THE JOURNAL of the New York State Nurses Association

SPRING/SUMMER 2009

- Barriers to health care for people with hearing loss: A review of the literature
  by Donna B. Scheier, MS, RN
- Returning to school: Experiences of female baccalaureate registered nurse students
  by Melanie Kalman, PhD, CNS, RN; Margaret Wells, PhD, NP, RN; and Carol Scheel Gavan, EdD, RN
- Articulating the value of psychiatric community health nurse interventions: A secondary analysis
  by Bonnie A. Sturm, EdD, RN

THE JOURNAL of the New York State Nurses Association

SPRING/SUMMER 2009, VOLUME 40, NUMBER 1

Editorial 3
by Craig R. Sellers, PhD, RN, ANP-BC, and Martha V. Whetsell, PhD, RN, ARNP

Barriers to health care for people with hearing loss: A review of the literature 4
by Donna B. Scheier, MS, RN

Returning to school: Experiences of female baccalaureate registered nurse students........ 11
by Melanie Kalman, PhD, CNS, RN; Margaret Wells, PhD, NP, RN; and Carol Scheel Gavan, EdD, RN

Articulating the value of psychiatric community health nurse interventions: A secondary analysis 17
by Bonnie A. Sturm, EdD, RN

What's new in the healthcare literature 24

Book review........ 26
by Ann M. Gothler, PhD, RN, CNE, ANEF

THE JOURNAL of the New York State Nurses Association

NYSNA Board of Directors

President..Linda O'Brien, MS, RN
President-Elect ....Karen A. Ballard, MA, RN
Vice President ....Lorna Samuels, MSN, ANP, GNP, RN, BC
Secretary..Mary J. Finnin, MS, RN
Treasurer..J. Howard Doughty, BSN, RN, CNOR

Directors at Large

Anne Bové, MSN, RN, BC, CCRN, ANP
Barbara Crane, RN, CCRN, RN, BC
Miriam Gonzalez, BS, RN
John Hiltunen, RN
Winifred Z. Kennedy, MSN, RN
Lydia Lopez, MSN, RN, C
José Mapalad Planillo, MSN, RN, CCRN, MBA, HCM
Judy Sheridan-Gonzalez, MSN, RN

The Journal of the New York State Nurses Association Editorial Board

Lisa A. Casler, MS, APRN-BC, NPP
Assistant Professor
Hartwick College
Oneonta, NY

Ann M. Gothler, PhD, RN, CNE, ANEF
Professor of Nursing
The Sage Colleges
Troy, NY

Peggy Jenkins, MS, RN
Professor of Nursing
Hartwick College
Oneonta, NY

Martha V. Whetsell, PhD, RN, ARNP
Associate Professor of Nursing
Lehman College/CUNY
Bronx, NY

Georgia (Nicki) Millor, DNS, MS, RN
Associate Professor, Dept. of Nursing
Nazareth College
Rochester, NY

Craig Sellers, MS, RN, APRN, BC
Director, Adult Nurse Practitioner Program
Associate Professor of Clinical Nursing
University of Rochester School of Nursing
Rochester, NY

Patricia Perry, PhD, RN
Research Specialist
Center for Nursing Research
Guilderland, NY

Tina Gerardi, MS, RN, CAE, *Chief Executive Officer*
Joely Johnson, MS, *Managing Editor*
Kristy LeComb, *Graphic Artist*

The Journal of the New York State Nurses Association is peer reviewed and published biannually by the New York State Nurses Association. ISSN# 0028-7644. Editorial and general offices located at 11 Cornell Road, Latham, NY 12110. Telephone: 518-782-9400. Fax: 518-782-9532. E-mail: info@nysna.org. Annual subscription: no cost for NYSNA members; nonmembers: $17.

The Journal of the New York State Nurses Association is indexed in the Cumulative Index to Nursing, Allied Health Literature, and the International Nursing Index. It is searchable in CD-ROM and online versions of these databases available from a variety of vendors including SilverPlatter, BRS Information Services, DIALOG Services, and The National Library of Medicine's MEDLINE system. It is available in microform from National Archive Publishing Company, Ann Arbor, Michigan. Acceptance of advertising does not mean endorsement by The New York State Nurses Association of the product advertised, the advertisers, or the claims made. Similarly, rejection does not necessarily imply that product offered for advertising is without merit, or that the manufacturer lacks integrity.

© 2009 All Rights Reserved • The New York State Nurses Association

EDITORIAL

Overcoming barriers and facing challenges

As this issue of the *Journal of the New York State Nurses Association* goes to press, summer has just begun. The guest editors and editorial board wish all of our readers a safe and healthy season. Our current issue includes three captivating articles by nurses. Please also take note of "What's New in the Healthcare Literature," where our editorial board members and colleagues discuss recently published research reports that we believe may be of interest to our readers. We hope you enjoy this issue and welcome your feedback or any other comments you wish to share about *Journal*.

In the first article, "Barriers to Health Care for People with Hearing Loss: A Review of the Literature," the author, Donna B. Scheier, explores barriers to accessing health care for patients with hearing loss. Scheier provides a clear discussion and differentiation among the terms deaf, Deaf, hard of hearing, and hearing loss. She describes the controversial concepts of the "deaf community" and Deaf culture. Issues related to the use of medical interpreters are also considered. Multiple barriers in accessing care for diverse populations, from pre-lingually deaf children to aging baby boomers with hearing loss, are noted, and the author makes excellent suggestions for beginning to remove such barriers.

In "Returning to School: Experiences of Female Baccalaureate Registered Nurse Students," Melanie Kalman, Margaret Wells, and Carol Scheel Gavan, from the State University of New York Upstate Medical Center College of Nursing, in Syracuse, N.Y., focus the reader's attention on the RN-to-BS student. In the article, the authors describe the results of their qualitative research study that touches on a topic important to the nursing profession. Meeting the multiple demands of home life and family responsibilities, professional and work roles, and the new position of being (once again) a student is compared to a juggling act comprising four themes: going back, sacrifices, managing, and rewards. This article offers good advice to nurses contemplating a return to school.

Finally, Bonnie A. Sturm presents her research in "Articulating the Value of Psychiatric Community Health Nurse Interventions: A Secondary Analysis." In this article, she explores the nature and the impact of therapeutic nursing interventions (TNIs) employed by psychiatric community health nurses (PCHN). Two relevant factors emerged from the data: (1) the human experience of psychiatric patients and (2) the lack of recognition of the value of TNIs by most medical insurers. Sturm reports that restriction on PCHN visits to patients causes stressful conflicts for both nurses and patients. The therapeutic effectiveness of nurses is recognized as important in clinical practice but is not taken into account when determining the length of therapy that patients need. Evidence-based research guides clinical practice. However, nurses need to recognize that new problems may arise from narrowly designed nursing research that addresses only one question. Nurses also need to consider health economics with its concerns about the costs of health care and the distribution of its resources.

The *Journal* Editorial Review Board is always open to prospective new board members. Candidates must be NYSNA members in good standing and should have a history of research publication. If you are interested in joining us in reviewing and critiquing the nursing-related manuscripts you see presented here, contact **journal@nysna.org** for an application.

Manuscripts are now being accepted for the Spring/Summer 2010 issue; the deadline is March 10, 2010. For information on submitting a manuscript for consideration, go to the publications area of **www.nysna.org**.

Craig R. Sellers, PhD, RN, ANP-BC
Martha V. Whetsell, PhD, RN, ARNP

Barriers to health care for people with hearing loss: A review of the literature

Donna B. Scheier, MS, RN

Abstract

Deaf individuals face many barriers when trying to access health care. The reasons why barriers are encountered, difficulties met as a result of the barriers, and ways that health professionals and others working with deaf people can overcome obstacles are included in this review of the literature. A brief summary of Deaf culture and history gives background information to better understand the problems. Misunderstandings by d/Deaf patients and hearing health professionals are addressed, as well as issues related to medical interpreters. This paper aims to make health professionals more aware of the needs and cultural differences that must be considered when providing care to the d/Deaf population.

Note: Throughout this literature review, the word deaf *is written with either an upper-case or lower-case "D." When referring to the audiological condition of deafened people,* deaf *is written with a lower-case "d." An upper-case "D" is used when writing about the Deaf culture, a group with which many prelingually deaf people affiliate themselves. Culturally Deaf people have their own language, specific customs, and ways of behaving (Padden & Humphries, 1988).*

Hearing loss can present difficulties in healthcare delivery in the United States. Those who are prelingually deaf often use American Sign Language (ASL) as their main mode of communication, which can constitute a barrier to being involved and knowledgeable about one's health care. The term prelingually deaf is used to describe people who lose their hearing before they have acquired language (Gilchrist, 2000). Postlingually deaf refers to later-deafened people who have language prior to hearing loss (Bat-Chava, Martin, & Kosciw, 2005). Many healthcare providers are unaware of ways to improve communication with deaf patients in order to provide them with a level of care equal to that of hearing people.

More than 20 million people in the United States have hearing loss (Harmer, 1999; O'Hearn, 2006; Sadler et al., 2001). Barriers that people with hearing loss encounter and their dissatisfaction with the healthcare

Donna B. Scheier is a staff nurse at Highland Hospital and an educator of deaf students in the Rochester Central School District, both in Rochester, NY.

Deaf culture has its own set of rules and behaviors that hearing people may not understand.

delivery system have generated recent studies and meta-analyses that address these problems. This paper provides a review of the literature that outlines what the problems are, determines why they exist, and identifies ways to begin solving them.

Overview

It has been noted that people with hearing loss find the entire healthcare system difficult to navigate; in addition, recent research trends illuminate the increased need for mental health services specifically tailored to the deaf population (Glickman & Gulati, 2003). Communication is paramount for the delivery of these services. Lack of background health information and the dearth of English language proficiency among the deaf impede good care.

The population of people with hearing loss is quite heterogeneous. Approximately 10% of Americans have some level of hearing loss and this number is expected to increase as Baby Boomers age. It is estimated that 50% of those age 80 and above have hearing loss. Whether an individual is prelingually or postlingually deaf, the exact age and level of hearing loss may affect how one navigates the world. It is inappropriate to categorize all people with hearing loss together (Tamasker et al., 2000).

Economic issues also present barriers to delivering optimal health care to deaf people; it costs more to spend the time to treat and teach such patients and to hire qualified interpreters. Healthcare workers need to find ways to work with this population to ensure the best care possible.

Methods

Research databases used for this literature review included: CINAHL, ProQuest Nursing Journals, Sociological Abstracts with Full Text, and Medline. The National Technological Institute for the Deaf (NTID) Wallace Library provided access to other deaf publications; NTID is part of the Rochester Institute of Technology in New York. St. John Fisher College's Lavery Library, also in Rochester, permitted the loan of excellent books on historical information, Deaf culture, and the healthcare needs of deaf people. Articles were read and reviewed for relevance to the subject; the majority were descriptive studies. The search was narrowed to articles and books that deal with problems deaf people have accessing health care and maintaining health.

A brief history of hearing loss

Historically, deaf people have been viewed as inadequate and inferior to hearing people. This negative prejudice has been evident since antiquity. Deaf people have been patronized, socially distanced, and discriminated against in a variety of ways (Lane, 1984). The deaf have been characterized by hearing healthcare professionals as aggressive, immature, impulsive, lazy, stubborn, suspicious, and unintelligent (Meador & Zazove, 2005; Parise, 1999).

The New Testament presents deafness as caused by evil spirits and in need of cure (Mark 17:25, The Holy Bible in Four Translations, 1972). Physicians in the past have unsuccessfully poured various potions into peoples' ears and produced loud noises to help them regain their hearing. Aristotle held the belief that thought was contingent on speech. Deaf people were thought to be unable to think because they could not hear or speak. *Deaf and dumb* or *deaf-mute* are derogatory terms that have their derivation in Aristotle's time (Van Cleve & Crouch, 1995)

In the 1870s Alexander Graham Bell promoted oralism, using speech for communication, in deaf education. Previously, deaf children used sign language and had deaf teachers (Gannon, 1981). Oral language learning can work for some deaf children, however, it can be unsuccessful and frustrating for the majority, denying them access to a full natural language. In residential institute schools, children were forbidden to use manual (sign) language but did so surreptitiously. Gannon (1981) and Lane (1984) strongly believe that oralism was detrimental to deaf education in this country and that deaf people have been suffering the effects of inadequate education since that time.

Understanding deaf culture

Although much has been written attempting to understand and improve the hardships that having a hearing loss entails, society continues to marginalize deaf people. Deaf people are treated as if their hearing loss is a pathology that needs to be cured. Many Deaf people lead rich and full lives and do not feel a need to be cured. Similarly, many Deaf people are proud to be deaf and part of a Deaf culture (Padden & Humphries, 1988).

Deaf culture has its own set of rules and behaviors that hearing people may not understand. For example, it is impolite not to maintain eye contact when speaking to a Deaf person. Also, rules concerning physical contact, touching, and pointing are different in Deaf culture. Deaf people view it as rude if they are excluded from a conversation. They want the same information that a hearing person would have. Environmental sounds that evoke a response, like a knock on the door, should be conveyed to a Deaf person. Abrupt changes in conversation topics and long goodbyes are commonplace in Deaf culture (Meador & Zazove, 2005).

Deaf people have a special bond with each other that in many cases is stronger than that with their hearing family members. In the past, most deaf students went to residential institute schools, where they lived with deaf peers and were easily understood. They developed a network of relationships that would last a lifetime (Allen, Meyers, Sullivan, & Sullivan, 2002).

Today, most deaf students are mainstreamed in classrooms with hearing children. It is estimated that more than 50,000 students who cannot hear speech, even with hearing aids, are enrolled in mainstream schools. Most school psychologists do not know sign language and students are being evaluated without sign language knowledge, resulting in inaccurate test scores (Vernon & Leigh, 2007).

Lieu and colleagues (2007) noted that "healthcare providers face particular challenges to become culturally and linguistically competent practitioners" (p. 239) and yet, in the first few lines of the article, the authors refer to "hearing impairment" (p. 239), a negative term for deafness. Jones, Renger, and Firestone (2005) refer to the Deaf community as "more than 2 million Americans who were significantly hearing impaired . . ." (p. 27). Deaf people are a community and see themselves not as hearing impaired, but as strongly Deaf. In addition, many Deaf people desire Deaf children. They are proud to be Deaf and have no wish to be able to hear or to be cured of their "affliction." This belief fuels the controversy of cochlear implant surgery for Deaf children (Padden & Humphries, 1988).

Misunderstandings

It is difficult to ascertain who is deaf and who is hard of hearing. The difference between audiologically deaf and hard of hearing is nebulous; it is not always clearly evident. Deaf people usually are those with a greater hearing loss or those who identify with Deaf culture. Hearing loss is measured in a variety of frequencies. More than a 90-decibel hearing loss is referred to as profoundly deaf. Anyone with any degree of hearing loss can use the term hard of hearing (Gilchrist, 2000).

The incidence of hearing loss is increasing. Many more premature babies are being born, and they can have complications that may lead to deafness (Msall & Park, 2008). Also, many Baby Boomers are losing their hearing because of exposure to loud noises (Daniel, 2007). High volumes over a prolonged period of time can lead to permanent hearing damage. It is estimated that the majority of hearing loss is attributed to excessive noise exposure (Gilchrist, 2000).

Those who are hard of hearing but not deaf may feel like they are in limbo; they do not fit into the signing Deaf world and they do not fit into the hearing world. People who are hard of hearing may feel frustrated that they cannot hear conversations. They also may be afraid of losing the rest of their hearing and becoming deaf. Animosity exists between hard of hearing and Deaf people (Harvey, 2003).

American Sign Language

American Sign Language (ASL), the sixth most commonly used language in this country, is not related to English (Singleton & Tittle, 2000). It is called American Sign Language because it is used by those in the northern hemisphere. ASL is a mix of native signs and French sign language. Some words are finger-spelled, borrowed from English the same way that the words gourmet, roulette, and taco are borrowed from French and Spanish (Grayson, 2003). ASL does not have a written form; however, deaf people must learn written English, which is quite a challenging feat (Allen et al., 2002).

Learning English for those who cannot hear is not easy. Acquiring a spoken language without the ability to hear requires intense study; the difficulty is mind-boggling. English presents such a challenge for deaf people that the average deaf high school graduate reads at a fourth grade level (Bat-Chava et al., 2005). Steinberg, Wiggins, and Barmada (2002) state that even well-educated deaf people may have difficulty understanding written English. Not understanding written healthcare information or directions for care can negatively affect outcomes (Allen, 2002).

Those who are native signers, that is, who learned sign language before a spoken language, are attuned to the subtleties of facial expression, as well as hand shape, movement, and location that convey meaning in ASL (Boudreault & Mayberry, 2006). Allen (2002) writes about a deaf end-of-life patient whose interpreter missed a vague sign for using the bathroom. If a deaf volunteer had not witnessed the encounter, the patient might have soiled himself and considered incontinent.

Lieu and colleagues (2007) wrote, "signing is not a word-for-word translation of the spoken or written words; rather it is a series of pictures that convey meaning" (p. 242). On the contrary, others feel that ASL is a rich and complicated language. Taken together, hand shape, palm direction, placement of the hand on the body or within the signing space, movement, and non-manuals (facial expressions) make up sign language. Sign order has rules and a strict grammar is followed, and the space that a person uses to sign has meaning (Padden & Humphries, 1988). A signing person may be able to tell where another signer is from by the way that he or she signs (Gilchrist, 2000).

Potential for miscommunication

ASL word order is not the same as English word order. A phrase written in English may have the exact opposite meaning to someone who uses ASL. If a hearing doctor says or writes that one may need surgery to a person who uses sign language and does not have proficient English skills, the person might think that he or she needs surgery in the month of May (Meador & Zazove, 2005).

Misunderstandings can occur in both the provider and patient. The provider may think that his or her intention was understood when it was not. The patient may think that he or she understood the meaning when he or she did not. This can lead to medication errors, missed appointments, and misunderstood diagnoses. Meador and Zazove (2005) report a deaf mother pouring oral antibiotic into her daughter's ear canal to cure an ear infection. Patients do not want to appear unintelligent and will nod "yes" in spite of not understanding. Open-ended questions that cannot be answered with a yes or no should be used to check for understanding (Wood, 2002).

The importance of facial expression

Sign language has multiple parameters beyond hand signs that are used to convey added meaning. A person can indicate the amount of pain they are experiencing through facial expression and movement. There are more than 250 facial expressions that give meaning. In addition, the location of pain is usually signed in the area of the body where the pain is occurring. Although ASL is very different from English, any idea or concept can be explained in ASL (Allen et al., 2002).

Healthcare providers should be especially careful about their own facial expressions. Grimacing when reading a chart can upset a deaf person. Deaf people are more attuned to facial expression than hearing people would be (Gilchrist, 2000).

Tasks that we take for granted may need extra explanation for a deaf person (Allen et al., 2002). A Deaf person may not know how to use a horizontal pictorial scale to rate pain level because they may be unfamiliar with values that increase from left to right, as readers of English routinely do.

The issue of interpreters

The Americans with Disabilities Act (ADA) of 1990 mandates language accommodations for people who are deaf or hard of hearing when they receive health care. Patients should be asked what means of communication they prefer. Some deaf people do not want to use interpreters because of privacy issues or are concerned that an interpreter will judge them (Glickman & Gulati, 2003; Wood, 2002).

Family members may volunteer to interpret, but this does not allow patients to speak frankly with healthcare providers and violates confidentiality laws. A patient might have a difficult time asking for an HIV test if his or her mother is interpreting. Family members may accidentally or intentionally misinterpret communication, be unfamiliar with medical terminology, or may not be fluent in sign language (Glickman & Gulati, 2003; Lieu et al., 2007; Wood, 2002).

Lip-reading needs

Some people prefer interpreters, while others are more oral and prefer lip reading. The best lip reader, however, can only see about 30-45% of English on the speaker's lips (Lieu et al., 2007). Many sounds look the same, for example a "B" and a "P" are identical on the lips. Context and accompanying gestures complete the information. It is easier to lip-read when one is familiar with the subject and the speaker (Iezzoni, O'Day, Killeen, & Harker, 2004).

A moustache or accent can make lip reading very difficult; surgical masks make lip reading impossible. Proper lighting and face-to-face communication is important and respectful to the deaf person. Providers should always face the person they are speaking to and avoid placing their hands near their mouth when speaking, leaving the lips unobstructed. It is important to get the person's attention before one speaks (Hochman, 2000; Wood, 2002).

Lip-reading takes vast amounts of concentration and leaves the hard-of-hearing person physically and mentally exhausted. Conversations in which multiple people are talking at the same time or where the listener is not able to see who is speaking are difficult for those with hearing loss. Background noise can also make speaking difficult to understand (Harvey, 2003).

One should not assume that a patient understands medical terms.

Special considerations

The adage "one picture is worth a thousand words" holds true for deaf people. Deaf people learn by seeing and doing. Pictorial aids and models can help a patient understand what is happening to his or her body. Showing a person how to use equipment or medication rather that explaining its use yields better results (Steinberg et al., 2005).

Language deprivation has profound effects. Glickman and Gulati (2003) hypothesized that lack of language sophistication contributes to cognitive delays that can never be recovered. According to Harmer (1999), linguistic deprivation "can lead to a preventable form of mental retardation" (p. 88). Arehart and Yoshinaga-Itano (1999) believe that early intervention services for deaf children prevent further developmental delays, but that these services may not negate an existing delay.

Many deaf people lack world knowledge because of linguistic inaccessibity and cognitive deficits caused by missing language during the critical language-learning period (estimated to be somewhere between 5 and 9 years of age). Fluent signers can recognize at what age another signer had learned sign language by his or her fluency and skill level (Glickman & Gulati, 2003).

Deaf people may invent reasons why something occurs to fill in the gaps and make sense of the world. Health-related vocabulary with which an English speaker would be familiar, for example, *bowel, hemoglobin, glaucoma, nausea, allergic,* or *penicillin,* might not have meaning for one whose first language was ASL. One should not assume that a patient understands medical terms. The provider should check for understanding, especially when giving information critical to care. Asking a patient to repeat medication directions might avoid errors. Some people with hearing loss feel stigmatized and pretend that they are hearing, further adding to the possibility of miscommunication, errors, and poor care (Bat-Chava, Martin, & Kosciw, 2005; Meador & Zazove, 2005; Tamaskar, 2000).

Reeves and Kokoruwe (2005) report that deaf patients experience heightened anxiety when they visit a doctor. Fear of receiving the wrong medication or not being understood could cause a patient to be anxious. A qualitative study by Steinberg and colleagues (2005) noted that fear was a major emotion for deaf people visiting a physician; they were afraid of not being understood.

Effects on communication

The consequences of healthcare communication inadequacies can be dire. Patients in the United Kingdom reported that they did not understand their diagnosis or medication directions, took a wrong dose, or woke from surgery to unexpectedly find a leg amputated (Reeves & Kokoruwe, 2005). Perhaps because of these negative experiences, the Deaf community is distrustful of the healthcare system (Steinberg, 2002).

The difficulty and frustration associated with communication in a hearing world contributes to proportionately higher rates of mental illness in the deaf population (Harmer, 1999). The inability to communicate with one's peers and family can lead to feelings of inadequacy and low self-esteem. Deaf people report that attending family events where more than one person speaks at a time creates stress and is socially isolating (Glickman & Gulati, 2003).

Deaf people find it difficult to converse with family members who might not be sensitive to their communication needs. Even if hearing parents attempt to learn sign language, they do not learn at the same rate as a young person acquiring language, making sophisticated conversations impossible (Snodden, 2008).

Lack of communication between deaf children and hearing parents can result in gaps of knowledge. Harmer (1999) gives the example of a hearing parent signing to a deaf child to brush his or her teeth. A hearing parent with a hearing child might say, "brush your teeth so you don't get cavities" (Harmer, 1999, p. 84). A hearing parent with a deaf child might only say, "brush your teeth" (Harmer, 1999, p. 84). The inability to use language fully results in inadequate health information conveyed to the child. Also, lack of incidental knowledge (such as what hearing people absorb from listening to conversations, the radio, and other sources) leaves a deaf person at a disadvantage (Harmer, 1999). It is interesting to note that Deaf children of Deaf parents who use sign language score higher on standardized tests than their deaf peers with hearing parents (Singleton & Tittle, 2000).

Glickman and Gulati (2003) mention that few parents become fluent in ASL due to the difficulty involved in learning and the fear that they will lose their child to Deaf culture, alienating him or her from the family. Family communication is sometimes strained because the majority of deaf people have hearing parents who are not fluent signers. Allen and colleagues (2002) estimate that 95% of deaf children have hearing parents, while Glickman and Gulati (2003) place the estimate at 90%. At any rate, most deaf children have hearing parents.

Not only families have difficulty in learning ASL; most healthcare providers do not know any sign language. Sadler (2001) states that it is impractical for physicians to learn sign language, since the average physician will have few deaf patients, if any. Learning just a few signs, however, shows the deaf patient that an attempt is being made to communicate. One of the largest barriers to health care for deaf people is a patronizing attitude (Lieu et al., 2007). Respect for and empowerment of the deaf person were important to the focus groups studied. Respect can be demonstrated by learning a few basic signs. This attempt at finding a way to communicate may also decrease patient anxiety (McAleer, 2006; O'Hearn, 2006).

Mental health services need to meet the communication and cultural needs of people with hearing loss. Glickman and Gulati (2003) recommended a culturally affirmative approach to mental health care for deaf people. They advocated not only accessibility and reasonable accommodation, which is mandated by the 1990 ADA, but a higher level of affirmative care that supports Deaf culture and is sensitive to Deaf needs. One example of the way mental health staff can accomplish this is to avoid the use of idioms that have no exact translation in ASL. Another affirmative action for mental health facilities that serve any Deaf patients is to hire a sufficient number of deaf staff members so the majority of staff are deaf and proficient in ASL. Hiring and training hearing staff with a cursory knowledge of ASL yields less than optimal care, especially in the mental health field where communication is paramount (Glickman & Gulati, 2003).

Mental health services for the deaf rarely have designated units with staff members who are sensitive to Deaf needs and know sign language. The vast majority of states do not provide services that are mandated by law. Gradually, more interpreters are being hired, but only for short time periods during emergency situations (Glickman & Gulati, 2003). Deaf people in most states receive substandard mental health care, worse than any other disability group (Vernon & Leigh, 2007). Sadler and colleagues (2001) stated that physicians often do not hire interpreters, and hospital staff members do not know how to arrange interpreting services or how to ensure that an interpreter is qualified.

DeVinney and Murphy (2002) detailed the experiences of a postlingually deaf woman who was admitted to a hospital for depression. Because she had clear, intelligible speech, the staff presumed she could hear, despite the patient telling them many times that she could not. Her anger was attributed to her illness rather than to the denial of her request for an interpreter and reasonable accommodations. The case ultimately went to court, indicating needed changes in the delivery of services (DeVinney & Murphy, 2002).

The problem seems global. In Brazil, deaf patients have the same communication issues and complain of healthcare providers' illegible handwriting, hurried manner, and lack of knowledge of Portuguese Sign Language (Cardoso, Rodrigues, & Bachion, 2006). Thomas and colleagues (2006) noted that similar barriers in mental health care exist in the United Kingdom.

Deafness and STIs

The deaf and hard-of-hearing population is believed to have a higher rate of HIV infection than hearing people (Bat-Chava et al., 2005). The incidence of STIs (sexually transmitted infections) and alcohol and substance abuse are also proportionately higher (Harmer, 1999). Bat-Chava and colleagues (2005) wrote that the largest barrier to AIDS prevention is communication. Deaf people are less likely to know what causes HIV infection and how to prevent it and are less likely to access care once they become ill. Many deaf people were never taught about human sexuality and therefore cannot understand how HIV is transmitted. Literacy levels impinge on health knowledge; educational materials written at an 8th grade level may be too advanced for many deaf people (Bat-Chava et al., 2005).

One study, based in New York State, evaluated knowledge levels of HIV and AIDS transmission routes and symptoms and found that deaf people who used sign language had the most misinformation. The population in Rochester was found to be the most informed of any demographic group, surpassing New York City and Albany. The authors believed that the National Technical Institute for the Deaf (NTID) and Rochester's large deaf population played a role in relaying accurate information (Bat-Chava et al., 2005).

The problem of deaf access to information is worse in developing countries. The Swaziland kingdom in southern Africa reportedly has the one of the largest HIV infection rates; it is estimated that 38.1% of the population is infected. Deaf individuals in Swaziland have limited access to educational materials and

rely on their deaf peers for health information. This "deaf grapevine" (Groce, Yousafzai, Dlamini, Zalud, & Wirz, 2006, p. 319) reinforces misinformation. Polygamy and low literacy rates among deaf people amplify the problem (Groce et al., 2006).

Legal obligations

Many healthcare providers, including physicians, do not know that they are obligated by law to provide an interpreter (Gilchrist, 2000). When using an interpreter, it is the responsibility of the healthcare provider to pay the cost of hiring an interpreter as described in the ADA. Such healthcare providers include physicians, nurse practitioners, and advanced practice nurses (Gilchrist, 2000). Federal Medicaid and SCHIP funding for sign language interpreters is available in some states (Youdelman, 2007). An interpreter should be certified with the National Registry of Interpreters and be knowledgeable in medical terminology. An interpreter agency may require a 2-hour minimum, forcing the provider to pay more than he or she can bill. If a deaf person needs to see a physician for a 5-minute visit, the physician might need to pay for 2 hours of interpreting (Sadler, 2001).

Steinberg, Sullivan, and Loew (1998) cautioned that an interpreter does not guarantee adequate communication. A provider may not know to talk directly to the patient and may instead address the interpreter. Languages cannot be translated exactly; at times things get lost in translation. DeBruin and Brugmans (2006) noted that Dutch interpreters for the deaf were not able to maintain neutrality and impartiality. Patients worry about confidentiality and privacy, especially when there is the likelihood that they will see the interpreter in other settings (DeBruin & Brugmans, 2006).

Suggestions for change

New technology that was not available years ago may help improve health care access for deaf people. One promising technological advance is telemedicine, where a patient can access an interpreter and physician by webcam, providing deaf-friendly health care in areas far from most facilities (Thomas, Cromwell, & Miller, 2006).

Pagers or vibrating devices given to patients in emergency room or doctor's office waiting areas can inform them when it is their turn (Lieu et al., 2007). If possible, intravenous lines should not be inserted into hands so the deaf person can continue to sign (McAleer, 2006). Modifications such as access to a TTY communication device, a qualified interpreter, and increased privacy should be offered to deaf patients (DeVinney & Murphy, 2002).

The question remains, however, of how to deliver health care of equal quality for both deaf and hearing patients. Learning a few signs and following the suggestions in this paper will not alleviate all barriers, but they are steps in the right direction. More research needs to be conducted to find ways to educate those who are prelingually deaf and give them access to better health education. Methods of educating healthcare providers in the needs and legal rights of deaf patients should be explored. Empowering those with hearing loss and teaching self-advocacy skills was not stressed in the literature. Also, many of the articles were several years old; perhaps there are newer tools for improving health care for deaf and hard of hearing people. Finally, future research should explore practitioners' feelings and possible buried prejudices toward those with hearing loss.

Conclusion

It is difficult to tell who can hear and who cannot; hearing loss is invisible. The articles in this review of the literature concurred that communication is the major barrier to health care for individuals with hearing loss. Although the ADA mandates interpreters for those who need them, healthcare providers do not use them consistently. Interpreters may not be certified and knowledgeable about medical issues. Other barriers include healthcare workers' lack of sensitivity toward people with hearing loss because of preconceived notions and marginalization of the deaf. Healthcare professionals are often not cognizant of Deaf culture and values and therefore do not understand Deaf behaviors.

Healthcare workers may discount or be unaware of the extreme impact of hearing loss on the ability to communicate, learn, and care for oneself. The pervasiveness of the effects of deafness should not be underestimated. Healthcare professionals should educate themselves about ways to reduce barriers and to ensure access to health care for all people.

REFERENCES

Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §2, 104 Stat. 328 (1991).

Allen, B., Meyers, N., Sullivan, J., & Sullivan, M. (2002). American Sign Language and end-of-life research in the deaf population. *HEC Forum*, *14*(3), 197-208.

Arehart, K. H. & Yoshinaga-Itano, C. (1999). The role of educators of the deaf in the early identification of hearing loss. *American Annals of the Deaf*, *144*, 19-23.

Bat-Chava, Y., Martin, D., Kosciw, J. G. (2005). Barriers to HIV/AIDS knowledge and prevention among deaf and hard of hearing people. *AIDS Care*, *17*(5), 623-634.

Boudreault, P., & Mayberry, R. (2006, August). Grammatical processing in American Sign Language: Age of first-language acquisition effects in relation to syntactic structure. *Language and Cognitive Processes*, *21*(5), 1.

Cardoso, A. H. A., Rodrigues, K. G., & Bachion, M. M. (2006). Perceptions of persons with severe or profound deafness about the communication process during health care. *Revista Latino-Americana de Enfermagem*, *14*(4), 553-560.

Daniel, E. (2007, May). Noise and hearing loss: A review. *Journal of School Health*, *77*(5), 225-231.

DeBruin, E., & Brugmans, P. (2006). The psychotherapist and the sign language interpreter. *Journal of Deaf Studies and Deaf Education*, *11*(3), 360-368.

DeVinney, J., & Murphy, S. (2002). Mental health experiences and deafness: Personal and legal perspectives. *Psychiatric Rehabilitation*, *25*(3), 304-309.

Gannon, J. R. (1981). Deaf heritage: *A narrative history of deaf America*. Silver Spring, MD: National Association of the Deaf.

Gilchrist, K. L. (2000). Through the looking glass: The lived experience of deaf people communicating with nurses, the meaning of health, and attitudes toward nurses. (Doctoral dissertation, University of Colorado, 2000). *Dissertation Abstracts International*, 61(07B), 3507.

Glickman, N. S., & Gulati, S. (2003). *Mental healthcare of deaf people*. Mahwah, NJ: Lawrence Erlbaum.

Grayson, G. (2003). *Talking with your hands, listening with your eyes: A complete photographic guide to American Sign Language.* Garden City, NY: Square One Publishers.

Groce, N., Yousafzai, A., Dlamini, P., Zalud, S., & Wirz, S. (2006). HIV/AIDS and disability: A pilot study of HIV/AIDS knowledge among a deaf population in Swaziland. *International Journal of Rehabilitation*, *29*, 319-324.

Harmer, L. M. (1999). Healthcare delivery and deaf people: Practice, problems and recommendations for change. *Journal of Deaf Studies and Deaf Education*, *4*(2), 73.

Harvey, M. A. (2003). P*sychotherapy with deaf and hard of hearing persons: A systemic model.* Mahwah, NJ: Lawrence Erlbaum.

Hochman, F. (2000). Healthcare of the deaf–toward a new understanding. *Journal of the American Board of Family Practice, 13*(1), 81-83.

Iezzoni, L. I., O'Day, B. L., Killeen, M., & Harker, H. (2004). Communicating about healthcare: Observations from persons who are deaf or hard of hearing. *Annals of Internal Medicine*, *140*(5), 356-362.

Jones, E. G., Renger, R., & Firestone, R. (2005). Deaf community analysis for health education priorities. *Public Health Nursing, 22*(1), 27-35.

Lane, H. (1984). *When the mind hears.* New York, NY: Random House.

Lieu, C., Sadler, G., Futterton, J., & Stohlman, P. (2007). Communication strategies for nurses interacting with deaf patients. *MedSurg Nursing, 16*(4), 239-244.

Mallinson, R. K. (2004). Perceptions of HIV/AIDS by deaf gay men. *Journal of the Association of Nurses in AIDS Care*, *15*(4), 27-36.

McAleer, M. (2006). Communicating effectively with deaf patients. *Nursing Standard*, *20*(19), 51-54.

Meador, H., E., & Zazove, P. (2005). Healthcare interactions with deaf culture. *Journal of the American Board of Family Practice*, *18*(3), 218-222.

Msall, M., & Park, J. (2008). The spectrum of behavioral outcomes after extreme prematurity: Regulatory, attention, social, and adaptive dimensions. *Seminars in Perinatology*, *32*(1), 42-50.

O'Hearn, A. (2006). Deaf women's experiences and satisfaction with prenatal care: A comparative study. *Family Medicine*, *38*(10), 712-716.

Padden, C., & Humphries, T. (1988). *Deaf in America: Voices from a culture.* Cambridge, MA: Harvard University Press.

Parise, N. (1999). *Breaking cultural barriers to healthcare: The voice of the deaf.* Unpublished master's thesis, McGill University School of Nursing, Montreal, Quebec, Canada.

Reeves, D., & Kokoruwe, B. (2005). Communication and communication support in primary care: A survey of deaf patients. *Audiological Medicine, 3*(2), 95-107.

Sadler, G. R., Huang, J. T., Padden, C. A., Elion, L., Galey, T. A., Gunsauls, D. C., & Brauer, B. (2001). Bring healthcare information to the deaf community. *Journal of Cancer Education*, *16*, 105-108.

Singleton, J. L., & Tittle, M. D. (2000). Deaf parents and their hearing children. *Journal of Deaf Studies and Deaf Education, 5*(3), 221-235.

Snoddon, K. (2008, June). American Sign Language and early intervention. *Canadian Modern Language Review, 64*(4), 581-604.

Steinberg, A. G., Barnett, S., Meador, H. E., Wiggins, E. A., & Zazove, P. (2005). Health care system accessibility: Experiences and perceptions of deaf people. *Journal of General Internal Medicine*, *21*, 260-266.

Steinberg, A. G., Sullivan, V. J., & Loew, R. C. (1998). Cultural and linguistic barriers to mental health service access: The deaf consumer's perspective. *American Journal of Psychiatry, 155*(7), 982-984.

Steinberg, A. G., Wiggins, E. A., Barmada, C. H., & Sullivan, V. J. (2002). Deaf women: Experiences and perceptions of healthcare system access. *Journal of Women's Health, 2*(8), 729-741.

Tamaskar, P., Malia, T., Stern, C., Gorenflo, D., Meador, H., Zazove, P. (2000). Preventive attitudes and beliefs of deaf and hard-of-hearing individuals. *Archives of Family Medicine, 9*(6), 518-525.

Thomas, C., Cromwell, J., & Miller, H. (2006). Community mental health teams' perspectives on providing care for Deaf people with severe mental illness. *Journal of Mental Health, 15*(3), 301-2313.

Youdelman, M. (2007, March). Medicaid and SCHIP reimbursement models for language services. Retrieved June 30, 2009, from http://www.fachc.org/pdf/mig_Medicaid-SCHIP.2007[1].pdf

Van Cleve, J. V., & Crouch, B. A., (1989). *A place of their own: Creating the deaf community in America.* Washington, DC: Gallaudet University Press.

Vernon, M., & Leigh, I., (2007). Mental health services for people who are deaf. *American Annals of the Deaf, 152*(4), 374-381.

Wood, B. (2002). Caring for a limited-English proficient patient. *Association of Operating Room Nurses, 75*(2), 305-308.

Returning to school: Experiences of female baccalaureate registered nurse students

Melanie Kalman, PhD, CNS, RN
Margaret Wells, PhD, NP, RN
Carol Scheel Gavan, EdD, RN

Abstract

Most nurses enter the profession at the associate degree (AD) level, however, the link between nursing education and patient outcomes supports the need for nurses to be educated at the baccalaureate level. The purpose of this phenomenological study of 11 AD nurses enrolled in a baccalaureate nursing program was to describe their perspectives on returning to school. The central question for this study was: "What are the experiences of RNs who return to school for a bachelor's degree after being nurses for at least 3 years?" A total of 11 baccalaureate nursing students were interviewed. Applying a phenomenological data analysis method, the researchers identified four themes in the context of juggling everything that was important in these students' lives: going back, sacrifices, managing, and rewards. Implications for nursing education and practice are made, including the need to encourage, support, and facilitate the process for nurses returning to school.

Leaders agree that nurses should be educated at the baccalaureate level (AACN, 2009; Nelson, 2002). However, most nurses today enter the profession at the associate degree level. In New York State in 2005, 76.9% of new registered nurses (RNs) were educated in associate degree programs, which is higher than the national percentage (American Association of Community Colleges [AACC], 2006). According to the 2004 National Sample Survey of Registered Nurses, between 2000 and early 2004, 56.9% of RNs received their initial nursing education in an associate degree program, 39.9% received their initial education in a baccalaureate or higher program, and only 2.8% graduated from a diploma program. In addition, the survey found that in 2004, almost 21% of nurses initially educated at the associate degree level received a bachelor's degree or higher.

Nurses are getting the message that the baccalaureate degree is needed and many are returning to school; however, more nurses need to be encouraged to return to school. Evidence is mounting that supports the link between nursing education and patient outcomes. Aiken and colleagues (2003) found that hospitals with more RNs with bachelor's degrees or higher had better patient outcomes. Canadian researchers provided additional support, finding that hospitals with a higher proportion of baccalaureate-prepared nurses had lower 30-day mortality rates. The sample consisted of patients with the diagnoses of acute myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, pneumonia, or stroke in 49 acute care hospitals in Alberta, Canada (Estabrook, Midodzi, Cummings, Ricker, & Giovannetti, 2005). In a more recent study, Tourangeau and colleagues (2007) determined that the hospital mortality rate was reduced when the number of baccalaureate-prepared nurses employed by the hospitals increased. Most recently, Friese, Lake, Aiken, Silber, and Sochalski (2008) found that hospitals whose nurses had more advanced educational preparation had lower mortality rates. Findings from these studies indicate that the educational level of the bedside nurse does matter.

Studies have demonstrated that the baccalaureate has a positive impact on patient outcomes and some nurses are returning to school; however, many nurses are not. Therefore, identifying ways to support nurses who return to school; and encouraging other nurses to return is paramount.

In an upper-division baccalaureate college of nursing in upstate New York, the majority of nurses who return to school have been out of school for many years. When nurses return for their bachelor's degrees, many experience role stress due to work and family commitments (Delaney & Piscopo, 2004). It is important to ascertain concerns of these students in order to help them be successful in earning their bachelor's degrees.

Melanie Kalman *is an associate professor of nursing and director of research;* ***Margaret Wells*** *is an assistant professor of nursing; and* ***Carol Scheel Gavan*** *is an associate professor of nursing, associate dean, and director of graduate nursing studies; all are with the State University of New York Upstate Medical University College of Nursing in Syracuse, NY.*

Review of literature

Studies of nurses returning to school document experiences of role strain or conflict as these nurses add the role of student. Campaniello (1988) found that baccalaureate students who were performing multiple roles did not have increased perceived role conflict; however, it was in their parental role that they felt role conflict. Those who had increased social support and flexibility with scheduling perceived less role conflict.

Lengacher (1993) found that the characteristics of personality, stage of career development, and marital status were significantly related to role strain in RN students returning to school. Zuzelo (2001) found that RN-to-BS students were challenged in meeting the demands of multiple roles; when necessary, they prioritized family and work over school demands. Thompson (1992) concluded that returning RN students who were able to maintain a balance while managing multiple roles were more likely to complete the program. Dailey (1994) found that nurses chose a distance education program because it offered more personal control and flexibility that was needed to juggle multiple roles. Ritchie, Evans, MacNeil, and Micsinszki (2005) studied Canadian RN nursing students in a BS program and found the overriding theme was "surviving" with three sub-themes: "the quest;" "the struggle," which included juggling multiple roles; and "the aftermath." Managing multiple roles can be very challenging for returning RN students.

Many studies of nurses who returned to school to attain a bachelor's degree found that returning nurses developed an increased commitment to nursing and a higher level of professionalism. Chornick (1992) compared the behaviors of RN-to-BS completion graduates with generic BS graduates and determined RN-to-BS completion graduates performed critical nursing activities as frequently as generic BS nurses yet demonstrated significantly more behaviors that indicated commitment to the profession. Witt (1992) compared RN-BS students with RN-BS graduates and concluded scores on work performance scales were higher for graduates than beginning students. In addition, graduates had a more positive image of nursing and were more likely to belong to professional organizations than beginning students.

Lillibridge and Fox (2005) found that RN-to-BS graduates felt they gained much new knowledge and had a more global perspective; however, they felt they did not "fit in" with generic RN students, and they needed support from the academic and work environments. In the United Kingdom, Wildman, Weale, Rodney, and Pritchard's (1999) survey of graduates of a post-registration nursing program demonstrated that the nurses had improved critical thinking skills, wider knowledge for practice, and greater ability to use research findings as a result of their advanced education. Interestingly, Zuzelo (2001) discerned that RNs returning to school felt that baccalaureate education had no real influence on the direct patient care they provided, yet they felt they grew professionally. The experience of RNs returning to school to attain a bachelor's degree usually results in a change for the nurse.

Nine research reports on the issue of RNs returning to school were reviewed, yet there are reasons for re-examining the issue in this study. First, it is important to hear from the RN student's perspective, which is best achieved through qualitative methods; three articles used a quantitative survey method (Campaniello, 1988; Delany & Piscopo, 2004; Lengacher, 1993). Second, while other authors used qualitative methods, the articles are more than 14 years old (Dailey, 1994; Thompson; 1992). Much has changed in both education and nursing and, because of that, the issue needs re-examining. Furthermore, Dailey (1994) examined Regent's College, where students learn by self-study and not in a traditional classroom. Chornick (1992) compared generic RNs to nurses in an RN-to-BS program. This is different from the current research question. Ritchie and colleagues (2005) investigated Canadian students; there may be different results with students in the United States (U.S.). The only recent researchers who examined returning U.S. RN students were Lillibridge and Fox (2005) and Zuzelo (2001). Lillibridge and Fox's (2005) study had a sample size of just 6 students. Neither of these studies queried students from New York State.

The purpose of this study was to describe the experiences of RNs returning to school for a bachelor's degree after working and being out of school for at least 3 years. Nurses who return to school at least 3 years after completing their initial nursing education are often older and have additional responsibilities from work and family commitments (United States Department of Health and Human Services, 2004). More research is needed to understand the needs of this unique group.

Method and sample

Using a phenomenological design, the researchers interviewed students at a college of nursing to elicit their perspectives on returning to school and to determine some of the barriers and supports they have encountered. The aim of phenomenological research is to "borrow other people's experiences in order to better come to an understanding" of that experience (Ray, 1987, p. 169). The research question was, "What are the experiences of RNs who return to school for a bachelor's degree after being nurses for 3 years?"

The sample was drawn from current students at an upper division state college of nursing in upstate New York that had an enrollment at the time of 90 undergraduate RN students who had been out of their basic nursing program for at least 3 years. Four of the 11 participants were diploma graduates and 7 were associate degree graduates. The mean age of the participants was 43.5 years with a range of 36-59 years. The mean years since their initial nursing education was 18 with a range of 4-39. All 11 participants were English-speaking and female. All students responded that their ethnicity was Caucasian. Those who volunteered to participate in the study had been enrolled in the program for a least a year, so the experience of beginning students was not captured. All students but one were part-time, taking two classes per semester.

After approval from the Human Subjects Review committee, the researchers conducted semi-structured, one-on-one, audiotaped interviews that were transcribed verbatim. Interviews of participants were conducted by one of the first two authors in a faculty office at the college of nursing (CON). Data analysis and coding were performed by all three authors.

The researchers recruited participants through the CON Web site and class announcements. Informed consent and demographic information, including age, ethnicity, type of basic nursing program, and years since basic nursing program, were obtained at the time of

Some of the women felt their jobs were stalled or that they wanted to advance themselves.

the interview. The interview schedule consisted of a broad opening question followed by probes to elicit individual perspectives, positive factors, and barriers to returning to school.

Data were coded using a method described by Paterson and Zderad as described in Munhall (2001). This coding consisted of three processes: intuiting, analyzing, and describing. Intuiting is similar to bracketing. The researchers examined preconceptions together before interviewing any students to come to "unknow" and to bracket assumptions (Munhall, 2001). Field notes were recorded during the interview and expanded upon immediately afterward so as not to lose initial impressions. Field notes consisted of observations about the subject including body language and nonverbal communication. Interviews continued until saturation was reached; for this study saturation was reached after the 11th interview.

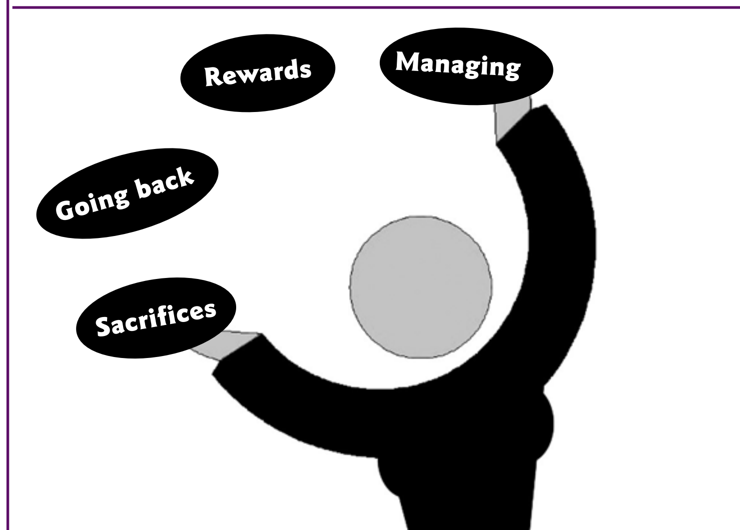
In the second step, Analyzing, the researchers compared and contrasted language within and between interviews, identified common themes, and identified how these themes interrelated (Boyd, 2001). Analyzing was completed in six steps: 1. coding each word or phrase; 2. determining that no two codes had the same meaning; 3. eliminating irrelevant words or phrases; 4. clustering similar codes together and theming the clusters; 5. rechecking transcripts; and 6. rechecking the entire process.

The last step, Describing, occurred when themes were reflected upon and central characteristics isolated. Ray described this as "reflecting deeply on the meaning of the whole of an experience" (1987, p. 169). This occurred separately by the researchers and then together. Scientific rigor was achieved through credibility, audibility, and fittingness (LoBiondo-Wood & Haber, 2005). Credibility, or the truth of the findings judged by the participants, occurred with member checking. Audibility, or accountability of the process, was measured by the carefully kept paper trail from the interviews through the final themes. Fittingness occurred when the themes became faithful to the experience of the participants and was confirmed through member checking of selected participants.

Results

Overall, returning to school was a juggling act for these women. What the women juggled was everything that was important in their life: family, work, personal goals, and school. Four themes emerged from the data: going back, sacrifices, managing, and rewards. When the women discussed any of the four themes they did so in the context of what was important to them. Therefore, each of the themes will be presented within the framework of family, work, personal goals, and school (Figure 1). All of the participants' names have been changed to preserve anonymity.

Figure 1. Four themes compete for the attention of nurses who return to school, resembling a juggling act.



Going Back

Most, although not all, of the women had expected to return to school for their degree, but had waited for the right time. When they decided to go back, there were either specific reasons, like divorce or future plans, or nonspecific reasons. Among those that had specific reasons, Marie said, "I had always wanted to go back. I felt like this piece [school] was missing, but I was in a marriage that really didn't support returning to school. So when I got divorced . . . I said, 'I am going to do it.'" Future plans were another impetus for returning to school. Lois and Carrie wanted to teach someday. Carrie said, "In order to do that, I was going to have to go back to school."

Children (family) exerted the biggest influence on when the women returned to school. Jem stated, "I always wanted to go on, but between working and kids, I put it off until they were old enough." McKayla chose to return to school when her children were young. After having a baby, she went from working full-time to working part-time. Since "I am part-time at work, I decided to come back to school since it would be easier . . . than trying to come back when I was full-time."

Work was another catalyst for returning to school. Some of the women felt their jobs were stalled or that they wanted to advance themselves. Lois stated, "I felt that I reached a standstill in my career. I wanted to advance. I felt stagnant." Similarly Mary said, "I decided to return to feel more secure in my profession." Susan was in an environment that valued a bachelor's degree and talked to peers. "They were excited about what they were doing. That was kind of an influence too." Jennifer decided to go back because "I could see the importance of it and I [felt I] had to professionalize nursing."

Sacrifices

Once they were back in school, the participants discovered they needed to make sacrifices. Carrie summed it up when she said, "It makes it more difficult to juggle the other roles." Sacrifices with the family were the women's primary concern. Mary stated, "I felt like I missed a lot of time with my son and family time together." McKayla claimed, "It has been very hard. I have had to put a lot of things on hold . . . things with my children. I try to get my school work done first, but sometimes it is hard to manage everything at once." Even though Susan's children were grown, she felt there were sacrifices. "I have grown children and grandchildren [who] still need support. It is hard to juggle, when you are working every other weekend and taking classes."

The women also had concerns about elderly parents. McKayla said, "I don't get to visit them as much, especially my mother. She doesn't understand, 'what do you mean you have to study for a test, why can't you do that another time?'" It is interesting that Susan said she wouldn't have seen her mother any more had she not been in school, but felt regrets anyway. "I feel like I miss out on some of the things that mothers and daughters like to do, such as just going out to lunch. Not that we would do that any more or any less." Amy felt her brothers had to pick up the care of her mother since she was so busy. "Probably [my] two brothers are the ones that are affected. Because I am not spending so much time with Mom, they need to pick up the slack."

There also were sacrifices with work. The nursing units where they worked had to be flexible, which was not an easy task when staffing was short. When asked about how easy it was to get time off for class, Susan said, "I think that it is more a unit thing. It's how much staff do we have? Are we short-staffed? Can we juggle? Can we be flexible?"

Some sacrifices with school related to accepting less than an 'A' as a grade. Lois received a 'C' in pathology. She talked about it: "First when I got the 'C,' I heard that that was a good grade in that course and not to panic. [But] it took me a while to deal with that. I just kind of pretended it didn't happen. I was a little angry at myself [because I felt] I should have done better." Susan said that for two semesters, "I ended up working nights and going to classes for 4 hours after work, which shows up in my grades. But I got through them, and I did okay. If I don't get the top grade in the class, it's okay, because I am juggling so many things."

Personal sacrifices included giving up personal pursuits, seeing friends, financial issues, sacrificing housekeeping standards, and sleep. Marie said, "I have a home now and I like gardening and I want to sew curtains. I had to put all of that on hold." Carrie acknowledged changes in friendships due to the added commitments of school. "Some friends that weren't as close, when I didn't have the time to put into it, those relationships fell off." All students received tuition reimbursement through work; however, finances were an issue for those who had to pay tuition up front. Hannah complained, "Coming up with $1,200 dollars for a [single] mother of three every semester is tough. So, I did wind up taking out a student loan because it is less of an aggravation than trying to scrape up the cash." Amy had concerns about her housekeeping: "It was difficult balancing school and job and work at home. Work at home is probably what suffered the most. Laundry would build up, floors aren't cleaned, kind of a general order of chaos." Mary expressed, "It is hard to be in school when you are a full-time mom and wife. It was not easy for me because I am still working full time. I am trying to do part-time school, and the only time I can study is at night when everyone else is sleeping."

Managing

The women had many coping strategies in order to manage all that they had to juggle. What helped was the support of their families and friends. Of the women who were married, most of the husbands were supportive. Jennifer said that her husband "helps me out with the housework. He will ask 'How do you think you did on the test? Good. Oh, great.'" Amy said her husband is "very quietly proud of what I do. I overheard him saying something to his Mom about what I was doing in school." Hannah's husband wasn't as supportive but she coped by "letting it roll off my back. I know what I need to do for my personal satisfaction."

Children were also supportive. Marie stated, "My son has been supportive. We did homework at the same time, so I didn't feel that we were taking time away from each other." Those women who were not married still felt support from family. Lois felt that, "They have been very supportive. They know when I have to study and they leave me alone."

To manage work the women required support both on an organizational level and a unit level. Support on the organizational level related to tuition reimbursement. All said that they couldn't go to school without tuition reimbursement. On the unit level, the women managed if there were no difficulties getting time off from work for school. If the work schedule was not flexible enough to allow time off for class, some, such as Susan, changed their jobs. She said, "I couldn't get the schedule I needed to come to classes." Others, like McKayla and Carrie, managed by working part-time. McKayla said, "I went part-time at work to be able to come to school." Carrie explained that she "dropped back in hours to go to school. What I find the hardest is keeping all the balls in the air. My job is actually divided into two different positions. School is not much of a challenge. My personal life I can handle. Each job that I do at work, I can handle. When I put all four of them together, it is a challenge to try to keep everything going." Amy had her own way of managing work and school: "I took a lot of personal time and I used up all of my [time] accruals."

The women believed that they received school support from the faculty and from the flexibility of the program. Most stated that faculty members were very helpful and understood the needs of adult learners. Lois said, "The professors at the college are willing to help and they understand that life sometimes gets in the way." Carrie explained, "One of the best things that the school can offer is the flexibility. The recognition that many of the [students] in the program are working, they already have a family, and most of the time they have their career goals in mind. Having that flexibility piece and recognizing what we are juggling has been a huge support for making it through the program."

Personal ways that they managed included not going to school full time, allowing more time for schoolwork, and increasing their efficiency. Jennifer "decided to go slowly, because I wanted to enjoy the process . . . without overdoing the stress angle." Both Susan and Carrie felt that they became more efficient. Susan said, "I tend to be very organized, and unless everything is done, I don't sit down. If I have a paper to write, I stay home and write the paper. I think this has made me more disciplined."

Rewards

The women received many rewards from returning to school. The reward most often mentioned regarding family was being a role model for their children. Susan stated, "I am a good role model for my kids. They understand how hard you have to work for good grades." Jem agreed, saying, "I think it is positive for my kids to see me going back." Carrie had a different perspective on being a role model. She said, "I think my children value getting their education while they are younger because they see the struggle that it is for me to juggle." Families were proud and rewarded because they had an advocate who could speak with other disciplines. McKayla said her family "is pretty impressed . . . and proud of me because I am the first one out of 10 kids to receive the bachelor's degree." Lois talked about a family illness. "My brother was in the hospital 3 weeks ago. The physicians there found out that I was a nurse, and that I was going to school; they were just unbelievably respectful and asked me questions as to how I thought he was doing. They relied on me to help my family."

The women were also rewarded at work because they felt that schooling led to better patient outcomes. Susan said, "I didn't realize how much using that information would affect my job. I think that it affects the outcome of the patients." She further explained that, "I need to be able to have discussions with the physicians and sound like [I] know what [I am] talking about. Learning how to talk to people and . . . how to communicate, so that you can improve things." McKayla agreed, saying, "As far as taking care of the patients, instead of just doing what the doctor ordered, now I can look at the whole picture [including] the emotional side of the patient and teaching them what they need to know." Lois succinctly stated, "School makes me think of things differently when I am working."

Regarding personal rewards, the women found that it solidified their belief in the value of education and the nursing discipline, and gave them self-confidence. Susan believed that, "nurses need to complete their bachelor's degree. That is an important piece that our profession misses." McKayla said, "It brought clarity to my nursing profession. Now I look at the whole picture." Amy, discussing her work, said, "I got excited about it again. [Going to school] was something that brought a little spark into a job that was getting stale." Marie said, "It helped my self-esteem a lot." Mary felt that, "[School] helped me gain more self-confidence, since I am from another country and I lack experience, it was really tough for me. I feel more secure because of the knowledge I gained."

When the researchers reviewed the theme of rewards within the sub-theme of school, "school" was defined differently than were the previous sub-themes. This change occurred to find ways that would improve the experience of returning to school and remove barriers for students. The women were happy to provide suggestions. There were logistic suggestions, such as Amy asking faculty to schedule all classes on one day and Jem asking for more summer classes. There were pedagogical suggestions, with Jem wishing there was more help on how to write papers after being out of school for so long. When asked how faculty could help, she suggested, "Maybe an APA class because you are really expected to know APA, and I have never heard of it before." Lastly, because these women worked and had family obligations, they tended to come to campus only for class. This meant that there was a feeling of isolation. Marie described it. "I knew some people in my classes, but they weren't my friends . . . I was really alone. It was very scary."

All of the women were excited about returning to school. Some, however, discussed specific reasons why they returned when they did, while others could not say why they returned at this point. They all made sacrifices but managed with various coping methods because they felt that school was rewarding for them. All the women juggled what was important to them: family, work, school, and personal needs.

Discussion

The authors captured the essence of the experience of returning to school for nurses who had been out of their initial nursing education for at least 3 years. Because the mean age of participants was almost 44 years and the mean number of years since initial nursing education was 18, these nurses had various life circumstances that influenced their educational experience.

As a result of this study, changes were made in the college of nursing to help address the concerns of returning RN students. Although not found in the literature, lack of peer support was a concern identified in the study that was addressed through the student association of the college of nursing (SACON). Monthly SACON meetings are held during the school year, but they are not well attended by nursing students because of lack of time due to commitments in their multiple roles. An online peer discussion forum was established to allow students to communicate with one another without having to be on campus. The effectiveness of this intervention has not yet been evaluated.

Dissatisfaction with the advisement process was identified as a concern by returning RN students in this study and others in the literature (Lillibridge & Fox, 2005; Ritchie et al., 2005; Zuzelo, 2001). The student advisement and orientation process has been changed to meet the needs of the students.

In the past, students were assigned advisors in the middle of the fall semester. This timing meant they had no designated person to contact if they had questions or concerns at the beginning of their program. Currently, as part of the orientation process, students are assigned advisors prior to starting classes. Students and advisors meet to choose courses for the fall and briefly discuss programs of study. This allows the students to connect with their advisors prior to starting classes and to have a contact person if problems arise early in the semester. Both faculty and students have been pleased with the change in the advisement process. Also, many students were anxious about the American

Psychological Association (APA) style manual. In an introductory course, faculty added APA exercises for students to practice. Faculty members also wrote a simple, one-page guide to APA style, which has been favorably received by students. In addition, more flexible and block scheduling is offered. Flexibility is achieved with a more liberal credit-transfer policy and block scheduling is offered, with three to four classes scheduled on one day of the week.

Although many of the participants expressed hardships associated with returning to school, each participant also expressed personal and professional rewards gained from attaining a bachelor's degree in nursing. In this study students found they had a higher level of professionalism after being in school but felt role strain, especially revolving around the parental role. This is consistent with the literature (Campanili, 1988; Chornick, 1992). These rewards have been shared with prospective students to help them make the decision to return to school. Prospective students are often not aware of subtle benefits of returning to school and this has been effective in recruiting students. Communicating the benefits of returning to school is needed because this may encourage more nurses to advance their education, improving patient outcomes.

This study has some limitations. Interviews were conducted by faculty members of the college in their offices. Students may not have freely expressed their negative feelings about the program. In general, students who agreed to participate expressed positive feelings about the program. Those who had negative experiences may have chosen not to participate; therefore, the experience of these returning RNs was not captured. The authors wanted to enroll newly admitted students in the study to elicit their concerns, but none volunteered. This is another limitation.

New RNs who have recently completed associate degree programs are returning to school to receive bachelor's degrees at an increasing rate. Younger nurses agree that their level of education matters. Research is needed to understand the experience of new RNs who return to school soon after completing their initial education. Overall concerns about juggling different roles need to be addressed.

In addition, the demographics presented limitations, including a lack of male participants, no participants of color, and only one participant whose primary language was not English.

Conclusion

The discipline of nursing recognizes the importance of the bachelor's degree as an entry level. These authors agree; however, since most nurses in New York State enter into the profession at an associate-degree level, returning to school has an impact on a significant number of nurses. It is not unreasonable to ask nurses to continue their education to attain a bachelor's degree, but the needs of these nurses must be considered by nurse leaders, educators, and employers. Several studies have shown that when hospitals employ greater numbers of bachelor's-prepared nurses, patient outcomes are improved. Nurses who return to school juggle many roles and need encouragement and support. Listening to their stories is a beginning; this study articulates the voice of returning RN-to-BS students.

REFERENCES

Aiken, L. H., Clarke, S. P., Chenung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association*, *290*(12), 1617-1623.

American Association of Colleges of Nursing. (1995). A model for differentiated nursing practice. Retrieved June 27, 2009, from http://www.aacn.nche.edu/Publications/DIFFMOD.PDF

Campaniello, J. A. (1988). When professional nurses return to school: A study of role conflict and well-being in multiple-role women. *Journal of Professional Nursing, 4*(2), 136-140.

Chornick, N. L. (1992). A comparison of RN-to-BSN completion graduates to generic BSN graduates: Is there a difference? *Journal of Nursing Education, 31*(5), 203-208.

Dailey, M. A. (1994). The lived experience of nurses enrolled in the Regents College nursing program. *Journal of Professional Nursing, 10*(4), 244-254.

Delany, C., & Piscopo, B. (2004). RN-BSN programs: Associate nurses' perception of the benefits and barriers to returning to school. *Journal of Nurses in Staff Development, 20*(4), 157-161.

Estabrooks, C. A., Midodzi, W. K., Cummings, G. G., Ricker, K. L., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research*, *54*(2), 74-84.

Friese, C. R., Lake, E. T., Aiken, L. H., Silber, J. H., & Sochalski, J. (2008). Hospital nurse practice environments and outcomes for surgical oncology patients. *Health Services Research, 43*(4), 1145-1163.

Lengacher, C. A. (1993). Development of a predictive model for role strain in registered nurses returning to school. *Journal of Nursing Education, 32*(7), 301-308.

Lillibridge, J., & Fox, S. D. (2005). RN to BSN education: What do RNs think? *Nurse Educator, 30*(1), 12-16.

Nelson, M. A. (2002). Education for professional nursing practice: Looking backward into the future, *The Online Journal of Issues in Nursing, 7*(2). Retrieved June 27, 2009, from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume72002/No2May2002/EducationforProfessionalNursingPractice.aspx

Rather, M. L. (1992). "Nursing as a way of thinking"—Heideggerian hermeneutical analysis of the lived experience of the returning RN. *Research in Nursing & Health, 15*, 47-55.

Ritchie, L. A., Evans, M., MacNeil, M., & Micsinszki, S. (2005). "Surviving:" Registered nurses' experiences in a baccalaureate nursing program. *International Journal of Nursing Education Scholarship, 2*(1), article 15. Retrieved June 26, 2009, from http://www.bepress.com/ijnes/vol2/iss1/art15

Thompson, D. (1992). Beyond motivation: A model of registered nurses' participation and persistence in baccalaureate nursing programs. *Adult Education Quarterly, 42*(2), 94-105.

Tourangeau, A. E., Doran, D. M., Hall, L. M., Pallas, L. O., Pringle, D., Tu, J. V., & Cranley, L. A. (2006). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57*(1), 32-44.

United States Department of Health and Human Services, Health Resources and Services Administration. (2004). National sample survey of registered nurses. Retrieved June 26, 2009, from http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/3.htm

Witt, B. S. (1992). The liberating effects of RN-to-BSN education. *Journal of Nursing Education*, *31*(4), 149-156.

Zuzelo, P. R. (2001). Describing the RN-BSN learner perspective: Concerns, priorities, and practice influences. *Journal of Professional Nursing*, *17*(1), 55-65.

Articulating the value of psychiatric community health nurse interventions: A secondary analysis

Bonnie A. Sturm, EdD, RN

Abstract

The purpose of this secondary analysis of qualitative data was to discover and articulate the nature and value of therapeutic nursing interventions (TNIs) utilized by psychiatric community health nurses (PCHNs). PCHNs encounter ethical conflict when faced with increasingly strict payment limitations on nursing practice (Sturm, 2004). This new analysis provides evidence of how TNIs, executed with a high level of sensitivity and skill, enable the PCHN to address and effectively manage the complex healthcare needs of patients with chronic mental illness. The author/researcher specifically analyzed qualitative data from two broad thematic categories of an ethnographic study of PCHN practice to explicate the nature and impact of TNIs employed by PCHNs in efforts to provide high-quality care. Specific TNIs were observed to be an integral part of the nurse-patient relationship and were executed by the PCHN, influencing patient self-esteem, socialization, and the capacity for autonomy.

This paper focuses on descriptive evidence of the nature and value of therapeutic nursing interventions (TNIs) and articulates some of the ethical dilemmas encountered by psychiatric community health nurses (PCHNs) when third-party insurance providers undervalue the professional skills and qualities required to provide these services. The PCHNs involved in this study were community health nurses with additional psychiatric nursing experience beyond the initial licensure level for a registered nurse (RN), but who did not have graduate degree preparation. TNIs are predominantly aimed at improving the psychological competency of the client and are not recognized as distinctly billable interventions by third-party payers in current United States insurance systems.

The author/researcher describes the ethical conflict experienced by these nurses when they recognized the fact that they possessed the skills and motivation to successfully help their clients but were faced with the impossibility of procuring payment for such services. Furthermore, the study findings illustrate the positive influence of specific, successful therapeutic nursing interventions provided for persons experiencing chronic and persistent mental illness as well as the impact of these TNIs on patient self-esteem, socialization, and capacity for autonomy.

The author previously reported on the findings of an original ethnographic study of psychiatric community health nursing practice including the design, methods, broad ethical issues encountered, and importance of the therapeutic relationship between the PCHN and the patient. Medically based nursing interventions (such as assessing wound healing) were funded with greater frequency than psychologically based interventions (such as assessing the degree of depression), a situation that revealed the issue of non-parity and contributed to the nurses' experience of moral distress (Sturm, 2004).

Nine broad thematic research categories were identified. The researcher's original field notes contained rich descriptions of nurse behaviors, experiences, and interactions. The two broad thematic categories coded as Nursing Interventions and Issues/Conflicts were chosen for this secondary analysis because they provided references to all areas in the original field notes that contained evidence of PCHN interventions as well as many types of issues and ethical conflicts that PCHNs experienced in practice.

***Bonnie A. Sturm** is an assistant professor of nursing at Seton Hall University College of Nursing, department of behavioral sciences, community, and health systems, in South Orange, NJ.*

The ethnographic study (Sturm, 2004) contained information and observations concerning many facets of daily agency life, nursing practice, nurse-patient interactions, leadership behaviors, nurse-supervisor interactions, and multidisciplinary interactions, some of which contained the potential for additional analyses. Polit and Beck (2008) explained that qualitative researchers commonly collect volumes of data that require further analysis beyond the original study and that a secondary analysis can allow the researcher to approach a higher level of analysis. The author's approach to this secondary analysis did not initially seek to answer a specific question. Instead, in keeping with the tradition of qualitative inquiry, the author sought to understand frequently occurring themes and issues within the context of their occurrence. These two categories of interest were chosen because of the richness of this data and the relevancy of this data to nursing issues and practice.

This secondary analysis found evidence of specific aspects of TNIs utilized by PCHNs and descriptions of ways in which TNIs influence particular patient outcomes. This study also discusses why TNIs are considered non-skilled and non-reimbursable PCHN skills and how this contributes to the nurse's experience of moral uncertainty and distress. Re-reading and analyzing the original data (field notes) referenced and cross-referenced under the broad thematic headings of Nursing Interventions and Issues/Conflicts resulted in the identification of nine new classification categories of TNIs.

The problem

There is an absence of current, in-depth, descriptive evidence explicating the nature and value of TNIs in the context of a PCHN home practice setting. By articulating the nature and value of TNIs identified in this analysis, an awareness for the potential worth of community-based psychiatric nurses and teams that can provide comprehensive holistic nursing care may be developed and given more serious consideration by the healthcare community. The final discussion portion of this paper posits reasons that and contexts in which TNIs provided by PCHNs should be considered reimbursable skills by third-party payers.

Background

Therapeutic nursing interventions

Therapeutic communication skills form an integral part of the nurse-patient relationship, and the importance of the one-to-one nurse patient relationship has been cited in the nursing literature for more than 50 years (Frisch & Frisch, 2006; Lego, 1999; Welch, 2005). PCHNs and administrative study participants explained that therapeutic communication skills (an integral part of TNIs) are currently identified by insurance providers and nurses as non-skilled, which is the terminology utilized to describe interventions that are non-reimbursable by third-party payers. This classification does not mean that nurses who use them can do so effectively without skill, but it clarifies that managed care insurance providers do not recognize the provision of such interventions as distinctly reimbursable. Non-HMO Medicare pays for very limited psychiatric nursing assessment under specific provider criteria, and Medicaid pays for some chronic care, which may include these interventions, but coverage for chronic psychiatric care involves particularly strict restrictions. The interpersonal therapeutic interchange of the PCHN with a patient is often viewed as a less important and less tangible aspect of the nurse's visit, when, in fact, it may actually hold the greatest value for the patient's ongoing welfare. Many nurses made comments similar to one nurse's statement, "No one pays for a nurse to just talk to the patients. It's hard to show how important this is."

The interpersonal interchange with a patient is often viewed as a less important aspect of the nurse's visit, when, in fact, it may actually hold the greatest value.

Simpson (2005) describes how the value of the day-to-day work of psychiatric nurses with their patients was diminished when it was restricted to the requirements of the nurses' coordinator/administrator role, a function that is given higher priority in today's healthcare systems. The nurses experienced this valuation as a conflict. Additionally, Rhein and Callahan (1999) emphasize the value of the role PCHNs play in advocating for the mentally ill living in the community. A PCHN engaged in a consistent nurse-patient relationship may be the very person who sees the early signs of patient decompensation, suicide risk, or the many subtle forms of functional loss.

The ethical dilemma

The ethical dilemma experienced by the nurses in this ethnographic study was palpable. One could see it in their expressions and hear it in their voices when they spoke of the unmet needs of their patients with chronic mental illness. The PCHNs consistently spoke about feelings of frustration and disappointment, and they exhibited resignation to the ongoing struggle required to gain permission from third-party payers for even one extra visit. The experience of an ethical dilemma in healthcare is often described in the literature as moral distress.

"Moral distress occurs when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action" (Raines, 2000, p. 30). Although this observer (as have others) frequently witnessed nurses engaged in caring acts and providing unconditional regard for their patients, those nurses did experience moral distress when they encountered a conflict between seemingly irresolvable issues in practice (Austin, Bergum, & Goldberg, 2003; Roberts, 2004; Sturm, 2004). When a nurse felt there were no further options, she often decided to move on to the next patient, conveying the sense that she had done what she could, even though it was not enough. The visible expression of what appeared to be a sense of loss and a resignation to conditions apparently outside of one's control was apparent. For example, leaving a patient's home after one particular visit, a nurse explained, "I stayed longer than I had time for; he has no family, and I only have permission for one more visit. He didn't even have the right medications in the house and he's just sleeping all day."

Nursing's ethic of care

Engaging with nurses in this practice environment enabled the author to document nuances of behavior that gave evidence of the nurses' conflicting feelings. It is important to note that nurses are influenced by an ethic of care in their aim to provide assistance that is helpful and good for the patient/family. The American Nurses Association (ANA) ethical code of conduct (2001) provisions 2.1 and 2.2 support the nurse's effort to attempt to resolve conflicts that may occur between the expectations of the healthcare organization plan and the nurse's assessment of what nursing interventions serve the patient's best interest. This includes the nurse's understanding of the uniqueness of the individual patient and the delivery of nursing interventions that meet that need. Nurses who attempt to adhere to these aspects of the ANA Code of Ethics find themselves in the midst of an uncomfortable conflict between contradictory professional aims, namely, care-based therapeutic interventions and the demands levied by the business of health care.

Method

This paper describes the results of a secondary analysis of qualitative data and serves to describe the value of TNIs that PCHNs utilized in practice to meet individualized care needs.

Ethnographic research takes place in the participant's natural setting, where the everyday life of the participants can be shared and the meaning of these experiences can be richly described, thereby contributing to the understanding of phenomena within the cultural context of the participant's world (Bogdan & Biklen, 2007; Geertz, 1973; LeCompte & Priessle, 1993; Macnee, 2004; Stommel & Wills, 2004; Wolf, 2007). It is the insider's or *emic* perspective that the researcher attempts to comprehend and explicate.

The original ethnographic study of psychiatric community health nursing practice was conducted between August 1, 2000, and July 7, 2001, and employed the traditional methods of ethnographic design, utilizing participant observation methods in field work, many semi-structured interviews, and analysis of agency documents; no patient records were utilized. Details of method and original analysis have been previously published (Sturm, 2004). The settings for data collection included the agency offices, multidisciplinary meetings, in-service meetings, home nursing visits, and time spent with nurses en route between any of these settings. Participants included nine PCHNs, a psychiatric clinical nurse specialist (PCNS), and a variety of multidisciplinary health professionals. All data was collected by the author. Regular meetings with an expert anthropologist guided the collection methods and original analyses.

Ethical considerations

Participant consent, agency permission, and institutional review board (IRB) approval were obtained. The nurses that participated were told that their willingness to allow the author to observe them was voluntary, and that they retained the right to refuse to participate at any time. Agreement stipulated that data obtained would be presented in anonymous and aggregate forms. Observations that included patients were recorded from the standpoint of the nurses' responses and actions and did not contain identifying links to any individual patient. The secondary analysis of original data included in this article is presented in aggregate and composite forms. Any names used in this manuscript are fictitious.

Analysis

A secondary analysis of the field notes was completed, extricating descriptive data from two broad thematic data categories clarified as Issues/Conflicts and Nursing Interventions, which were chosen from the original nine broad thematic categories previously identified (Sturm, 2004). This secondary analysis involved re-reading the portions of the original field notes, which were located by following references and cross-references indexed under the two broad thematic categories and their subcategories. The researcher discovered that the field notes contained rich descriptions of TNIs used in PCHN practice, as well as issues surrounding their use. This evidence was essentially coded and conceptualized to represent nine classification categories identified as TNIs observed in practice (Figure 1).

Figure 1. Secondary analysis process and findings: The nine TNI classification categories.

Two Broad Thematic Categories (with a combined total of 12 sub-categories)	Nine Newly Identified Classification Categories (derived from Issues/Conflicts & Nursing Interventions)
Issues/Conflicts	**Therapeutic Nursing Interventions (TNIs)**
1. Issue: advocacy	
2. Issue: autonomy of patient	
3. Issue: autonomy of significant other	1. Rapport
4. Issue: beneficence	
5. Issue/Conflict: many examples	2. Affirming/Empowerment
6. Ethical issues	3. Reflection
7. Nurse's coping with conflict	
	4. Reality Orientation
Nursing Interventions (home visits & environments)	
1. Nursing intervention: therapeutic and "skilled"	5. Confrontation
	6. Humor
2. Nursing intervention: therapeutic, but not reimbursable or well-documented	7. Active Listening
3. Patient's identified benefits of psychiatric nursing visits	8. Modeling
4. Environments (office and home)	
5. Patient visit situations (all visits)	9. Support Sense of Control

Results: TNIs and PCHN effectiveness

This section identifies nine classifications of TNIs that were observed in practice and that were extracted from the secondary analysis of seven previously identified sub-categories of the broad thematic category termed Issues/Conflicts and five sub-categories of the broad thematic Nursing Interventions category. Seven of the TNI strategies are aspects of competently executed therapeutic communication techniques. The eighth and ninth strategies include: Modeling, which is identified as a TNI that promotes patient skill development in assertiveness and advocacy; and Support Sense of Control, which is a TNI that supports patient autonomy and self-esteem. Examples of these TNIs, along with evidence of how these TNIs can influence patient outcomes, is presented in the form of qualitative data-based patient care scenarios.

1. Rapport:

PCHN Cynthia Jones explained her insights regarding the need to develop rapport with the patient. "It's very important; just going down a checklist of psychiatric and mental status assessment questions is de-humanizing and interferes with developing a therapeutic rapport. While the assessment is the task of the visit, the relationship is what matters to the patient."

2. Affirmation and Empowerment:

PCHN Anita Smith had a patient with two diagnoses: depression and leg ulcers. She asked her patient to take more responsibility for his wound care by preparing the equipment and removing the dressings before she arrived. Asking a patient to do this is not especially unusual, but what stood out was how Smith clarified the rationale. "It empowers him to take responsibility for some of his care; it gives him more personal strength." The patient's expression and posture demonstrated how positive he felt about this affirmation. This TNI provided an example of holistic PCHN care.

3. Reflection:

Numerous patient-nurse interactions demonstrated reflective communication techniques and evidence of affective caring, which encouraged patients to talk about their feelings directly and to become more aware of those feelings in themselves. One patient was observed speaking to PCHN Jill Roberts. The patient's eyes began to well with tears as she stated, "Talking about my husband and my kids brings up memories." There was a palpable sense of release and emotion (which included feelings concerning her husband's recent death) as the nurse listened to the patient's feelings. This patient suffered from depression and having the intentional nursing support and encouragement to talk about her feelings was an important aspect of her care.

4. Reality Orientation:

Reality orientation as a TNI (as distinguished from the usual issue of a sense of time or place) is another important aspect of therapeutic communication. PCHN Sara Johnson utilized this skill to help a patient, Mrs. Barry, to face some difficult obstacles and to move forward. Mrs. Barry talked a great deal about feeling sad, about having lost interest in her life, and about her fear of going outside (she was agoraphobic). PCHN Johnson directed her to concentrate on the here and now, to think less about broad-based fears, and instead to focus on something positive she could do to get certain services she needed. Mrs. Barry was able to identify someone with whom she was willing to go out of the house as well as another agency that she might call for meals; she also demonstrated success in making a phone call to a doctor. Each time Mrs. Barry faced an obstacle, PCHN Johnson reinforced the choice or helped her to modify the idea. Following the visit, the nurse stated that she did this to build the patient's self-confidence and to help her to see that she could face the problem and do something positive for herself.

5. Confrontation:

Sometimes nurses use the communication technique of confrontation to help patients acknowledge ambivalence between action and feelings, the rationale being that self-awareness enhances growth and autonomy. PCHN Helen Woodbury described her experience with confrontation in relation to a patient, Mr. Perry. When the nurse arrived unexpectedly early for the home visit, she observed Mr. Perry proceeding to yell violently at his wife and to accuse her of not doing certain things he had told her to do. PCHN Woodbury chose to confront the patient with his behavior and the reality of the many helpful things his wife did do for him. Mr. Perry seemed able to acknowledge his behavior, which was a positive step for him. It is likely that meaningful confrontation was possible because the PCHN Woodbury had been working with Mr. Perry for many weeks and had a relationship with him. Confrontation is a technique that is generally avoided until an interpersonal relationship is established with the client (Stuart & Laraia, 2004).

It is important to note here that the nurse was a psychiatric nurse who provided therapeutic communication interventions to a patient who had psychological issues complicated by the nature of his disease, a history of anxiety attacks, and symptoms of a personality disorder, but that the reason she was able to bill for this visit was to provide wound care to the patient. PCHN Woodbury and her supervisor subsequently explained that a psychiatric nurse was assigned to follow this case because other medical-surgical nurses had a great deal of difficulty coping with this patient's behaviors and treatment choices.

6. Humor:

The use of humor as an aspect of therapeutic communication was observed on several occasions. Humor is an intervention that can make the patient feel more relaxed and at ease with the nurse, but it must be appropriate to the individual situation. In a grounded theory study by Scanlon (2006) the use of humor by psychiatric nurses is spoken of as an understated skill and notes that psychiatric nurses use humor as a way to develop a friendly quality, which can develop the therapeutic relationship. This is clearly related to the development of rapport.

Struthers (1999) studied community psychiatric nurse accounts of the use of humor in working with patients and found that the use of humor as a therapeutic skill helped in the development of trust and patient insight, but it was also noted that humor could have harmful effects if the patient perceived it as ridicule. It is necessary for the PCHN to be able to differentiate the use of humor as a beneficial intervention from the use of humor that can be perceived as ridicule. Although humor is classified as a TNI, the use of this skill requires interpersonal expertise and insight, and the extent to which PCHNs possess this skill has not been established. Sometimes humor is used

Every nurse that participated in this study expressed frustration with the lack of payment for services that they saw as necessary for the welfare of their patients.

to make one feel more comfortable, but in the patient situations that were observed, the use of humor was intentional and a part of therapeutic communication that supported the rapport between the nurse and the patient. One nurse altered her manner of speech to reflect a lighter style that the patient seemed to enjoy. Another nurse joked about the type and repetition of questions involved in gathering a detailed history. Another nurse used humor when assessing mental status, explaining that whether or not the patient gets the joke can tell her something about the degree of dementia. This, she felt, was better than resorting to repetitious direct questions.

7. Active Listening and Observation:

Active listening and observation on the part of the PCHN is another aspect of therapeutic communication. For active listening to occur, the nurse needs to give full and mindful attention to what the patient is saying, as well as simultaneously observing nonverbal communication. During the home visits many instances of active listening and observation were witnessed. The nurses attentively asked questions and listened to patient responses concerning their experiences of pain, fear, frustration, or need. In one instance with a patient, Mrs. Jones, special skills were clearly required. Many of the things she liked to talk about tended to provoke discomfort in the average person and could be very repetitive. Her ability to communicate was constricted by aphasia, a degree of psychosis, and hypomania. The nurse's ability to listen to Mrs. Jones's concerns with care and intention, but without criticism, was clearly observable and it altered Mrs. Jones's mood for the better. PCHN Lynn Oxford stated that she and her supervisor were talking about whether her visit was a duplication of services, as the patient already visited a psychiatrist once a week. Although this patient saw a psychiatrist for 30 minutes, Mrs. Jones clearly demonstrated a need to be heard and understood beyond that limited session. Mrs. Jones was easily frustrated and social/group daycare situations were intolerable for her. The opportunity to express her thoughts and emotions to her nurse appeared both necessary and therapeutic. This visit did not fall under the usual category of skilled-reimbursable nursing services, and most insurance companies would consider this a duplication of services. PCHN Oxford expressed particular frustration with the lack of Medicare and HMO payment for psychiatric patient visits. Her supervisor stated, "Medical-surgical patients are more often covered for their treatments, it is much more difficult to get reimbursement for psychiatric patients."

Every nurse that participated in this study expressed frustration with the lack of payment for services that they saw as necessary for the welfare of their patients. This scenario illustrates how the competent use of TNIs by the PCHN in providing active listening, assessment, and care is under-recognized and undervalued by third-party payers and is a stressful dilemma for PCHNs.

8. Modeling:

In the field of education, the act of modeling by the teacher is considered by many to be an important aspect of the learning process. Modeling is also a therapeutic strategy to promote assertiveness and advocacy used by PCHNs in practice. It is important to be aware, however, that it takes time to develop sufficient trust and rapport with patients so that when modeling takes place, the patient is interested and open to learning skills that the nurse demonstrates and speaks about. PCHN Kathy Fitzgerald made home visits to Mrs. Diaz, which included modeling interventions provided over time. At the time of data collection, Mrs. Diaz had been PCHN Fitzgerald's patient for 5 or 6 years on the long-term care (LTC) program. Because Mrs. Diaz financially qualified for Medicaid and because she had both complex physical problems and depression, she had been accepted onto the LTC program by the Department of Social Services; it is unusual for a patient with a primary psychiatric diagnosis to be eligible for this type of ongoing care. Patients with chronic depression frequently battle feelings of helplessness. PCHN Fitzgerald demonstrated assertive behavior and was able to teach Mrs. Diaz how to advocate more effectively for her own needs.

The success of this intervention supports the rationale that consistent ongoing assistance with a primary psychiatric nurse in the patient's home setting does support positive change. Mrs. Diaz explained how helpful her nurse had been in straightening out an incorrect phone bill, and she then described how the act of witnessing this process had helped her to follow through on an issue she had a week later with the pharmacy. Mrs. Diaz stated, "Sometimes you need someone like Kathy to get on board and get things straight. You have to be very firm with people sometimes; Kathy can really do that well." After she saw PCHN Fitzgerald stay on the phone for over half an hour with the phone company to get her bill straightened out for her, Mrs. Diaz felt able to persevere with a problem at the pharmacy and was able to succeed in that endeavor independently. Mrs. Diaz sounded proud of her accomplishments. She gained the courage to call her doctor and request a medication change at a later date, without the degree of intimidation she had harbored previously. In this way, PCHN Fitzgerald advocated for the patient and actively modeled behaviors designed to help the patient to self-advocate.

9. Support Sense of Control:

PCHN Marsha Roth conducted a numerical pain assessment with a patient, Mrs. Fine, who suffered from severe arthritis and depression. She responded to Mrs. Fine's answers with a tone of voice that conveyed care and sensitivity. PCHN Roth designed a medication schedule that gave Mrs. Fine more control over the frequency with which she used a medication to control chronic and, at times, severe pain. Mrs. Fine explained during the visit that this worked better for her because she knew she had another pill if she really needed it. Although

this patient's condition was chronic, the nurse's interventions assisted the patient in learning ways to cope with her feelings, improve her mood, more effectively manage her mental status, and participate in controlling her physical pain. The reason the nurse could follow this patient consistently, was because she qualified for a Medicaid long-term care program primarily due to her diabetes and advanced age.

Analysis conclusions

This analysis serves to articulate and emphasize the importance of increasing the recognition of the value of TNIs provided by PCHNs. Two major points emerged from the data: Nursing interventions that guide small behavioral improvements or maintain a patient with chronic illness are seldom reimbursed (not valued) by most insurers and, consequently, nurses experience a stressful conflict when they are financially restricted from providing services that they have seen to make a positive difference in patients' lives.

Many of the scenarios demonstrating how TNIs make a difference took place only because these patients had either Medicaid long-term care coverage with mixed medical-psychiatric diagnoses, or other medical issues had made Medicare coverage possible for longer than the common one- or two-visit limit.

In addition, the reimbursement restrictions of third-party payers normally curtail nursing visits to a one- to two-visit time frame. Patient non-compliance and inconsistent adherence with prescribed medication, healthcare regimens, and medical appointments are common complications for persons with mental illness. The unpredictable observable patient behaviors, including hallucinations, delusions, paranoia, confusion, and impulsive, manipulative, or controlling behavior, represent additional obstacles to the delivery of quick teaching interventions that could have any impact on the patient's ability to comply with a therapeutic regimen. This makes it frequently impossible to deliver TNIs with enough ongoing consistency to create a lasting positive outcome.

Discussion

Ethical aspects of the therapeutic relationship

The preceding scenarios provide insights into particular needs and specific characteristics of the PCHN's experience serving a vulnerable population. The identification of specific nursing behaviors utilized in the therapeutic relationship (TNIs) and integrated with aspects of the PCHN role have been presented to document how these specific TNIs, executed by a skilled PCHN, can actually make a difference in the quality of life experienced by persons with chronic mental illness. It is valuable to consider the impact of these TNIs on patient self-esteem, socialization, and capacity for autonomy (Sturm, 2008).

Nursing literature supports creating individualized nursing care approaches for those with mental illness as an effective means to improve self-esteem and socialization (Beeber, Canuso, & Emory, 2004; Seo, Byun, & Kim, 2007; Sturm, 2007). The development of self-esteem in adulthood takes place over time and in connection with relationships that can empower individuals to recognize their own worth. Self-esteem can be fostered and supported through consistent, intelligent psychiatric nursing interventions.

Great skill is required from the nurse in order to engage in a consistent, caring, and intelligent relationship with a person experiencing chronic mental illness. This sensitivity relates back to the philosophical underpinnings characterizing the interpersonal relationship as described by Peplau (1997). A consistent, interpersonal, therapeutic relationship with a nurse has the potential to foster trust and to make guidance acceptable, while demonstrating respect for the rights of the patient. This relationship allows patients to experience themselves as persons whose particular needs are worthy of both acceptance and individualized approaches. Since nurses are educated within a holistic framework of care, they are particularly suited to helping a client to cope with a combination of psychological, spiritual, and physiological needs.

Without consistency and sensitivity, which lay the groundwork for trust in the nurse-patient relationship, guidance can assume a quality of being rigidly imposed. When nurses had only one or two visits, they were observed making efforts to avoid getting too involved, providing quickly delivered instructions, promptly reviewing medications, and performing a mental status assessment to avoid a potential immediate crisis. This left the nurses feeling frustrated, as they lacked the billable time to provide ongoing TNIs in practice. When efforts originally aimed to guide turn into rules that lack the element of human caring, the patient inevitably challenges such rules. Persons with chronic mental illness are quite sensitive in perceiving whether the healthcare provider is offering guidance that is primarily intended to help them to find personally satisfying ways to manage their lives as contrasted with guidance that is designed to efficiently manage an "out of control" person's life according to third-party payer's criteria.

Making TNIs reimbursable

Nurses have traditionally sought to meet the needs of vulnerable populations and to advocate for their needs. PCHNs are in a unique position to understand and address the multiple health needs of persons with chronic mental illness. TNIs, which include aspects of the interpersonal nurse-patient relationship, have been articulated as comprising a particular set of skills that enable the PCHN to provide needed healthcare services, deliver caring guidance, support self-esteem, develop socialization skills, and advocate for client autonomy. The fact that TNIs utilized by PCHNs are not considered distinctly billable services by third-party payment systems, when more concrete, medically based tasks such as wound care are, creates an ethical dilemma for the PCHN attempting to provide holistic, quality care to a marginalized population. The care-giving skills and perceptive humanistic responses particular to the PCHN are undervalued homecare services.

A study by Tsai, Chen, and Yin (2005) concluded that a hospital-based homecare model was more cost-effective than a conventional outpatient follow-up model evaluated over a 1-year period. Healthcare services and constraints differ globally; however, this study implies that home visits can be a cost-effective alternative to outpatient clinic type services. In consideration of quality of care, individual rights, and mounting fiscal issues, further research is needed to answer the following question.

If the use of TNIs by PCHNs, as a part of consistent, ongoing home visits to patients with primary psychiatric diagnoses were reimbursed by United States insurance mechanisms, would these patients be managed more effectively within their home and community environments, thereby contributing to an overall decrease in cost of care, with a subsequent decrease in hospital recidivism rates? The PCHNs observed in this study consistently spoke of the good they could accomplish if they were permitted to utilize their skills (TNIs) in providing ongoing, consistent visits to patients with chronic mental illness. The nurses expressed doubt as to whether these skills would ever be recognized for payment and most basically accepted the limitations of the system. Researcher observations of the mood and voice tonality of the nurses demonstrated disappointment and resignation. The dilemma created by restrictions on visits where TNIs are the major skill needed challenges principles inherent in psychiatric professional nursing practice.

Conclusion

The author hopes that articulating the value and nature of TNIs as researched and documented in this particular practice setting will provide impetus for needed healthcare reform and call attention to the value of the skills that psychiatric nurses working in the community can provide through ongoing, consistent, individualized nursing care. Community-based psychiatric nursing services may be feasible alternatives to those institutions, nursing homes, and day programs that are currently used for the management of the needs of persons living in the community with mental illness. The concept of such teams may suggest ways to provide needed assistance that are more humane, individualized, and sensitive to a patient's right to choose to remain in a home environment with ongoing consistent nursing visits when needed.

REFERENCES

American Nurses Association (2001). *Code of Ethics for Nurses with Interpretive Statements.* Silver Spring, MD: American Nurses Publishing.

Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses experience of moral distress. *Nursing Inquiry, 10*(3), 177-183.

Beeber, L. S., Canuso, R., & Emory, S. (2004). Instrumental inputs: Moving the interpersonal theory of nursing into practice. *Advances in Nursing Science*, *27*(4), 275-286.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education* (5th ed.). Boston: Pearson.

Frisch, N. C., & Frisch, L. E. (2006). *Psychiatric mental health nursing* (3rd ed.). New York: Thomson Delmar.

Geertz, C. (1973). *The interpretation of cultures.* New York: Basic Books.

LeCompte, M. D., & Preissle, J. (Eds.). (1993). *Ethnography and qualitative design in educational research*. San Diego, CA: Academic Press.

Lego, S. (1999). The one-to-one nurse-patient relationship. *Perspectives in Psychiatric Care, 35*(4), 1-40.

Macnee, C. L. (2004). *Understanding nursing research: Reading and using nursing research in practice.* Philadelphia: Lippincott Williams & Wilkins.

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10*(4), 162-167.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice.* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.

Raines, M. L. (2000). Ethical decision making in nurses relationships among moral reasoning, coping style, and ethics stress. *JONA's Healthcare Law Ethics & Regulation, 2*(1), 29-41.

Rhein, T., & Callahan, R. R. (1999). Psychiatric home health: Patient advocacy in the home setting. *Home Health Care Management and Practice*, *11*(3), 25-32.

Roberts, M. (2004). Psychiatric ethics: A critical introduction for mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 11*(5), 583-588.

Scanlon, A. (2006). Psychiatric nurses' perceptions of the constituents of the therapeutic relationship: A grounded theory study. *Journal of Psychiatric and Mental Health Nursing,13*(3), 319-329.

Seo, J. M., Byun, E. K., & Kim, C. K. (2007). Social skills training as nursing intervention to improve social skills and self-esteem of in-patients with chronic schizophrenia. *Archives of Psychiatric Nursing, 21*(6), 317-326.

Simpson, A. (2005). Community psychiatric nurses and the care coordinator role: Squeezed to provide 'limited nursing.' *Nursing and Healthcare Management & Policy, 52*(3), 689-699.

Stommel, M., & Wills, C. E. (2004). *Clinical research: Concepts and principles for advanced practice nurses.* Philadelphia: Lippincott Williams & Wilkins.

Struthers, J. (1999). An investigation into community psychiatric nurses' use of humor during client interactions. *Journal of Advanced Nursing*, *29*(5), 1197-1204.

Stuart, G., & Laraia, M. (2004). *Principles and practice of psychiatric nursing.* St. Louis, MO: Mosby.

Sturm, B. A. (2004). Ethics and care: An ethnographic study of psychiatric community health nursing practice. *Archives of Psychiatric Nursing, 18*(3), 106-115.

Sturm, B. A. (2007). Issues of ethics and care in psychiatric homecare: Multidisciplinary perspectives revealed through ethnographic research. *Home Health Care Management and Practice, 19*(2), 1-10.

Sturm, B. A. (2008, July). *The invisible nature of psychiatric community health nurse interventions: An issue of ethics and care.* Paper presented at the International Conference on Nursing Ethics, Yale University, New Haven, CT.

Tsai, S., Chen, M., & Yin, T. J. C. (2005). A comparison of the cost effectiveness of hospital-based home care with that of a conventional outpatient follow-up for patients with mental illness. *Journal of Nursing Research, 13*(3), 165-173.

Welch, M. (2005). Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing, 14*(3), 161-165.

Wolf, Z. R. (2007). Ethnography the method. In P. L. Munhall (Ed.), *Nursing research: Qualitative perspective.* (4th ed., pp. 293-319). Sudbury, MA: Jones & Bartlett.

WHAT'S NEW

IN THE HEALTHCARE LITERATURE

Preventing infection

Fields, L. B. (2008). Oral care intervention to reduce incidence of ventilator-associated pneumonia in the neurologic intensive care unit. *Journal of Neuroscience Nursing, 40*(5), 291-298.

Ventilator-associated pneumonia (VAP) is a preventable, hospital-associated infection that often occurs in intubated patients who are on mechanical ventilation for more than 48 hours. With mortality rates of 15% to 50% (Porzencanski & Bowton, 2006) and an estimated cost of $135,795 per hospital stay (CMS Office of Public Affairs, 2008), VAP is a high cost to society. As a result, this preventable condition is a candidate for removal from Medicare coverage, which will have a major impact on hospitals' bottom line. A randomized clinical trial was recently conducted to determine the effect of heightened oral hygiene interventions on VAP rates.

The sample included 200 ventilator-dependent patients on a 24-bed neurological critical care unit between October 2005 and June 2007. Participants were blindly assigned to a control or intervention group, and nurses documented care on worksheets accordingly. The control group members' teeth were brushed daily with a Toothette disposable oral care swab as needed; the intervention group members' teeth were brushed every 8 hours with a suction toothbrush.

The effects of increased oral care were so successful that the study became a performance improvement project, and all participants received care initially designed for the intervention group. Implementation of the oral hygiene kits cost an additional $12,000 per year, yet was cost-effective in decreasing the incidence of VAP. After a total of 1,850 ventilator days on 345 patients, researchers found a clinically significant decrease in VAP rates from 6.49% to 0.62%. Six months after the cessation of the study, VAP rates increased from 0.62% to 1.17% as a direct result of the discontinued use of the nursing worksheets. The results of this study demonstrate how an increase in oral care for patients can decrease the incidence of VAP, save money, and save lives.

References

Centers for Medicare and Medicaid Services. (2008). CMS proposes additions to list of hospital-acquired conditions for fiscal year 2009 [Fact sheet]. Baltimore, MD: Author.

Porzecanski, I., & Bowton, D. (2006). Diagnosis and treatment of ventilator associated pneumonia. *Chest, 130*(2), 597-604

Erin Fleming, *Hartwick College, Oneonta, NY*
Peggy Jenkins, *Hartwick College, Oneonta, NY*

Pet therapy

Adamle, K. N, Riley, T. A., & Carlson, T. (2009). Evaluating college student interest in pet therapy. *Journal of American College Health, 57*(5), 545-548.

First-year students' introduction to campus life is stressful, and lack of acclimation leads to higher attrition rates. Multiple research studies have shown that animal-assisted therapy can support and enhance quality of life and decrease stress in people suffering from disease. A dearth of research exists exploring animal-assisted therapy for healthy adults experiencing transient stressful situations. The purpose of this study was to investigate first-year college students' previous pet relationships and to assess interest in campus pet therapy designed to provide social support and stress reduction during adjustment to college.

In a large, public, Midwestern university, 246 of approximately 3,800 first-year students, self-selected for health issues orientation sessions, participated in the cross-sectional study. Informed consent was obtained prior to participation. Students completed a multiple-choice, yes/no questionnaire and an open comment section on previous relationships with pets, pet therapy program knowledge, and interest in campus pet therapy. An orientation session included explanation of theories and pet therapy, a question-and-answer session, and physical contact with animals in the presence of handlers.

The majority of participants were single, Caucasian, and female; 91% owned a pet at home, 92.5% considered the pet an important aspect of their lives, and 90.3% stated they felt comforted by their pet's presence when stressed. Dogs were significantly perceived to be comforting using the Mann Whitney U test ($p < .00$); cats were not statistically significantly seen as supportive and comforting. Only 41% of participants were aware of pet therapy, however, 96% expressed desire to be involved in a campus pet therapy project. Qualitative analysis identified three themes: a feeling of loss for family pets, positive interest in a campus pet therapy project, and requests for pet visitation in residence halls.

This study supports the interest in the development of a campus pet therapy project as an adjunctive social support service to promote first year students' well-being and acclimation to college life. Further study is necessary to understand the impact of animal-assisted activity in first year students' stress levels and adjustment to college.

Cynthia Ploutz, Hartwick College, Oneonta, NY
Peggy Jenkins, Hartwick College, Oneonta, NY

Glucose control

NICE-SUGAR Study Investigators, Finfer, S., Chittock, D. R., Su, S. Y., Blair, D., Foster, D., Dhingra, V., et al. (2009). Intensive versus conventional glucose control in critically ill patients. *New England Journal of Medicine*, *360*(13), 1283-1297.

In the early 2000s, a significant change in nursing practice regarding the management of glucose control occurred, moving practice from conventional control (<180 mg/dl), to tight control (81-108 mg/dl) (Van den Berghe, 2001). The standard of practice of glucose control is now subject to yet another change due to increasing cases of hypoglycemia. A recent study was conducted to determine the differences in outcomes between intensive glucose control and conventional glucose control in critically ill patients.

The sample consisted of 6,104 people from 42 hospitals who were randomly categorized into intensive or conventional glucose monitoring. Treatment groups had similar baseline characteristics. Regular insulin was administered according to parameters set for each group, and the interventions were discontinued if the patient returned to a regular diet or was discharged. The primary outcome measured was death from any cause within a 90-day time frame after randomization. An unadjusted chi-square test was performed in order to analyze this outcome.

The researchers found patients in the intensive control group had a significant increase for mortality ($p = 0.02$). The mean blood glucose level was 144mg/dl for the conventional group and 115mg/dl for the intensive-control group. Insulin administration was more frequent for intensive control (97.2% vs. 69.0%, $p < 0.001$), and a larger average dose was administered (50.2+38.1 vs. 16.9+29.0 units per day, $p < 0.001$) to the intensive group. Severe hypoglycemia was more likely to occur in the intensive-control group than in the conventional group ($p < 0.001$).

With a stronger statistical power than previous studies, this study's findings suggest a decreased mortality rate as well as a decrease in episodes of hypoglycemia if less than 180 mg/dl is the target for glucose control. The findings are strong evidence to suggest a change in nursing practice from tight glucose control to more conventional glucose control. A joint review by the American Diabetes Association supports the findings of this study; however, they suggest using caution against a quick swing in practice toward a lack of glucose control (Tamler, 2009).

References

Tamler, R. (2009). *Joint statement from the American Diabetes Association and American Association of Clinical Endocrinologists on the NICE SUGAR study on intensive versus conventional glucose control in critically ill patients.* Alexandria, VA: American Diabetes Association.

Van den Berghe, G., Wouters, P., Weekers, F., Verwast, C., Bruyninckx, F., Schezt, M., et al. (2001). Intensive insulin therapy in critically ill patients. *New England Journal of Medicine*, *345*(19), 1359-1367.

Amelia Feller, Hartwick College, Oneonta, NY
Peggy Jenkins, Hartwick College, Oneonta, NY

Workplace safety

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Predicting patient aggression against nurses in all hospital areas. *British Journal of Nursing*, *18*(8), 476-483.

Workplace violence (WPV) between patients and nurses has become an increasingly significant problem ranging from verbal abuse, bullying, and threatening actions to physical assault. Nurses can use the WPV assessment tool to avoid a dangerous event by identifying five individual behaviors that show potential violence: staring, tone of voice, anxiety, mumbling, and pacing. Limited research has examined WPV in a non-psychiatric setting. The purpose of this study was to identify factors that alert the nursing staff to the possibility of WPV between patients and nurses in a non-psychiatric setting.

The researchers used a qualitative case study explorative research design. Face validity was established through a pilot study. Informed consent was gathered from all participants. Written surveys were mailed to 322 nurses, 113 (34%) nurses working in a variety of hospital areas responded. Semi-structured interviews conducted with 35 participants reached theoretical saturation after 20 interviews. Theoretical saturation occurs when data gathered from interviews becomes repetitive.

The researchers' results reinforced the first five components to predicting WPV and recognized four additional components. The four additional components linked to an aggressive event were emotional cues, disease process, assertive/non-assertive behaviors, and resources. Patients may exhibit emotional cues such as fear, unhappiness, dissatisfaction with care, or frustration. Disease processes that may warn the nurse of a violent event are confusion, organic disorders, or intoxication with drugs or alcohol. Patients who are assertive or non-assertive may exhibit disrespectful and confrontational behaviors leading to violence. Resources and organizational factors predisposing a violent event include staff inexperience, staff knowledge/skill level, and long wait periods.

The study expands on a previous assessment tool by distinguishing additional behaviors to predict WPV in all hospital settings. This tool can help nurses to predict patient aggression and assist nurses to prevent WPV and promote patient safety, which supports the American Association of Critical-Care Nurses Healthy Work Environment initiative.

Reference

American Association of Critical-Care Nurses [AACN]. AACN stands for establishing and sustaining healthy work environments: A journey to excellence. *American Journal of Critical Care*, *14*(3), 187-197

Catherine Scorzafava, Hartwick College, Oneonta, NY
Peggy Jenkins, Hartwick College, Oneonta, NY

BOOK REVIEW

Ann M. Gothler, PhD, RN, CNE, ANEF

Summers, S., & Summers, H. J. (2009). ***Saving lives: Why the media's portrayal of nurses puts us all at risk.*** **New York: Kaplan.**

This book takes on a difficult task: The authors strive mightily to impress upon media creators, as well as nurses, the sweeping negative impact the media's portrayal of nursing has had—and continues to have—on patient care. The chapters provide an intense analysis of media depictions as contrasted with real nursing, and the implications that both have for recruitment and the quality of work life for nurses.

The authors (co-founders of the nonprofit organization The Truth About Nursing, formerly The Center for Nursing Advocacy) present ideas that are clearly valuable to registered nurses, particularly in areas of orientation and staff development. The conversation that they document could also be useful to increase insight and spur discussion among undergraduate and graduate nursing students.

When the book turns to dissection of popular television programs, the list of physician and non-physician characters is helpful, particularly for those who have not kept current with nightly dramas and comedies that take place in fictionalized healthcare settings. The book highlights just how often on television nursing tasks are depicted as being carried out by physicians. It becomes obvious why the public has come to find it acceptable to use nurses as pretty props in beer commercials or rock music videos. According to the media, the doctors are the ones carrying out all the crucial, life-saving duties and also providing all of the psychosocial care. On TV, nurses hardly speak, let alone provide professional, skilled care.

Overall, the book is very convincing to the reader. The authors' thorough documentation of the current state of affairs is certainly valuable as a stimulus for further discussion. Unfortunately, the book is difficult to make one's way through. The text probably would have had a greater impact if sections had been edited to more clearly differentiate the major ideas presented; there seems to be some repetition of ideas in the second half of the book.

As an educator, I feel it would be interesting to see a condensed version that could be used in the teaching environment or as a staff development tool. The summary of major concepts and ideas should also find its way to publication in nursing journals.

Call for Papers

The Journal of the New York State Nurses Association is currently seeking papers for the Spring/Summer 2010 issue.

Authors are invited to submit scholarly papers, research studies, brief reports on clinical or educational innovations, and articles of opinion on subjects important to registered nurses. Of particular interest are papers addressing direct care issues. New authors and student authors are encouraged to submit manuscripts for publication.

Information for Authors

For author's guidelines and submission deadlines, go to the "Publications" area of **www.nysna.org** or write to **journal@nysna.org**.

Call for Editorial Board Members

Help Promote Nursing Research

The Journal of the New York State Nurses Association is currently seeking candidates interested in becoming members of the publication's Editorial Board.

Members of the Editorial Board are appointed by the NYSNA Board of Directors and serve one six-year term. They are responsible for guiding the overall editorial direction of *Journal* and assuring that the published manuscripts meet appropriate standards through blinded peer review.

Prospective Editorial Board members should be previously published and hold an advanced nursing degree; candidates must also be current members of NYSNA. For more information and to request a nomination form, write to **journal@nysna.org**.

NYSNA's Statewide Peer Assistance for Nurses

program offers a range of services to address alcohol and drug-related problems,

- Information and Education about addiction and peer assistance
- Prevention and Identification resources and strategies
- Ongoing Support and Advocacy for recovering nurses
- Linkages with other peer assistance programs and treatment providers

A Registered Professional Nurse answers this number. He/she can provide information or linkages appropriate to the needs of the caller.

Call our Confidential Statewide Helpline

1-800-45-SPAN-1 (toll free in NY & NJ) 45-7726-1

518-782-9400, ext. 265 (all other states)

New York State NURSES ASSOCIATION

New York State Nurses Association
11 Cornell Road, Latham, NY 12110 • Phone **(518) 782-9400** • Fax (518) 786-3007
e-mail: span@nysna.org • website: www.nysna.org

11 Cornell Road, Latham, NY 12110