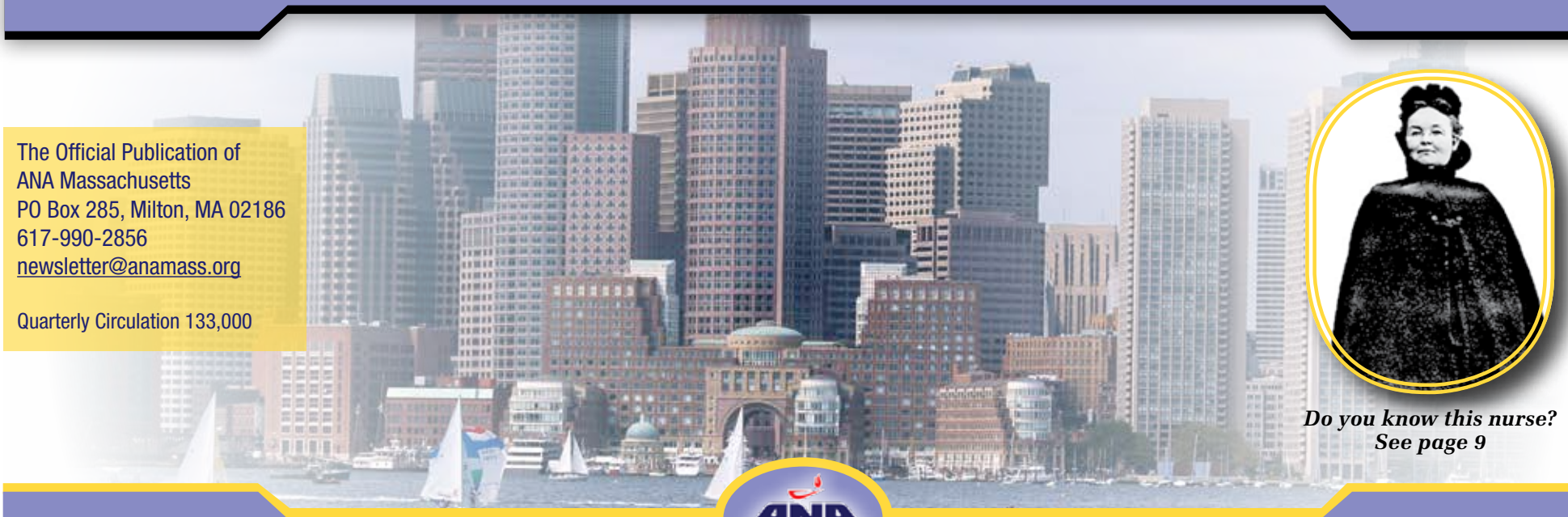
MASSACHUSETTS REPORT ON NURSING



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Do you know this nurse?
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Vol. 16 No. 2

ANA MASSACHUSETTS
AMERICAN NURSES ASSOCIATION

June 2018

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Join ANA Massachusetts today!

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A Day to Lobby
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SAVE THE DATE

To register for events go to www.anamass.org.

October 19, 2018
ANA Massachusetts Fall Conference
Sturbridge Host Hotel, Sturbridge, MA

Check out www.ANAMASS.org for up to date event information

Update on Staffing Ballot and Coalition Membership

Julie Cronin, President Elect
Donna Glynn, President
Diane O'Toole, Executive Director

In November 2018, citizens of the Commonwealth Massachusetts will likely be able to cast their vote in favor of or in opposition to mandated staffing ratios. The American Nurses Association has developed evidence based, safe staffing guidelines in a comprehensive white paper. The ANA Massachusetts believes that strict staffing ratios undermine a nurse's critical thinking and involvement in patient care, and dilutes the guidelines outlined by ANA. We favor a flexible plan that allows nurses, not legislators or the general public, to consider the acuity of their patients, the skill mix of nurses and a variety of other factors when deciding on patient care assignments.

When the potential arose for ANA MA to join the Coalition to Protect Patient Safety, the Board of Directors commenced an arduous process of deliberation as to whether or not to join in a coalition in opposition to the ballot initiative. ANA MA is a strong, supportive voice for the issue of safe staffing and believes that we have the gold standard of staffing guidelines in the ANA white paper. Ultimately, the Board decided that joining the Coalition would strengthen the voice we have in opposition and would offer opportunities in a variety of forums with key stakeholders to present the ANA Safe Staffing guidelines as a viable option for staffing determinations instead of the strict ratios. The Coalition has adopted and promotes ANA's safe staffing guidelines and they have been incorporated in the presentations that are being given at hospitals throughout Massachusetts.

We realize that there may be many questions regarding this important issue. We urge everyone to access and read the ANA Safe Staffing White Paper as it is a comprehensive guide to nurse staffing. Also, please do not hesitate to reach out to the ANA Massachusetts Board with additional questions or concerns. We will continue to provide updates as to the current state of the staffing ballot and the Coalition. Below are some resources we hope can provide some clarification and guidance.

COMMONLY ASKED QUESTIONS

WHAT IS THE ANA MASS SAFE STAFFING POSITION AND WHY ARE WE OPPOSING THE MNA BALLOT INITIATIVE?

The nurses who are members of MNA, like all nurses in the Commonwealth, provide compassionate, patient centered and evidence based care to the residents of Massachusetts. They are our colleagues. We do not however support the strict staffing ratio ballot initiative.

WHAT IS THE ANA MA SAFE STAFFING POSITION?

ANA MA supports optimal staffing as essential to providing excellent nursing care with optimal patient outcomes. We support staffing models that consider the number of nurses and/or the nurse-to-patient ratios and can be adjusted to account for unit and shift level factors. Factors that influence nurse staffing needs include: patient complexity, acuity, or stability; number of admissions, discharges, and transfers; professional nursing and other staff skill level and expertise; physical space and layout of the nursing unit; and availability of or proximity to technological support or other resources.

Nurse staffing is clearly more than numbers. We favor a plan with enough flexibility to allow the nurse at the bedside to decide how they provide care after careful consideration of the acuity of the patient, the experience level of the nurse, and the resources available on the unit. We also support staffing committees made up of more than 55% clinical nurses to guide organizations in assignment making. We believe organizations need to be held accountable when staffing is not appropriate.

HOW IS THIS DIFFERENT FROM THE MNA STAFFING BALLOT INITIATIVE?

The impact of the ballot initiative would remove clinical input while staffing hospitals day in and day out. Assignments are made on the basis of patient needs on any given day and require professional input. Putting strict ratios into law makes the government, who are not nursing professionals, decide each day what patients will need. Although this measure sounds good on the surface, and recognizing that some nurses have supported this measure with the perception that it will provide more nurses, in actuality, it can create more disparate nursing coverage for patient care. Moving staffing decisions away from the professional nurses in an organization on a daily basis ultimately increases rigidity, and could actually limit needed coverage on a particular unit, because nurses would be assigned by law, not by patient need.

RESOURCES FOR YOUR REVIEW

ANA Safe Staffing White Paper:
http://c.ymcdn.com/sites/www.anamass.org/resource/resmgr/docs/NurseStaffingWhitePa per.pdf
ANA Safe Staffing Model Legislation:
http://c.ymcdn.com/sites/www.anamass.org/resource/resmgr/health_policy/2018_House_staffing_legislat.pdf

Update on Staffing Ballot continued on page 3

President's Message

Donna M. Glynn, PhD, RN, ANP

I am honored and excited to begin my journey as the President of ANA Massachusetts. As a constituent member of the American Nurses Association, our chapter is recognized as the voice of nursing in the Commonwealth through advocacy, education, leadership and practice. We are facing many challenges related to nursing practice and will need to stand united to maintain our high professional standards.

The nurse of the future is now faced with many new and complex challenges. This complexity and richness of the nursing profession is paralleled by the complexity of its practice. Nursing is interdisciplinary and an interprofessional nexus of roles and obligations. Professional Nursing has been described as a hybrid of advocacy, medicine, engineering, ministry, teaching and caring. Nurses need to be prepared to practice safely, accurately and compassionately in a wide variety of settings. Moreover, nurses learn and work under less than optimal circumstances. Nurses must function within the complicated, chaotic and dysfunctional environment of the US health care system. With health care disparities at crisis proportions, nurses struggle to uphold and transmit their core professional values of keeping patient safe in a complex health care system.

The landmark Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* in 2010, is a thorough examination of how nurses' roles, responsibilities and education must change to meet the needs of an aging, increasingly diverse population and to respond to a complex, evolving health care system. The recommendations in the report focus on the critical intersection between the health needs of patients across the lifespan and the readiness of the nursing workforce. These recommendations are intended to support efforts to improve health care for all Americans by enhancing nurses' contributions to the delivery of care.

So let's take a few moments to evaluate the IOM recommendations 8 years later and see where the future of nursing truly stands.

Nurses should practice to the full extent of their education and training. Patients, in all settings, deserve care that is centered on their unique needs and not what is most convenient for the health professionals involved in their care. A transformed health care system is required to achieve this goal. Transforming the health care system will in turn require a fundamental rethinking of the roles of many health professionals, including nursing and particularly advanced practice nursing. Nurses have the opportunity to play a central role in transforming the health care system to create a more accessible, high-quality system for patient care. However, the constraints of outdated policies, regulations, and cultural barriers, including those related to scope of practice, will have to be lifted.

ANA Massachusetts supports legislation to remove barriers to advance practice and provide patients with high quality Nurse Practitioner care. In addition, ANA MA is working to remove restrictions related to Nurse Anesthetists and Psychiatric Nurse Specialists care.

Nurses should achieve higher levels of education and training through an improved educational system that promotes seamless academic progression. Major changes in the U.S. health care system and practice environments will require equally profound changes in the education of nurses both before and after students and novice nurses receive their licenses. Nursing education at all levels needs to provide a better understanding of and experience in care management, quality improvement methods, systems-level change management, and the reconceptualized roles of nurses in a reformed health care system. Nursing education should serve as a platform for continued lifelong learning and include opportunities for seamless transition to higher degree programs. Nursing education must respond to the underrepresentation of racial and ethnic minority groups and men in the nursing workforce; the nursing student body must become more diverse. Finally, nurses should be educated with physicians and other health professionals as students and throughout their careers.

Nurses need to be full partners with all health care professionals in redesigning the health care system in the United States. Health care is broken. And we as nurses have the answers. The nursing profession must produce leaders throughout the health care system, from the bedside to the boardroom, who can serve as full partners with other health professionals. Being a full partner involves taking responsibility for identifying problems and areas of waste, devising and implementing a plan for improvement, tracking improvement over time, and making necessary adjustments to realize established goals. Serving as strong patient advocates, nurses must be involved in decision making about how to improve the delivery of care. An Act Relative to the Governance of the Health Policy Commission has been filed in support of the ANA Massachusetts efforts to ensure that a Registered Nurse be appointed to the Health Policy Commission.

And perhaps our greatest challenge is related to the staffing question on the November ballot. ANA Massachusetts opposes the Staffing Ballot proposal, as we have opposed many similar proposals in years past. If passed, this law would forever damage the nursing profession and our ability to deliver the best possible care. Massachusetts consistently has one of the highest rankings in healthcare quality in the nation, and we, the professional nurses of the Commonwealth, play a significant role in delivering that care. Putting ratios into law lets the government, not nursing professionals, decide what patients need based on a one-size-fits-all approach. Patients and nurses are not numbers. We join the Coalition to Protect Patient Safety in opposing this rigid approach to patient care which will undermine the decision making of professional nurses.

ANA Massachusetts supports optimal staffing as an essential component of providing nursing care to our patients. Many factors influence nurse staffing, including patient complexity, acuity, stability, admissions, discharges, transfers, support staff, physical space and hospital-wide resources. It is our decision-making ability that serves as the critical component in assessing the numerous variables that affect patient assignments. These are very real concerns, but this proposed law is not the solution. Nurse staffing is clearly about more than fixed ratios. It is time for professional nursing to advocate for our practice – in the right way. By creating advocacy that raises awareness among both legislators and the general public about solutions that do work, we can get this right as a united group. Getting the right staffing requires nurses and management to work together.

While the issue of staffing is complex, it is not unsolvable. It challenges our profession to create dynamic solutions. I ask each of you to read the Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes White Paper http://c.ymcdn.com/sites/www.anamass.org/resource/resmgr/docs/NurseStaffingWhitePaper.pdf created by the American Nurses Association. The key findings in the document state that optimal staffing is essential for professional nursing practice. Fixed staffing models like the one that will appear on November's ballot fail to consider the hour to hour changes that are the norm in a patient care environment. Flexible staffing models, where the number of nurses and/or nurse to patient ratio is adjusted upward or downward to account for unit factors that include patient condition, complexity, nursing skill level and fluctuation in census need to be developed and implemented. Staffing care models must be created with the input of clinical direct care nurses to ensure success.

So there are viable options to staffing challenges. We can advocate for our practice and our patients by opposing the ratio ballot question and supporting the decision making practices of professional nursing. WE can do this without a ballot mandate.

So, we have a busy year ahead. But we are nurses and we can handle the challenges which face our profession. I will work with the Health Policy Committee, Conference Planning Committee, Technology Committee and the Board of Directors towards our mission and strategic plan. I look forward to ANA Massachusetts celebrating legislative successes, continuing to provide our nurses with high quality educational programs, and working as advocates for our patients, ourselves and our professional practice.

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Update on Staffing Ballot continued from page 1

ANA STAFFING GUIDELINES	PROPOSED BALLOT INITIATIVE
NURSE DRIVEN STAFFING	**GOVERNMENT MANDATED STAFFING**
UTILIZES EVIDENCE BASED STAFFING METHODOLOGY PROCESS	**MANDATES FIXED RATIOS AT ALL TIMES**
ACCOUNT FOR MANY FACTORS IN NURSE STAFFING: PATIENT ACUITY AND COMPLEXITY	**REMOVES ABILITY TO VARY STAFFING BASED ON MULTIPLE FACTORS: LIMITS NURSE ABILITY TO SHIFT ASSIGNMENTS BASED ON ACUITY**
NUMBER OF ADMISSIONS, DISCHARGES & TRANSFERS	**LACK OF FLEXIBILITY - RATIOS REMAIN THE SAME DESPITE RAPID SHIFTS IN PATIENT NUMBERS**
EXPERIENCE LEVEL OF NURSES	**SKILL MIX NOT CONSIDERED**
PHYSICAL SPACE	**NOT CONSIDERED**
LAYOUT OF NURSING UNITS	**NOT CONSIDERED**
AVAILABILITY OF OTHER RESOURCES (EG: NURSING SUPPORT STAFF/TECHNOLOGY)	**DOES NOT ACCOUNT FOR CONTRIBUTIONS OF NURSING SUPPORT STAFF AND THE INTERDISCIPLINARY TEAM**

IMPORTANT POINTS FROM THE LITERATURE

"No empirical evidence supports that a specific numbers assigned through mandatory ratios achieve better patient outcomes."
Blakeman Hodge, M., Romano, P., Harvey, D., Samuels, S., Olson, V., Sauve, M., & Kravits, R. (2004). Licensed caregiver characteristics and staffing California acute care hospital units. *Journal of Nursing Administration, 34(3),* 125-133.

"Once passed into law, legislation is difficult to change if research disproves its effectiveness and public and private support of the nursing profession could be affected negatively."
Buerhaus, P.I. (2010). It's time to stop the regulation of hospital nurse staffing dead in its tracks. *Nursing Economic$ 28(2)*, 110-113.

"Another major concern with mandatory nurse-patient ratios is ignorance of critical factors, such as nurse education, skills, knowledge, and years of experience."
Chapman, S. (2009). How have mandated nurse staffing ratios affected hospitals? Perspectives from California hospital leaders. *Journal of Healthcare Management, 54(5)* 321-335.

"Mandatory staffing ratios also ignore other critical criteria necessary for adequate staffing decisions, including patient acuity and required treatments, length of stay, team dynamics of staff, physician preferences, environmental limitations, variations in technology, and availability of ancillary staff."
Douglass, K. (2010). Ratios – If it were only that easy. *Nursing Economic$, 28(2)*, 119-125.

"Since the passage of California Assembly Bill 394, which mandated minimum, specific, and numerical nurse-patient ratios in hospitals, three studies (Bolton et al., 2007; Donaldson et al., 2005; Greenberg, 2006) found no significant impact on nursing effectiveness."
Bolton, L., Aydin, C., Donaldson, N., Brown, D., Sandhu, M., Fridman, A., & Aronow, H (2007). Mandated nurse staffing ratios in California: A comparison of staffing and nursing-sensitive outcomes pre- and post-regulation. *Policy, Politics and Nursing Practice, 8(4)*, 238-250.

"Due to the mandated ratios which were implemented in California, hospital administrators have made difficult decisions and changes. These include reduced hiring and dismissal of ancillary staff, holding patients longer in the emergency department, hiring more agency and per diem nurses, and cross training nurses to cover breaks."
Douglass, K. (2010). Ratios – If it were only that easy. *Nursing Economic$, 28(2)*, 119-125.

We sincerely thank you for your commitment to the American Nurses Association Massachusetts and to our wonderful profession. Please reach out to us at any time regarding this issue or others.

EDITORIAL

Emotional Intelligence:
Essential Competencies for Nurses

Susan A. LaRocco, PhD, MBA, RN, FNAP

Emotional intelligence has been described as "the ability to perceive, understand, and control one's own emotions as well as that of others" (Marquis and Huston, 2017, p. 68). First described by Mayer and Salovey in 1990, the concept was further refined and popularized by Daniel Goleman (1995). Goleman describes five components of emotional intelligence. They are: self-awareness; self-regulation; motivation; empathy; and social skills. It is clear that emotional intelligence is essential for nurses to provide safe, competent care.

Self-awareness comes when we are not only aware of our mood, but also when we are thinking about the mood. Are we angry? Do we feel resentful? Are we nervous? Being able to identify our emotional state, and then consider the factors causing it and the behaviors that often result from that mood allows us to modify our behavior. This leads to the second component: self-regulation or self-control. Managing our emotions allows us to express anger or frustration more appropriately. As a result, communication is more productive, focused on results rather than emotional outbursts. The third component, motivation, results in a passion to pursue goals with energy and commitment. As nurses, we strive to provide the best possible care for our patients. We routinely go "above and beyond" for our patients. Nursing is a career, a calling, not just a job.

Empathy, the fourth component, is an emotion well known to nurses. Empathy is identification with, or experiencing of, the feelings of another person. It involves being able to accept the emotions of another person and to understand these emotions. It is the way that we feel a patient's pain when they have been given a poor prognosis or the joy they experience when a baby is born. It is the reason that we cry and laugh with patients. The fifth component of emotional intelligence is social skills. This involves being able to build networks and to navigate relationships. Again, this is an essential skill for all nurses. Relationships with patients, with family members, with the interprofessional team, with support staff are all essential to excellent patient care. Our ability to communicate with the team and to facilitate team cohesiveness is one of the ways that we encourage safe and effective patient care.

While the research on emotional intelligence and nursing is still in the early stages, there is extensive research on the role of emotional intelligence in other industries such as construction and air transportation. However, even before we have more research to support the importance of emotional intelligence, common sense tells us that we need to teach these skills to nursing students and to encourage all nurses to constantly work to improve their emotional intelligence.

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Marquis, L. & Huston, C. (2017). *Leadership Roles and Management Functions in Nursing: Theory and Application* (9th ed.). Philadelphia: Wolters Kluwer Health
Salovey, P., & Mayer, J. D. (1990). *Emotional intelligence. Imagination, Cognition, and Personality*, 9, 185-211. https://doi.org/10.2190/DUGG-P24E-52WK-6CDG

Celebrating Nursing Excellence – ANA Mass Awards

Living Legend

Jeanette Ives Erickson, RN, DNP, NEA-BC, FAAN

Nominated by Debra Burke

Jeanette Ives Erickson, RN, DNP, NEA-BC, FAAN

Jeanette Ives Erickson is being recognized for her exceptional leadership, vision, and tactical prowess. During her 21-year tenure as Senior Vice President for Patient Care and Chief Nurse at Massachusetts General Hospital, Jeanette advanced nursing practice and patient- and family-centered care both within the organization and around the world. When she first took the helm of Patient Care Services, Jeanette and her executive team articulated a shared vision, a set of guiding principles, and a professional practice model that served as a blueprint for professional practice. It was important to her to establish a narrative culture as a way to share best practices and advance a culture of excellence. Under Jeanette's leadership, Patient Care Services created The Institute for Patient Care comprised of The Norman Knight Nursing Center for Clinical & Professional Development; The Maxwell & Eleanor Blum Patient & Family Learning Center; The Yvonne L. Munn Center for Nursing Research; and The Center for Innovations in Care Delivery. She drove implementation of the Staff Perceptions of the Professional Practice Environment Survey and an interdisciplinary collaborative governance structure that placed clinical decision-making with staff closest to the bedside.

Jeanette advocated for the hospital's first endowed nursing chair: The Paul M. Erickson, Endowed Chair in Nursing, which was followed by The Connell-Jones Endowed Chair in Nursing and Patient Care Research; The Dorothy Ann Heathwood endowed chair in Nursing Education; and The MGH Trustees Endowed Chair in Nursing and Patient Care Professional Practice. Research at all levels of nursing practice flourished as a result of Jeanette's efforts to generate and sustain research funding. Her shepherding of the Innovation Unit Initiative saw widespread dissemination of evidence-based solutions, increased efficiency in work flow, the introduction of new technology to support practice, and a mandate for all members of the team to practice to the full extent of their licensure. This initiative saw the creation of a new clinical role at Mass General—attending registered nurse—a position that transformed the care-delivery model. While at the helm, Jeanette developed a robust awards and scholarship program that supported the professional development of hundreds of clinicians and support staff. She was a trailblazer in the area of diversity and inclusion, successfully increasing the number of minority employees in clinical and professional positions and raising awareness of cultural competence throughout the organization. Her work in elevating the knowledge and skill of nurses in under-served areas is unparalleled and continues—from overseeing comprehensive disaster-relief efforts to providing expert nursing consultation in the United States, Europe, Asia, and the Middle East.

Nurses at the Awards Banquet

It is gratifying that the American Nurses Association Massachusetts is recognizing in Jeanette what her friends and colleagues have seen for decades—the spirit and soul of a living legend.

Living Legend

Marilyn Lewis Lanza, DNSc, ARNP, CS, FAAN

Nominated by Carol Glod

Marilyn Lewis Lanza, DNSc, ARNP, CS, FAAN

Dr. Lanza has been a leader in nursing for decades, specializing in psychiatric nursing, advanced practice, and as a dedicated researcher focusing on workplace violence. She has done extensive research, writing and lecturing on assaultive patients. Dr. Lanza was one of the first researchers to document staff reactions to being assaulted. Her current research includes factors contributing to blame placement, simulation methodologies to study assault, development of clinical pathways for use of the community meeting as a prevention and/or intervention to assaultive behavior, and a treatment model for psychodynamic group psychotherapy as an interaction for assaultive men and batterers. Most recently she is the principal investigator of two national studies "Violence, Assessment, Mitigation and Prevention" and "Aggressive Behavior: A Multi-Pronged Approach."

Dr. Lanza has spent much of her career at the Veterans Administration, creating innovative models for advanced practice nursing. She has served as mentor and supervisor to hundreds of students and staff. She continues to actively publish and present nationally and internationally, and was recently honored for her work in Australia.

Arthur L. Davis Publishing Agency Scholarship

Brittany Durgin, RN, BSN

Nominated by Julie Cronin, RN, DNP

This scholarship is made possible through the generosity of the publisher of the *Massachusetts Report on Nursing*

Brittany Durgin, RN, BSN

Brittany Durgin joined the Radiation Oncology Department at Massachusetts General Hospital after transitioning with a strong nursing background from an inpatient medical oncology unit. She cares for patients of all ages and disease sites, but has become an expert in the care of patients with thoracic malignancies. She is always presenting innovative solutions and ways of improving workflows in the department. She was a "super user" as the hospital transitioned to an online medical record system and is a go-to preceptor to new staff joining the team. Brittany's dedication to patient care put her at the center of a new procedural sedation initiative in the ambulatory care radiation oncology department. Brittany was an integral member of the team that spearheaded this program and transformed the way patients receive care in the department.

Brittany is an Oncology Certified Nurse and was recognized as an "Advanced Clinician" within the MGH's Clinical Recognition Program. Brittany has decided to pursue a Master's degree in nursing from the University of Southern New Hampshire. She is balancing taking on her course load with working full time, and is doing so with ease. In a short time, she has proven that she has the potential to advance the nursing profession. Brittany will undoubtedly continue to grow and expand her knowledge base, and to utilize her skills in leadership going forward. She is and will continue to be a strong nursing leader and role model.

Community Service Award

Maryellen Maguire-Eisen, MSN, RN

Nominated by Maura Flynn, MPP, RN, DNC

Maryellen Maguire-Eisen, MSN, RN

"Community Service is a form of paying it back" according to Maryellen Maguire-Eisen, the founder and Executive Director of the Children's Melanoma Prevention Foundation. She is an exemplary nurse and has made a positive impact through her "in kind" work in many Massachusetts communities and others across the country. The Children's Melanoma Prevention Foundation (CMPF) is a 501(c)(3) educational foundation whose mission is to prevent skin cancer one child at a time through education and advocacy. CMPF provides children and their caregivers with the necessary information to prevent overexposure to ultraviolet (UV) radiation (a known carcinogen) and to recognize the signs of melanoma and other skin cancers. When caught early, most skin cancers are curable.

When Maryellen was a young nurse her mother developed a "changing" mole on her neck. She saw two physicians both of whom told her not to worry because it was a mole that she had her whole life. Soon after, a friend and dermatology resident came to dinner, spotted the melanoma and arranged for treatment. Maryellen has shared that although a nurse, she didn't even know what melanoma was. She soon came to realize just how important this incidental diagnosis was and that even nurses need more comprehensive skin cancer education. Thanks to the intervention, her mother survived for another thirty years. Maryellen went on to a career in oncology nursing and obtained her master's degree at Simmons's College in 1990. Her thesis, *Nurse's Knowledge of Melanoma and How it Relates to Clinical Practice* was done under the direction of Dr. Judy Beal and was her first real attempt at paying it back.

Maryellen worked as a nurse practitioner in dermatology prior to starting the Children's Melanoma Prevention Foundation in 2003. Because she believed that skin cancer was the one cancer where nurses could truly make a huge difference she sought out other nurses to help with the foundation's mission. In 2017, CMPF was recognized by the Center for Disease Control and Prevention (CDC) for partnering with nurses to promote the Surgeon General's Call to Action to Prevent Skin Cancer.

Under Maryellen's direction CMPF developed their signature SunAWARE National Curriculum and Community Initiative to raise awareness and teach sun protection and skin cancer prevention to children and the people who care for them (parents, coaches, healthcare professionals, etc.). The program is designed to be fun and informative, as well as interactive. The foundation's SunAWARE educators have directly provided the SunAWARE Program to over one million children and adults in schools and the community both locally and nationally. All programs are provided free of charge with the support of corporate and individual donations.

Maryellen oversees a dedicated staff, board of directors, and advisory council. In addition, Maryellen has sought out and partnered with numerous organizations including the Dermatology Nurses' Association (DNA), MA Association of Public Health Nurses (MAPHN) the MA Department of Conservation and Recreation (DCR), US

Celebrating Nursing Excellence – ANA Mass Awards

Sailing, and others. Through their Boston Harbor SunAWARE Project, CMPF was able to collaborate with the National Park Service to provide education and sunscreen for thousands of visitors and tourists along with onsite community education.

CMPF is actively involved in community and legislative advocacy. CMPF was instrumental in advocating for the Massachusetts indoor tanning ban for minors signed into law by Gov. Baker in 2016. This year, CMPF is championing and supporting bills that will allow children to bring sunscreen to school without a doctor's prescription or note.

Community service is at the root of CMPF's mission and Maryellen couldn't be more proud of the small role that she has played in "preventing skin cancer one child at a time."

Loyal Service Award

Sandra Reissour, MSN, BS, RN

Nominated by Jeanne Gibbs, MSN, RN

Sandra Reissour, MSN, BS, RN

Sandra Reissour is the epitome of a loyal member of American Nurses Association Massachusetts. She is a founding member of the organization and her commitment to its' mission remains steadfast to this day. She attended the first strategic planning meeting at Regis College to brainstorm the viability of developing a State Constituent Member Association in Massachusetts. She accepted the challenge from Karen Daley to consider the possibility of setting up a committee that would investigate the creation of an Accredited Approver Unit. She then worked tirelessly to see that goal reach fruition.

That committee, the Continuing Education Committee, first met in August of 2001 to begin the process of applying to be accredited as an Approver of Continuing Nursing Education through the American Nurses Credentialing Center's Commission on Accreditation (ANCC). By the fall of 2003, this important goal was realized. This accreditation designation supported a goal of the new organization to provide ANCC Approved Continuing Nursing Educational activities to RNs in the Commonwealth. It also served as a much needed revenue source to support the overall functions of this young start up.

Her diligence remains consistent throughout the year, every year, in setting and reaching new goals to maintain the excellence of the Accredited Approver Unit.

She serves as a Senior Nurse Peer Reviewer of applications, both Individual Activity and Approved Provider Unit, submitted to the Approver Unit to provide ANCC Approved contact hours to Continuing Nursing Education (CNE) activities. She often mentors Nurse Planners during this process. Importantly, during this time, Sandra has shared her expertise with countless new Nurse Peer Reviewers in their orientation to the ANCC approval process.

During her 15 year tenure as chair and/or co-chair of the Accredited Approver Unit, she has created monthly agendas, kept precise meeting minutes which serve as a historical record and other invaluable services to insure that the work of the committee is supported.

Sandra has been involved in an ongoing manner in ensuring that the Approver Unit and its CNE providers are current with ANCC criteria. She submits articles and updates to the *Massachusetts Report on Nursing*, the ANA MA newsletter, to share information with providers and RNs in the Commonwealth. She serves as our Nurse Peer Review Leader Judy Sheehan's designee on conference calls with other Approver Units and ANCC as requested.

Sandra co-wrote an article for the Administrative Angles section of the *Journal of Continuing Education in Nursing* in 2010 which highlighted the work of the Approver Unit in working with Approved Providers in the area of identifying outcomes. She then co-presented this work at an ANCC conference.

Sandra was an integral part in reaching our goal to achieve Accreditation with Distinction in 2014 and the ANCC Premier Program award in 2016. Both are national designations.

Friend of Nursing Award

Representative Pat Haddad

Nominated by Diane Hanley and Diane O'Toole

Representative Pat Haddad

Representative Pat Haddad is a supporter of the ANA MA Bill to put a registered nurse on the Massachusetts Health Policy Commission. She is also a strong supporter of the Nurse Practitioner bill, which is one of the ANA MA priority pieces of legislation. Rep. Haddad is currently the top ranking female at the State House as Speaker Pro Tempore and a strong supporter of nursing issues.

Representative Haddad represents the people of the Fifth Bristol District which is located on Massachusetts' South Coast. Her communities include the agrarian town of Dighton, the Fall River suburb of Somerset, the Ocean Grove/Gardners' Neck neighborhoods of Swansea (Precinct 2) and the city of Taunton's Weir Village (Ward 6 and Precinct 1A) and a portion of East Taunton (Precinct 4B).

She serves on the Joint Committee on Rules, the House Committee on Ethics and the House Committee on Rules. She has served in the House of Representatives from 2001.

Mary A Manning Mentoring Award

A. Lynne Wagner, EdD, MSN, RN, FACCE

Nominated by Stephanie Ahmed

A. Lynne Wagner, EdD, MSN, RN, FACCE,

A. Lynne Wagner, EdD, MSN, RN, FACCE, has a long history of mentoring across her nursing career, demonstrating vision and caring for fellow nurses and community members, changing policy in many situations.

After a personal prepared childbirth in 1970, Lynne wanted to mentor and empower women to have a fulfilling birthing experience. Lynne earned her Lamaze Childbirth Education Instructor Certification in 1973 and began 30 years of teaching childbirth education classes, mentoring over 3,000 couples and single-moms to shape positive childbirth and parenting experiences. She also taught and mentored nurse childbirth instructor-trainees for Lamaze International Teacher Training Program for 16 years, to carry the torch in humanizing the birthing experience. She is a Fellow of the American College of Childbirth Education.

Fitchburg State University Nursing Department hired her in 2004 to develop a mentoring program to increase high-risk nursing student success as part of the Federal NuCLI grant. Over two years, Lynne facilitated a successful mentoring program between FSU and Middlesex Community College nursing students and RN mentors at Emerson Hospital.

In 2007, Lynne published the first Model of Caring Mentorship for Nurses, based on Watson's Caring Science. Her model is being used by several hospitals and school of nursing programs, most notably by UMass Lowell's Department of Nursing, Diversity Program and Stanford Healthcare System in CA.

Lynne was first Director of Watson's Caring Science Institute's Caritas Coach Education Program (CCEP) 2008-2011, a 6-month program that mentors nurses and other health care providers world-wide in being leaders in promoting healing caring practices and work environments.

Lynne founded the Massachusetts Regional Caring Science Consortium in 2013, a grass root gathering of nurses around caring practice, which has blossomed from small evening meetings to biannual half-day conferences.

President's Award

Nancy W. Gaden, DNP, RN, NEA-BC

Presented by Diane Hanley

Nancy W. Gaden, DNP, RN, NEA-BC

The President's Award is given annually by the President to recognize a person, or group of people, who have made an impact on the president or the profession of nursing.

I have the distinct pleasure of bestowing the President's Award to Nancy Gaden, Chief Nursing Officer at Boston Medical Center. I have had the great pleasure to work with Nancy for more than a decade. We currently work together at Boston Medical Center. Prior to this, we worked together at Hallmark Health System, where she served as Vice President, Patient Care Services/ Chief Nursing Officer. Under her leadership, we were designated Magnet, the first system in New England. Prior to her tenure at Hallmark, Nancy served as Chief Nursing Officer at St. Elizabeth's Medical Center, South Shore Hospital and Milton Hospital. She received her Bachelors from the University of Rochester, her Masters from Boston College and graduated with her Doctorate in Nursing Practice from Regis College.

Sometimes it is difficult to find the right words to say to someone who means so much to me. Nancy, you are a wonderful boss, nurse leader, and friend. You are an exemplary and visionary leader dedicated to professional nursing practice and optimal patient outcomes. Your perseverance, integrity and people-loving nature are just a few of your qualities that continue to inspire me. You have inspired and motivated me during difficult times when I needed words of encouragement. Not only have you been a fantastic mentor to me, but in turn, you have impacted how I mentor other people.

Nancy, I recall coming to your office, after the nominating committee reached out for the umpteenth time, asking me to consider running for the office. I said to you, it is a meeting every other month and we are focusing on healthy nurse, healthy nation. It shouldn't impact my BMC role much at all… well, of course all that changed. You have listened, provided support, advice, encouragement and the ability to devote the time necessary to do the important work of ANA Mass in this difficult time.

I will always be grateful to you for your support and kindness, especially this year, as I served as President for ANA Massachusetts. Thank you!

Nurses at the Awards Banquet

Celebrating Nursing Excellence – ANA Mass Awards

Excellence in Nursing Education

Nancy Schappler Morris, PHD, RN, ANP-BC

Nominated by Carol Bova

Nancy Schappler Morris, PHD, RN, ANP-BC

Dr. Morris is an Associate Professor at the University of Massachusetts Medical School Graduate School of Nursing where she teaches primarily in the PhD program. She received a B.S. in Nursing from Salve Regina College and a M.S. and Ph.D. in Nursing from Boston College. Dr. Morris has taught nursing since 1996, first at the University of Vermont and currently at UMass Medical School. Nancy combines extensive experience in patient care as a nurse practitioner with a love of teaching. She creates a consistent, innovative, and up-to-date classroom environment and is especially known for her expertise in health literacy and patient communication. Nancy is loved by her students. Students consistently remark that Nancy makes them feel respected, listened to and confident when taking on new challenges. Dr. Morris is a master teacher who is preparing the next generation of nurses who will steward our discipline.

Excellence in Nursing Practice Award

Victoria Caisse, BSN, RN

Nominated by Myra F. Cacace, GNP/ADM-BC and Valerie Cacace Sharpe

Victoria Caisse, BSN, RN

I was a patient at Massachusetts General Hospital, from October 6-8th, 2017. I am not a real fan of being on the receiving end of health care, but when this was unavoidable, I had the great fortune to be cared for by a real nurse…an amazing woman who told me that she would be there for me until I was totally comfortable. But most importantly, also gave excellent nursing care to my daughter, Valerie, a first-grade teacher who is not used to the hospital scene or seeing her mother in so much pain. As my daughter said, "I never really understood what nurses (let alone my mother) really did until that night. I am so happy to find the perfect way to say 'thank you' to an excellent nurse who showed me how to be proud of my mom!"

Victoria worked tirelessly to collaborate with me to develop a care plan, executed that plan flawlessly and continued frequent assessments throughout the night and literally pulled me from the brink of despair. If that is not excellence in nursing practice, then nothing is! I asked around and found out that her colleagues all considered her their role model and that Victoria would know what to do to make me (and all her patients) feel better. Victoria is Excellence in Nursing Practice personified.

Excellence in Nursing Research

Ruth Remington, PhD, AGPCNP-BC

Nominated by Coleen Toronto, PhD, RN, CNE

Ruth Remington, PhD, AGPCNP-BC

Dr. Ruth Remington is a distinguished nurse researcher who has achieved significant and sustained national recognition for her work and whose research has impacted the nursing profession and the populations it serves. Dr. Remington's research is multifaceted with a primary focus in gerontological nursing with interest in four distinct areas: nutrition and hydration in older adults, symptom management in dementia, palliative care in older adults, and outcomes of care in nursing homes.

Dr. Remington's inter-professional work includes a ten-year history of working with a neuro-biologist in the translation of bench level research that led to commercialization of a nutritional product that is available to the community. Her research has resulted in publication of over 50 peer-reviewed articles and book chapters in nursing and inter-professional publications and in nearly half of these as first-author. Dr. Remington has been continuously funded for 20 years and all of these studies resulted in one or more publications. Since her National Institute of Nursing Research funded dissertation work, Dr. Remington has received funding from national, state and local levels. At the national level she received funding from HRSA, and the national Alzheimer's Association. At the state level she received funding from the Department of Higher Education and most recently at the local level, funding for an ancillary study that will explore the relationship of weight loss and cognition. Additional funding sources include foundations, various nursing professional organizations, and university sponsored grants.

Excellence in Nursing Practice Award

Mary-Ellen Meltzer, PMHCNS-BC, CST

Nominated by Phyllis Moore, DNS, PMHCNS-BC

Mary-Ellen Meltzer, PMHCNS-BC, CST

Mary-Ellen has achieved a reputation as an excellent practitioner, professional leader, professional teacher, and professional colleague to many advanced practice nurses in the mental health field. She has always had an interest in mental health practice. Since she received her Master of Science in Psychiatric Nursing in 1991 from the University of Rhode Island, she has been in private practice and a faculty member at several colleges including her present position at the University of Massachusetts/Boston.

Mary-Ellen's private practice demonstrates excellent care to adult, geriatric and adolescent populations. As a clinical nurse specialist she provides psychopharmacology, dialectic behavior therapy, and sexual health therapy to individuals and couples. She is one of few who attended the University of Michigan and is recognized as an AASECT Certified Sex Therapist.

Mary-Ellen is an outstanding example of what clinical excellence means. She states that her goal is "to improve the emotional and relational health and well-being of her patients." Daily, she accomplishes this goal and more.

ANA MA Board Members

President Diane Hanley and President's Award Recipient Nancy Gaden

Curry College Nurses at the Awards Banquet

Celebrating the 75th Anniversary of the Establishment of the US Cadet Nurse Corps of 1943

Dr. Barbara Poremba
Professor Emeritus of Nursing,
Salem State University

"They saved lives at home so others could save lives abroad"

Seventy-five years ago, in 1943, the United States was experiencing a critical shortage of nurses. With 1 out of 4 nurses having volunteered to serve in the armed services, the health care system was on the verge of collapse in the homeland.

Although the value of nurses had been identified in the care of soldiers in the World War I and by the highest rate of civilian mortality caused by the Great Influenza Pandemic of 1918 where a lack of trained nurses could be directly attributed to mortality, the number of nurses being produced could not keep up with the demands of the country.

In order to meet urgent needs, Representative Frances Payne Bolton of Ohio, a champion of nursing education, introduced legislation for the Nurse Training Act of 1943. She had seen first-hand how nurses made a positive impact on the health of the community while accompanying a public health nurse caring for people who lived in city tenements.

Representative Frances Payne Bolton of Ohio

On July 1, 1943, The Bolton Act as it was called, established the U.S. Cadet Nurse Corps under the U.S. Public Health Service and military. Founding Director of Nursing Education, Lucile Petry, RN was the first woman to hold such a high office as head of a division in the USPHS, reporting directly to the US Surgeon General Thomas Parran. Upon the insistence of the then first lady Eleanor Roosevelt, the Cadet Nurse Corps was amended to prevent racial discrimination allowing for 3,240 minorities to join the service as nurses in an era of segregation.

Lucile Petry (RN) Director of the Cadet Nurse Corps from 1943–48. First woman to head a division in the USPHS Photo Courtesy of the Smithsonian

Once meeting accreditation and other standards, 86% or 1,125 of the 1,300 nursing schools in the country were accepted for participation in the nation's first accelerated nursing education programs. Massachusetts had 58 schools of nursing accepted as cadet nurse training programs. Most offered 24-30 months of curriculum followed by 6 months of what might be called a nurse internship as a Senior Cadet.

Because of a very successful recruiting campaign, 180,000 young women between 17 and 35 with at least a high school diploma and having good mental and physical health answered the call to duty and voluntarily enrolled in the US Cadet Nurse Corps avoiding any need for a nursing draft. They were issued grey and red trimmed military uniforms and beret and entered intensive nursing training, pledging their "service in essential nursing for the duration of the war."

By the end of the war in 1945, the US Cadet Nurse Corps was providing 80 percent of the nursing care in U.S. hospitals. The Corps remained active until 1948 with a total of about 125,000 women completing their training and caring for wounded soldiers on their return to military hospitals. After their discharge from service, some went on to enlist in the Army or Navy. Others who went into civilian service provided nursing care in their communities for an average of 28 years.

Although the US Cadet Nurse Corps operated under the U.S. Public Health Service and military, it is the only uniformed service that was not given veteran status on discharge. Several bills have been introduced in Congress to rectify this oversight but all have failed.

Last year, ***HR 1168 the United States Cadet Nurse Corps Equity Act*** was introduced in the House of Representatives by Congresswoman Nita M. Lowey (D-Rockland/Westchester NY) and Representative Leonard Lance (R-NY) to grant veteran status to the US Cadet Nurse Corps. So far, there are no members of Massachusetts delegation to the House of Representatives who have signed on in support of this bill.

Sadly, the continued delay in passing this bill is a dishonor to the service of the members, of the corps as few are still alive and those who are, are well into their 90s. The cost of providing veterans benefits to these women would be minimal by any government standards compared to those provided to other veterans over their lifespan.

Cadet Nurse Pledge and Uniform

58 Massachusetts Schools of Nursing trained US Cadet Nurses

It is time to honor these young women who enlisted in a uniformed all female nursing corps in wartime, who trained and worked under military standards and who are credited with saving the United States Health Care System from collapse for their service to our country.

Let's make the 75th Anniversary of the US Cadet Nurse Corps a call out for the passage of the HR 1168 the United States Cadet Nurse Corps Equity Act.

US Cadet Nurse Corps March

"We're the Cadets,
We're the Corps,
Doing our part to help the nation win the war,
Doing the job we're chosen for,
United States Cadet Nurse Corps"

Dr. Poremba can be reached at bporemba@salemstate.edu

In the Next Issue of the *Massachusetts Report on Nursing*: Meet US Cadet Nurse Mary Maione of Hamilton, MA

The author welcomes hearing from anyone with personal stories about members of the US Cadet Nurse Corps.

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The United States Cadet Nurse Corps [1943-1948] and other Federal nurse training programs. United States Government Printing Office, Washington, 1950

Recruiting Poster

Clio's Corner

Anne Hervey Strong, Mary Beard and Gertude Weld Peabody: Pioneers in Public Health Nursing

Mary Ellen Doona

Following the Civil War (1861-1865), Massachusetts became increasingly industrialized with people migrating from rural farms to the centers of manufacturing that had harnessed rivers – the Merrimack and the Charles among them – to power mills and factories. Wave after wave of immigrants fleeing famines and pogroms in Europe also poured into the United States so that by 1900 over ten million of seventy-six million Americans were of foreign birth. Nine million of them had arrived in the decade of the 1880-1890s. Some native-born Bostonians recoiled in fear and distrust. They favored an Immigrant Restriction League in 1894, literacy tests and quotas to stem the influx of immigrants. Other Bostonians pricked by conscience and conviction cared for these new Americans. If Boston was to be a moral society, they believed, sickness had to be tended for it shared a common root with sin. Where disease flourished, crime prospered.

Phebe Adam and Abbie Howes, who established the Instructive District Nursing Association (IDNA) of Boston in 1886, sent Amelia Hodgkiss, its first nurse, into homes to care and to teach. Starting on February 8, 1866, Hodgkiss and Celia Somerville made 7182 home visits to 707 patients that first year. Seven years later, in 1893, Somerville represented the IDNA at the World's Fair in Chicago where the twenty-five year old Trained Nurse Movement was making its formal debut to society. She called for nurses of refined sensibilities and strong religious feeling to devote themselves to this new area of nursing. With a recruiter's fervor, Somerville told nurses that they might dispel disease and purify the "the darkness, disease and foul air" of life in tenements. It would take more than nurses to rectify the poor sanitation, faulty drainage, unclean water and lack of heat that made the crowded tenements the breeding ground for disease. Cholera, typhoid fever and dysentery flourished in the squalor while the crowded conditions made pneumonia, flu, tuberculosis and diphtheria the leading causes of mortality. Skin diseases were the natural outcome of the lack of water for bathing, while unrelieved poverty took its toll on psychological health. Infants were among the most vulnerable as was evidenced by the brevity of their lives.

Gertrude Weld Peabody

Soon after Somerville's made this call for public health nursing, Gertrude Weld Peabody (1877-1933) chose the IDNA, one of her family's philanthropies, as the focus of meeting her own moral obligations to society. She was a member of old Boston society and academic Cambridge's elite: the daughter of Harvard Professor, Francis Greenwood Peabody; the niece of the Harvard President, Charles Elliot; and, the sister of a Harvard educated doctor, a Harvard educated lawyer and a brother who had died of typhoid fever. Peabody made no apologies for using her position in society for the benefit of the IDNA saying it added weight to her words. Not only would she commit her best efforts to IDNA's purpose, she made the advance of its nurses her special mission.

The timing was perfect. Nursing's leaders had pulled the diaspora of graduate nurses into professional organizations, known now as the National League for Nursing and the American Nurses Association. Nurses scattered across the country were communicating with each other on the pages of their own professional periodical, the *American Journal of Nursing*. They read Sophia Palmer's report that nurses were working out a plan for educating pupil nurses in the basic sciences at the college level as a preliminary to their clinical nurses training. Palmer had in mind the Simmons Female College in Boston's Fenway section that had opened in 1899 that had been established thanks to the bequest of John Simmons (1796-1870).

Simmons had amassed his considerable wealth as a tailor after standardizing the sizes of men's suits that made their purchase a quicker venture. Simmons must have used needlewomen for the extensive labor his suits required given that sewing machines were not patented until 1845. At the time, sewing a shirt by hand required fourteen and a half hours and by a sewing machine only an hour and fifteen minutes. By the time sewing machines were extensively used in clothing manufacture, Simmons had sold his successful clothing business and was investing in real estate in Boston's financial district.

Needlewomen may have inspired Simmons' bequest to found a College that would enable women to acquire an independent livelihood. The realization of his plan fit into nurses' hopes for standardizing nursing education. They seized the moment with Lucy Lincoln Drown of Boston City Hospital, Mary Riddle of Newton Hospital, Pauline Dolliver of Massachusetts General Hospital, Anna Jamme of the New England Hospital for Women and Children, Annie McDowell and Miss Hutchinson meeting at the Thorndike Hotel on Boylston Street to develop a proposal. The nursing institute the nurses presented to Dean Sarah Louise Arnold (1859-1943) was not realized, but in March 1902, a new general science course became available for women preparing for medicine or nursing.

Meanwhile the nurses of the IDNA continued to care for Boston's sick and to educate them about healthier ways of living. Others in the larger health arena preached the gospel of prevention especially after the Rockefeller Foundation began to focus on the public's health and investigate the root causes of social problems. Still more changes occurred with the Carnegie Foundation funding Abraham Flexner's study of medical education. His findings, published in 1910, led to the elimination of medical schools that were schools in name only in favor of medical degrees that were earned at a post baccalaureate level. From 1911 through 1917 nurses sought a similar

study of nursing education only to have proposal after proposal rejected.

But society's attitudes regarding the public's health continued to broaden. In 1911 Gertrude Weld Peabody's uncle pronounced from his Harvard platform that public health was a "work of sure and pure beneficence." Plans to establish the National Organization of Public Health Nursing (NOPHN) succeeded in 1912 with Lillian Wald (1867-1940) as its first president. Mary Beard (1876-1946) an experienced visiting nurse in New York and an activist in creating the NOPHN became the Director of the IDNA that same year. Then in 1916 Simmons invited Anne Hervey Strong (1876-1925) to teach public health nursing in association with the IDNA. Strong was more than qualified. She had a degree from Bryn Mawr (1898), a nursing diploma from Albany Hospital School of Nursing (1906), study and teaching experience at Teacher's College (1913-1914) and clinical experience at Wald's Henry Street Settlement House in New York's lower East Side. In two years time, 1918, Simmons appointed Strong as Director of its new School of Public Health Nursing.

With the School established and Mary Beard leading the NOPHN as its president, Gertrude Peabody contacted the Rockefeller Foundation only to be rejected as nurses had been since 1911. Then she wrote to John D. Rockefeller Jr. whom she and her family knew from vacationing in Maine. The Peabody family and the Rockefeller family worshipped together each Sunday in the same church. That relationship also rested on her uncle, President Elliott, and her brother, Dr. Francis Peabody's professional connections with Rockefeller. Using her position in society to add weight to her words met with success. On the same day, October 3, 1917, that Rockefeller contacted the Foundation, it responded: "The work of the NOPHN certainly falls within the field in which the Foundation is deeply interested." Ten days later the Foundation met with Mary Beard and the officers of the NOPHN among whom was Vice-president Gertrude Weld Peabody.

Mary Beard joined the Rockefeller Foundation as it focused on nursing while Anne Hervey Strong served with Josephine Goldmark as she collected data on the state of nursing education. The study published its findings in 1923: *Nursing and Nursing Education in the United States,* more familiarly known as the *Goldmark Report*. After Harvard declined implementing its recommendations, Yale University accepted and established its School of Nursing.

Decades have passed since 1886 when the IDNA of Boston began its work to care for and to educate the people it served. That commitment to people's health continues in the VNA Care of Boston. Similarly the School of Public Health Nursing founded in 1918 continues in the nursing programs at Simmons College that long ago John Simmons' bequest made possible.

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Who is the Nurse in the Masthead?

Amelia Hodgkiss

Amelia Hodgkiss, a graduate of the New England Hospital for Women and Children, Training School for Nurses, made the first visit of the Instructive District Nurses Association of Boston on February 8, 1886. The IDNA had just been founded that year by Phebe Adam and Abbie Howes. Hodgkiss and Celia Somerville, another NEHWCSON graduate made 7,182 home care visits to 707 patients. For one hundred and thirty-two years, Hodgkiss and Somerville's successors have cared for people in their homes. Generous Bostonians supported this care from the beginning and throughout its subsequent iterations as the Visiting Nurse Association of Boston, and more recently, as VNA Care.

Anne Hervey Strong in black dress at left rear and Mary Beard directly in front of her with students of the School of Public Health Nursing/ Instructive District Nursing and children; Circa 1910. Credit: Simmons College Archive

2018 Annual Spring Conference

Running a Clinical Marathon: Keeping Up with the Rapid Changes in Clinical Practice

Cynthia Ann LaSala, MS, RN, Chair, Conference Planning Committee

Conference Planning Committee Chair, Cynthia Ann LaSala,

Over ninety participants gathered at the Dedham Hilton Hotel on Friday, April 6th for the ANA MA Annual Spring Conference. The purpose of this education program was to provide attendees with information related to the latest innovations, evidence-based findings, and the assessment, diagnosis, treatment, and practice implications in stroke, diabetes, heart failure, psychiatric response in the medically ill patient, and oncologic implications in acute and chronic Illness.

Mary Guanci

Mary Guanci, MSN, RN, CNRN, from Massachusetts General Hospital, opened the program with an update on stroke and its impact on nursing practice. Emphasis was on stroke recognition using the F.A.S.T. acronym: Face (Does the face look uneven?); Arm (Does one arm drift down?); Speech (Does the speech sound strange?); Time (It's time to call 911!). The etiologies, medical management and treatment strategies, as well as surgical interventions were discussed for ischemic versus hemorrhagic stroke. A stroke in patients with atrial fibrillation has been shown to be almost twice as likely to result in disability or death when compared to other etiologies. Understanding the risk factors, prompt recognition and treatment are essential to improving patient care outcomes. Participants were updated regarding the use of reversal agents for Warfarin and NOAC (no vitamin K antagonist oral anticoagulation group) in treating intra-cranial hemorrhage. Some promising research findings were presented relative to the treatment of proximal vessel occlusion and the significance of "stroke windows" of time for administering TPA and interventional TPA. Ms. Guanci concluded her presentation with an overview of nursing interventions in caring for patients with ischemic stroke particularly the assessment, education, and support regarding the causes and implications of depression as a frequent outcome of stroke.

Myra Cacace

Myra Cacace, MS, GNP/ADM-BC, from Reliant Medical Group Endocrinology Department in Worcester and past ANA MA President, provided an excellent overview of Type 1 (no endogenous insulin), Type 2 (insulin resistance), and gestational (pregnancy) diabetes, treatment modalities, and the important role nursing plays in positively impacting patients' compliance in managing their disease. Potential etiologies for hyperglycemia such as autoimmune disorders, cystic fibrosis, viral illness, and medication-related, were discussed.

Ms. Cacace also provided a review of the all-important role that glucose and insulin play in the body's normal physiology and some of the pathophysiological changes that occur in the diabetic patient as well as the class, generic/trade names and primary actions for the myriad of medications that are currently available to treat Type 2 diabetes. Ms. Cacace emphasized the significant role that nursing plays in impacting positive patient care outcomes through prevention, prompt recognition, and treatment of complications as well as patient and family education regarding adopting a healthy lifestyle that includes good nutrition, exercise, medication management, and ongoing glucose monitoring.

Susan Finn

Susan Finn, RN, MSN, AOCNS, from Massachusetts General Hospital concluded the morning session with a comprehensive overview of cancer epidemiology, statistical data related to the incidence of cancer in the U.S., the socioeconomic impact of a cancer diagnosis, options for medical management including targeted and engineered cellular therapies, and the nursing assessment and management in cancer patients receiving these therapies. The cost of treating cancer patients by the year 2020 is projected to reach $156 billion and the global incidence of new cases and deaths due to cancer is estimated at 15 million and 12 million respectively. It is also projected that 80-90% of patients in developing countries will have incurable cancer upon diagnosis which will contribute to approximately a 50% long-term survival rate in comparison to the U.S. The biology of cancer and treatment advances in chemotherapy, immunotherapy/biotherapy, use of monoclonal antibodies as well as the adverse effects associated the various therapies were presented.

Judy Sheehan

Judy Sheehan, MSN, RN-BC from Butler Hospital, Providence, RI opened the afternoon session with a thoughtful discussion regarding the behavioral management of psychiatric symptoms in patients with multiple medical co-morbidities. Ms. Sheehan opened her presentation by reviewing four provisions of *The ANA Code of Ethics with Interpretive Statements* that address the compassion and respect for the human dignity of persons, the nurse's primary commitment to the patient, nurse advocacy, and the nurse's role in inter-professional and community collaboration regarding human rights, reducing health disparities, and health policy. Examples of medical problems that place patients at risk for psychiatric symptoms include diabetes, traumatic brain injury, substance use disorder, delirium, depression, cardiovascular disease, and bipolar disease. Patients who are impoverished and/or experience adverse life events are at heightened risk for both medical and mental conditions. Practice recommendations include self-awareness of personal biases and stereotypical behaviors and the negative impact these elements can have on nursing judgment, the need for nursing assessment of medical conditions in patients over 60 with new-onset psychiatric symptoms, the importance of extensive lab screening among vulnerable populations, being careful not to dismiss the complaints of patients with psychotic symptoms given their frequent struggle with accurately describing symptoms, and the importance of timely comprehensive assessment of patients with chronic psychiatric symptoms.

Mary Beth Harrington

Mary Beth Harrington, PhD, RN, ANP-BC, CCRN-K from the VA Boston Healthcare System closed the program with a presentation related to the prevalence, treatment, self-management, and long-term planning/care of patients with heart failure. Heart failure is the primary diagnosis in more than 1 million U.S. hospitalizations and the leading rate of hospital readmissions amounting to 25% at 30 days and 67% in one year. The classifications and biomarkers related to heart failure were described. Dr. Harrington provided a comprehensive review of drugs used in the treatment of heart failure including beta-adrenergic blockers, ACE inhibitors, angiotensin receptor blockers, and aldosterone antagonists. Other treatment modalities such as implantable devices, cardiac resynchronization therapy, and invasive monitoring as well as treatment guidelines for heart failure based upon stage, functional class, and other physiological and diagnostic findings were discussed. Dr. Harrington emphasized the importance of screening for health literacy, cognitive impairment (i.e. dementia, delirium), depression, and other patient characteristics such as age, gender, socioeconomic factors given their ability to negatively impact self-care. In closing, the role of palliative care was discussed as an important but infrequently used option in optimizing symptom management and improving the quality of life in patients with heart failure and other chronic progressive diseases.

Participants circulated among the various exhibitors and 11 poster presentations (an all-time high!) throughout the day. As always, programs such as this would not be possible without the support of the exhibitors and sponsors.

Last but not least, a huge "thank you" is extended to the outstanding efforts and ongoing commitment of Conference Planning Committee members, Mary Hanley, Joan Clifford, Maura Fitzgerald, Julie Cronin, Terri Przybylowicz, and ANA MA Executive Director, Diane O'Toole and Lisa Presutti, Office Administrator, for their untiring support. Stay tuned to learn more about our day-long fall conference scheduled for Friday, October 19th at the lovely Sturbridge Host Hotel. The Conference Planning Committee will present the morning session and will focus on domestic violence. The content for this program will meet the new educational requirement for RN re-licensure in Massachusetts. The afternoon session will be presented by our colleagues on the Health Policy Committee. The focus will be safe staffing in light of the proposed staffing legislation that will be on the ballot in Massachusetts in November.

Spring Conference Poster Presentations

Conference attendees voted to select the best posters at the conference.

First Place
Implementing Complementary Therapies for Stress Reduction in Nurses While Improving the Quality and Care of our Patients
Mary A. Absi MSN, RN
Heather Hogan BSN, RN
Santina Wilson BSN, RN, HN-BC
Brigham and Women's Hospital

Second Place
Creating Narratives after Reiki with Patients with Cancer
Maria Rosen, PhD, RN, PNP-BC
MCPHS University

Third Place
Nurse Tank
Nicole Lincoln MS, RN, APRN-BC, CCRN
Diane Hanley EJD, RN-BC
Alix Carey
Nancy Gaden, DNP, NEA-BC
Boston Medical Center

Other Posters
Targeted Nursing Competency Assessment for Reduction of CLABSI and PIV Related Infections
Pamela Corey, MSN, EdD, RN, CHSE
Boston Medical Center

Innovations in practice: Secondary Infusions, a common source of missed or under delivery
Kerin Kingsbury, BSN, RN
Ivenix, Inc

Palliative Care Programs Reducing Hospital Admissions in Heart Failure Patients
Kathryn McKenna-Weiss, BSN, RN, CCRN
MCPHS University

Nurturing Future Leaders
Olga Van Dyke, MSN, CAGS, RN
Mahmoud Kaddoura, PhD, CAGS, NP-C, CNE
Betty Cheng, MSN, FNP-BC, RN
Bunker Hill Community College

Transforming Clinical Experience: Improving Quality of Care
Betty Cheng, MSN, FNP-BC, RN
Mahmoud Kaddoura, PhD, CAGS, NP-C, CNE
Olga Van Dyke, MSN, CAGS, RN
Bunker Hill Community College

Screening Mammography: Shared Decision Making in Primary Care and the Role of the Nurse Practitioner
Chong-Ae Donahue, BSN, FNP MSN
MCPHS/Ridgewood Nursing Center

Our Side of the Bed
Catherine Saniuk, RN, MS
Diane Hanley, MS, RN-BC, EJD
Nancy Gaden, DNP, RN, NEA-BC
James Holsapple, MD
Jane Keilty BSN, RN
Patricia Lyons, RN, MSN, CNS-BC
Boston Medical Center

Nurses' Culture of Health Initiative: Leadership for Transformational Change in Health Care Delivery
Eleanor Vanetzian, RN, PhD, CS
University of Massachusetts, College of Nursing

THANK YOU

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Care Dimensions
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Emmanuel College
Boston University Nursing Archives Associates
Regis College
Terri Arthur

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Toni Abraham
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Kate Duckworth
Mary Grant
Jim Kernan
Cynthia LaSala
Sarah Pasternack
Janet Ross

A Day to Lobby

Christina Saraf and Arlene Swan-Mahony
Co-Chairs of Health Policy Committee

On Tuesday, March 20th, ANA MA was proud to host the first Lobby Day at the Massachusetts State House. One could feel the excitement of the audience as more than 130 registered nurses and nursing students sat in the Great Hall. The energy within the room was palpable as many were experiencing the State House for their very first time.

Sitting on the edge of their chairs, the attendees listened and learned about ways to become involved and to advocate for their patients and the profession including writing a letter, testifying at a public hearing or meeting with their legislators. As the object of Lobby Day focused on Advocacy, three legislative bills (noted below) supported by ANA MA were presented to the nursing audience; the nurses were asked to discuss the key points of each bill when meeting with their legislators later in the morning. After a thorough discussion, the room became an interactive environment in which questions, experiences and comments were heard.

The bills that were discussed are:

- H1681/S615, An Act relative to the Governance of the Health Policy Commission. This bill would require that a registered nurse be appointed as a member of this commission. Currently there is no representation from the nursing profession. The Massachusetts Health Policy Commission is an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care.
- H1144/S1167, An Act relative to Safe Patient Handling in Certain Health Care Facilities. This bill would require the replacement of manual lifting and transferring of patients with powered transfer & lifting devices. This legislation would require each facility to create a committee in which half the members shall be front-line non-managerial employees who provide direct care to the patients. This committee would be charged with performing a needs assessment with the goal of safe patient handling and mobility.
- H2451/S1257, An Act to Contain Health Care Costs and Improve Access to Value Based Nurse Practitioner Care as Recommended by the Institute of Medicine (IOM) and the Federal Trade Commission (FTC). The bill would allow nurse practitioners to practice to the full extent of their education and training.

Our next agenda item was to learn about the staffing ballot initiative that may be placed on the ballot in November 2018. As we all believe in safe staffing, ANA opposets the mandated staffing ratio proposal and outlines their approach within the ANA White Paper (www.anamass.org). The audience gained a comprehensive understanding on the implications and misconceptions surrounding mandated staffing ratios. With this in mind, this decision should be determined by nurses and not the general public.

We were graced by the presence of two legislators, Representatives Kay Khan and Denise Garlick, who began their careers as nurses. Both reflected on how nursing became the catalyst in their legislative careers where they could continue to advocate at a different level for healthcare issues. Their down-to-earth demeanors showed the approachable side of legislators easing the audience into the next task at hand.

As the nursing professionals split into smaller groups, they still felt the togetherness that linked them within the Great Hall. They embarked on a first time journey to visit their legislators and discuss the important legislation at hand. Being met by eager legislators and staff, the nurses shared their experiences and knowledge about these important issues. They were the experts and realized at that moment that their voices were powerful and that they could make a difference. A happy ending to a very successful Lobby Day!

MA State Representative Bill Driscoll Jr. with nurse constituents on Lobby Day

Response to *Thoughts of a New Nurse*

by Kayleigh Coburn in the Massachusetts Report on Nursing (December 2017)

Not too many years ago – 15 to be exact, I took my first shift as a new nurse fresh off orientation. It still seems like yesterday and the *new nurse in me* is now seen as an expert to others. Expanding on the wonderful insights shared by Kaleigh, I would like to ask my fellow, experienced nurses, what we are doing to nurture, support and encourage the newest generation of nurses like Kaleigh to succeed. All too often I watch fellow coworkers laugh or make snarky remarks when a "newer" nurse asks a question that may seem simple. That question being asked by the new nurse may be critical to a patient's safety. Questions can range from how to page a doctor to the bedside to decision making about a lifesaving intervention, both of which can impact patient safety and quality of care. What are we doing to ensure that the "new nurse" feels confident to ask questions and know that we as experienced nurses support one another and "have her back?"

It can feel very lonely and isolating as a new nurse when you feel your coworkers are only watching every step you make in an effort to find you making a mistake. How does this behavior improve patient care? Does this type of nursing still exist? From being a staff nurse 15 years later – I know it still exists. I implore all the nurses reading this article to find the time to mentor and coach our new nurses. As nursing professionals in healthcare, we need to support each other and build each other up, not knock each other down. Kayleigh reminds us what it was like to perform CPR, be stuck by a needle and watch a patient die. Her message is clear and our response as experienced nurses must be also. We must ensure that we support a new nurse during these difficult and stressful events. Take a moment to debrief with the new nurse and discuss how they felt and what they learned. Ask them, "What can I do to support you." Many times, a new nurse may just need an ear to listen or a shoulder to cry on.

The challenges nurses face daily are many. It just takes a positive and motivating group of nurses to make the hard work of nursing seem seamless and effortless. It takes a village to care for patients and most importantly to care for each other. Thank you, Kayleigh, for your words of wisdom. I wish you the best in your blossoming nursing career.

Cidalia J. Vital, MS, RN, CNL, CPAN
Proud ANA-MA member since 2003
PhD Candidate- University of Massachusetts-Amherst

Reflections from Past Presidents

ARe You IN Revisited

Tara M. Tehan, MSN, MBA, RN, NE-BC, SCRN

ARe you IN? During my tenure as ANA MA President, I posed this question to the nurses of Massachusetts and asked you to commit to engaging in the issues that faced our patients, our profession, and the community at large. Four years later, this call to action seems more important than ever. Some of the issues loom larger than ever: the opioid crisis, keeping our schools safe, and measures to protect our environment. And some of the same professional issues we faced four years earlier, we face again.

But what does engagement mean? Engagement starts with awareness, staying current on issues pertinent to our professional practice. This is often done through our professional organizations and by proactively reading about and discussing the issues. Beyond awareness, we must take the time to truly understand an issue, to move beyond the rhetoric, and to sort through the facts and perspectives, to come to an informed opinion. Finally, as the most trusted profession, we must use our knowledge to help our patients and communities decipher the complex issues facing us today. Professional engagement strengthens our ability to advocate for our patients and our profession.

The opportunities, and *responsibilities*, that come with being an engaged professional seem specifically relevant to the topic of Registered Nurse Staffing. This fall, voters may be asked to make decisions regarding our professional practice. They will be asked to vote on a ballot initiative that would determine mandated nurse to patient ratios. Staffing is a complex issue that requires the consideration of many factors such as the skill and experience of the RN and the clinical team, patient specific factors such as patient acuity, and the environment and resources of the unit. While there is evidence to support the positive influence of patient ratios on patient and nursing outcomes (Aiken, et. al, 2010), evidence also demonstrates that patient safety and patient outcomes are influenced by a multitude of factors including the work environment and education of the RN. But there are many who try to boil this complex issue down to ratios.

As nurses we have a professional responsibility to be an honest broker regarding issues concerning health and wellness. As the most trusted profession we must help individuals and communities understand complex issues, to help them navigate the nuanced language we take for granted, and to decipher facts from fake news. So I ask you, once again, ARe You IN? Our patients and profession depend on it.

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The Constitution and Public Health

Inge B. Corless, PhD, RN, FNAP, FAAN
Professor, School of Nursing, MGH Institute of Health Professions

Inge B. Corless, PhD, RN, FNAP, FAAN

We the People *of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.* Preamble to the United States Constitution. (Archives.gov)

In the Preamble to the U.S. Constitution, insuring domestic tranquility is mentioned as one of the reasons for the development of the Constitution for the United States. It may be argued as to the interpretation of the phrase "insure domestic tranquility." For some it may refer to the relationships among the states that had been established at the time. It may also result in ensuring the enjoyment of the blessings of life and liberty. If such is the case, then tranquility and security in one's home, workplace, or school are encompassed by this statement. Indeed, safety and happiness while referring to the 13 colonies are basic to the Declaration of Independence and to the people inhabiting the colonies.

It may be argued that these references are with regard to the relationship of communities and colonies to each other; that these statements refer to the conditions of the time. And they do, and they don't. While inspired by the conditions obtaining at that time, changes have been made to the Constitution. Such changes include ensuring the right to vote for people of various races and ethnicities (Amendment XV) and "sex" (Amendment XIX).

The right to bear arms is enshrined in the second Amendment.

A well-regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed. (Archives.gov)

There is an indication that the right to bear arms was meant to allow citizens to respond, as members of the militia, to a dictator, and at that time, King George III was perceived as such. The Declaration of Independence enunciated all of the infringements and transgressions that necessitated the rupture of relations between England and the 13 Colonies. The Constitution provided the basis of a new government that ensured the remedies to what was perceived as tyrannical government.

Just as the Bill of Rights modifies the Constitution and expands our understanding making it pertinent to current conditions, so too should our laws specify the right to bear arms. Notwithstanding a Supreme Court ruling (2008), which pertained to the District of Columbia and allowed the possession of a handgun in the home and reversed previous rulings, such a law must cover technology not available when the Bill of Rights was enshrined in our pantheon of founding documents. These technologies, applicable to firearms, include:

1. The restriction of assault rifles, sawed-off shot guns, semi-automatic guns, and bump stocks.

Other issues that need to be addressed with regard to all weapons include:

2. Increasing the age to 21 when a weapon may be purchased
3. Restriction on the sale of products at gun shows
4. Background checks
5. Improved systems of identification of potential shooters through various technological linking systems
6. Red Flag laws identifying individuals who have indicated they plan to commit violent acts

This is not a constitutional issue, although it has been framed as such. The second amendment refers to the conditions obtaining at that time when adult male citizens constituted the militia. That is not the case today when we have U.S. Armed Forces and the National Guard. Today it is a public health issue!

Since the 1800s there have been numerous shootings that have transpired in schools (K12Academics.com). Most of these have been one-on-one. On April 9th, 1891, this changed when a seventy- year old man used a shotgun and opened fire at St. Mary's Parochial School in Newburgh, N. Y. with minor injuries (K12.Academics). Some of the mass shootings that have occurred since then include:

1966	University of Texas	15 fatalities
1999	Columbine High School	13 fatalities
2007	Virginia Tech University	32 fatalities
2012	Sandy Hook Elementary School	26 fatalities
2015	Umpqua Community College	9 fatalities
2018	Marjory Stoneman Douglas High School	17 fatalities

Like those who are reading this article, I had seen news of these shootings on TV and in the newspapers. I was horrified and upset but after some reflection went back to my work and so did many of us, other than those directly affected. But this time was different; the Marjory Stoneman Douglas students wouldn't allow us to go back to our private fretting. They declined our condolences and insisted on action. And when our Provost at the MGH Institute of Health Professions, Dr. Alex Johnson provided an opportunity for faculty and staff to meet (there were subsequently opportunities for the students to meet), two of us were very vocal about our thoughts on the subject. The Provost graciously invited us to provide our thoughts in writing with a guest submission on his blog. He had already written one blog on the subject.

Parts of this essay are from that blog. Being an academic I thought it best to obtain some data and brushed up on the Declaration of Independence, Constitution, and Bill of Rights before I wrote the blog. It was clear to me that the Bill of Rights has been misinterpreted as I indicated. Further, the connection of the right to bear arms only in association with service in the militia has been disputed in the Supreme Court. Based on District of Columbia v. Heller 554 U.S. 570 (2008)

In the U.S. Court of Appeals vs. the District of Columbia Circuit, Justice Antonin Scalia wrote for the majority that an individual had the right to have arms in one's home independent of service in the militia, whereas Justice Stephens argued that the bearing of arms was associated with militia service. Justice Scalia's argument won the approval of the majority of the Justices resulting in referral to the second amendment of the Bill of Rights vouchsafing the right to bear arms as an individual right apart from service in the militia. The manner in which the Bill of Rights is being interpreted is a relatively recent phenomenon given the 5-4 Supreme Court Decision was published on June 26, 2008. That is only ten years ago. Prior to that time, the interpretation differed.

The "March for Our Lives" took place in Washington, Denver, Los Angeles, Boston and elsewhere on March 24th. Did you march? Did you speak up? Will you vote? I did march as I didn't want the students to stand alone and thanks to many of you and our fellow citizens and most of all, the students, they didn't march alone; they don't stand alone.

You may have a different opinion on this issue. The question we need to address is where do we agree and how do we collaborate to save lives. None of us want innocent people injured (or anyone for that matter) and certainly not children in our schools or their teachers and other adults working there. How can we achieve that? (And I know we have other problems with innocents being killed that also need to be addressed).

A recent letter in the Lancet (March 23, 2018) called for a change in how we frame this issue. They advocated for #GunSafetyNow. This is an illustration of starting with something most, if not all, of us can agree upon. Briggs and Fisher (2018) compared deaths due to gun violence in the U.S. and England in 2016 with 36,658 deaths in the U.S. and 26 deaths in England in the year that ended in March, 2016 (Office for National Statistics, Homicide, 2017). They attribute the differences to the approaches taken regarding guns.

With an emphasis on gun safety, let us support and stand with the courageous and eloquent Marjory Stoneman Douglas High School students and others who are expressing their sorrow by civic action demanding a public health intervention: gun law limits, limits that will save lives. Let us help make this time different by emphasizing gun safety. We as nurses can help make it so. The students won't allow us to look away. They have demanded action. And while we're only too aware that the time for change was yesterday. Failing that, it is now. Will you help?

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- National and State-Level Lobby Days
- Lobbying on issues important to nursing and health care and advocating for all nurses
- Representing nursing where it matters/ representation in the MA State House
- Speaking for U.S nurses as the only U.S.A member of the International Council of Nurses
- Protecting and safeguarding your Nursing Practice Act Advocating at the state level
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Vision

As a constituent member of the American Nurses Association, ANA Massachusetts is recognized as the voice of registered nursing in Massachusetts through advocacy, education, leadership and practice.

Congratulations to Dr. Judy Beal

Judy Beal, DNSc, RN, FNAP, FAAN, Dean of the School of Nursing and Health Sciences at Simmons College in Boston, was elected as American Association of Colleges of Nursing (AACN) chair-elect for two years and will serve as Board Chair from 2020-2022. Dr. Beal was named an ANA MA Living Legend in 2016.

Judy Beal

Congratulations to Dr. Inez Tuck

Inez Tuck, PhD, MBA, MDiv, RN, FAAN, Dean of the School of Nursing at MGH Institute of Health Professions received the Excellence in Nursing Education Award from the New England Regional Black Nurses Association. She was described in her nomination letter as "a transformational leader who embraces transparency, collaboration and clear, concise communication." Dr. Tuck has been at MGHIHP since 2016.

Advocacy in Action

One Nurse's Voice Toward Improving Care in Long Term Care Facilities

Luciana Ludiciani, BSN, RN

The elderly living in long term care facilities deserve better care. Nurses can improve both the care and the quality of life for the elderly living the remaining chapter of their lives in a long term care facility. According to the Henry J. Kaiser Family Foundation, in 2015, over 40,000 people resided in nursing home facilities in Massachusetts. As both a family member and a registered nurse who worked in a long term care facility, I would like to share some challenges and suggestions for improvement.

1. **Low nurse to patient ratios** are a major concern in long term care facilities with reports of 1 nurse to 30 patients. As nurses, we know that safe staffing is important to give quality care.
2. **Low patient care technicians or certified nursing assistants (CNAs) to patient ratios** are also concerning. These workers, who are 91 percent female, 35 percent African American, and 20 percent foreign-born, provide the majority of hands-on care. Approximately 650,000 nursing assistants are employed by the nation's long term care facilities. These positions are characterized by low wages, erratic, often part-time schedules, limited support from supervisors and, little chance to advance professionally. In addition, many do not receive training to care for dementia patients. https://phinational.org/press-release/poor-quality-nursing-assistant-jobs-undermine-care-america%E2%80%99s-nursing-homes.
3. **Housekeeping personnel are also understaffed and underpaid**. I have observed that the facility lobby often appears clean while a dementia unit, a shower stall, or a patient's room is not. When my grandmother was a resident on a dementia unit the weekends were always understaffed with one housekeeping person for 30 beds. This hardworking woman cleaned soiled bathrooms, washed floors, dusted rooms, and disinfected shower stalls all by herself.
4. A study by the US General Accountability Office (2008) indicated that surveys put out by states do not reflect the total problem occurring in licensed nursing facilities. According to Long-Term Care Ombudsman programs, in 2003, there were more than 20,000 complaints of **exploitation, neglect, and abuse** coming from nursing homes and assisted living facilities. The most common type of abuse reported was physical abuse. https://www.nursinghomeabusecenter.com/elder-abuse/statistics/.

In order to improve care, nurse's voices must be heard (see Table 1). Quality of care consists of assessing needs and having compassion. Unfortunately, due to the shortage of long term care beds, many facilities have lowered their standards. People who are more fortunate can afford private care. Those who are less fortunate cannot. My hope is that attention can be drawn to these issues, and that improvements are made. As a nurse and a family member I have several recommendations:

1. The public needs more education and awareness regarding living wills, health care proxies, legal guardianship, senior care options, and elder service attorneys. With advanced medical technology, seniors are living longer and healthier lives. However, at some point, long term care will often be needed. Family discussions of the patient's wants and needs are better discussed prior to dementia or worsening conditions.
2. To effect change, I believe that regulatory agencies must have **frequent and unannounced** inspections. From my personal experience, prior to an "unannounced" inspection staffing improved, units were cleaned, and everything was in tip top shape. After the inspection, the staffing shortage and lack of cleanliness resumes. Inspections should occur more frequent than every 9 to 15 months. I recommend that local and state representatives visit facilities as well. If the long term care facilities are in violation of basic safety standards, there should be financial consequences related to Medicare or private insurance company reimbursement.
3. We need to balance the needs of the individual with the needs of the facility. While the bottom line of the facility is vital for its success, we must enforce standards and ensure the ethical care of those residing within the facility. The overwhelming majority of long term care facilities are private and for profit (69.8%, 2014) https://www.cdc.gov/nchs/fastats/nursing-home-care.htm. The average cost of long term facilities in Massachusetts is $353/day while the national average is $228/day https://www.seniorhomes.com/s/massachusetts/nursing-homes/.

The theme for this year's National Skilled Nursing Care Week (May 13-19, 2018), was "Celebrating Life's Stories." As nurses, we can help with this. Nurses have the power to improve care and dignity for those living in long term care facilities. I expressed my concerns to my Representative Theodore C. Speliotis. I also submitted a letter of concern to Governor Charlie Baker. As nurses, we have an obligation to voice concerns towards and attempt to change the dynamic of the operations of long term care facilities. If you see something that can be improved, I hope you will too.

Table 1

	Comments by Nurses and Patient Families
Short Staffing	• *The elderly residents may see a nurse to receive a medication; otherwise they are parked in a chair.* • *"I have worked in many environments: critical care, acute care, hospital setting, rehabs, and skilled nursing facilities. It is unfortunate to report that some of the worst care I have seen has been in nursing homes. These facilities are chronically short staffed. The staffing they do have is subpar. Caring for the elderly is a difficult task. These patients have multiple physical and mental issues.* • *The overworked CNAS have unreasonable assignments and can only provide quick daily care.*
Care not being given	• *Often friends and family members come in and do the care that is not being done by the staff."* • *I had dealt with a lot of issues regarding my son's PCAs as I observed him in a nursing home setting for three months. Sadly, nothing is perfect and no one will take care of your loved one like you would. I also think regular visits keep things more consistent. However, care should be given without family members acting as "police."*
Cost	• *For this care, the nursing home takes their homes, social security checks, and pensions. The patient is allotted only $72.00 a month!! Outrageous!!!!! As a healthcare worker for 40 years I am outraged by this system of care. Each of us will be faced with either placing a family member in long term care or finding ourselves being placed as a patient!! Changes need to be made!! Soon!!"*

The author wishes to thank her family, friends, and colleagues for their support during her grandmother's nursing home experience.

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