused, Innovative, Data-Driven, Impactful, Effective and Inclusive. A longtime member of ANA, Cipriano has served on the Board of Directors for two terms and was the inaugural Editor in Chief of the ANA journal the American Nurse Today. She has served in leadership and faculty positions at the University of Virginia since 2000.

A dynamic and motivating speaker Cipriano has accepted an invitation to speak at the 110th Annual Meeting of the New Hampshire Nurses Association on October 12, 2016 at the Holiday Inn Downtown Concord, NH. Members and non-members are invited to attend. Tickets for the event with dinner are available at https://www.eventbrite.com/e/nhna-2016-annual-awards-banquet-tickets-26571297466.

It is with great pleasure that I greet you in my first address as the incoming president of our NH State Nurses Association. I could not be more privileged to serve in this capacity in a profession that makes up the largest contingency of the health care workforce and is known as the most trusted of all professionals. Historically, nurses have made an impact in so many areas that have led to advances in the health care, nursing practice and the overall well being of individuals and communities. I come behind a line of legacy makers, Florence Nightingale, Mary Seacole, Mary Mahoney and my all time favorite Lillian Wald. All of who embraced advocacy and were change makers in their day for the nursing profession. I stand on the shoulders of these legends and the many nurses of today who are just as dedicated to serve in this profession and support nurses at all levels of practice.

I had the opportunity this summer to attend the ANA Membership Assembly with our Interim Executive Director, Judy Joy and Past President Peggy Lambert. Meeting Pam Cipriano, who is the President of the American Nurses Association and drawing from her enthusiasm and energy, I look forward to taking on the charge of growing our Association and leading our profession in NH to tables with our policy makers on issues that are important to nurses and the communities we serve. It was an amazing experience to meet nursing leaders across the country, change makers and legacy holders! I was so encouraged and felt so empowered to step into this new role of service to our association, our profession and you our fellow nurses.

I became a member of our state association when I graduated from nursing school in 1996. The greatest benefit of belonging to our state association came when I became a more active member. I can tell you that being a part of this association has been a wonderful experience presented with many learning opportunities for me over the past few years. I have been able to expand in my leadership roles and develop my advocacy skills. I truly believe as we stand together, united in our voices we will make a difference in the nursing shortage, mentoring our new nurses and addressing emergent health issues facing our society today. The sole purpose of promoting and preserving the health and well-being of individuals and our communities is at the heart of our practice. This year, our Board and Commissions will work to build the capacity of the association to support you, our most valued asset.

You’ve chosen a profession that practices the art of healing and caring, of providing hope and courage. Our association is here to support you in all areas of nursing practice.

Please be sure to notify us with address changes/corrections. We have a very large list to keep updated. If the nurse listed no longer lives at this address—please notify us to discontinue delivery. Thank You!

Please call (603) 225-3783 or email to office@nhnurses.org or Nursing News in the subject line.

President’s Message continued on page 2
Guidelines for Submissions to NH Nursing News

NH Nursing News (NHNN) is the official publication of the New Hampshire Nurses’ Association (NHNA). Submissions will be considered for national and state membership publication. NHNN is published quarterly—January, April, July, and October. Submissions should include the author’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.

President’s Message continued from page 1

The Association is ours and we make it as strong as we are. I truly believe in what Florence Nightingale said about nurses that we should be in positions to take care of and support the nursing profession, and through our Nurses Association we have the opportunity to do so.

I hope to accomplish three main goals during my tenure as your president: to provide opportunities for increased advocacy; engagement and support of all nurses. Working with our Board and Commissions, I hope to be able to engage you to be more active with our professional nursing association during the legislative sessions, to support and advocate for one another and for our state Nurses Association during the legislative sessions, to support and advocate for one another and for our state Nurses Association in all of the activities that support the work that we do, as we think about our future in nursing.

Looking forward to a great year!

The New Hampshire delegation to the ANA Membership Assembly with ANA President Cipriano (r-l) Judy Joy, Interim NHNA ED, Cipriano, Peggy Lambert, NHNA Past President, President Bobbie Bagley

October, November, December 2016

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VISION STATEMENT

Cultivate the transformative power of nursing.

Adopted 10-20-2010.

MISSION STATEMENT

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

Adopted 10-20-2010.

University of Wisconsin

GREEN BAY

B.S.N.-LINC

BSN-LINC: 1-877-656-1483 or bsn-linc.wisconsin.edu

MSN-LINC: 1-888-674-9842 or uwgb.edu/nursing/msn

RN’s WANTED

Part time positions available each shift. $1500 SIGN ON BONUS being offered for candidate willing to work full-time combo of both shifts (in 2/week rotation, five 3-11’s and three 11-7’s). Must be responsible, able to work efficiently & independently, possess strong leadership and clinical skills. Must be NH registered, previous experience with SNF/LTC preferred. Working knowledge of PCC a plus. Excellent pay and benefit package offered to those who qualify!

To schedule interview, contact Patti Roger at (603) 379-1504.

University of Wisconsin

Green Bay

BSN-LINC

MSN-LINC

3-11 & 11-7

RNs

wanted

College of Nursing

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Calling all RN’s & LPN’s!

Looking for a change? How about sharing your knowledge and skill by teaching LNA classes!

We are currently hiring Nurses to teach per diem, part time positions available each shift. $1500 SIGN ON BONUS being offered for candidate willing to work full-time combo of both shifts (in 2/week rotation, five 3-11’s and three 11-7’s). Must be responsible, able to work efficiently & independently, possess strong leadership and clinical skills. Must be NH registered, previous experience with SNF/LTC preferred. Working knowledge of PCC a plus. Excellent pay and benefit package offered to those who qualify!

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NHNA was well represented at the recent ANA Membership meeting at ANA headquarters in Washington DC by President Bobbie Bagley, Past President Peggy Lambert and Interim ED Judy Joy.

The NH delegation joins others nurses in front of the Capitol Building for Lobbying Day

President Bagley reviews the issues at the Assembly meeting

Peggy(l) and Judy (r) meet a California colleague during an evening function

President Bagley and Past President Lambert listen to delegate discussion during the Assembly meeting.

(r-l) Bobbi, Peggy, Katherine, Judy and Sophie represented New Hampshire in lobbying representatives and senators on NH nursing issues. Katherine and Sophie are NH residents attending nursing school in Virginia.

The New Hampshire Delegates meet with Congresswoman Ann McLane Kuster representing New Hampshire’s second district.
100,000 Nurses and Nursing Students Needed for Study

One of the longest running studies of health is expanding, and needs your help! The Harvard School of Public Health and Brigham and Women’s Hospital are excited to announce that the Nurses' Health Study, for the first time, is now accepting both male and female participants! Previous cohorts taught us much of what we currently know about how diet and lifestyle can affect risk of developing cancer and other serious health conditions, and you can help by completing simple web-based surveys every 6 months.

If you are 19 or older (and under 46), and born after January 1st, 1965, JOIN the study! It only takes 40 minutes a year. Student nurses are also invited! It does NOT require travel to Boston, as questionnaires are online and any lab studies are done at your own facility at no charge.

http://www.nhs3.org/

Elliot Hospital RN Receives 11th Annual Clint Jones Nursing Award

Anna R. Lamothe, RN BSN, a nurse at the Elliot Hospital was the 2016 recipient of the Clint M. Jones New Hampshire Nursing Award, the tenth year the award has been offered. Lamothe, a graduate of Worcester State College, received the annual award during a special Nurses Week celebration held May 5th at Elliot Hospital in Manchester, NH.

The Clint Jones Nursing Award was created in 2006 by the Foundation for Healthy Communities to honor the memory of the former director of the Foundation’s N.H. Nursing Workforce Partnership. The award recognizes a registered nurse practicing in New Hampshire for at least one year but not more than six years, who exemplifies quality, compassionate nursing care and demonstrates a commitment to a career in nursing. “Clint worked with extraordinary enthusiasm and commitment at the Foundation for Healthy Communities and with several other New Hampshire organizations to encourage people to pursue a nursing career,” said Shawn LaFrance, the executive director of the Foundation for Healthy Communities. “This award in Clint’s name is one way to honor those who work so hard to care for patients across the state.”

Lamothe joined the staff at Elliot Hospital in 2014 and currently serves on the hospital’s Fitch Unit working with oncology patients, and serves on the Unit Practice Council focusing on improving the delivery of patient care. “We are pleased that Anna was selected for this year’s Clint Jones Award,” stated Jean Ten Haken, Chief Nursing Officer, Elliot Health System. “Her ability to perform the science of nursing, such as the tasks of physical care, in addition to taking the art of nursing which are the soft skills that nurses develop over a period of time, is exemplary.

In nominating Lamothe for the award, Sharon Kostansek, MS RN, CNML, Clinical Nurse Manager, cited both her support of her fellow colleagues and her dedication to her professional advancement, and highlighted her commitment to her patients and their families. “Anna exemplifies compassion every day, whether it’s engaging the patients and their families at rounds or comforting them through a difficult time. She always goes above and beyond to make a difference in the lives of her patients and their families,” offered Kostansek.

As they have every year, Clint’s family, represented by his son, Matt, attended the ceremony held at Elliot Hospital to present the award to Lamothe. “As always, it was a pleasure to be a part of the Clint Jones Nursing Award ceremony,” stated Clint Jones’ son, Matt Jones. “Like previous winners of the Clint Jones Nursing Award, Anna is truly a deserving recipient, exemplifying what it means to be a nurse and representing New Hampshire at the highest level.”
Call to Action – We Need You!

Are you a current NH Nurses Association member looking for ways to serve your profession and increase your involvement with the organization? Perhaps you are looking to become a member and would like to grow with us?

Our 2016 Election is coming up and we encourage you to submit your intent to apply for our open positions:

**PRESIDENT ELECT:** performs duties as designated by the President and Board of Directors, and shall assume the duties of the President in the absence of or at the discretion of the President. The President-Elect shall be elected to serve one year in that role during the President’s second year in office, and shall then serve a two-year term as President. The President becomes the Immediate Past President upon completion of the term as President.

**SECRETARY:** accountable for record keeping and reporting of minutes of NHNA and its Board of Directors. (Two-Year Term)

**BOARD OF DIRECTORS – NEW GRAD:** Exercises corporate responsibility and provides for implementation of association policies and position statements approved by the members; establishes policies and procedures for the transaction of business, coordination of association activities and operation, and assumes responsibility for fiscal solvency. Must be a recent graduate” of an RN licensure program: within 5 years prior to being elected.

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**COMMISSION Opportunities:** (May be elected or appointed to two year terms)

**CONTINUING EDUCATION:** Review and grant ANCC approval for CE activities submitted by providers. Experience in nursing staff development and with ANCC procedures required [3 available positions]

**GOVERNMENT AFFAIRS:** Study health issues and recommend effective legislative action; evaluate other proposed legislation and recommend appropriate action to the NHNA Board. Assist with legislative events [3 available positions]

**NURSING PRACTICE:** Develop programs & activities related to: educational & delivery systems for practice; economics of practice & health care; rights and responsibilities of nurses; ANA Standards & Code for nurses [3 available positions]

Interested in serving the nurses of New Hampshire and growing your professional organization? It easy! Go to the NHNA website and complete an intent-to serve form:


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As our state and nation were founded nursing was for the most part a personal rather than a professional commitment. There was no understanding of the disease process or bacterial infection and the American colonists witnessed disturbing outbreaks of diseases. The plight of the revolutionary soldier was particularly alarming for in addition to suffering the wounds of battle, his poor living conditions gave rise to epidemics of cholera and typhus, dysentery and pneumonia. Wives, friends and relatives of these soldiers voluntarily followed the military units and ministered to the sick and wounded. These “camp followers,” as they came to be known, were invaluable for they kept the sick and wounded clean and comfortable and fed. Trained nurses were as yet unknown in this new land.

Almost a century later in 1861 when the Civil War began in this country there were still virtually no trained nurses in the country. Florence Nightingale was continuing her efforts to improve the care of the English soldier after the Crimean War. Her organizational skills could have been used to advantage here in America for women in both the north and the south were volunteering to care for the sick and wounded and there was great need of an organized nursing service. One of those who assumed a leadership role at this time was Clara Barton who labored diligently in war and peace for the establishment of the American Red Cross.

After the Civil War this country experienced an industrial and technological revolution. Immigrants flocked to these United States and cities grew rapidly. Public health and social problems abounded. During the nineteenth century drew to a close the needs of hospitals prompted the establishment of training schools for nurses. The first training school for nurses in New Hampshire was opened at New Hampshire State Hospital in 1888.

With the turn of the century came a beginning concept of professional nursing and nurses began to organize themselves for the improvement of patient care. The forerunner of the American Nurses Association was founded in 1896 and the forerunner of the National League for Nursing in 1893. Here in New Hampshire nurses who had graduated from the state’s training school programs were also feeling the need to organize.

Our Association’s Founding – 1906

In April of 1906 fifty of New Hampshire’s graduate nurses met in Concord to discuss the need they felt for a state nurses association. A month later on May 28, 1906, a second meeting was held at the state hospital and a permanent association to be known as the Graduate Nurses Association of New Hampshire was formed.

The following officers were elected:

- President Miss Ada J. Morey, Wilder, VT
- First Vice President Miss Ada F. Shepard, Hanover, NH
- Second Vice President Miss Grace Haskell, Dover, NH
- Recording Secretary and Treasurer Mrs. Clara V.S. Glidden, Concord, NH
- Corresponding Secretary Miss Blanche Truesdell, Concord, NH
- The Executive Board of the new association included these five officers and four other members: Miss Robina Thompson, Manchester, NH; Miss Van Vranklin, Concord, NH; Miss Ida Nutter, Laconia, NH; Miss Lisie Thompson, Keene, NH.

The Articles of Incorporation were filed in the office of the Secretary of State on October 2, 1906. The objectives of the association were centered on “the welfare of its membership and the profession, the health of mankind and the education of nurses.” The new state organization voted to affiliate with the American Nurses Association and the affiliation was quickly negotiated in order that the new association would be entitled to send a delegate to the national convention in May of 1907.

The New Association’s First Task – State Registration for Nurses – 1907

Realizing that state registration for nurses would be to the advantage of both the public – the consumer of nursing service – and the profession, the first members of the Graduate Nurses Association of New Hampshire worked vigorously toward informing both the legislators and the public of the importance of a nurses “registration bill before the 1907 state legislature. Their efforts were rewarded when on May 7, 1907 Governor John McLane signed the bill into law.

The nurse registration legislation provided for:

1. State registration by examination for graduate nurses from hospital schools giving a course of at least two years.
2. A waiver clause covering a three-year period for graduate nurses already practicing, and nursing students then enrolled in schools,
3. A registration fee of $5.00
4. The appointment of a board of five nurse examiners to serve as inspectors of schools of nursing
5. A regret who was responsible to see that the act was carried out.

The nurses who comprised the first Board of Nurse Examiners were:

- Miss Blanche Truesdell of Concord, its first President;
- Miss Augusta Robertson of Manchester, its first Secretary;
- Miss Ida Nutter of Laconia, Miss Ida Shephard of Hanover, and Miss Annie Alpahng of Portsmouth.

These nurses met as a Board for the first time on May 23, 1907, and at that time forty-six graduate nurses were recommended for registration. Provision was also made for the examination of nurses practicing in New Hampshire who were not graduate nurses. The decision was made that nurses entering training after March 7, 1910 would take an examination before being recommended for registration. The work of assisting training schools in planning educational programs was started with the preparation of a syllabus which outlined the organization of a school, the requirements which prospective students should fulfill to be eligible for admission to a school, a minimum curriculum of three years, and a list of suggested texts and reference books.

Next Issue:

The examination for nurses after March 7, 1910.
The American Recovery and Reinvestment Act (ARRA) of 2009 included the Health Information Technology for Economic and Clinical Health Act (HITECH) to provide stimulus for the provision of electronic access for consumers as a way to improve patient engagement. As described by the act, meaningful use of a tethered personal health record, or called a patient portal was theorized to improve patient care and was viewed as an effective way to reduce cost and increase patient satisfaction. Accordingly, meaningful use of electronic access to the percentage of patients who access and use the patient portal gives insight to jobs@spauldingyouthcenter.org. No phone calls please. For consideration please submit a letter of interest, resume and three references via e-mail to jobs@spauldingyouthcenter.org. Spaulding Youth Center offers a generous fringe benefits (full-time positions) and shift differential pay when applicable.

KUDOS

Medicaid Medical Care Advisory Committee, provided guidance on state regulations and testifies on legislative issues. Her strong leadership was evident last year as parents, patients and professionals gathered in Concord to advocate for improved Medicaid reimbursement. “Many don’t know Sandra’s passion for providing home health services to New Hampshire’s most fragile patients,” says Interim president Richard Petersen. “The respect she receives from staff and physicians in neonatal intensive care units from Dartmouth to Boston is unmatched.”

Sandra Poleatewich, RN, receives the Home Care Service Award from Gina Balkus, CEO at the Home Care Association of New Hampshire, while Karen Michel, president of the Association, board of directors and executive director at the Rockingham VNA and Hospice in Exeter looks on.

Maribeth Dubosque, RN, of the Portsmouth Hospital Wound Care Center was honored as employee of the month in August 2016. Her nomination letter stated “Maribeth’s patient care is second to none. Patients feel comfortable and secure knowing she is advocating for them and providing quality care. Maribeth is always approachable, committed and willing to go above and beyond in whatever is asked of her.”

Patient Portal Use in a Community Medical Group

Pamela Kallmerten, RN, DNP

Ed Note: The New Hampshire Nursing News is committed to disseminating research and quality improvement initiatives conducted by NH nurses. Abstract submissions welcome.

The global aim of this two part research translation and healthcare improvement program was to promote patient engagement by identifying the factors that affect a patients’ decision to use a patient portal as well as to identify potential strategies to promote portal use. Phase I of the project involved surveying both patient portal users (n=235) and non-users (n=36) to determine the presence of any barriers or facilitators. The survey was based on the Health Information Technology Acceptance Model by Kim and Park (2012). In addition, baseline patient engagement was assessed using the Patient Activation Measure (PAM®).

The perception of usefulness as well as the related outcomes of attitude and intent to use the technology. In addition, if a patient perceives that the patient portal is useful, they are 1.44 times more likely to register and use a patient portal. There were no differences in patient engagement levels between portal users and non-users.

In Phase II, the data analysis guided the selection of an intervention, a pilot of Open Notes by volunteer community medical group providers as a strategy to possibly increase the percentage of patients who access and use the patient portal. Patient perceptions as to benefits and risks of viewing their office visit note will guide facility decisions to optimize portal use.

Pamela Kallmerten RN DNP completed her practice dissertation and graduated in May 2016 with her doctorate from the University of New Hampshire.

Three nurses at Littleton Regional Healthcare recently received BSN degrees. Medical Surgical Unit nurse Patricia Belanger RN BSN has received her Bachelor of Science in Nursing degree, Summa Cum Laude, from the University of Maine in Fort Kent. Trish has been with LRH since 2008 and has recently accepted a leadership position in one of the hospital’s specialized care units.

Cori Elliott RN BSN, Emergency Department RN, graduated Cum Laude with her BSN in December from University of Maine- Fort Kent Campus and is currently attending Rivier University in Graduate Studies for Family Nurse Practitioner. Cori has been a nurse for 10 years with most of her experience occurring in the Emergency Department and Critical Care Unit. Cori is an AHA Instructor and enjoys learning and training with other health care providers.

Christina Morancie RN BSN recently received her Bachelor’s Degree in Nursing, Summa Cum Laude, from the University of Maine, Fort Kent Campus. She has been at nurse at LRH for eight years, the last seven years as a perioperative nurse scrubbing and circulating surgical cases. Chris is a founding member of LRH’s Nursing Professional Practice Evaluation Council. Congratulations, Trish, Cori and Chris on obtaining your BSN.

Kiersten Hasselbarth, RN, was honored with the fourth annual Nursing Excellence Award by Littleton Hospital Chief Nursing Officer Linda Gilmore. The award is presented annually to a nurse that best embodies a level of excellence in nursing care and compassion.

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RECRUITMENT AND SELECTION

Caring and Compassion on Campus and Beyond

Because every child deserves a childhood and a future.

Spaulding Health Care’s mission is to build a healthier world through quality care and services that empower people to reach their greatest potential. As part of that mission, Spaulding is committed to providing high quality programs and services designed to foster the “younger minds, younger hearts” of young people with specific developmental and behavioral challenges. We are working to fulfill our promise of excellence to be able to bring a unique combination of knowledge and skill to the experience of life and the challenges of living and learning in our community.

We offer excellent pay, wonderful benefits, paid vacation, tuition reimbursement, retirement and all in a warm, exciting and compassionate team setting!

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BELKNAP COUNTY NURSING HOME, Laconia, NH has RN, LPN & LNA job opportunities for qualified individuals who want to be leaders and make a real difference in the lives of our residents and to promote our mission:

To care for our residents, as ourselves, with compassion, dignity and respect.

For further information and to view full job descriptions, visit the Human Resources link at http://www.belknapcounty.org.
Marylee A. (Curran) Woodall
White Mt Grad
12 years until her retirement in January. Sister Helen was a Professor of Nursing at Great Bay Community College for Nurse Educator
NHTI Grad
OB Nurse
Jeanine M. (Lambert) Towle, 85, passed away May 15, 2016. Jeaninne was a proud graduate of the Wentworth Institute of Technology. A ADN graduate of the New Hampshire Technical Institute she practiced nursing at Southern New Hampshire Medical Center and St. Joseph’s Hospital, Nashua, for many years.

Nancy L. (Melendy) Sullivan, 61, died unexpectedly at her home on May 30, 2016. A ADN graduate of the New Hampshire Technical Institute she practiced nursing at the New Hampshire Veterans Home for many years prior to her retirement in January. She was a dedicated nurse and teacher. Sister Helen had been previously employed as a Nursing Supervisor at Mt. Carmel Nursing Home, Program Director at NH Catholic Charities, Instructor of Nursing at Rivier College, and Staff Educator at Health Dialog, Inc. Sister Helen was most recently a Professor of Nursing at Great Bay Community College for 12 years until her retirement in January. Sister Helen was a member of the Society of Sisters for the Church.

White Mc Grad
Marylee A. (Currayn) Woodall, 70, a Berlin NH native, passed away June 9, 2016. She was a graduate of the N.H.

Technical College in Berlin. She was employed as a nurse at Coos County Nursing Home for many years prior to her long term illness.

St. A's Educator
Rose Brodeur Freeman, 98, passed away on June 10, 2016. She obtained her nursing diploma from Sacred Heart Hospital School of Nursing in Manchester and later graduated from Saint Anselm College with a BSN. She earned a master’s from Boston University before joining the faculty at Saint Anselm.

Office Nurse
Dorothy (Dot) (Challifour) Descoteaux, 83, died June 12, 2016, after a brief illness. She received her nursing diploma from Notre Dame de Lourdes Hospital in Manchester in 1954 where she was employed as a Charge Nurse for several years before working in the office of Dr. LeClerc.

Visiting Nurse
Mary A. Vesy (Clifford) Mulrennan, 82, died June 25, 2016. She practiced as a registered nurse for VNA of Rockingham for over 41 years.

School Nurse
Jane Hartford Winslow, 67, died June 26, 2016. She obtained her nursing diploma in Vermont and later earned her B.S. from New England College. She practiced as a school nurse in the Deerfield, Epsom, Salisbury, Webster and Penacook elementary schools.

Army Nurse
Ethel Susie “Kim” C. Kimball, 88, died July 10, 2016. She was a diploma graduate of the Mary Hitchcock School of Nursing.

Nurse Educator
Sister, Dr. Helen Marie Burke, 80, passed away May 30, 2016 following a brief illness. A Manchester native she earned her Bachelor of Science in Nursing at St. Anselm College and her Master’s in Nursing at Boston College. At age 70, she received her Doctor of Education at the University of Massachusetts, Lowell. A beloved nurse and teacher, Sister Helen had been previously employed as a Nursing Supervisor at Mt. Carmel Nursing Home, Program Director at NH Catholic Charities, Instructor of Nursing at Rivier College, and Staff Educator at Health Dialog, Inc. Sister Helen was most recently a Professor of Nursing at Great Bay Community College for 12 years until her retirement in January. Sister Helen was a member of the Society of Sisters for the Church.

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Rose Brodeur Freeman, 98, passed away on June 10, 2016. She obtained her nursing diploma from Sacred Heart Hospital School of Nursing in Manchester and later graduated from Saint Anselm College with a BSN. She earned a master’s from Boston University before joining the faculty at Saint Anselm.
Marion L. (Alexander) Burnham died July 31, 2016. She practiced as a Parish Nurse at Concord Hospital before retiring.

Dayle Burnham was a Parish Nurse Pioneer. She was born in 1941 and grew up in Laconia, New Hampshire. She attended the Mary Hitchcock School of Nursing and practiced at Frisbie Memorial and Wentworth Douglas Hospitals. After relocating to New Hampshire, she practiced in the psychiatric unit at the Elliot Hospital and then as a nurse educator. She obtained a master’s degree in Community Health from Springfield College in 1998.

In 1996, Dayle’s career led her to Community Health Services at Catholic Medical Center, where she called to embark on an exciting adventure; becoming the first director of the Parish Nurse Program. The program is a volunteer-based nursing organization aimed at joining the efforts of area churches, maximizing the quality of life for the community’s citizens by facilitating health care in a faith-based setting. The program focuses on addressing the spiritual, emotional, and physical needs of the person, providing them with better access to nurses and invaluable resources.

In 1974 she began practicing at Crotched Mountain Rehabilitation Center. In 1976 she practiced at the Nashua Memorial Hospital in 1930. She had practiced at the Claremont General Hospital and then at VNA for many years.

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Care of the Obese in Advanced Practice Nursing: Communication, Assessment, and Treatment

Paperback, 377 pages

Reviewed by Alex Armitage, MS, APRN-BC, CNL

There are some books which are timely, and this is one of them. In an era where more than two-thirds of adults are considered to be overweight and more than one-third of adults are considered to be obese, we are faced with this epidemic on a daily basis. As nurses and nurse practitioners these frightening statistics impact every aspect of our practice, in every specialty area, in a very real way.

Talking with patients about weight and weight loss can be a daunting prospect. This book is unique as it provides nurse practitioners practical tools with which to communicate, assess, and treat obese patients. Designed to help nurse practitioners easily broach an uncomfortable topic, the book walks the reader through the exam, providing tips on effective communication, understanding lifestyle constraints, and working with the patient to improve their condition without shame. A key aspect of the book is an multidisciplinary approach and evidence-based treatment. With the focus on both pediatric and adult obesity prevention and treatment, the ultimate goal is improvement in overall quality of life.

The book is divided into 5 parts. The first is a simple introduction to obesity, the epidemic and the role of the nurse practitioner. Part 2 focuses on communication with both the pediatric patient as well as the adult patient. How to initiate weight conversations with patients is a central discussion, and there are case studies demonstrating key points. Part 3 looks at assessment, including the genetics involved in obesity. The physical assessment of both adult and pediatric patients, including assessment of physical activity, dietary and psychological assessments is detailed. Part 4 looks at disease management and common comorbidities including hypertension, dyslipidemia, cardiovascular disease, diabetes and many obesity related diseases. There is discussion on prevention as well as a discussion on weight cycling and the related health consequences. Part 5 outlines obesity related treatments. The initial discussion is on addiction and eating disorders. Subsequent discussions included pharmacological therapy, surgical therapy and costs associated with obesity treatments. Lifestyle medicine is outlined and multidisciplinary approaches are emphasized. Finally, in the appendix, there are a significant number of resources for both the practitioner as well as the patient.

This book’s strength lies in the fact that all facets of working with obese patients are covered with current and evidence-based medicine and solid nursing care strategies. The author bolsters the writing with real-life examples that provide the patient’s perspective and help nurse practitioners understand how to provide a better quality of care to these vulnerable patients.

Alexandra Armitage is a Nurse Practitioner and a certified Clinical Nurse Leader, specializing in neurology and neurosurgery; bringing evidence-based practice to the bedside to improve patient care, patient outcomes and institutional viability.
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River Valley Obtains National Accreditation

Three years after its registered nursing program was stripped of its accreditation, River Valley Community College was notified by the Accreditation Commission for Education in Nursing that the program has been reaccredited for five years. “It is quite an accomplishment to have the program back in place,” said Pat Shinn, River Valley nursing department chair. “The community needs it and the nursing community needs it.” Shinn, who became chair in January 2014, said the accreditation for the RN program will cover students at the Claremont and Keene campuses. “Outcome information program and employment rates were two key pieces of data that were not being obtained.”

The accreditation commission had cited the college for noncompliance on two standards: curriculum and evidence that the curriculum was developed by the faculty and weren’t being measured nor was there a plan to develop and maintain evaluation by the facility. Finally, the commission noted that license examination passing rates were about 8 points below the state average in 2012.

One improvement made by the college was the addition of a course in human development, which had proven to be a weak area for RVCC students taking the registry exam. The school also created one-credit seminar courses on topics such as resume writing, studying, test-taking, and course expectations, rather than including them with disease-related coursework. “We reworked the courses so they flowed better for the students.”

Keene State Nursing Student Sues

A Keene State College nursing student has sued the college after officials removed her from a required clinical component of the program just months shy of graduation. Jillian Marlowe of Holden, Mass., alleges in her lawsuit – filed in U.S. District Court in Worcester, Mass., – that officials at the college were motivated to remove her from the “preceptorship” because they didn’t believe she could pass the nursing licensure test. She argues that she was never given written warning or a chance to fix the issues before she was removed. For their part, college officials said that her skills were lacking to the point of being unsafe. She is seeking reinstatement to the preceptorship, and monetary damages. “In an effort to save its fledgling program,” Marlowe’s attorney Ryan Avery wrote in the complaint, “Keene State College has taken several underhanded and unlawful steps to screen out the plaintiff and other students already enrolled in the nursing program that are perceived by the defendant as unlikely to pass the national licensure exam.”

Named in the suit are Keene State, the University System of New Hampshire, Keene State Nursing Director Thomas W. Connelly Jr. and Rebecca Lytle, the dean of graduate and professional studies. According to Keene State officials Marlowe is currently enrolled in Keene State’s nursing program, but has an incomplete in her preceptorship. “Keene State College is aware of the lawsuit, and is dedicated to helping the student successfully complete the nursing program. The college will vigorously defend the suit,” the lawsuit states. Keene State officials in sworn affidavits claim that it was Marlowe’s poor clinical skills and inability to do basic nursing tasks – such as take vital signs – properly that got her removed from her preceptorship. The lawsuit claims that at least one other student was similarly removed to that alleged by Marlowe. As part of the lawsuit, Marlowe filed a motion for an injunction asking for immediate reinstatement to the preceptorship so she could finish her coursework. U.S. District Judge Timothy S. Hillman denied the injunction request but ordered the college to produce clarification on what is required for Marlowe to finish her degree.

Student’s Complaint

Marlowe’s complaint was presented in the court documents: There are two parts to the four-year nursing program. The first two years are classroom study, the final two are a combination of classroom study and clinical practice. During the clinical portion, students enter into the preceptorship in December 2015, Marlowe, who was starting the second half of her junior year, was accepted into the clinical portion of the program. A year later, in January 2016, she began her preceptorship at Home Healthcare, Hospice & Community Services. In February 2016, she was asked to perform a head-to-toe exam on a patient and, by her own admittance, struggled with it. She reported this as part of “weekly reflection” reports she submitted to her academic adviser, Patricia Osimo. On March 1, Osimo requested a meeting with Marlowe. When Marlowe arrived at the meeting Osimo was there with Connelly and Assistant Dean of Graduate and Professional Studies Karrie Kelch, who told her she was being removed from the preceptorship.

At the time they told her she was out because of the concerns raised by her preceptor over her difficulties with the head-to-toe exam as well as general concerns over her medical knowledge and overall performance compared to other students in the nursing program. At this meeting, Avery alleges, Osimo and Connelly also called into question her future ability to pass the nursing board exam. Marlowe claims she received no written warnings or concerns regarding her performance, nor a clinical contract and remediation program – something the lawsuit says is afforded to struggling students, according to the student handbook. Instead, during the March 1 meeting, Avery alleges, Connelly, Kelch and Osimo suggested she switch her major so she could graduate with an allied health degree, which would not allow her to take the board exams. Someone who goes into the allied health field works under the supervision of a technologist or therapist and is qualified to become a physical, occupational, recreational or respiratory therapy assistant or radiological or lab assistant. Marlowe appealed this decision and then sent a letter to the college through her attorney, demanding reinstatement. In a letter dated April 14, 2016, officials relented and said she could finish her courses and get a new preceptorship in the summer of 2016. However, in an April 25 letter, they told her there was a new plan. She would be placed once again with HCS, but she could only finish her preceptorship after she completed a paid internship at HCS – as a licensed nursing assistant – in summer 2016. If she successfully completed the internship, she could then start her clinical preceptorship in the fall of 2016. Marlowe refused and filed suit.

Keene State Assessment

Keene State officials say in court documents that Marlowe had been struggling long before her preceptorship. They contend, in the documents, that their main concerns came from Marlowe’s preceptor, who told officials she was unorganized in her examinations, failed to ask patients enough information to get a clear picture of what ailed them, did not understand some medical terminology and didn’t know how to perform some of the clinical tasks. The lawsuit claims that at least one other student was given a similar assessment to that alleged by Marlowe. As part of the lawsuit, Marlowe filed a motion for an injunction asking for immediate reinstatement to the preceptorship so she could finish her coursework. U.S. District Judge Timothy S. Hillman denied the injunction request but ordered the college to produce clarification on what is required for Marlowe to finish her degree.

ST. ANSELM’S JUNIOR EYES OLYMPICS

Saint Anselm College nursing student Nick Richardson ’18 says he learned to walk while holding a field hockey stick, so it’s no surprise that this summer he was named to the U.S. Men’s Field Hockey Development Team and played his first game with the U.S. Men’s National Team against Canada’s Olympic team on July 7. Richardson was one of six players brought up to the development squad and has in Surrey, Canada. In addition to playing in Canada, the Netherlands and the Netherlands. In 2015, he spent a year abroad in Australia and New Zealand. He played for a local boys team. Having been chosen for the States team playing in the World League Round 1 in the United States in the Olympics. His ultimate goal is to play for the

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.
NCLEX Reconsidered

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

1. Gas tamponade was used to flatten the retina of a patient during retinal detachment surgery. During the admission assessment what action should the nurse implement first?
   a. check pupil responses in both eyes
   b. confirm the patient is in the ordered position
   c. medicate for a dull headache
   d. obtain vital signs

2. After obtaining report on your orthopedic floor, which patient should the nurse assess first?
   a. 84 yo female with fractured right femoral neck in Buck’s traction
   b. 64 yo female with left total knee replacement who is confused
   c. 88 yo male with post right total hip replacement with an abductor pillow
   d. 50 yo male with continuous passive motion device and JP drain

3. A patient arrives in the urgent care clinic and is diagnosed by the ARNP with an ankle sprain. What does the nurse include in discharge teaching?
   a. Rest, elevate the extremity, apply ice, and apply a compression bandage
   b. Perform range of motion to avoid muscle atrophy, apply heat, partial weight bearing
   c. Reduce pain with moist heat, then apply ice to reduce swelling, and elevate the ankle
   d. No weight bearing until seen by the orthopedic surgeon the following day, analgesics for pain

4. In explaining to a patient the purpose of triple therapy for a gastric ulcer the nurse explains that the tetracycline will:
   a. improve pepsin function
   b. prevent an esophageal infection
   c. combat H. pylori
   d. decrease the chance of aspiration pneumonia

5. The nurse is preparing to insert a nasogastric tube in a patient with an ileus. The insertion can be facilitated by:
   (Select all that apply)
   a. Administering conscious sedation
   b. Dextrose in water through a straw
   c. Offer sips of water through a straw
   d. Tipping the patient’s forehead back during nasal insertion
   e. Offering petroleum ointment for nasal lubrication

Answers can be found on page 16
CANDOR when Harm Occurs

Health care delivery systems are not perfect. Any nurse knows and is aware of patients who have been harmed during care delivery. Despite the national attention to patient safety by the Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, an alarming number of patients every year are harmed. Never events still occur. More than 1.5 million preventable infections occur annually among inpatients. Recent research shows a significant correlation between the frequency of adverse events and malpractice claims. Patient satisfaction and patient experience of care surveys have been shown to predict malpractice risk. How health professionals respond to a patient who has been harmed can predict satisfaction.

A recent toolkit has been developed by the Agency for Healthcare Research and Quality to assist nurses and others with a response. The CANDOR process (Communication and Optimum Resolution) is implemented in three phases containing 8 modules. It is estimated that an organization can implement CANDOR in 12-18 months. The program is free with online resources and videos.


ANCC Magnet Appraisers
Visit New Hampshire

Two New Hampshire acute care facilities recently hosted American Nurses Credentialing Committee Magnet Reviewers. The Magnet site review is part of the application process to achieve Magnet recognition. The nurse visitors seek to “verify, magnify and amplify” materials that are submitted early on in the application process. A new drug, from conception to market, takes 14 years.

Southern New Hampshire Medical Center hosted Magnet visitors in July. According to Ann McLaughlin, SNHMC Magnet Coordinator, “every visitor is looking with a different lens, and every application is a new experience.” SNHMC has been a Magnet facility for the past 8 years; recognition is awarded for a four year period.

Wentworth Douglas Hospital hosted Magnet visitors early in September, marking the first time they have been reviewed. Both facilities will learn the outcome of their applications during late fall.

DID YOU KNOW?

...a less invasive implantable cardioverter defibrillator is available with fewer complications experienced by patients requiring ICDs. The new model is implanted subcutaneously and does not require vascular access for lead wires placed into the heart chambers.

...30% of the US population claims a sensitivity to scents worn by others. Over one quarter of patients with asthma say that artificial scents worsen their disease. Research has indicated that scents cause irritant-triggered neutrophilic inflammation of the airways.

...it now takes an average of 17 years for new knowledge generated by researchers conducting randomized controlled trials to be incorporated into practice. A new drug, from conception to market, takes 14 years.

...primary care providers indicate that they have seen a patient’s overall health improve after adopting an animal. Sixty percent of PCPs surveyed have recommended that a patient get a pet.

...rapid response teams have been significantly shown to reduce hospital mortality and reduce in-hospital cardiac arrest. The presence of a physician has not been associated with improved outcomes at rapid response calls.

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Lyme disease (LD) is caused by the bacterium Borrelia burgdorferi. In the northeastern and upper Midwest, Ixodes scapularis is the tick responsible for LD. This tick also transmits Anaplasma phagocytophilum (Anaplasmosis) and Babesia microti (Babesiosis) infection which are both associated with more severe and prolonged symptoms than those of LD.

It is believed that most humans are infected from the bite of immature ticks called nymphs. They are very tiny and difficult to see on the body. Nymphs feed during the spring and summer months. Adult ticks can also transmit LD and are most active during the cooler months of the year. Generally, the tick must be attached for 36 – 48 hours to transmit the bacterium (Centers for Disease Control and Prevention [CDC] 2015; Heymann, 2015; Kimberlin, 2015; National Institutes of Health [NIH], 2016).

Early symptoms of LD may be mild and can mimic many other disease conditions. The table below represents the usual presentations. Fever and general symptoms can occur in the absence of the classical erythema migrans (EM) rash, more commonly known as the “Bull’s Eye” rash. The CDC suggests that the rash occurs in approximately 70-80% of infected persons. For those who are at risk and seek medical care, the diagnosis is typically apparent. For others, the healthcare provider must use both the clinical symptoms combined with laboratory tests for LD to make the diagnosis (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016). 

Diagnosis

Diagnosing LD in the absence of the classic EM rash can be difficult. Laboratory blood tests is helpful if used correctly and performed with validated methods. In LD endemic regions, a clinical diagnosis can be made in patients presenting with an EM rash, with or without the knowledge of a tick exposure. Providers should also have a high index of suspicion even if the rash does not present as the classic Bull’s Eye but the patient has concerning tick exposure. Serological tests in the early stages of illness should be interpreted with caution as antibodies against Ixodes scapularis. This tick also transmits Anaplasma phagocytophilum (Anaplasmosis) and Babesia microti (Babesiosis) infection which are both associated with more severe and prolonged symptoms than those of LD.

This 2-step method is important because EIA may yield false-positive results in patients with other spirochetal infections (i.e., syphilis, leptospirosis, relapsing fever), certain viral infections (i.e., varicella, Epstein-Barr virus), or other autoimmune diseases (i.e., lupus, HIV, rheumatoid arthritis) (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; IDSA, 2006).

Preventative treatment should also be considered for asymptomatic individuals who have been bitten by Ixodes scapularis. A single dose of doxycycline can be given when all of the following circumstances exist: (a) the attached tick can be reliably identified as an adult or nymphal tick that is estimated to have been attached for >36 hours on the basis of engorgement of the tick with blood or of certainty about the time of exposure to the tick; (b) prophylaxis can be started within 72 hours of the time that the tick was removed; (c) ecologic information indicates that the local rate of infection of these ticks with B. burgdorferi is >20%; and (d) doxycycline treatment is not contraindicated (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; IDSA, 2006).

Laboratory testing sensitivity increases in patients who have progressed to later stages of illness (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; Infectious Disease Society of America [IDSA], 2006).

A 2-step approach is recommended for serologic diagnosis of LD. Both steps can be accomplished using the same blood sample. First, a quantitative screening is done using an enzyme immunoassay (EIA). Specimens that yield positive or equivocal results should then be tested by Western immunoblotting. Western immunoblot should not be performed if the EIA test is negative or instead of an EIA. When testing to confirm early disease without EM, immunoglobulin (Ig) G and IgM assays should be performed. To confirm late disease, only IgG should be performed as false-positive results may occur with the IgM. A positive IgG immunoblot requires detection of antibody (“bands”) to ≤5 kDa polypeptides while a positive IgM immunoblot requires detection of antibody to ≤2 kDa polypeptides. Results are considered positive if both the EIA and immunoblot are both positive. (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; IDSA, 2006).

This 2-step method is important because EIA may yield false-positive results in patients with other spirochetal infections (i.e., syphilis, leptospirosis, relapsing fever), certain viral infections (i.e., varicella, Epstein-Barr virus), or other autoimmune diseases (i.e., lupus, HIV, rheumatoid arthritis) (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; IDSA, 2006).
A small percentage of patients may experience lingering symptoms of fatigue, pain, arthralgias and myalgias after treatment is complete. The infection is gone but symptoms remain. These symptoms can last for more than 6 months. This is sometimes called, “chronic” LD but is more appropriately known as “Post-treatment Lyme disease Syndrome” (PTLDS). More research is needed to determine the exact cause of PTLDS but the current belief is that the lingering symptoms are not due to persistent infection with *B. burgdorferi* but the result of residual damage to tissues or an autoimmune reaction that occurred during the infection. The prolonged use of antibiotics for PTLDS has not been proven to be beneficial. Additionally, long-term use of antibiotics has been associated with serious complications and should be avoided (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016; IDSA, 2006).

Prevention is Key!

Minimizing exposure to ticks is the single best defense against LD and other tickborne infections. Preventive measures are recommended year round but extra awareness is warranted during the warmer months (April – September) when ticks are most active. If possible, avoid areas where ticks live, especially wooded, brushy areas with long grass. The following simple precautions are recommendations to decrease the risk of getting LD (CDC, 2015; Heymann, 2015; Kimberlin, 2015; NIH, 2016):

- **Covering** up by wearing shoes/boots, light colored clothing with pants tucked into socks or boots. Try to stick to trails and avoid walking through low bushes and long grass. Keep your dog on a leash.
- **Prevent blood-sucking** by following all directions and applying repellent with a 20 percent or higher concentration of DEET to your skin. Parents should apply repellent for their children. Apply products with permethrin to clothing or bug pretreated clothing.
- **Tick-proof your yard** by clearing brush and leaves where ticks live. Keep woodpiles in sunny areas.
- **Perform tick checks** on yourself, your children and your pets after spending time in wooded or grassy areas. Shower as soon as possible after coming indoors.
- **Remove a tick** as soon as possible by gently grasping the tick near its head or mouth with tweezers. Don’t squeeze or crush the tick, but pull carefully and steadily.
- **Don’t assume you’re immune.** You can get Lyme disease more than once.

**Epidemiology**

Lyme disease (LD) is the most common vector-borne disease in the United States. During 2014, 96% of all cases occurred in 14 states in the northeast and upper Midwest. Additionally, LD was the 5th most common nationally notifiable disease in 2014.

Delaware Division of Public Health (DDPH) utilizes the National Notifiable Diseases Surveillance System (NNDSS) and case definitions developed by the Council for State and Territorial Epidemiologists (CSTE) for data collection and reporting of LD, and all other reportable diseases and conditions, to the CDC. CSTE case definitions enable public health agencies to classify and count cases consistently across reporting jurisdictions and should not be used by healthcare providers to determine how to meet an individual patient’s health needs. For LD, the surveillance case definition was developed for national reporting of LD; it is not intended to be used in clinical diagnosis.

**The Controversy**

Lyme disease is also a very controversial illness. The existence of “chronic” LD induced by a persistent infection with the Lyme spirochete, *B. burgdorferi*, and the method of treatment are at the forefront of this controversy. As the incidence of LD continues to rise, the most basic questions surrounding LD remain. The focus of this polarizing controversy: Who has the disease? Why do some people remain sick after treatment? And how should they be treated? These questions are contested bitterly and publicly. The debate reflects a gaping divide in the medical community in which the vast majority of providers align with the CDC and the Infectious Disease Society of America (IDSA) versus a small group of providers that believe patient’s symptoms are due to persistent infection and prescribe long-term antibiotic treatments and other alternative therapies which have not proven to be beneficial in robust clinical trials. The published results of this research and clinical trials were subject to rigorous statistical, editorial and scientific peer review. Moving forward the general consensus both sides can agree on is that prevention is key and also that more funding is needed for further research into the long-term effects of LD (Auwaerter, 2007; Fallon et al., 2008; Feder et al., 2008; Klempner et al., 2001; Krup et al., 2003; Lantos, 2001; Marquez, 2010; Patel, Grogg, Edwards, Wright, & Schwarz, 2000).

References


Paula Eggers is an Infectious Disease Epidemiologist for Delaware Division of Public Health. Paula has greater than 31 years combined experience in critical care nursing and epidemiology. She holds dual degrees in Nursing and Community Health.

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Looking into hearing loss

Hearing loss, the most common sensory deficit in humans, diminishes quality of life and impairs the ability to communicate in everyday life. The World Health Organization (WHO) defines hearing loss as a sensory impairment in which a person can no longer hear and understand.8

Impact on patient safety

With more than one-fifth of all Americans experiencing hearing loss, nurses are increasingly likely to care for patients with this sensory deficit. Nonadherence to the treatment plan, including prescribed medications, is greater among patients experiencing hearing loss.4 Because it results in higher healthcare costs and greater morbidity and mortality, nonadherence has a significant negative impact on patient safety.4

In fact, Cardenas-Valladolid et al. found that hearing-impaired older adults taking multiple medications had double the risk of nonadherence when compared with others without hearing loss. This nonadherence occurs, they surmised, because hearing-impaired older adults have a poor understanding of the patient teaching provided by nurses and other healthcare professionals. They also found that healthcare professionals significantly overestimated their patients' adherence to prescribed therapies. A lack of good communication between healthcare professionals and patients was the real problem, they concluded.3

Legal concerns

Safe nursing care depends on good communication between nurses and patients. Equal access to safe, effective care is mandated by federal antidiscrimination laws. Legally, nurses have an obligation to do whatever it takes to effectively communicate with patients who are hearing impaired. For example, nurses are expected to ask the patient or the family to explain the patient’s communication needs and describe the communication services required.5

Without good communication, patients and caregivers can encounter these barriers to safe patient care:

- The nursing process isn’t appropriately implemented.
- Patients misunderstand important information.
- Informed consent for treatment isn’t provided.
- Medication regimens aren’t followed.5

Nurses should be aware of their patients' needs, willingly listen to their needs, and remain flexible and open to providing necessary support services.4 Nurses must also be aware of all support services and resources available in their facility to facilitate communication.

Don’t let family and friends act as language interpreters. They don’t have adequate medical interpretation skills and are too personally and emotionally connected to their loved one to remain objective. Their involvement can lead to role confusion, breach patient confidentiality, cause a conflict of interest, and prevent effective communication and decision-making between the patient and the healthcare team. Always rely on a trained language interpreter, if available, or an assistive device or strategy approved for use in your facility.

Care strategies

First and most important, ask hearing-impaired patients for their preferred methods of communication.5 In a clinic or outpatient setting, the message can be conveyed with posters, appointment screen messages, and flyers.4

In an inpatient facility, admission procedures include hearing assessments.4 When deficits are identified, they should be highlighted in the patient’s medical record. Then add a screen message that all staff will see.4 Ask how the patient prefers to communicate; for example, by lip reading, language interpreters, written information and notes, voice recognition software, or a combination.5,6 Remember that during times of stress, fatigue, and illness, patients have a reduced ability to concentrate and focus, and a reduced ability to write and read information, thereby worsening their ability to hear and understand.4

Encourage your hearing-impaired patients to wear hearing aids (if available) and learn sign and lip-reading strategies.4 Be aware, however, that lip reading is inaccurate and shouldn’t be relied upon as a sole method of communication.

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very helpful. Clearly dictate words into the microphone, Put important information in patient handouts. Here’s effectiveness. make sure you’re thoroughly familiar with how it works If using a technology-enhanced communication device, something, correct him or her in a respectful way. of misunderstanding. If the patient misunderstands patient and watch the nonverbal responses for signs saying the same phrase over and over.8 occur, explain things in a different way rather than what he or she understands. When misunderstandings happen, explain things in a different way rather than saying the same phrase over and over.4-6 Speak clearly and distinctly, but not too slowly or in an exaggerated way. Never shout. Preface main conversation topics with your patient’s name. Eliminate medical jargon whenever possible; use short words and conversation topics with your patient’s name. Eliminate distractions to a minimum.6-8 As much as possible, keep extraneous noise and your patient. Speak directly to the patient, not into a patient, position yourself on the same level, and make Even when using a language interpreter, face your patient. Speak directly to the patient, not into a computer screen, and avoid interrupting the patient. As much as possible, keep extraneous noise and distractions to a minimum.6-8

Courteously and empathetically listen to your patient and watch the nonverbal responses for signs of misunderstanding. If the patient misunderstands something, correct him or her in a respectful way.

If using a technology-enhanced communication device, make sure you’re thoroughly familiar with how it works and continuously evaluate its quality, usability, and effectiveness.

Put important information in patient handouts. Here’s where voice recognition software (speech to text) can be very helpful. Clearly dictate words into the microphone, show the on-screen written transcript during your conversation and dictation, and give related printouts to your patient. With all written information you share, consider carefully the patient’s literacy level and language skills.

If you work in a clinic or outpatient facility, encourage hearing-impaired patients to book and confirm appointments electronically through text messages, secured online website scheduling, or e-mail. Also, instead of calling hearing-impaired patients from the waiting room, use a visual call system display using their first name and last initial or walk over to them and escort them to the exam room. Don’t violate patient privacy by speaking loudly within the hearing range of others.

Speak up for safety

While performing patient teaching with Mrs. S, her nurse asks her what communication strategies will best help her understand her new medications. She says she’s a high school graduate who’s literate in English and that although she’s very hard of hearing, she’ll be able to “catch” most things as long as the nurse takes her to a quiet private place, speaks slowly, faces her at eye level, and supplements the teaching with printed information. During the teaching process, the nurse periodically asks Mrs. S to repeat important points and provides feedback as needed. At the conclusion of this teaching/learning session, Mrs. S thanks her nurse for all the help and support. She says that because the nurse took extra time with her, she feels quite confident that she’ll be able to take her new medications exactly as prescribed.

Having patient safety strategies for specialty populations is important for all healthcare organizations. A well-written policy that can be used by managers and employees to respond to hearing impaired patients will help organizations function at their highest capacity to provide excellent patient care and customer service. Following these policies and documenting the care you provided may protect you from being named in a lawsuit.

References

Adapted from “Tune into safety for hearing-impaired patients” by Linda S. Smith, PhD, MS, RN, CLNC. This article originally appeared in the June 2015 issue of Nursing © 2015 Wolters Kluwer Health.

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Selfie Corner

We want to see the faces of New Hampshire Nurses. Send your #NHNurseSelfie to office@nhnurses.org or post it to the New Hampshire Nurses Association’s Facebook page. Make sure to identify yourself and your friend. You may see your selfie in the next New Hampshire Nursing News. A great way to surprise and honor a colleague, a respected preceptor, a great mentor or a new grad!

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