Leslie Verucci started her career as a Licensed Practical Nurse graduating from Delcastle Technical High School. She continued her education and earned an associate degree at Delaware Technical and Community College, then earned her BSN from Wilmington College, and her MSN from the University of Delaware. She is a Certified Adult Health Nurse Practitioner and has a Post Masters Certificate in Family Medicine. She also completed the Clinical Nurse Specialist program in cardiopulmonary health.

Leslie works as an APRN in the Medical Support Unit at the Helen F. Graham Cancer Center providing care to cancer patients to prevent delay in their treatment plan and/or prevent unnecessary emergency room visits. She also works at Christiana Care’s Medical Aid Unit. She has been practicing as a Nurse Practitioner since 2001.

She is the past president of the Delaware Nurses Association and a member of their Professional Development Committee. She is the legislative liaison for Delaware Diamond Oncology Nurses Society.

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This edition of The DNA Reporter will provide you with articles about active immunity through vaccination. The articles include information on the ethics of flu shots, lessons learned from not getting the flu vaccine, re-emergence of vaccine-preventable childhood diseases, and the use of vaccines for HPV and shingles.

Vaccines have saved tens of millions of lives over the years, but there is still a lot of controversy as to the safety and efficacy in their use. This controversy seems to pit the rights of the individual against the current evidence and a lot of controversy as to the safety and efficacy in their use. This controversy shingles.

The mission of the Delaware Nurses Association is to improve healthcare in Delaware by the advancement of nursing. Quarterly publication direct mailed to approximately 12,000 RNs and LPNs in Delaware.
research that shows that immunizations are essential to the primary prevention of disease from infancy through adulthood. The reduction and elimination of vaccine-preventable diseases has been one of the greatest public health achievements in the United States. This past year marked the 100th anniversary of the 1918 influenza flu pandemic that swept the globe. This flu outbreak is still one of the deadliest disease outbreaks in recorded history. It is estimated that about 500 million people became infected with it, and the number of deaths was estimated to be at least 50 million with about 675,000 occurring in the United States. Since the 1918 pandemic, advancements have been made in understanding and treatment of flu, but flu viruses still continue to pose a serious public health threat. Flu viruses continue to circulate in animals—mainly birds—and seasonal flu vaccines also are produced and stored by the U.S. government for possible use during a pandemic event. In the past 100 years, we’ve come a long way in developing methods to track, prevent and treat flu, but we still have a long way to go.

Vaccinations protect the individual and the public from life-threatening, preventable diseases. Healthy individuals, as well as the most vulnerable, benefit from vaccinations. Health care providers, patients, families, and caretakers benefit from becoming immunized. Neonates, pediatrics, the immunocompromised, and individuals experiencing chronic diseases are especially at high risk for developing preventable disease complications and should receive vaccines. Building trust and encouraging a non-confrontational discussion promotes interactions that are positive. Nurses have a responsibility in advocating for necessary vaccines throughout an individual’s health care continuum and providing the facts to help patients and families make informed decisions.

Thank you to our authors, who are passionate and willing to help us in talking to and assisting our patients, families and ourselves in making our personal best decisions.

Authors, Michelle Gamble and Bet Key Wong both look at issues regarding the flu. Michelle reviews the ethics of mandatory flu vaccine in healthcare workers and Bet discusses differences between the common cold and the flu. She discusses the need to vaccinate to prevent the flu, timing in which the vaccine should be given and the importance of preventing the spread of the flu. Katherine King discusses shingles, what it is, the complications that can occur and information regarding the shingles vaccine such as age, present vaccines on the market and the efficacy. Brian and Teresa Wharton provide great information on the re-emergence of childhood diseases that can be prevented with the use of vaccines. They add what nurses need to know when discussing this sometimes challenging topic with parents and what is available to assist nurses in this discussion. Lastly, Brian Wharton and Jessica Holden discuss the latest hot topic in the use of vaccines, Human Papillomavirus (HPV). They do a great job in providing us information on what HPV is, how it is diagnosed, the risk to the population, ways to prevent cancers and protect later in the life of our young population.
I am grateful and humbled to assume the office of President of the DNA. I would first like to thank our outgoing President, Leslie Verucci, for her leadership and especially thank her for her kind words about me in the last edition of The DNA Reporter. I look forward to Leslie’s continued participation in DNA.

I have met or worked with many of you when I practiced as a staff nurse, charge nurse and supervisor in four of Delaware’s acute care hospitals, in a physician’s office, home care, and in an outpatient dialysis center. I also worked for a state social services agency and social service/legal hybrid agency and was a hospital nurse recruiter. Then after many years as a nurse, I became an attorney – almost on a whim.

When the opportunity to become an attorney presented itself, I grabbed it and began practicing law – along with part time nursing – at the ripe old age of 41. I was a Deputy Attorney General and worker’s compensation Hearing Officer and I am now a civil litigator and Director (partner) with Elzufon Austin and Mondell, PA, in Wilmington. My nursing background dovetails nicely with my healthcare, personal injury, and professional negligence areas of practice.

I am also a long-time member of the Delaware fire service, and a fire school and American Heart Association instructor. I am married to Felisha Marcus Alderson, who is also a nurse and active DNA member, and we are the proud parents of Paige, who is an attorney, and Max, who is an EMT.

As I write this in early November, I can say that all of the pre-election political ads caused me to dread turning on the TV. Those ads showed me that our political discourse has become so polarized, abhorrent, and off-putting that many people simply turn away. Nurses simply cannot do that. Never before has it been so important for nurses to step up and be heard; so important that ANA declared 2018 as the year of advocacy for nurses. 2019 will be equally important.

While ANA’s focus is national, DNA focuses upon local and statewide issues that directly impact nurses, the practice of nursing, and healthcare in general. Increasing that local and statewide advocacy will be my focus as your President. I hope to inspire all of you to join in this daunting effort. It is long past time for nurses to take our place with those who make policy decisions that so profoundly affect our lives and livelihood day in and day out.

The bases of our status as the most trusted of professions is public appreciation and respect for our collective knowledge, skills, and caring values; attributes that we must share with our elected officials on a regular basis. We are the ones who every day and, in every way, almost instinctively heal and comfort others, often in the face of great adversity and limited support. Who better to step forward to lead our state to a better place, a place where all people have access to quality and affordable healthcare?

I want to end by congratulating RN Melissa Minor Brown on her election to the Delaware House of Representatives and commend and console RN Louisa ‘Louie’ Phillips for her well-run but unfortunately unsuccessful bid for the Delaware Senate. I hope these two role models inspire more nurses to run the next time around!

Call for Abstracts for DNA Reporter

Nursing Practice and Healthcare Transformation

Abstract content must support factors driving innovation and change in nursing practice to include triple aim goals, interprofessional models, future nursing practice, and personalized health care decision-making.

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Balance as healthcare workers are given back their autonomy but with multiple professional organizations such as the Advisory Committee on vulnerability but died as a result of healthcare-acquired influenza. The risk infected eight patients, three of which died (Maltezou & Tsakris, 2011). Despite recommendations from a goal that 90% of healthcare workers in the U.S. would be vaccinated in influenza worldwide (WHO, 2018). Nosocomial influenza constitutes a serious risk among high-risk (WHO, 2018). Nosocomial influenza is identified as having a high probability of transmission from healthcare workers to patients and from patients to healthcare workers (Huttunen & Syrjanen, 2014). Vivid and heart breaking examples of nosocomial influenza put a face on an otherwise abstract risk. Some of the cases illustrated in one article were: a low-birthweight neonate, bone marrow transplant recipient, elderly patient hospitalized with chronic obstructive pulmonary disease, and an outbreak of H1N1 in a hematology clinic that infected eight patients, three of which died (Maltezou & Tsakris, 2011). Huttunen and Syrjanen (2014) described healthcare workers as potential vectors for many infectious diseases, including influenza, which is not typically considered a healthcare-associated infection. Seasonal influenza was identified as having a high probability of transmission from healthcare workers to patients and from patients to healthcare workers (Huttunen & Syrjanen, 2014). Vivid and heart breaking examples of nosocomial influenza put a face on an otherwise abstract risk. Some of the cases illustrated in one article were: a low-birthweight neonate, bone marrow transplant recipient, elderly patient hospitalized with chronic obstructive pulmonary disease, and an outbreak of H1N1 in a hematology clinic that infected eight patients, three of which died (Maltezou & Tsakris, 2011). Huttunen and Syrjanen (2014) described healthcare workers as potential vectors for many infectious diseases, including influenza, which is not typically considered a healthcare-associated infection. Seasonal influenza was identified as having a high probability of transmission from healthcare workers to patients and from patients to healthcare workers (Huttunen & Syrjanen, 2014). Vivid and heart breaking examples of nosocomial influenza put a face on an otherwise abstract risk. Some of the cases illustrated in one article were: a low-birthweight neonate, bone marrow transplant recipient, elderly patient hospitalized with chronic obstructive pulmonary disease, and an outbreak of H1N1 in a hematology clinic that infected eight patients, three of which died (Maltezou & Tsakris, 2011). Huttunen and Syrjanen (2014) described healthcare workers as potential vectors for many infectious diseases, including influenza, which is not typically considered a healthcare-associated infection. Seasonal influenza was identified as having a high probability of transmission from healthcare workers to patients and from patients to healthcare workers (Huttunen & Syrjanen, 2014). Vivid and heart breaking examples of nosocomial influenza put a face on an otherwise abstract risk. Some of the cases illustrated in one article were: a low-birthweight neonate, bone marrow transplant recipient, elderly patient hospitalized with chronic obstructive pulmonary disease, and an outbreak of H1N1 in a hematology clinic that infected eight patients, three of which died (Maltezou & Tsakris, 2011). Huttunen and Syrjanen (2014) described healthcare workers as potential vectors for many infectious diseases, including influenza, which is not typically considered a healthcare-associated infection. Seasonal influenza was identified as having a high probability of transmission from healthcare workers to patients and from patients to healthcare workers (Huttunen & Syrjanen, 2014). Vivid and heart breaking examples of nosocomial influenza put a face on an otherwise abstract risk. Some of the cases illustrated in one article were: a low-birthweight neonate, bone marrow transplant recipient, elderly patient hospitalized with chronic obstructive pulmonary disease, and an outbreak of H1N1 in a hematology clinic that infected eight patients, three of which died (Maltezou & Tsakris, 2011).
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Bet Key Wong, MSN, RN, CNOR

Bet Key Wong is an adjunct fellow at the UPenn Center for Public Health Nursing. She is a peripatetic nurse with special interests in health literacy, infectious control, surgical site infections, and workforce development. She received her BS from Brown University, her MS from University of Rochester, and her MSN from Worcester State University.

In 1918, 100 years ago, the world experienced the worst flu pandemic with an estimated 50 million deaths globally and 675,000 of those occurring in the United States. At that time, there were no vaccines, and a feverish flu to the flu were limited to isolation and hand hygiene. In addition, people were dying from isolation due to the inability to get food and care (Centers for Disease Prevention and Control [CDC], 1918 Flu Pandemic, 2018).

In early 2018, people were lining up to get the flu vaccine and hospitals were setting up pop-up triage units to treat a severe flu outbreak. According to the CDC (Oct 25, 2018), an estimated 80,000 deaths were due to seasonal influenza (flu) and complications and about 80 percent of children who died from the flu were not fully vaccinated against the influenza virus. The winter flu season was not as effective as prior years (CDC, Summary of 2017–2018 Flu Season, 2018).

Although vaccines to prevent the flu in 2018 were available to the public, the vaccine against a virulized vaccine inactivated influenza virus last winter was not as effective as prior years (CDC, Summary of 2017-2018 Flu Season, 2018). In addition, there was confusion between symptoms of the flu and a cold based on symptoms alone as such etiquette remains low. The flu outbreak in early 2018, according to Grohskopf et al (2018), is a good reminder of the importance of hand hygiene, surgical site infections, and other acute care during viral illness.

The CDC APIC also recommends that vaccination be offered by the end of October (Grohskopf et al., 2018a). Their reason for recommending vaccination are based on their unpredictability of the onset of the flu season. In addition, children aged six months through eight years old are assigned two doses of the influenza vaccine and they should have their first dose once the vaccines are available and their second dose (which must be administered at least four weeks or more after the first dose) by the end of October (Grohskopf et al., 2018a). In the event of limited supplies of vaccines, the ACIP recommendation is based on recent studies that recommend the use of quadrivalent inactivated influenza vaccine (LAIV4) but the ACIP voted in February, 2018b).

Flu vaccines, like other vaccines, contain components that may cause allergic reactions and studies have shown that allergic reactions to flu vaccines are rare, the CDC (2018) recommends all vaccine providers be CPR (Clinical Preventive Resuscitation) to offer the flu vaccine. When caring for patients, health providers should receive any licensed, recommended, and age-appropriate influenza vaccine (Grohskopf et al., 2018a). If the CDC APIC recommends all vaccine providers be CPR (Clinical Preventive Resuscitation) to offer the flu vaccine.

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References:


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Bet Key Wong
In the United States, 99% of adults have serological evidence of varicella zoster virus and are therefore considered to be at risk for developing herpes zoster or shingles (Johnson et al., 2015). According to the Center for Disease Control (CDC, 2018), there are one million cases of shingles each year in the United States, and this number continues to rise with advancing age. McLaughlin, McGinnis, Tan, Mercantante, and Fortuna (2015) pointed out that in Delaware, the estimated total cost associated with shingles for those aged 50 and older was $262.2 million annually. Considering the average duration of the shingles symptoms, the economic burden to prevent shingles, the historically low rate of those receiving the shingles vaccine is a public health concern.

**What is it?**

Herpes zoster, or shingles, is caused by the varicella zoster virus. After the initial illness of “chicken pox,” the virus remains dormant in the sensory neuronal ganglia where it lies at rest, without causing symptoms. When the immune system is compromised, the virus reactivates and causes a painful rash and/or pain in the areas of the body where the rash is expected to appear. McLaughlin, McGinnis, Tan, Mercantante, and Fortuna (2015) estimated the cost of one case of shingles in Delaware to be $2,749. Over the course of 10 years, the cost per person is estimated to be $27,490.

**Complications:**

The most common complication of shingles is post-herpetic neuralgia; a longer lasting pain syndrome caused by nerve damage related to the virus and inflammation (Friesen, Chateau, Falk, Alessi-Severini, & Bugden, 2017). Post-herpetic neuralgia causes severe constant or intermittent pain in the areas of the body where the rash is expected to appear. When the pain lasts longer than three months, it is referred to as post-herpetic neuralgia (Purnell, 2014). The blisters scab over typically in seven to ten days and resolve within two to four weeks.

**Vaccinating against Shingles:**

Vaccinology aims to control and prevent diseases with vaccines. Vaccines contain a modified or weakened version of the pathogen that causes a disease. When introduced into the body, the vaccine stimulates an immune response against the pathogen, but is not effective enough to cause the disease. If the patient is infected with the disease in the future, the immune system will recognize it and fight it off before the disease has a chance to cause symptoms.

Shingles is caused by the varicella zoster virus, which is the same virus that causes chicken pox. After an initial infection, the virus remains dormant in the body. Following the initial infection, the immune system produces a strong response to the virus. This response prevents the virus from spreading throughout the body and causing the disease. However, as people age, the immune system becomes less effective. This can lead to the reactivation of the virus, causing shingles.

**Efficacy:**

The efficacy of the Shingrix vaccine was studied in two large randomized, placebo-controlled clinical trials, one including adults 50 years to 70 years, and the other 70 years and above (Symonik et al., 2018). The results of the studies indicated an 85.70% efficacy rate with no substantial difference in the rate of decline in immune response over time from 97.6% in year one to 87.9% in year four (Symonik et al., 2018). The safety and efficacy of Shingrix for those immunocompromised has been demonstrated in two studies. One suggested that receiving shingles vaccine is safe and effective for those with immunocompromised (Symonik et al., 2018). The other study found that Shingrix is safe and effective for those with HIV (Symonik et al., 2018).

**What can we do as nurses?**

The overall financial cost and potential health burden of shingles continues with advancing age, and the risk of developing shingles increases with advancing age. McLaughlin, McGinnis, Tan, Mercantante, and Fortuna (2015) pointed out that in Delaware, the estimated total cost associated with shingles for those aged 50 and older was $262.2 million annually. Considering the average duration of the shingles symptoms, the economic burden to prevent shingles, the historically low rate of those receiving the shingles vaccine is a public health concern.

**What is Zostavax?**

In review of the incidence rate of shingles, there is a rapid rise beginning at 50 years of age, worsening up to 85 years of age where there is a 30% increase in incidence per year (O’Donnell, Sharpin, & Janotha, 2006). In 2006, Zostavax was introduced and approved for use in preventing shingles (McCall and Parker 2013). It is a live attenuated, or weakened, vaccine that is given as a single dose subcutaneous injection for adults 60 years of age and older (McCall and Parker, 2013). Although this vaccine is considered very safe, due to it being a live virus, it is contraindicated for those with immunocompromising diseases, or immunocompromised (O’Donnell et al., 2018). Potential side effects of the Zostavax vaccine include local pain, swelling, and erythema at the site of the injection (Purssell, 2014).

**Efficacy**

A systematic review of 12 years of experimental and observational evidence revealed the vaccine efficacy above 50% during the three years following vaccination (Dooling et al., 2017). After three years, vaccine effectiveness decreases to less than or equal to 24% (Dooling et al., 2017).

In 2016, 33% of adults aged ≥60 years reported receipt of the Zostavax vaccine (Dooling et al., 2018). Cited potential barriers for patients receiving the vaccine are lack of awareness regarding the need for the vaccine, side effect fears, lack of recommendation by the healthcare provider, and the belief that receiving the vaccine is “wise” (McLaughlin et al., 2015). Barriers noted for providers included not having the vaccine available to store the vaccination, lack of including vaccination information during routine visits, and lack of provider’s awareness of vaccine visit over preventa (O’Donnell et al., 2018).

**What is Shingrix?**

Shingrex was approved for use for the prevention of shingles in October 2017. It is an adjuvanted live subunit vaccine given through a single dose, usually in the same shot as the annual flu vaccine. The vaccine is administered in two doses, 2-6 months after the initial vaccination (Symonik, Farrokh, Gandhi, & Fortuna, 2018). Risk factors for shingles include secondary skin infections, cranial nerve complications including peripheral nerve palsies, ophthalmic shingles, and visceral nerve involvement (McCall & Parker, 2013).

**References**


Re-Emergence of Vaccine-Preventable Childhood Diseases

Brian Wharton, MSN, RN, CPEN, CPST
Teresa Wharton, ADN, RN, CEN

Brian Wharton earned his BSN and MSN from Wilmington University. He is a certified Pediatric Emergency Nurse and is the pediatric coordinator at Christiana Care Health System in Newark, Delaware. Brian is an adjunct nursing instructor at Wilmington University. He is an active member of the American Nurses Association, Emergency Nurses Association, Pediatric Trauma Society, and the Society of Pediatric Nurses. Brian has an extensive background in working with children and adolescents in an acute psychiatric setting prior to becoming an RN. He currently develops and conducts education on numerous pediatric topics, secondary traumatic stress, and providing care for families who are involved in child custody or incivility at CCHS and other institutions. Brian can be reached at bwharton@christianacare.org or at his personal email pedsrn2012@gmail.com.

Teresa Wharton is a graduate of Delaware Technical Community College and is currently attending the BSN program at Wilmington University. She is a certified Emergency Nurse (CEN) and is currently working as the Emergency Department Educator at a rural community hospital. Teresa is an active member of the Emergency Nurses Association. She creates and conducts education to meet the needs of the Emergency Department. Teresa is currently collaborating to enhance the critical care nursing internship program and also functions as a preceptor to ACLS, PALS, and BLS. Teresa enjoys new challenges and educating her colleagues. Teresa can be reached at nuerotmasia@aol.com.

In the last century, vaccinations are one of the most important advancements in keeping children and adults healthy. Due to the rise of preventable diseases and concerns about vaccine safety, vaccinations are decreasing and re-emerging (Center for Disease Control [CDC], 2015; Davis, 2016; Phadke, Bendnarczyk, Salman, & Omer, 2016). Diseases such as polio, pertussis, measles, mumps, and rubella that were once eliminated are reappearing.

Re-emergence of vaccine preventable diseases

The re-emergence of childhood diseases has caused a great deal of speculation amongst health care providers. The answer for this is very clear; it is due to hesitancy or refusal to vaccinate children (CDC, 2015; Edwards & Hackell, 2016). Weithorn and Reiss (2016) explained that there are three main groups of parents that don’t want their children vaccinated: vaccine rejecter parents, vaccine resistant parents, and vaccine hesitant parents. Parents that hesitate or refuse vaccinations put their children at risk along with those that are medically ineligible (Phadke et al., 2016). There are many misconceptions that may lead a parent to refuse or become reluctant to vaccinate their children. According to Weithorn and Reiss (2016), “Parents who refuse vaccinations for their children are often influenced by misleading characteristics of vaccine risks promulgated on the internet and in the media” (p. 1611). For example, the incidence of a severe allergic reaction associated with vaccination is less than one in a million children vaccinated (CDC, 2015; Weithorn & Reiss, 2016), and there have been unfounded speculations that vaccinations are unnecessary or may be linked to autism (Edwards & Hackell, 2016). Vaccine safety is the utmost priority, even after the long and arduous process of developing a vaccine, there is the grueling task of obtaining licensure. Once licensure has been secured, the vaccine is continuously monitored by the CDC, Food and Drug Administration (FDA), and other regulating agencies (Edward & Hackell, 2016). Dispelling the myths and misconceptions about vaccinations need to be the forefront of conversations with patients.

Why Vaccinations?

Vaccinations are a tool or weapon that if used correctly can eradicate or eliminate specific childhood diseases (Zingman, 2014). When parents choose not to vaccinate their children, they directly place those that are ineligible to receive the vaccinations at a greater risk (CDC, 2015; Weithorn & Reiss, 2017). Herd immunity is a concept where the majority of a population becomes immunized to an infectious disease by receiving immunization (CDC, 2015; Weithorn & Reiss, 2016), and there have been unfounded speculations that vaccinations are unnecessary or may be linked to autism (Edwards & Hackell, 2016). Vaccine safety is the utmost priority, even after the long and arduous process of developing a vaccine, there is the grueling task of obtaining licensure. Once licensure has been secured, the vaccine is continuously monitored by the CDC, Food and Drug Administration (FDA), and other regulating agencies (Edward & Hackell, 2016). Dispelling the myths and misconceptions about vaccinations need to be the forefront of conversations with patients.

What do Nurses Need to Know?

It is challenging for healthcare providers to diagnose and treat diseases that have not been seen for decades. It is imperative for healthcare providers to familiarize themselves with the specific disease process, signs and symptoms, diagnoses criteria, and treatment of these once eliminated infections (CDC, 2015; Edwards & Hackell, 2016; Zingman, 2014).

Educating patients and their families is a priority for healthcare providers. A non-judgmental yet candid discussion highlighting the risks versus benefits of vaccinations revolving around patient specific concerns should be initiated by the healthcare provider to patients across the lifespan. To facilitate learning, the development of a patient education packet can be created in having the material readily available for immediate discussion and can allow patients to have the information to review at a later time. When developing a patient education packet consider including the following:

- Disease fact sheet with the incidents of outbreaks in your region
- Vaccination information sheets
- Myth busting fact sheet
- Immunization plan and CDC vacation schedule
- Open discussion sheet for questions and concerns

The CDC has a plethora of information available for public consumption via their website allowing self-regulation of immunization schedules and a down loadable app to keep track of their vaccination progress (CDC, 2018). The re-emergence of vaccine-preventable diseases present new challenges for healthcare providers. Healthy People 2020 acknowledged that “Infectious diseases are a critical public health, humanitarian, and security concern; coordinated efforts will protect people across the nation and around the world” (n.d., para 3). Nurses are the frontline defense in coordinating with, advocating for, and educating patients and their families. In response to this crisis it is imperative that healthcare professionals be ready and willing to meet these new challenges. Beneficence, encouraging patient autonomy, and do no harm govern practice to protect and assist patients in reaching optimal health.

References:

cines-herd-immunity-and-disease-re-emergence-whats-the-deal/
Brian Wharton, MSN, RN, CPEN, CPST
Jessica Nolden, BSN, RN, CEN

View Brian Wharton's full Bio on page 7.
Jessica Nolden earned her ADN from Delaware Technical & Community College and her BSN through Wilmington University. She is currently enrolled in a DNP/FNP program through the University of Delaware with aspirations of becoming an educator, as well as a clinician. She is a Certified Emergency Nurse at Christiana Care Level 1 Trauma Center for the last five years and serves on the Pediatric Resource Team. Jess is married to a supportive husband and is the proud mother of two beautiful young girls. Jess can be reached at molder@chriatianacare.org

Introduction

The Human Papillomavirus (HPV) is the most commonly contracted sexually transmitted infection (STI) and the most under vaccinated. According to the Centers for Disease Control (CDC) “70 million Americans, most in their late teens and early 20’s, are infected” (CDC, 2018a). HPV can ultimately resolve itself without causing any health issues, but it can be fatal if spreads. Understanding HPV and how it is transmitted, along with understanding the manifestation of the disease, are the first key steps in becoming more empowered to preventing this disease.

What is HPV?

HPV is a common sexually transmitted disease that affects men and women. The virus infects itself, through genital contact, into healthy cells that quickly reproduce in the body. Transmission happens through small tears in the epithelium during vaginal, anal, or oral contact. A healthy immune system can fight the infection. If HPV is not destroyed then the virus can stay in the body potentially causing cancer (CDC 2018a; Healthy Delaware, 2017). Healthy Delaware (2017) reports, “high-risk” infected people is immunocompromised the opportunistic HPV infection will have more devastating effects due to the inability to fight off the infection. HPV can cause genital warts many years after the transmission (CDC, 2018a). If this is noticed, the infected person may seek treatment. Genital warts can occur alone or clusters and present in cauliflower-shaped appearance (CDC, 2018a).

Diagnosis and Treatment

Diagnosing HPV can be challenging as many infections are asymptomatic and there are not many approved HPV tests available (ASHA, 2016; CDC, 2018a). The majority of HPV cases are discovered when symptoms (genital warts) or health problems are developed from long-term infection and when screening for cervical cancer during Pap smear testing (ASHA, 2016; CDC, 2018b). There is also an “at-home” kit available for women that detects cervical cancer. This requires samples to be sent back to the company for results. A diagnosis of genital warts usually comes from visual examination by a provider along with a thorough health history. DNA testing can be utilized by a provider as a screening tool. The HPV virus can stay in the body with men outside of medical research studies” (2016). “Right now, HPV tests are not approved for use with men outside of medical research studies” (2016). A pap smear examination by a provider is crucial for men as this may be the only way to detect a possible HPV infection (ASHA, 2016).

When caring for men that are high-risk for HPV infection, evaluation poses many challenges according to the ASHA (2016), “right now, HPV tests are not approved for use with men outside of medical research studies” (2016). A pap smear examination by a provider is necessary for the HPV virus itself (ASHA, 2016; CDC, 2018a). Treatment is based on how the HPV presents. In the case of genital warts, the healthcare provider can utilize a chemical treatment and surgical techniques (CDC, 2018a). The HPV virus is still under the skin and proper precautions need to be discussed with the patient. If the HPV infection is early and presents as precancerous lesions, these can be surgically removed or destroyed by laser technology (CDC, 2018a). Patients who are immunocompromised must be followed closely by a trained healthcare provider.

Prevention

Prevention is key to combating HPV and safeguarding young people for devastating effects that can present 20 years down the road. The prevention of HPV has been acknowledged as a public health priority by the CDC and President’s Cancer Panel (Kulczycki, Qu & Shewhuck, 2016). This health priority should be no different in Delaware where, approximately 15% out of every 100,000 people with HPV have cancer associated with the virus (CDC, 2018b; Healthy Delaware, 2017).

Screening should be utilized when appropriate as the first lines of defense are through assessment by healthcare providers. Vaccinations are underutilized, and the rates are not adequate to combat this potentially devastating virus. Although healthcare provider recommendations are influential; they are not enough to persuade patients to get vaccinated (Kulczycki et al., 2016). The primary care provider must seek to understand the patient’s (or parent’s) perceptions about the HPV vaccinations and dispel negative myths. A sincere and honest conversation must happen to express the serious consequences of not receiving the HPV vaccination. Healthcare providers should be having in-depth conversations with parents of pre-teens and early-adolescents.recommend from: http://www.immunizedelaware.org/wp-content/uploads/Delaware_HPVReport_Mar2017.pdf


Conclusion

HPV is a very widespread sexually transmitted infection that can lead to genital warts and also cause various types of cancers (CDC, 2018a). Underutilization, ways to protect and against HPV must become priority to decrease rates of infection. Vaccinations and prevention strategies must be available for health and wellness, can lead the charge to educate patients and their families about HPV.

References


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Feedback from one event. However, an evaluation question about individual activities and making changes in those based on learner outcomes should be used to leverage the value of continuing professional development, the provider unit, and organizational and quality outcomes that are in measurable terms become action statement that expresses anticipated quantifiable improvement.

Quality Outcomes 2: How the evaluation process for the Provider Unit resulted in the development or improvement of an identified quality outcomes measure for the provider unit.

Quality Outcomes 2 (QO2) is a process of evaluating data in aggregate resulting in the advancement or improvement of the provider unit. The criterion is evaluating how the provider unit, as a whole, works together to determine the status of specific outcomes. O04a and Q02 require that measurable outcomes are specific to the development or improvement of the Provider Unit. O04a is asking for at least one meaningful and measurable outcome related to the provider unit whereas Q02 requests that the evaluation process for the outcomes listed be described.

Q02 addresses how the Provider Unit evaluates whether there was a change, such as developments and improvements? More specifically, Q02 is where the Primary Nurse Planner can provide insight into the process and methods used to collect aggregate data and evaluate outcomes specific to the Provider unit. Keep in mind that these outcomes will produce tangible evidence to show progress, opportunities and/or areas for improvement for your provider unit.

In addition to learner needs, quality outcomes that purposefully align with the organization's strategic goals is an excellent avenue to show how the results may provide a positive impact. The first step in the process is for the provider unit to develop quality outcome measures for a specific period. These quality outcomes are written in measurable terms for O04a. For example, a provider unit's quality outcome measure might be "By December 31, 2019, the number of nurse planners in the provider unit will increase by 15%.” Setting this outcome measure is based on the evaluation process (Q01) used by the provider unit. Q02 gives the provider the opportunity to consider how evaluation data can be used to improve its functioning.

Collecting aggregate data for a QOM is different from evaluating individual activities and making changes in those based on learner feedback from one event. However, an evaluation question about the provider unit's operations after multiple activities offered over several months will be a resource to collect aggregate data related to the provider unit. An example is what is the learners' perception of the provider unit's operations after multiple activities offered over the next year, the primary nurse planner and his/her team might decide to implement strategies to enhance the professional development of the learner by utilizing appropriate learner engagement strategies within the next 12 months. The aggregate data collected over the two-year time frame will allow the primary nurse planner to compare data from two separate years. This work supports the quality improvement of the provider unit and supports its value in helping to meet the strategic initiatives of the organization by ensuring active learner engagement strategies.

A few questions to consider when answering Q02 are not limited to:

- What problems or opportunities were identified in the evaluation process (Q01)?
- What opportunities exist to improve provider unit processes based on that evaluation data?
- What is realistic for the provider unit to accomplish to address these problems or opportunities?
- What strategies will be used to meet these identified outcome measures?
- How will the changes or improvements be measured?

Writing outcomes and developing evaluation processes is a key responsibility for all Primary Nurse Planners. Creating goals and outcomes for the Provider Unit is essential for growth and quality. Using aggregate data to analyze outcomes provides tangible evidence to assist in declaring an outcome met or not. Create a method to analyze data and practice writing outcomes to help overcome the challenge of Q02 & O04b. A meaningful, measurable outcome that is strategic to your organization is worth more than an unmeasurable list.
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