

2008 NURSING ANNUAL REPORT



With the Patient, Every Step

Dear Nursing Colleagues:

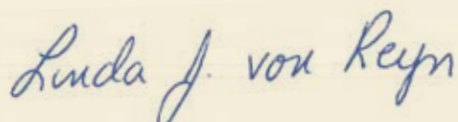
It is with great pleasure that we introduce to you the 2008 Nursing Annual Report. This past year marked momentous milestones, exceptional achievements as well as significant challenges that led us to reflect on who we truly are as nurses at Dartmouth-Hitchcock. The year 2008 was a year of transition, in both leadership and in the way we practice patient care. In a time of transition and great change come some growing pains, but this change can ultimately result in a tremendous transformation.

As documented within this annual report, one of our most significant transitions was also one of our most outstanding accomplishments – the launch of our re-invigorated shared governance structure. We both are amazed and enormously proud of the tremendous work that Nursing has undertaken in redesigning the shared governance structure. Stemming from work on the nursing strategic plan in January 2008, the Nursing Practice Council began the design work for a transformational model at DHMC. The redesign occurred in two phases. The first phase included development of a conceptual model; the second phase was the implementation, which included the elements of elections, communication, and orientation. Elections occurred in September, and the large turnout demonstrated the enthusiasm for this incredible transformation. This re-organized structure truly gives all D-H Nursing a shared vision and a set of common goals that will guide all that we do to provide the highest quality patient care in a safe environment.

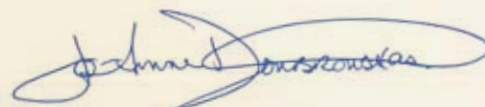
Our shared governance councils, both central and unit-based, will promote consistency and excellence in the care that we provide to our patients. “Pockets of excellence” can be more easily replicated across the organization. The council structure will also promote professional development, quality improvement, and clinical research possibilities for our many colleagues within the community of Nursing. We expect the first year to be a large and exciting learning experience for all of us. We truly believe the shared governance structure is a means for our Nursing staff to be better patient advocates and to help bridge the transition as patients move through the continuum of care. By transforming the shared governance structure, we will partner with each other so that we can assure the public that Dartmouth-Hitchcock Medical Center is committed to providing safe, high-quality, patient-centered care. Within the pages of this annual report, you will find numerous stories detailing how the care provided to our patients has been improved by partnerships between nurses and others across the continuum of care and at the transitions of care.

And lastly, all of us are affected by the nursing leadership transitions that have occurred over the past year. We want to thank each of you for your support during this leadership changeover, and to assure you that we will continue to provide the needed stability and foundation for all D-H nurses to be successful with their daily work of providing excellent patient care. As we work together to continue this journey of change, collaborations, and partnerships, we look forward to the future of D-H Nursing as we successfully advance our mission of providing the best possible care to our patients and families, and for that we can only say, “Thank you.”

With Respect and Appreciation,



Linda von Reyn, RN, PhD
Acting Chief Nursing Officer

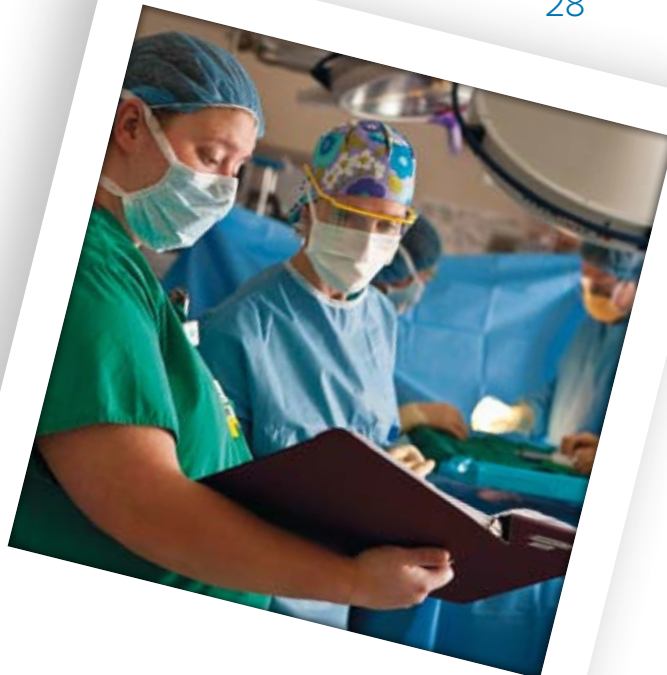


Jo-Anne Dombrowskas, RN
Executive Chair of Nursing

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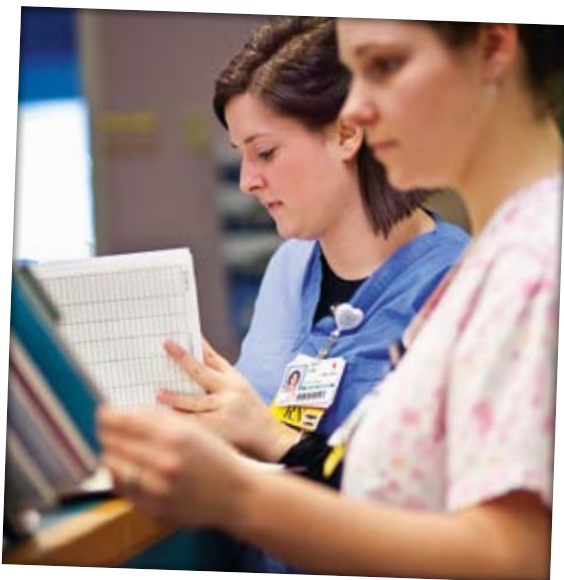
Every Nurse A Leader

"It's generating a lot of excitement amongst the nursing staff," says Terri Rodee, RN, a nurse in DHMC's Endoscopy Unit. "Those of us who provide direct patient care now have a voice in making decisions that affect not only our individual practice but also the day-to-day activities of our units." She is talking about the medical center's recently revised model for shared governance—a new framework that is designed to enhance decision-making and shared leadership throughout DHMC's nursing community.

The concept of shared governance has been in place at the medical center since the 1980s. "We're working to build on that tradition, while expanding and improving upon our processes, as part of an overall effort to align our nursing strategic plan with the organization's mission, vision, and goals," says Jo-Anne Dombrowskas, RN, a nurse in the Intermediate Cardiac Care Unit who was elected Executive Chair of Nursing to lead and coordinate the new structure.

A "Bottom Up" Approach

One of the biggest changes on the hospital-wide level has been the transition from a single Nursing Practice Council (NPC), composed of about 40 members, to six smaller Decisional Councils. These councils are focused on the areas of Practice, Quality, Research, Professional Development, Advanced Practice Nursing, and Management.



Jen McAfee, RN, (left) and Kimberly Belanger, RN, on 3W. Accountabilities for direct care nurses in the shared governance structure include practice and professional development.

To ensure adequate representation from all nursing areas across the institution, the units are organized into districts—including Medical/Surgical, Critical Care, Perioperative Services, Maternal/Child, and Outpatient services—with an equal number of nurses in each district. Direct care nurses run for election to the Decisional Councils through their affiliation with a particular district.

Meetings for the six hospital-wide councils take place monthly. A Nursing Executive Steering Council—which includes the chairs of each of the Decisional Councils, as well as acting Chief Nursing Officer Linda von Reyn, RN, PhD, and Dombrowskas—then meets to hear the results from all of the councils' decisions, to resolve any issues that come up and to help move the work of the councils forward.

"It's very much a 'bottom up' rather than 'top down' approach," says Dombrowskas. "Whether our work involves helping to implement the organization's new electronic health record or addressing our various Magnet quality initiatives, we believe that decisions are most effective when they're closest to the point of care. This format is not only giving staff nurses an opportunity to have an active role in all decisions that are being made, it's allowing ambulatory nurses and inpatient nurses to work more closely together."

Spreading Excellence

One of Dombrowskas' major goals going forward is to improve communication within the nursing community at DHMC. "We're using a variety of communication channels to keep everyone fully informed about what's happening," she says. "One key to enhancing communication is the ongoing development of the unit-based councils. Once they're all up and running we can better link the work we're doing on the unit to hospital-wide levels. We would like to have more standardization with what we're doing, while still allowing autonomy at the unit level, so that 'pockets of excellence' can be more easily replicated across the organization."

"We're in the process of setting up our bylaws and getting two councils up and running in Endoscopy," says Rodee. "One great benefit of doing this work at the local level is the opportunity we have for collaboration and making the unit councils multidisciplinary. When you involve different members of the care team in the decision-making process, it increases staff morale and ultimately leads to better patient care."

According to von Reyn, the shared governance model is an excellent example of the organization's overall goal to build an empowering culture.

"I think participating in the councils helps every nurse to develop their leadership abilities," she says. "It also engenders a sense of ownership and accountability for their practice as they strive to provide our patients and families with the best care possible." ●



“Whether our work involves helping to implement the organization’s new electronic health record or addressing our various Magnet quality initiatives, we believe that decisions are most effective when they’re closest to the point of care.” says Jo-Anne Dombrowskas, RN, Executive Chair of Nursing.



Members of the Professional Development Council reviewing the Staff Nurse Recognition Program.



Mary Catherine Rawls, RN-BC, MS, ONC, and Cynthia Stageman, RN, BSN, OCN, share a light moment during a Practice Council meeting.



A Bridge for Safe Transitioning From Hospital to Home

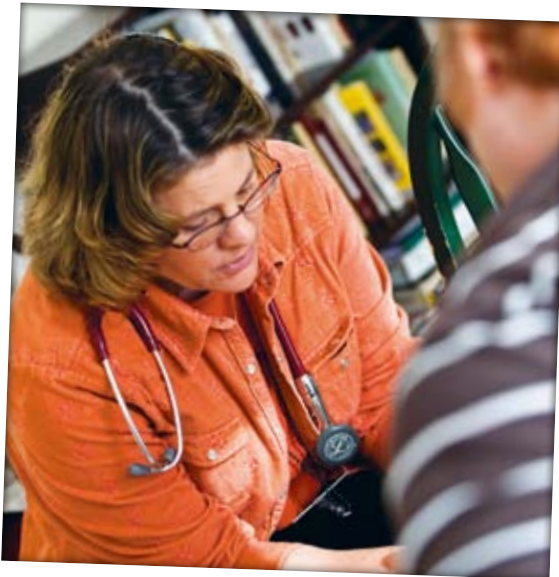
Patients being cared for on the One East Medical Specialties Unit are among the most complex and fragile at DHMC. "These are patients who typically have multiple chronic illnesses, who are on many medications, who are elderly, and who may have some memory impairment issues," explains Ellen Thompson, RN, a Nurse Manager in the Care Management Department.

"Usually they're admitted because of an acute exacerbation of their condition (such as getting pneumonia as a complication of their COPD) or perhaps they've fractured a hip from a fall and need surgery," says Thompson. "Once they've recovered and become stable enough for discharge, they may still be considered high risk in terms of suffering a setback and ending up back in the hospital."

Making the Transition

To help ensure that these patients can make a safe and successful transition from hospital to home, DHMC has created the Bridge Program. Staffed by Drs. Chris Allen and Brooke Herndon, nurse practitioner Nancy Redfield, case manager/social worker Licia Berry-Berard and administrative assistant Katie Dagneau, the Bridge Team works with care teams at the medical center and in the community to provide support, medical care, and resources during each patient's transition.

The process begins with a referral from the hospitalists or clinical resource coordinators (CRCs). "The CRCs contact us when they identify a patient who is a good candi-



Nancy Redfield, ARNP, makes home visits to ensure that patients like Harry Connington of Norwich, Vt. successfully transition from hospital to home.



Since last spring, more than 140 patients have been referred to the Bridge Program, with 83 successfully discharged.

date," says Redfield, ARNP, who is the only Bridge Team member dedicated full time to the program. "The patient and family are approached while in hospital about a referral to the Bridge Program. If they are interested, a member of the team calls and sees the patient within a couple of days of discharge."

The initial home visit—which includes giving a physical assessment, reviewing medications, and developing a plan of care in coordination with the home healthcare providers and the patient's personal physician—helps to set up the team's interactions with the patient and family for the ensuing four to six weeks.

Staying Safe and Healthy

"Patient outcomes data has shown that most readmissions occur within the first seven days after discharge, so we focus on making sure that the discharge plan fits and is working effectively," Redfield says.

"Visiting the home gives us a broader perspective. We're able to evaluate how the patient manages in his or her home with the plan of care determined during hospitalization. We look at the environment, and assess if it supports the patient's needs and ability to function well. We discuss any safety issues that need to be addressed," she adds.

"We provide a lot of education to the patient, reinforcing how important it is for them to call us if they start experiencing symptoms that we call 'red flags,' and we engage the patient's support system as much as possible in this process. I always leave room in my schedule to make an urgent visit if needed."

Since it officially began offering its services last spring, more than 140 patients have been referred to the Bridge Program with 83 successfully discharged. "We've sent out satisfaction surveys to both patients and primary care physicians and have received very positive feedback," says Thompson, who manages the Bridge Program. "It's nice to be able to provide a service that not only helps patients stay safe and healthy, but helps them to stay home, which is where they really want to be." ●

In Memory of Elsa F. Hintze

One day a few years ago, while working as a transport aid for DHMC's Volunteer Program, Elsa Hintze was pushing a patient in a wheelchair to her appointment. As they chatted, the 82-year-old woman lamented to Elsa, "It's really awful to get old." Elsa listened sympathetically and agreed. "How old are you?" asked the patient. "Well, I'm 96," Elsa answered quietly.

"Elsa told me later that the poor woman was so astounded, she nearly fell out of her wheelchair!" recalls Brenda Jordan, ARNP, a nurse practitioner at Dartmouth-Hitchcock at Kendal, who cared for Elsa up until her death last June at age 102. "For a number of years, Elsa also volunteered at Kendal—she would come down to the nursing home early in the morning, always meticulously dressed, to help the nurses get all of the patients to the dining room. She'd help the patients with their breakfast and sit and talk with them. Elsa's compassion and caring for others was just one of the many things that made her such an amazing lady."

Indeed—consider her academic and professional accomplishments. At a time when few women were obtaining higher-level education, Elsa earned Bachelor's and Master's degrees in Nursing from Columbia University and a Doctorate in Education (Ed.D.) from New York University. During her career, she was a nurse and an educator at a number of hospitals in and around New York City. Elsa held many leadership positions at local and state levels, helping to develop curriculum for schools of nursing and winning numerous awards for her service.

"Elsa was devoted to excellent patient care and was truly one of the pioneers of advancing nursing curriculum and moving nursing into the higher education institutions," says Nancy Formella, MSN, RN, President of Mary Hitchcock Memorial Hospital, who got to know Elsa while serving on the Board at Kendal. "She was a person who was ahead of her time, and who I think deserves some of the credit for nursing being viewed as the profession it is today."

To honor Elsa and what she meant both to her community and to the nursing profession, DHMC and Elsa's family and



friends established the Elsa F. Hintze, Ed.D., Excellence in Nursing Endowment in 2006—to support professional development opportunities for nurses employed by DHMC. Much of the support received for the fund was made possible by Elsa's niece, Judy Frank, MD, MS, a former pediatrician at DHMC and strong advocate of nursing who passed away in September of 2008.

"Having no children of her own, Elsa was very dedicated to her family, and was especially close to Judy and her family," says Formella, who has made a generous commitment to the Hintze endowment that reflects her ongoing dedication to outstanding nursing at DHMC. "Taking time to honor people who came before us and who really built the foundation and set the stage for where we are now is very important—it's something that I'd like to see us to do more of," she says.

"One of my favorite memories of Elsa was at Nurse's Week a few years ago," she adds. "We would always ask her to come and participate in presenting the award in her name. We were able to find a copy of a book on surgical nursing that she had contributed to but had somehow lost over the years. When I presented it to her, it was a very emotional moment and Elsa was just speechless. It seemed like a small gesture, but I felt so strongly that I wanted to do something for her because she had done so much for us. She was a delightful person. I really miss her—we all do." ●

Cancer Care Throughout the Whole Continuum

One of the best forms of treatment currently available to patients who have been diagnosed with a blood cancer, such as multiple myeloma or lymphoma, is bone marrow or peripheral blood stem cell transplantation.

"In a blood or bone marrow transplant (BMT), immature blood cells are collected either from the patient or someone with matching blood chemistry and are infused into the patient's blood stream after chemotherapy or radiation," explains Virginia Bayliss, RN, Unit Leader for the Hematology Special Care Unit (HSCU) at DHMC. "Because the chemo or radiation usually kills the bone marrow along with the cancer cells, stem cells are transplanted to allow the bone marrow to regrow and start producing cancer-free blood cells again."

The procedure, which requires several weeks of daily treatment and monitoring, has historically been provided on an inpatient basis only. But now, thanks to a collaborative effort involving inpatient nurses in the HSCU and BMT coordinators in the clinic setting, some patients are able to receive their treatments on an outpatient basis.

Preparing for Transplant

The process starts when patients are referred to DHMC's Norris Cotton Cancer Center for a consult visit with the transplantation team. "We meet with the patients and their families as part of this visit to begin planning and teaching for stem cell transplant," says Lynn Root, RN, Blood and Marrow Nurse Coordinator. "We spend a lot of time initially on education, reviewing things like functional status, mobility, and nutrition to help prepare them for transplantation."

Before a patient is cleared to receive a transplant, an initial course of chemotherapy is often given to reduce the amount of cancerous cells in the blood. Several days of laboratory and diagnostic tests are then performed to determine the patient's detailed medical condition, obtain medical clearance, and decide when the patient is ready to proceed. Blood stem cells are collected from the patient or matching donor by apheresis in the medical center's blood bank or through a bone marrow aspiration. These cells are frozen and stored until it's time to reintroduce them to the patient.

"The entire transplantation process requires a lot of coordination between providers and resources, both in the community and at DHMC," says Root. "We function as part of a large, multidisciplinary team and our role is to make sure that patients get the right care at the right time through the whole continuum."



Collaboration between caregivers (left to right) Idalina Williams, RN, Lynn Root, RN, and Ginny Bayliss, RN, provides a better care experience for cancer patients like Sheila Swett of Norwich, Vt.

Outpatient Treatments

When patients begin the two-step transplant phase—which includes a major course of high-dose chemotherapy, followed by infusion of harvested stem cells—their care is turned over to the nurses in the HSCU.

“If patients have a manageable treatment schedule, if their side effects are predictable, and if they have a full-time caregiver, we’re able to treat them on an outpatient basis,” Bayliss says. “For the actual transplant, though, we typically admit them, since some patients will have a reaction.”

During this phase, patients spend on average three to six hours a day in the unit receiving their treatments. “We watch them closely for things like nausea and fever and react to their lab results, giving them potassium or blood infusions if they need them,” she explains. “We also do any teaching that needs to be done with the patient and their caregiver. “When they’re finished for the day, they’re able to either go home or stay in a local hotel. If they need us, they can call the unit 24/7.”

At discharge, the HSCU nurses turn the patient and family back over to the coordinators for post follow-up care. “The collaboration between our inpatient and outpatient caregivers works very well,” says Root. “It gives patients the highly-specialized care they need during transplant and if any complications arise, while affording them a much-needed break from the hospital. They also get to develop relationships with their care team early on in the process. That makes for a more satisfying care experience—not only for patients and families but also our nursing staff.” ●

Seamless Services:

A Multidisciplinary Approach Across Units

Managing patients who take Coumadin® (known generically as warfarin)—an anticoagulant prescribed to prevent and treat blood clots associated with certain cardiopulmonary conditions—can be a tricky business. If levels of the drug drop too low, the patient's risk of developing a clot that may travel to the brain or lungs increases. If levels rise too high, the patient will be at increased risk for bleeding.

"It's a delicate balancing act," explains Chris DiPaola, RN, an anticoagulation specialist at DHMC who is one of only 64 nurses in the U.S. to hold national board certification in anticoagulation therapy. "Coumadin® has a narrow therapeutic range and treatment for each patient is highly individualized. In addition, factors such as diet, medications, and illness can alter the drug's effectiveness."

Led by Chris DiPaola, RN, DHMC's inpatient anticoagulation service has improved in-range ratios and reduced average length of stay for patients.



Complex patients (with co-morbidities) who have been hospitalized may be at higher risk of slipping out of their therapeutic range. “The approach to anticoagulation therapy can vary, depending on the type of treatment a patient is receiving,” says DiPaola. “And, if there are changes in services—like when a patient moves from the ED to the ICU, then to a medical specialty unit and back to the ICU—that can put them at risk for having something go off kilter with their anticoagulation care plan.”

Providing Seamless Care

As part of an institution-wide effort (launched in 2006) to ensure that these patients are managed optimally across the continuum of care that they receive, DiPaola was asked to help lead a multidisciplinary effort focused on enhancing DHMC’s inpatient anticoagulation services.

“We had started looking at the inpatient setting and realized that there were opportunities to improve care coordination and the discharge process,” she says. Working collaboratively with Edward Merrens, MD, who directs DHMC’s hospitalist services, DiPaola decided to concentrate her efforts on the 1 East and 3 East Medical Specialty Units, where many of the patients needing anticoagulation therapy reside. Today, she still focuses her energies there but also provides consultation to other units when needed.

“A typical day for me includes running reports to determine all patients in house who are on Coumadin®, doing chart reviews, and making rounds to ensure that each patient’s dosing looks appropriate,” explains DiPaola. “If it doesn’t, I’ll page the care team to make a recommendation on a plan to keep them in their therapeutic range.”

Better Outcomes

In addition to doing patient care and teaching, DiPaola provides education to nursing staff and residents, and also carves out some time for research. “Dr. Merrens and I received a grant to do a study measuring the effectiveness of our inpatient anticoagulation service, and were able to show that having an organized consultation service has allowed us to improve our in-range ratios and decrease average length of stay for patients.”

Task forces charged with addressing other aspects of the overall initiative continue to make progress as well. Those inroads include developing a prophylactic order form that is compliant with Joint Commission and National Patient Safety Goal standards, creating a more standardized and seamless transition process between inpatient and outpatient care, and making sure that all protocols are up to best practice standards, says DiPaola, who chairs the DHMC Anticoagulation Committee.

“I think one of the most important things we’ve learned from this process is how important a multidisciplinary approach—one which ideally includes a physician, nurse and pharmacist—is to providing optimal anticoagulation management,” she adds. “The level of collaboration and support that exists here at DHMC is exceptional. As our whole service continues to evolve, we stand to learn so much from each other. And it’s all to the benefit of our patients.” ●

Nurturing Team Dynamics

Between Providers, Caregivers and Patient

Just as Ted Davis and his group had reached the 12,000-foot summit of Mount Hood in Oregon last June, a fast-moving snowstorm enveloped them. "The snow fell so quickly that we had no tracks to follow," recalls Davis. "It took us a long time, but we found our way back down. We also helped a father and son off the mountain. I think we were very fortunate—that same storm killed a climber on Mt. Rainier because his group couldn't find their way down."

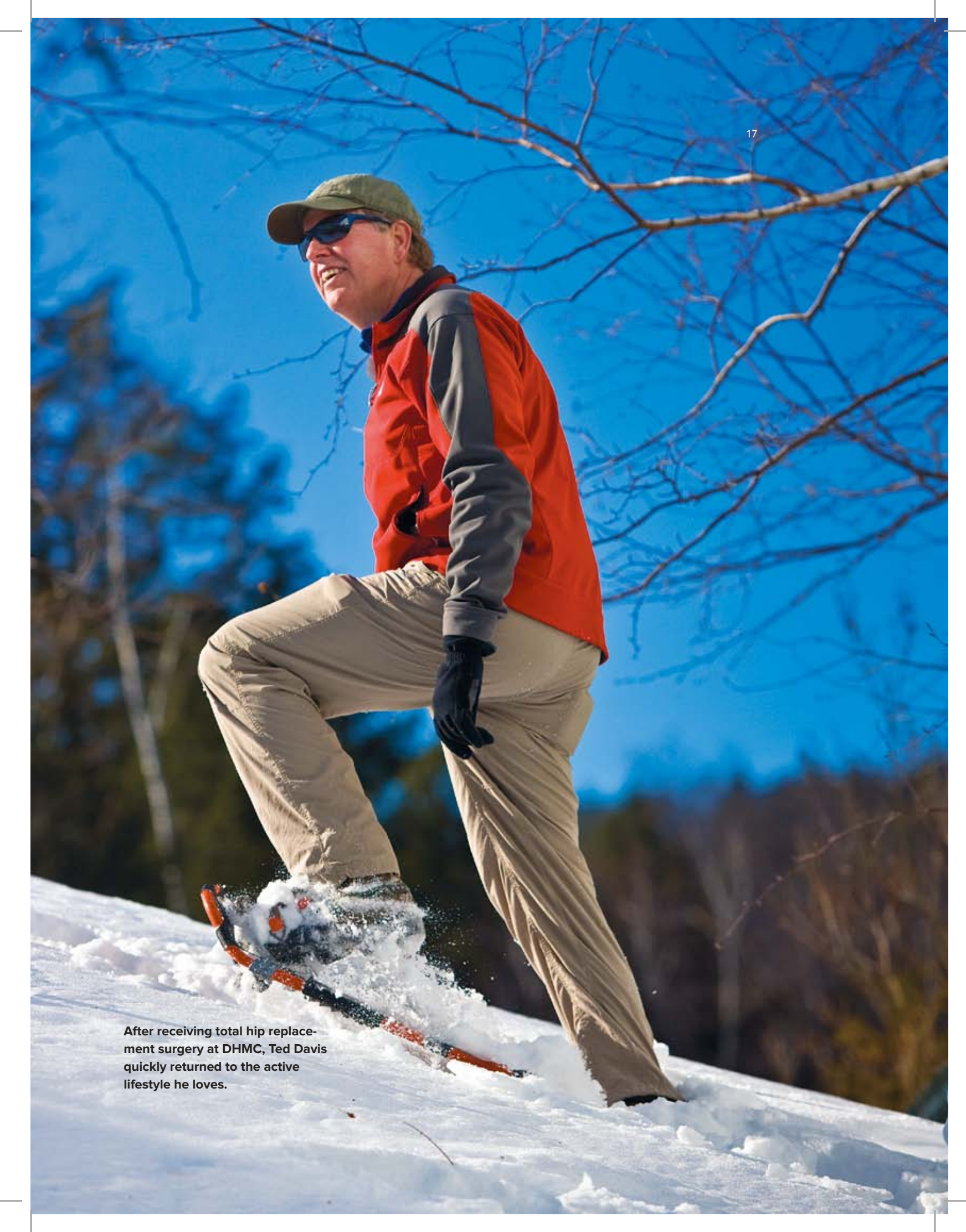
Another remarkable detail in Davis' story is that his 12-hour journey took place only four months (to the day) after having total hip replacement surgery at DHMC. "The care that I received from my surgeon Dr. Stephen Kantor and my entire care team was excellent, and it played a key role in helping me get back to doing what I like to do," says the 55-year-old sportsman who most enjoys the challenge of high-altitude mountaineering. "I felt like the whole care process, from beginning to end, went very smoothly."

Better Education Earlier

Providing high-quality care that feels seamless to the patient has been the goal of an initiative launched by inpatient and outpatient orthopaedic nurses in 2006. "We saw opportunities to make improvements over the continuum of care for patients and families that ultimately also helped to reduce variations in practice and length of stay," says Nancy Karon, RN, BSN, a clinical coordinator on the 3 West Orthopaedics Unit.

"Historically, what would happen is the patient would come in and see their doctor in clinic, they'd book their surgery, then wind up over on 3 West—and maybe they went to class somewhere along the way," explains Deb Jadczyk, BS, RN, nurse coordinator for the Total Joint Arthroplasty Team. "It was impossible for our inpatient nurses to teach patients all they needed to know in the short time they were here at DHMC." Now, patients meet with their doctor and also a nurse (who is assigned to them in clinic) and receive education well in advance of the day of surgery. This includes attending a pre-op class, taught by Jadczyk as well as members of the inpatient nursing team.

Patients receive an educational binder as well as an educational DVD, that include information about preparation for the surgical experience, as well as what to expect in the hospital and once they're discharged. "The DVD, which we've just added recently, includes visual demonstrations of all exercises that are part of the patient's physical therapy program," says Jadczyk. "We

A man in a red and grey jacket, khaki pants, a green cap, and sunglasses is skiing down a snowy slope. He is smiling and looking to the left. The background shows a clear blue sky and bare tree branches.

After receiving total hip replacement surgery at DHMC, Ted Davis quickly returned to the active lifestyle he loves.

wanted to provide our patients with a comprehensive package of information that was theirs to keep and refer to over time—the concept of patients working in partnership with their care team is very important at DHMC.”

“I found the materials and the pre-op class to be very valuable,” says Davis. “You go over everything you need to know about your procedure ahead of time while you’re clear-minded, as well as things you’ll need to be focused on afterwards like precautions and physical therapy, so you feel well-prepared for your hospitalization and recovery phase. It was also comforting to be with other people in the class that were in the same situation. And, the nurses were accessible, helpful, and friendly whenever I had questions about anything—I felt well cared for.”

Tighter Coordination

One of the main differences in the new model of care versus what was done in the past is the number of nursing interventions that take place at pivotal points in the care process, not only with patients but also between the care teams themselves.

Nancy Karon, RN, BSN (top), and Deb Jadcak, BS, RN. “We no longer think of ourselves as ‘inpatient’ or ‘outpatient’—we think of ourselves as ‘the team.’”



"It allows us to start our coordination of care earlier," says Karon. "For example, the plan of care that's filled out in clinic for each patient gets forwarded over to the inpatient team. Then a daily 'huddle' takes place where the multidisciplinary team talks about the patients coming in the next day. For patients with special needs, we receive the information well in advance. In all cases, this allows us to be better prepared to meet each patient's individual needs."

"Overall, I think it's really brought inpatient and outpatient nurses together," says Jadcak. "Our roles are different, but our goal to provide quality care to our patients in a manner that feels seamless is the same. And it's truly changed the way that we approach our work. We no longer think of ourselves as 'inpatient' or 'outpatient'—we think of ourselves as 'the team.'"

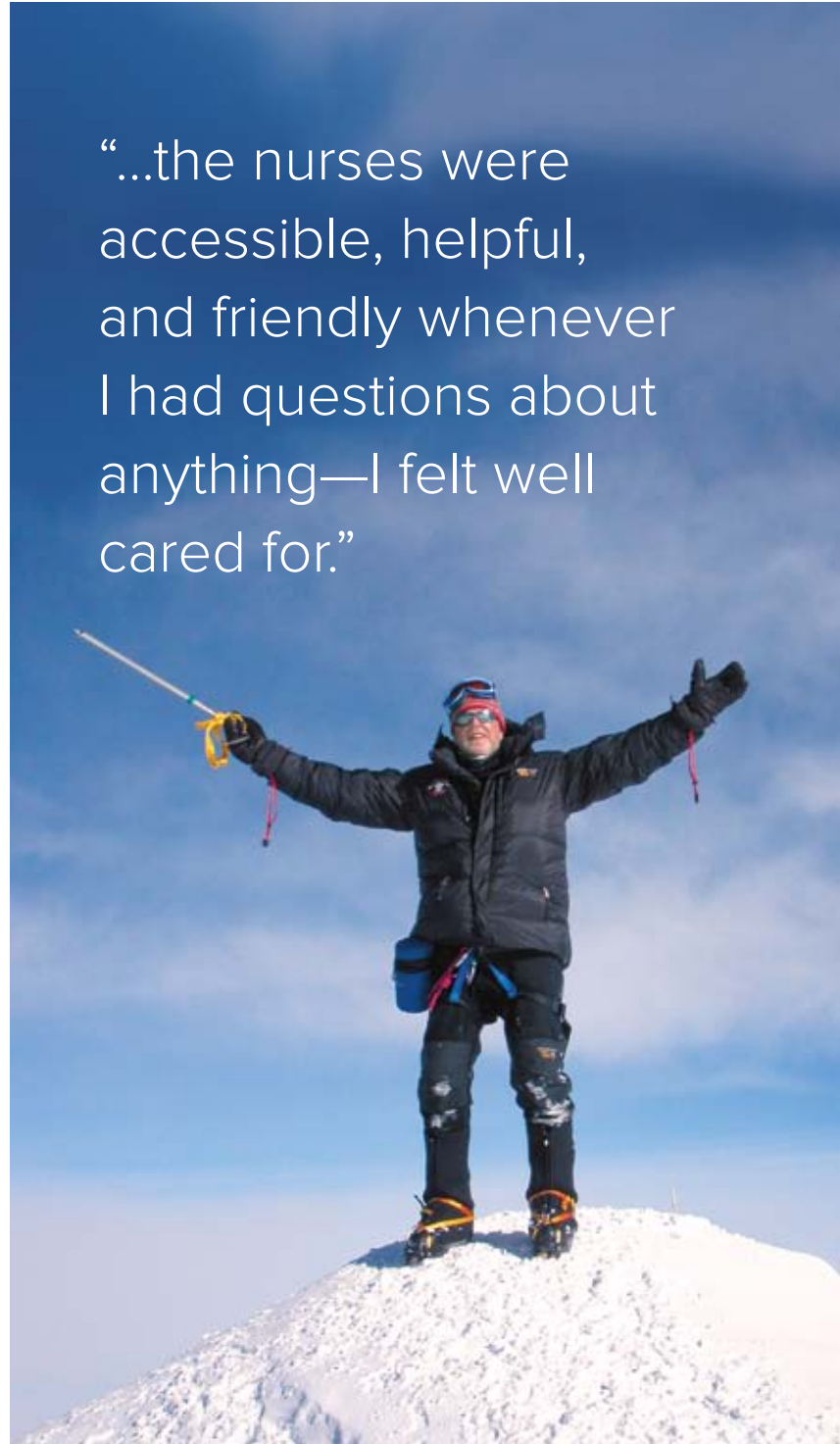
Onward and Upward

Davis' new hip has functioned very well, allowing him to resume all of his favorite activities, which include biking and kayaking. But nothing calls to him like high-altitude mountaineering. "As T.S. Eliot once wrote, 'Only those who will risk going too far can possibly find out how far they can go,'" he explains. "And planning these various climbing expeditions really motivates me to train hard and to stay in optimal shape."

In 2009, Davis plans expeditions to Mexico, Oregon and Washington to climb Mount Orzibal (18,800 feet), Mount Hood (11,249 feet) and Mount Rainier (14,411 feet). He hopes for better weather conditions this time around. "Though my other hip isn't bothering me right now, I know from Dr. Kantor that I'll need to have it replaced as well at some point," says Davis. "When that time comes, I won't hesitate to go back to DHMC."

Ted Davis atop Alaskan peak, Danali, in 2005. In June 2009, he plans to climb Mount Hood in Oregon and Mount Rainier in Washington.

"...the nurses were accessible, helpful, and friendly whenever I had questions about anything—I felt well cared for."



Central Coordination, Better Patient Outcomes

An increasing incidence of diabetes. A traditional resistance to treating hospitalized patients aggressively with insulin. New standards for tighter glucose control of patients in the hospital. These factors were all in play five years ago when DHMC began an institution-wide effort to improve the care of its patients with diabetes.

“Under the leadership of our medical director, Dr. John Butterly, we formed a diabetes quality improvement group to look at improvement opportunities,” says Mary Wood, RN, Diabetes Clinical Nurse Specialist, who provides education for staff, nurses, and patients. “One area of focus was the inpatient setting. Prior to that time, no authoritative body had given us guidelines for what a blood sugar should be when a patient is in the hospital. But with the new standards, there was clear recognition that tighter blood sugar control could make a difference in patient morbidity and mortality.”

Danielle Basta, ARNP, (left) and Jeanne Jacoby, ARNP, provide tighter glucose management for inpatients, helping them to recover more quickly and to go home faster.



Meeting New Standards

To help the group meet these new standards, DHMC created two new nurse practitioner positions (under the Section of Endocrinology) to focus on the medical management and glucose control of patients in the hospital. In 2007, Danielle Basta, ARNP, and Jeanne Jacoby, ARNP, began offering this expertise to all inpatient units.

There are a number of reasons why patients with diabetes who are hospitalized for a serious illness or injury can be difficult to manage. "One is that their care teams are understandably focused on their primary diagnosis, which is not usually their diabetes," explains Basta. "And each patient responds differently to a unit of insulin, so every day the doses need to be evaluated and adjusted for the individual patient. This can be especially tricky if a patient is poorly controlled, very ill, or if they have some intricate medical problems. That's usually when we're called."

"Another reason is that the guidelines we have now for tight blood sugar control in the hospital are fairly new," says Jacoby. "There is still a tendency for people (not just at DHMC but everywhere) to fall back on the traditional, 'sliding scale' way of treating blood sugars, which is to only treat if it's high, because of the fear of causing low blood sugars in the hospital. But we now know that giving insulin proactively is actually safer and better for the patient. It helps them to recover more quickly, to feel better faster, and to be able to go home sooner."

Making a Difference

Internal studies conducted by the Section of Endocrinology confirm that the service is helping DHMC to achieve better patient outcomes. "I think that reflects not only that our approach is effective, but also that the staff are doing an excellent job identifying problems with patients and working with us to improve their care," says Basta.

This cross-collaboration includes close coordination with Wood to ensure that patients' educational needs are met, and developing a plan of care that extends through the discharge process. "Whenever Jeanne and Danielle discharge a patient, they always arrange a follow-up visit and send a note to the primary care provider," says Wood. "We provide very clear information to the patient about how their treatment is going to change once they get home and how they will need to monitor and make adjustments for that change."

"Even though we are inpatient-focused, I think that our approach strongly supports improving care across the continuum for patients," says Jacoby. "Whether they're here or at home, our efforts help to make sure that their diabetes continues to be an important diagnosis that requires constant attention." ●

Managing the Passage

Chronic Illness from Childhood to Adulthood



It's a cold, dreary afternoon in November, but Tyler Howard isn't going to complain about the weather. "Aside from school, it's one of the few chances I have to get out of the house," he says of his regular visits to the medical center, with a smile.

Howard, an 18-year-old quadriplegic who is totally dependent on a ventilator, has been coming to DHMC's Children's Hospital at Dartmouth since age three, when a disorder called transverse myelitis left him paralyzed from the neck down with a complex set of medical issues. "One recent complication that I'm being treated for is a blood clot in my left leg," he says.

Despite having to deal with these challenges, Howard recently began making the trips to and from his home in Charlestown, New Hampshire, without his parents, and now sees adult rather than pediatric providers for his primary care. "It feels good to be able to transport as an adult (with my nurse) and to be able to start to make some healthcare decisions directly with my doctors and care team," he says.

Meeting the Challenges

Howard is one of about a dozen chronically-ill patients with significant disabilities who have successfully made this transition over the past two years, thanks to a collaborative effort between Pediatrics and General Internal Medicine (GIM).

But transition planning, which state and national healthcare agencies are now encouraging more hospitals to do, can be a difficult process. "In the past, a lot of kids like Tyler didn't live to be adults—they had only pediatric caregivers," explains Ellen Heuduska, RN, a Continuing Care Man-



ager in Pediatrics who coordinates the transition program. "But because of advances in medicine and technology, many now live well into adulthood."

This has created a number of new challenges for patients, families, and adult providers. "There's just so much involved in caring for these kids, and a lot of things change as they reach adulthood—including their care needs, insurance,

Tyler Howard, with Susie Whitcomb, RN, has successfully transitioned from pediatric to adult providers for his primary care.

“It’s tough to deal with some days; there aren’t any good services available in the community for people like me.”

and the community services that they’re eligible for,” says Heuduska. “And then you have the parents who have been involved in every aspect of their kid’s care and still see them as children; you have adult providers who are unfamiliar with this patient population and all of their special needs; and you have the patient who’s gotten to know their whole pediatric team so well they’re like a second family. Making that transition can be scary for patients and families.”

“I was a little afraid at first about meeting new medical staff and having them learn all of my care,” says Howard. “But the transition has been gradual, and I think it’s worked really well. The doctors, nurses, and other staff that I’ve met are very nice, and they’ve made me feel comfortable. I feel more at ease knowing that they’re going to listen to me and to what I need.”

A System for Transitioning

More than two years ago, a committee was formed by members of Pediatrics and GIM for the purpose of developing a system to transition patients who “age out” of Pediatrics and have complicated chronic care issues.

Each December, the pediatric providers are asked to identify the patients on their panel who are eligible for



Lynn Blenfleck, RN, who cared for Tyler when he was a young child, stops by to say, “Hi.”



Susie Whitcomb, RN, with Tyler, who now transports as an adult to his appointments and interacts directly with his care team.

transition and who may require assistance with the process. Those patients are then contacted either by Heuduska or her social work partner, Maureen Kaplan, LICSW, with the offer of care management transition services.

“We in pediatrics prepare a detailed patient summary and send it to GIM,” says Heuduska. “Charles Hoag, RN, Nurse Manager in GIM, does a great job working with GIM providers to match the patient with the right team. We then have a transition meeting which includes the patient and family, the primary care provider in Pediatrics, the new team in GIM, and myself. We talk about the patient’s care, what the current issues are, and begin the transition. Tyler’s care, for example, involves a lot of phone support, so I’m staying involved for a while to help make the transition as smooth as possible.”

Becoming More Independent

Over the past six months, the transition program has helped Howard to function more independently—for example, he now works directly with his home healthcare providers. And since graduating from Fall Mountain High School last June, he has been taking college preparatory classes.

“There’s a group from ATECH Services that’s been helping me with assistive technology for my wheelchair,” he says. “We found a new piece of equipment called the Quad Joy Mouse that I’m really excited about. It’s opened up a whole new world for me in terms of what I can do on the computer—I’m looking to go into a graphic design field after college.”

Still, living with a significant disability and chronic illness has many challenges. “It’s tough to deal with some days; there aren’t any good services available in the community for people like me,” explains Howard. “I mean, I love my mom and stepdad but like any teenager, I don’t want to be stuck with them twenty four seven. And when I see people walking around, like friends coming and going, and they’re able to drive cars and do other things, it’s a reminder of what I don’t have. But, I feel very privileged to have such a great family and medical team supporting me. I give them all the credit in the world, and I thank them from the bottom of my heart.” ●

“When I see people walking around, like friends coming and going, and they’re able to drive cars and do other things, it’s a reminder of what I don’t have. But, I feel very privileged to have such a great family and medical team supporting me. I give them all the credit in the world, and I thank them from the bottom of my heart.”



A Single System of Care

For Patients, Visitors and Employees

On July 4, 2008, DHMC's Lebanon campus became smoke-free and tobacco-free. This accomplishment represented an important milestone in the medical center's goal to achieve the healthiest population possible in its region. It also served as an anchor point for a series of tobacco-free initiatives launched in recent years to support patients, visitors, and employees in the inpatient and outpatient settings.

A concerted effort to improve tobacco cessation resources for inpatients began in early 2006 when members of DHMC's Tobacco Treatment Taskforce secured a grant from the New Hampshire Department of Health and Human Services. "The group developed a standardized process for offering tobacco cessation advice and assistance to hospitalized patients," says Ellen Prior, RN, a tobacco treatment specialist (TTS) who focuses on developing tobacco treatment systems and coordinating tobacco resources at DHMC.

This work has included partnering with the New Hampshire Tobacco Prevention and Control Program to educate clinicians about the U.S. Public Health Service Guidelines 5As (Ask, Advise, Assess, Assist and Arrange) Model; establishing physician order sets for tobacco use admission forms; and developing educational packets for adult, pregnant, and teen patients, which include a listing of local resource programs.

Training Treatment Providers

Though grant funding ended in 2006, the group has continued to expand its efforts, taking advantage of the tools and momentum created. It has recruited a large number of clinicians to be



part of a tobacco treatment team, making scholarships available for advanced training through the University of Massachusetts Medical School.

“The role of the tobacco treatment team is to act as an educational resource for their unit or clinic and the community,” explains Prior. “They also facilitate referrals to New Hampshire and Vermont quit lines, which have shown to be an effective counseling strategy for people. A number of team members have become certified as tobacco treatment specialists (TTS) and regularly provide consultations throughout our facility.”

In addition, TTS team members rotate their schedules to offer two-hour clinic interventions twice a week in DHMC’s Health Education Center. “We average between 15 and 20 people per clinic—folks who come in for an appointment, as walk-ins, or who are just interested in getting a carbon monoxide (CO) screening,” she says. The team also partners with organizations like the American Cancer Society throughout the year to provide CO screenings and educational displays in high-traffic areas throughout the medical center.

A Tobacco-Free Environment

To help maintain a tobacco-free campus, DHMC provides nicotine lozenge “comfort packs” for clinic patients and visitors. “We want folks to know that it’s a tobacco-free campus campaign, not an anti-smoker campaign,” Prior says. “We understand that tobacco dependence is a chronic condition that often requires repeated intervention.”

DHMC’s thoughtful planning and extensive communication around the tobacco-free campus initiative prompted many of its employees who have used tobacco to seek help in quitting before the July 4 “go live” date. “Through the Health Improvement Program, employees can receive personalized quit support from trained specialists, and through their health benefit also receive full coverage for nicotine replacement therapy or cessation medications,” she says. “This is key, as research shows that medication and counseling give people the best chance of quitting and remaining tobacco-free.”

“Over the past couple of years, we’ve accomplished a lot in terms of building a system of care here to address tobacco addiction,” adds Prior. “Whether you’re a patient in the hospital or in the clinic, a visitor or an employee, we have trained specialists and resources in place to help you.” ●



Tobacco treatment team members Ellen Prior, RN (opposite page), and Megan Doty, RN (above), provide carbon monoxide screenings and education throughout the medical center.

DHMC NURSING SHOWCASE

Certifications

AACN Certification Corporation

Progressive Care Certified Nurse

Reginald F. Babin, RN, PCCN

Critical Care Nurse

Andrew Jones, RN, BSN, CCRN, CEN, CFRN

JoElla McCarragher, RN, MSN, CCRN

Jason Moores, RN, CCRN

Patrick O'Connell, RN, CCRN

Julie Pratt, RN, BSN, CCRN, EMT-Paramedic

Karen Ryan, RN, CCRN

Nancy Stanhope, RN, CCRN

Patricia Vinson, RN, CCRN

Tracy Webster, RN, CCRN

American Board of Neuroscience Nursing

Certified Neuroscience

Registered Nurse

Judy Graham, RN, CNRN

ABPANC American Board of Peri-Anesthesia Nursing

Certified Ambulatory Peri-

Anesthesia Nurse

Ellen Chaput, RN, CAPA

Pamela Higgins, RN, BSN, CAPA

Celeste Wetherell, RN, BSN, CAPA

Doris Williams, RN, BSN, CAPA

ANCC American Nurses Credentialing Center

Adult Nurse Practitioner

Brenda Jordan, ARNP, MS, APRN-BC

Certified Pediatric Nurse

Stacy Dube, RN-BC, BSN

Clinical Specialist in Gerontological Nursing

Brenda Jordan, ARNP, MS, APRN-BC

Family Nurse Practitioner

Brant Oliver, ARNP, MSN, FNP-BC

June Rhoda, ARNP, MSN, FNP-BC

Anna Schaal, ARNP, MSN, FNP-BC

Medical Surgical Nursing

Abby Dowling, RN-BC, BSN

Angela Price, RN-BC

Nursing Professional Development

Veronica A. Daley, BSN, RN-BC, CNN

Amy Eilertsen, MN, RN-BC

Jean Picconi, RN-BC, MSN

Mary Catherine Rawls, RN-BC, MS, ONC

Psychiatric and Mental Health

Certified Nurse

James Biernat, RN,

Psychiatric Mental Health Nurse

Practitioner/Adult Psychiatry

Brant Oliver, ARNP, MSN, PMHNP-BC

Board of Certification for Emergency Nursing

Certified Emergency Nurse

Matthew Choate, RN, BSN, CEN

Tara Levicy, RN, CEN

June Stacey, RN, BSN, CEN

Cathryn Zampieri, RN, CEN

Certified Flight Nurse

Tracy Webster, RN, CFRN

CCI Competency and Credentialing Institute

Certified Nurse Operating Room

Elizabeth Jones, RN, BSN, CNOR

Lisa Puccio, RN, BSN, CNOR

Infusion Nurses Certification Corporation

Certified Registered Nurse Infusion

Lorrie Kelly, RN, CRNI

Katherine Rutledge, RN, BSN, BC, CDE, CRNI

International Board of Lactation Consultant Examiners

Certified Lactation Consultant

Kathleen Craig, RNC, BSN, IBCLC

Ann Martel-Marton, RN, IBCLC

IOMSN International Organization of Multiple Sclerosis Nurses

Specialty Certification in Multiple Sclerosis

Brant Oliver, ARNP, MSN, MSCN

National Association of Orthopaedic Nursing

Orthopaedic Nursing

Tracie Farley, RN, ONC

Nancy Karon, RN, BSN, ONC

Michael Perryman, RN, ONC

Mary Catherine Rawls, RN-BC, MS, ONC

Jaime Wetmore, RN, BSN, ONC

Andrea Wyle, RN, BSN, ONC

National Board for Certification of Hospice and Palliative Nurses

Advanced Certified Hospice and Palliative Nurse

Ann Frego, RN, CHPN

Brenda Jordan, ARNP-BC, CHPN

Joanne Sandberg-Cook, ARNP, CHPN

National Certification Board for Diabetes Educators

Certified Diabetic Educator

Katherine Rutledge, RN, BSN, BC, CDE, RNCI

National Certification Corporation

Inpatient Obstetric Nursing

Kathleen Craig, RNC, BSN, IBCLC

Mary Scott-Macnow, RNC

Neonatal Intensive Care Nursing

Tammy Lambert, RNC, BSN

Brenda Martin, RNC

Karen Vergura, RNC, BSN

Oncology Nursing Certification Corporation

Oncology Certified NurseCalc

Stacey Aldrich, RN, BSN, OCN

Loraine Brenner, RN, BSN, OCN

Anita Concilio, RN, OCN

Monica Esch, RN, BSN, OCN

Jennifer R. Holl, RN, BSN, OCN

Elizabeth Lewis, RN, OCN

Tracy J. Ramsay, RN, BSN, OCN

Rebecca Thurner Longley, RN, BSN, OCN

Sallie Yurkosky, RN, OCN

Heather Zelonis, RN, OCN

SOCRA Society of Clinical Research Associates

Certified Clinical Research Professional

Betsy Greene, RN, BSN, MBA, CCRP

J. Dean Jarvis, RN, BSN, MBA, CCRN, CCRP

University of Massachusetts Medical School

Certified Tobacco Treatment Specialist

Elizabeth Maislen, ARNP, CTTS

Wound, Ostomy and Continence Nursing Certification Board

Certified Wound Care Nurse

Carmeleta Beidler, RN, BSN, CWCN

Education Updates

Claudette Brochu, RN, BSN, CCRN received a Bachelor of Science degree in Nursing degree from the University of Phoenix.

Judith Dixon, RN, MSN, received a Master of Science in Nursing degree with a Community and Public Health Specialty from the University of Vermont.

Ellen M. Lavoie Smith, PhD, APRN, BC, AOCN received a PhD from the University of Utah.

Karli Nissenbaum, RN, BSN, received a Bachelor of Science degree in Nursing degree from Kaplan University

Brant J. Oliver, ARNP, MSN received a Master of Public Health (MPH) degree from Dartmouth Medical School, NH.

Tracy J. Ramsay, RN, BSN, OCN received a Bachelors of Science in Nursing degree from Excelsior College.

Scholarships Awarded

Madlyn R. Smith
Promise Award

Catherine Mayer, RN, BSN, OCN
Medical Hematology Oncology

Anna Hoobing Smith
Promise Award

Virginia Beggs, ARNP, MSc
Heart Failure and Cardiomyopathy Program, Section of Cardiology

Marisa Smith
Promise Award

Joann Frampton, RN
Comprehensive Breast Program

Elsa Frank Hintze Magnet
Scholarship for Nursing Excellence

Sheila Keating, RN
Otolaryngology

Linda Nekoroski, RN
Pediatrics

The Levine Nursing
Continuing Education Award

Melissa Dell'Api, RN, MSc
ICN

Gladys A. Godfrey
Scholarship

Jaime Godin, LNA
Birthing Pavilion

Evidence-Based Practice
Scholarship

Katie Steuer, RN, BSN, CNOR
Operating Room

Katherine Rutledge, RN, BSN, BS, CRNI, CDE
IV Team

Susan Bartlett, RN
Birthing Pavilion

Tricia Barr, RN
Anesthesia



Katelyn Sheaff, RN, BSN, with patient Marilyn Bedell on 3 West .

DHMC NURSING SHOWCASE

**James W. Varnum
Scholarship Awards**Pursuing Associate's Degree in
Nursing:**Karen Appleton, LNA**
Inpatient Surgery**Lora Fleming, LPN**
Specialty Medicine Float**Robin Goodrich**
Pediatric Resource Specialist**Regina Keating, LPN**
Medical Hematology Oncology**Sarah Knight, LPN**
General Surgery**Rebecca Pratt, LPN**
Dartmouth Hitchcock Keene**Laura Salas**
Certified Surgical Technologist**Nichole Sorenson, RN**
Peri-operativePursuing Bachelor's Degree in
Nursing:**Teresa Banks, RN**
CVCC**Michelle Buck, RN**
Deployment Team**Lisa Carter-White, RN**
Operating Room**Jo-Anne Dombrowskas, RN**
ICCU**Tina Durgin, LPN**
Dermatology Clinic**Karen Ekstrom, RN**
Neuroscience**Nicola Felicetti, RN**
Medical Specialties**Lise Fex, RN**
Inpatient Surgery**Lindsay Hitchcock, RN**
Cardiac Clinical Resource Coordinator**Sharon Houle, RN****Sheila Keating, RN**
ENT Clinic**Constance McCoy, RN**
Plymouth Pediatrics**Teresa Moulton-McKinley, RN**
Emergency Department**Kathleen Nielsen, RN**
Clinical Resource Coordinator**Carissa Thurston, RN, CNRN**
Neurosurgery**Todd Walker, RN**
Operating Room**Kristina Waters, LNA**
CVCC**Allison Weglarz, RN**
Medical Specialties**Kathy Whitcomb, RN, CRRN**
Neuroscience Special Care
UnitPursuing Master's Degree in
Nursing:**Olushola Alaka, RN, BSN**
CVCC**Meghan Beaulieu, RN, BSN**
ICN**Deborah Cantlin, RN**
Family Medicine Clinic**Karen Chandler, RN, CCRN**
CVCC**Kathleen Craig, RNc, BSN,**
IBCLC
Birthing Pavilion**Evelyn Hanscom, RN, BSN**
PACU**Colleen Harrington, RN, BS,**
MEd
Operating Room**Lorraine Leonard, RN, BSN/
HSM**
Operating Room**Patricia Mock, RN BSN CCM**
Care Management**Justin Montgomery, RN, BSN**
Healthy Aging Center**Rosanne Palmer, RN, MSN**
Cardiology Admissions Access
Nurse**Allison Winchester, RN, BSN**
ICN**Jessica Wood, RN, BSN**
Birthing PavilionPursuing Doctorate of Nursing
Practice:**Wendye DiSalvo, ARNP, MSN,**
AOCN
Hematology/Oncology**Deborah Pullin, ARNP**
CHaD Child Advocacy and Pro-
tection Program

Karen Pippin,
Nursing Assistant,
works with a patient in
in Radiation Oncology.

Grants Awarded

Marie Bakitas, ARNP, DNSc, FAAN, was the Primary Investigator for the National Palliative Care Research Center; Junior Faculty Career Development Award; mentored by Hilary Llewellyn Thomas, PhD, for a project titled "Decision-making and Decision Support Needs of Women with Metastatic Breast Cancer."

Marie Bakitas, ARNP, DNSc, FAAN, was the consultant at the National Cancer Institute: PHS 2008-1; Topic Number: 246; Title: "Integrating PRO in Hospice & Palliative Care"; (Primary Investigators: Weiss, Byock, Rabow).

Brant J. Oliver, ARNP, MSN, received a grant from Bayer Healthcare for a project titled "Self-efficacy Improvement in Multiple Sclerosis: A 12-month Pilot Study of a New Psycho-educational Intervention for Self-efficacy and Immunotherapy Treatment Adherence."

Ellen Lavoie Smith, ARNP, PhD, AOCN, received a Clinical Translational Science Award (CTSA) for a project titled "Assessing the Challenges of New Hampshire's Cancer Survivors" at the Dartmouth Center for Clinical and Translational Science (DCCTS).

Other Awards

Judith Dixon, RN, MSN, received the *Award for Clinical Excellence*. This award is given to one graduate nursing student each year from the Vermont State Nurses Association.

Peter Nolette, RN, BSN, MBA, CWCN, was one of three recipients of *The James W. Varnum Quality Health Care Award*. This award recognizes employees or volunteers whose work embodies a deep commitment to creating and sustaining an environment of high quality patient- and family-

centered care at Dartmouth-Hitchcock Medical Center.

Anna Schaal, ARNP, MSN received the *Advanced Practice Nursing Excellence Award* for Academic Accomplishments.

Arete Awards:

Rhonda Dowling, RN
Same Day Program

Monica Esch, RN, BSN, OCN
Radiation Oncology

Justin Harris, RN, BSN
Pediatric Intensive Care Unit

Mary Hoh, RN
Operating Room

Helen Huff, RN
Intensive Care Unit

Deborah Jadczyk, BS, RN
Outpatient Orthopaedic Surgery

Dong Sun Kim, RN
Inpatient Surgery

Patty Macleay, RN
Post Anesthesia Care Unit

Mandy Martel, RN
Birthing Pavilion

Marjorie Renee Martin, RN
Medical Hematology

Jason Moores, RN, CCRN
Cardiovascular Critical Care Unit

June Motyka, RN
Inpatient Surgery

Denise Nykiel, RN
Medical Specialties

Barbara Power, RN, MBA
Neuroscience Special Care Unit

Katherine Rutledge, RN, BSN, BS, CRNI, CDE
IV Services

Karen Sheehan, LPN
Dermatology

Katherine Stevenson, RN
Inpatient Surgery

Tiffany Sykes, RN
Intermediate Cardiac Care Unit

Bethany Truell, RN, BSN
Medical Specialties

Robin Wagner, RN, BSN
Psychiatry

Susan Whitcomb, RN
Pediatric Outpatient Services

Penny Willoughby, RN, BSN
Care Management

Cindy Wolkin, RN
Vascular Surgery

Professional Activities

Suzanne Beyea, RN, PhD, FAAN

- Member: National Patient Safety Foundation Research Grant Review Committee
- Member: United States Pharmacopeia's Safe Medication Use Expert Panel
- Member: Sigma Theta Tau International: Renewable Gifts Committee
- Editorial Board: AORN Journal

Meg Bourbonniere, PhD, RN

- Reviewer for: Research in Geriatric Nursing, American Journal of Nursing, Journal of the American Geriatrics Society, Geriatric Nursing
- Member, Technical Advisory Committee, Health Effects Related to Airport Activity, RI Department of Health
- Session Chair, Education II, 61st Annual Scientific Session, Gerontological Society of America

Ellen Ceppetelli, RN, MS, CNL

- Board of Advisors, NIOSH Education & Research Center, Occupational Safety and Health, Harvard School of Public Health, Chair 08-09

Matthew Choate, RN, BSN, CEN

- President, Upper Valley Chapter, AACN (American Association of Critical Care Nurses) 2008-09
- President-Elect, Vermont State Council, ENA (Emergency Nurses Association) 2008-2010
- Chair, Government Affairs Committee, Vermont State Council ENA, 2008
- Elected to the Vermont State Senate, November 2008 (will serve 2009-2010)

DHMC NURSING SHOWCASE

Professional Activities (cont.)

F. Joe Desjardins, Med, BSN, RN-BC

- Chairperson, Informatics Committee, National Nursing Staff Development Office

Amy Eilertsen, RN-BC, MN

- Reviewer for Clinical Simulation in Nursing

Kyle Madigan, RN, CFRN, CEN, CCRN, CTRN

- President- Elect, Air & Surface Transport Nurses Association

Maureen Quigley, ARNP

- Member of Integrated Health Program Committee, ASMBS (American Society for Metabolic and Bariatric Surgery)
- Member of ASMBS RN Certification Exam Review Committee
- Exam writer, ASMBS RN Certification Exam
- Co-chair ASMBS Advanced Practice Networking Group
- Member ASMBS Advanced Practice Preceptorship Committee

Anna Schaal, ARNP, MSN

- Member, Putting Evidence into Practice (PEP) Project Team for Prevention of Bleeding Resource Card, Oncology Nursing Society.

Ellen Lavoie Smith, ARNP, PhD, AOCN

- Chair, Oncology Nursing Committee, Cancer and Leukemia Group B Organization

June Stacey, RN, BSN, CEN

- President-Elect, Vermont State Council, Emergency Nurses Association

Linda von Reyn, RN, PhD

- Board of Directors, Kendal at Hanover

Publications

Bakitas M., Ahles, T.A., Skalla, K., Brokaw, F., Byock, I., Hanscom, B., Lyons, K.D., & Hegel, M.T. (2008). *Proxy perspectives about end-of-life care*. *Cancer*, 112(8),1854-1861.

Bakitas, M., & Barnett, K. (2008). Palliative and End of Life Care: In *All-in-one Care Planning Resource: Medical, Surgical, Pediatric, Maternity, and Psychiatric Nursing Care Plans*. 2nd edition, ed. P. Swearingen. St. Louis: Mosby. Pp. 105-116.

Beyea, S. C. (2008). *Being a patient safety leader*. *AORN Journal*, 87(1),221-223.

Beyea, S. C. (2008). *Are You "Just a Nurse"?* *AORN Journal*, 87(2), 441-442, 444.

Beyea, S. C. (2008). *Learning more about the science of patient safety*. *AORN Journal*, 87(3), 633-635.

Beyea, S. C. (2008). *Placing patient safety first*. *AORN Journal*, 87(4), 829-831.

Beyea, S. C. (2008). *Actively participating in an organization's safety initiatives*. *AORN Journal*, 87(5), 1011-1013.

Beyea, S. C. (2008). *Keeping nurses safe*. *AORN Journal*, 87(6), 1237-1239.

Beyea, S. C. (2008). *Speaking Up for Quality and Safety*. *AORN Journal*, 88 (1), 115-116.

Beyea, S. C. (2008). *2009 Patient Safety Goals: A Perioperative Nursing Priority*. *AORN Journal*, 88(2), 459-462.

Beyea, S. C. (2008). *Promoting a culture of safety by addressing bad behavior*. *AORN Journal*, 88(4), 637-639.

Beyea, S. C. (2008). *Exploring online resources for perioperative nurses*. *AORN Journal*, 88(5), 825-826.

Beyea, S. C. (2008). *Published resources for improving patient care*. *AORN Journal*, 88(6), 10091011.

Bourbonniere, M., & Strumpf, N. E. (2008). *Enhancing geriatric nursing competencies for RNs in nursing homes*. *Research in Gerontological Nursing*,1,171-175.

Desjardins, Joe F. (2008) *Budgeting for Nursing*, in Sandra Bruce (Ed.), *Core Curriculum for Staff Development*, 3rd ed. Pensacola, FL: National Nursing Staff Development Organization.

DiSalvo, W. M., Joyce, M. M., Tyson, L. B., Culkun, A. E., & Mackay, K. (2008). *Putting Evidence Into Practice: Evidence-based interventions for cancer-related dyspnea*. *Clinical Journal of Oncology Nursing*, 12(2), 341-352.

Levin D.L., Garg A., Hall L.J., Slogic S., Jarvis J.D., & Leiter J.C. (2008). *A prospective randomized controlled blinded study of three bronchodilators in infants with respiratory syncytial virus bronchiolitis on mechanical ventilation*. *Pediatric Critical Care Medicine*. 9(6), 598-604.

Madigan, Kyle (2008). *Now, intraosseous infusions for adults*. *American Nurse Today*, (3), 11-12.

Maynes, R. (2008). *Human patient simulation in ambulatory care nursing*. *AAACN Viewpoint*, 30(1), 1.

Montgomery, J., & Mitty, E. (2008). *Assisted living column. resident condition change: Should I call 911?* *Geriatric Nursing*, 29(1), 15-26.

Oliver B.J. (2008). *Screening and treatment of depression in multiple sclerosis*. *International Journal of MS Care*, 10(1), 50.

Oliver B.J., Ryan K.A., Boyle L., Wishart H., Flashman L., Stevenson J., Stewart J., Yazinski N., Bowen S., & Kasper L.H. (2008). *Targeted psycho-educational intervention in multiple sclerosis*. *International Journal of MS Care*, 10(1), 28.

Proehl, Jean A. (2008). *Emergency Nursing Procedures*, 4th Ed. St. Louis: Saunders-Elsevier. The following DHMC nurse authors have contributed chapters to the above book:

- **Stacey, J.** Phlebotomy for Laboratory Specimens; Central Venous Pressure Monitoring; Lumbar Puncture; Paracentesis; Emergency Childbirth; Ear Irrigation.
- **Quigley, M.** Therapeutic Phlebotomy; Wound Anesthesia: Local Infiltration and Topical Agents; Positioning the Hypotensive Patient; Doppler Ultrasound for Assessment of Blood Pressure and Peripheral Pulses; Eye Irrigation; Suture Removal; Staple Removal; Fluorescein Staining of Eyes; Assessing Visual Acuity.

Rhoda, June E. (2008). *Radiation Exposure and Computed Tomography in the Emergency Department*. *Advanced Emergency Nursing Journal*. 30(3), 271-282.

Schaal, A.D., Skalla, K., Mulrooney, T., Stearns, D., Smith, E. (2008). *Building a collaboration of Hematology-Oncology Advanced Practice Nurses Part 2: Outcomes*. *Oncology Nursing*. 35(6), 875-878.

Skalla, K. A., & Caron, P. A. (2008). *Leadership & professional development. building a collaborative hematology/oncology advanced nursing practice: Part I*. *Oncology Nursing Forum*, 35(1), 29-32

Smith, E. L. (2008). *Clinimetric Properties of Chemotherapy-Induced Peripheral Neuropathy (CIPN) Measurement Approaches*. University of Utah College of Nursing. Published dissertation.

Smith, E. L., Beck, S. L., & Cohen, J. A. (2008). *The Total Neuropathy Score (TNS): A Tool for Use by Oncology Nurses When Measuring Chemotherapy-Induced Peripheral Neuropathy*. *Oncology Nursing Forum*, 35 (1), 96-102.

Smith, E. L., Meyer, L. P., Bakitas, M., Homel, P., Kingman, L., Fadul, C. E., & Bookbinder, M. (May 2008). *The Influence of Improved Neuropathic Pain Screening, Assessment, and Treatment on Patient and System Outcomes*. *Oncology Nursing Forum*, 35, (3), 510.

von Reyn, L. (2008). *High Fidelity Patient Simulations in Hospital Based Competency Development*. In Nehring, W.M., Lashley, F.R. (Ed.), *High-Fidelity Patient Simulation in Nursing Education*. Sudbury, MA: Jones and Bartlett.

Presentations

Bakitas, M. *Palliative Oncology: Developing a Program of Clinical Research*. Yale University School of Nursing, CT. (January).

Bakitas, M. *Anxiety and Depression in Oncology Care*. ARNP guest lecture, Yale School of Nursing, CT. (February)

Bakitas, M. *Measuring Outcomes in Palliative Care Research*. Palliative Care Journal Club, DHMC, NH. (February)

Bakitas, M. *Developing a Program of Research in Palliative Oncology*. University of Vermont, VT. (February), University of Alabama, Birmingham, AL (February).

Bakitas, M. *Geriatric Pain and Palliative Care for Emergency RNs*. Lake Morey, VT. (April).

Bakitas, M. *ENABLE II: Results of the RCT*. NCCC Cancer Control, DHMC, NH. (June), Comprehensive Breast Program, DHMC, NH. (November), Norris Cotton Cancer Center Grand Rounds, DHMC, NH. (November).

Bakitas, M. *Developing Clinically Relevant Oncology Research*. Yale New Haven Hospital Oncology Nurses, CT. (July).

Beyea, S.C. *Using the Evidence to Keep Nurses Safe and Avoiding Hazards in Nursing Practice*. Hot Topics in Nursing, Manchester, NH (March).

Beyea, S.C. *What Would Florence Do? Special Nursing Grand Rounds*, Bassett Healthcare, Cooperstown, NY. (June).

Beyea, S.C. *Interruptions, Disruptions, and Hazards in Healthcare*. Interdepartmental Grand Rounds, Bassett Healthcare, Cooperstown, NY. (June).

Beyea, S.C. *Communicating in the Midst of Interruptions and Distractions*. *Perioperative Nursing: Communication in the OR, The Key to Excellence in Practice*, Dartmouth-Hitchcock Medical Center, Lebanon, NH. (September).

Bourbonniere, M., Nicholson, N., & Drickamer, M. *Inadequate information in patient handoffs from hospital to nursing home*. 61st Annual Scientific Sessions, Gerontological Society of America, National Harbor, MD. (November).

Bourbonniere, M. *Mental status assessment*. Best Nursing Practices in the Care of Older Adults, Lebanon, NH. (September).

Bourbonniere, M. *Physical restraint use*. *Fundamentals of Geriatrics*, Rhode Island Hospital, The Warren Alpert Medical School of Brown University, Department of Medicine, Division of Geriatrics, Providence, RI. (April).

Choate, Matthew. *Poisons, Poisons, Everywhere*. Making Waves Critical Care Conference, DHMC, Lebanon, NH. (March).

Desjardins, Joe F. *Developing Educational Podcasts and Videocasts*. MMSDO Convention, Minneapolis, MN. (July).

Eilertsen, Amy. *State of the Art in Precepting*. The First Annual DHMC Conference on Nursing Excellence, Woodstock, VT. (April).

DHMC NURSING SHOWCASE

Presentations (cont.)

Eilertsen, Amy. *Developing Effective Skills Stations in a Nurse Residency Program.* 12th International Nursing Learning Resource Centers Conference, San Jose, CA. (June).

Greer, S.E., Gupta, R., Odell, C., & McCarragher, J. *Use of a Human Patient Simulator Improves Team Performance.* American College of Surgeons 94th Annual Clinical Congress, San Francisco, CA. (October).

Jordan, B.L. *Non-Pharmacologic Management of Behavioral Symptoms in Dementia and Delirium.* Gerontology Update 2008: Dementia, Delirium and Palliative Care. (April).

Jordan, B. L. *When Elderly Patients Are Experiencing Respiratory Distress.* St. Anselm, Manchester, NH. (September).

Jordan B.L. *Medication Challenges in the Elderly Patient and Delirium vs Dementia: Knowing the Difference – How to Manage Confusion.* Nursing Connections, Central Vermont Hospital, Barre, VT. (November).

Jordan, B.L. *What is Geriatric Nursing?* River Valley Community College, Claremont, NH. (December).

Madigan, Kyle. *Transport Physiology.* National Flight Nurse Academy, Cleveland, OH. (August).

Madigan, Kyle. *Transport Safety.* National Teaching Institute, Chicago, IL. (May).

Madigan, Kyle. *Blast Injuries.* National Teaching Institute, Chicago, IL. (May).

Martel-Martin, Ann. *Breastfeeding—The Way Nature Intended.* Sociology of Reproduction class, University of Vermont, Burlington, VT. (December).

Oliver, Brant. *Symptom Management in RRMS.* DHMC Continuing Medical Education, Monadnock Hospital, NH. (November).

Oliver, Brant. *Patient Education and Nursing Management in MS.* Office of Professional Development, Springfield Hospital, VT. (October).

Oliver, Brant. *Collaborative Management of MS.* DHMC Continuing Medical Education, New London Hospital, NH. (September).

Oliver, Brant. *Mood vs. Cognitive Disorders in MS.* National MS Society, Concord, NH. (September).

Oliver, Brant. *Psychoneuroimmunology of MS.* EMD Serono, Baltimore, MD. (July).

Oliver, Brant. *Psychiatric Problems/Emergencies.* DHMC Continuing Medical Education, Lebanon, NH. (May).

Oliver, Brant. *Medical Grand Rounds: MS for PCPs.* DHMC/Bayer Health, Manchester, NH. (March).

Picconi, Jean. *Streamlining Simulation As a Learning Strategy for Experienced RNs During Orientation.* International Nursing Association for Clinical Simulation and Learning, San Jose, CA. (June).

Piper, Deborah M. *Shoulder Dys-tocia Update.* American College of Nurse-Midwives NH Chapter Meeting, Lebanon, NH. (November).

Quigley, M. *Redesigning Health Care: Problems and Opportunities. Obesity: Costs, Comorbidities, and Cures.* Dartmouth College, Thayer School of Engineering, NH. (November).

Quigley, M. *The Epidemic of Obesity, Obesity-related Comorbidities and Bariatric Surgery Options, The Pre-operative Evaluation Process at DHMC, Case Studies.* The Obesity Epidemic: Pills, Portions, Knives Forks and Hoops, St. Anselm College, NH. (November).

Quigley, M. *Considerations in the Respiratory Care of Patients with Morbid Obesity.* VT/NH Society for Respiratory Care Annual Meeting, Killington, Vermont. (October).

Quigley, M. *Considerations in the Care of Post-operative Adjustable Gastric Banding and Gastric Bypass Patients.* AORN Update, DHMC, Lebanon, NH. (October).

Quigley, M. *An Overview of Obesity and Related Comorbidities, Best Practices in Nursing Assessment and Care; and Surgical Treatment of Morbid Obesity & Post-Bariatric Surgery Care.* Obesity: A Health Care Crisis, Central Vermont Medical Center, Barre, VT. (September).

Quigley, M. *Pre-and Post-operative Management of the Bariatric Surgery Patient.* OB/GYN Grand Rounds, DHMC, Lebanon, NH. (March).

Rawls, M.C. and Karon, N. *Engaging Nurses in the Early Detection of Patient Deterioration.* 12th Annual Magnet Conference, Salt Lake City, UT. (October).

Rawls, M.C. and Karon, N. *Engaging Nurses in the Early Detection of Patient Deterioration.* Nursing Grand Rounds, Dartmouth-Hitchcock Medical Center, Lebanon, NH. (December).

Sandberg-Cook, J. *Falls Prevention.* Best Practices in Geriatric Nursing, DHMC, Lebanon, NH. (September, January).

Sandberg-Cook, J. *Best Practices in Falls Prevention.* NNEGEC, Lebanon, NH. (December).

Sandberg-Cook, J. *Poly-pharmacy.* Mud Season Nursing Symposium, Bartlett, NH. (April).

Sandberg-Cook, J. *Care of the Complicated Geriatric Patient in the Community.* Gerontology Update 2008, (April).

Schaal, Anna. *Evaluating Transitional Care Summaries.* Northern New England Clinical Oncology Society, Whitefield, NH. (October).

Smith, E. L., Cohen, J., Pett, M., & Beck, S. L. *Clinimetric Properties of Chemotherapy-Induced Peripheral Neuropathy (CIPN) Measurement Approaches*. 22nd Annual Neuroscience Day, Dartmouth College, Hanover, NH. (April).

Smith, E. L., Meyer, L. P., Bakitas, M., Homel, P., Kingman, L., Fadul, C. E., & Bookbinder, M. *The Influence of Improved Neuropathic Pain Screening, Assessment, and Treatment on Patient and System Outcomes*. Oncology Nursing Society Congress, Atlanta, GA. (May).

Schaal, A., DiSalvo, W., Scott, M., Gates, C., Urquhart, L., Skalla, K., & Smith, E. *Creating and Implementing Transitional Care Summaries*. Oncology Nursing Society Advanced Practice Nursing Conference, Seattle, WA. (October).

Beck, S. L., Berry, P., Towsley, G., Brant, J., & Smith, E. L. *Development of the Pain and Nursing Care Quality (PaNCQ) Survey: Phase 3*. Western Institute of Nursing Research Conference, Portland, OR. (April).

Smith, E.L. *Assessment Chemotherapy-Induced Peripheral Neuropathy (CIPN): Which Measurement Approaches are Best*. Nursing Grand Rounds. DHMC, Lebanon, NH. (April).

Smith, E.L. *Nurse Measurement of Chemotherapy-Induced Peripheral Neuropathy (CIPN)*. NH Chapter Oncology Nursing Society, Lebanon, NH. (March).

Smith, E.L. *Developing a Cancer Survivorship Program*. St. Joseph's Hospital Survivorship Committee, Center Harbor, NH. (March).

Smith, E.L. *Clinimetric Properties of Chemotherapy-Induced Peripheral Neuropathy (CIPN) Measurement Approaches*. 22nd Annual Neuroscience Day, Dartmouth College, Hanover, NH. (February), University of Indiana, Indianapolis, IN. (November), University of Michigan, Ann Arbor, MI. (April),

University of Utah, Salt Lake City, UT. (April), University of Massachusetts, Boston, MA. (March).

Stageman, Cynthia. *Care of the Patient Having a Prostate Seed Implant*. DHMC, Lebanon, NH. (December).

Stageman, Cynthia. *Cervix Cancer Treatment Using Ring and Tandem*. DHMC, Lebanon, NH. (December).

Strumpf, N. E., & Bourbonniere, M. *Developing statewide commitment for the nursing home collaborative: The experience of the University of Pennsylvania HCGNE and its work group partners for change in LTC*. In C. Beck (Chair), Hartford Centers of Geriatric Nursing Excellence Nursing Home Collaborative. 61st Annual Scientific Sessions, Gerontological Society of America, National Harbor, MD. (November).

Truman, J., & Edson, T. *Emergency Go Kit and Caddy*. Society of Otorhinolaryngology and Head and Neck Nursing, Chicago, IL. (September).

Van Cleave, J., Bourbonniere, M., & McCorkle, R. *Recruitment of Older Adults for Cancer Clinical Trial*. 61st Annual Scientific Sessions, Gerontological Society of America, National Harbor, MD. (November).

Poster Presentations

Bourbonniere, M., & Strumpf, N. E. *Using Evidence to Deliver Evidence-Based Education to RNs in Nursing Homes*. 7th Annual Summer Institute on Evidence-Based Practice: Innovation for Quality & Safety. San Antonio, TX. (June).

Brochu, Claudette. *Implementing Oral Care Guidelines Without Breaking the Bank*. National Magnet Conference. Salt Lake City, UT. (October).

Ceppetelli, E. *Outcomes of a Practice/Education Partnership: A Faculty Shortage Solution in Rural New England*. Nurse Faculty/Nurse Executive Summit. Scottsdale, AZ. (December).

Ceppetelli, E. *Interdisciplinary Partnership Outcome: A Nurse Shadowing Elective for Medical Students*. National Magnet Conference. Salt Lake City, UT. (October).

Kaneko, T., Dixon, J., Borden, P., Schoolwerth, A. *Multidisciplinary CKD Care Enhances Outcomes at Dialysis*. American Society of Nephrology. Philadelphia, PA. (November).

Schaal, Anna. *Creating and Implementing Transitional Care Summaries*. Oncology Nursing Society Advanced Practice Nursing Conference. Seattle, WA. (November).

 **DARTMOUTH-HITCHCOCK**
MEDICAL CENTER
One Medical Center Drive
Lebanon, NH, 03756
www.dhmc.org

Executive Editors
Paula Johnson
Jo-Anne Dombrowskas

Managing Editor
Nora Lusterio

Writer
Tim Dean

Photographer
Mark Washburn

Art Director
David Jenne

Contributors
Mary Jo Slattery, Suzanne Beyea

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