MASSACHUSETTS REPORT ON NURSING

Do you know this nurse?
See page 5

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ANA MASSACHUSETTS
AMERICAN NURSES ASSOCIATION

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Join ANA Massachusetts today!

Clio's Corner:
75th Anniversary Memorial of the Cocoanut Grove Fire
Pages 4-5

Nurses and the Centennial of the Halifax Explosion
Page 10

Delirium in the ICU – A Patient's Perspective
Page 12

2018: Year of Advocacy

Join Us at Lobby/Advocacy Day

Christina Saraf and Myra Cacace
Co-Chairs of ANA MA Health Policy Committee

The American Nurses Association has designated 2018 as the Year of Advocacy. In concert with this initiative, ANA Massachusetts invites you to participate in our own Lobby Day, also known as Advocacy Day, on Tuesday, March 20th. Massachusetts nurses from all disciplines will meet at the Massachusetts State House, in the Great Hall of Flags, to learn about important issues for nurses and the patients and families we serve.

Lobby/Advocacy Day will give nurses the opportunity to meet their own state lawmakers to garner support for important healthcare legislation such as a nurse seat on the Massachusetts Health Policy Commission, safe patient handling and scope of practice issues. Lawmakers (most of whom are not nurses) want to hear from us. By telling our stories, we give lawmakers the opportunity to better understand important issues affecting nursing practice and healthcare because WE are the experts! Legislators look to us for insight and understanding of these and other healthcare issues. Getting to know our personal representatives and senators, and offering to be a resource to them gives us a greater voice in policy formation.

Hillary Clinton stated "If you believe you can make a difference, not just in politics, in public service, in advocacy around all these important issues, then you have to be prepared to accept that you are not going to get 100 percent approval." These words teach us that we must be nurse advocates in order to gain support for our ideas. The lengthy deliberate process allows many opposing voices to be heard. We strive with purposeful efforts in hopes of successful passing of legislation.

Since ANA announced 2018 as The Year of Advocacy, this day has even greater meaning. As the largest healthcare profession, our strength comes in our unity. Coming to Lobby/Advocacy Day will give nurses the chance to SHOW that unity, as we come together to advocate on behalf of our patients and our colleagues for excellent healthcare in the Commonwealth. Register today at www.anamass.org!

Congratulations to the 2018 LIVING LEGENDS

Jeanette Ives Erickson, DNP, RN, NEA-BC, FAAN
Marilyn Lewis Lanza, DNS, RN, FAAN

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SAVE THE DATES

See page 3 for information on upcoming events!

President's Message

Diane Hanley, MS, RN-BC, EJD

After lengthy discussions and deliberations over the last several months, the American Nurses Association (ANA) Massachusetts has decided to join the Coalition to Protect Patient Safety in opposition to the Massachusetts Nurses Association's (MNA) proposed staffing ballot question.

Our commitment to safe staffing principles and solutions is central to ANA Massachusetts' mission. However, the strict staffing ratios, as dictated by MNA's proposed ballot question, will not improve safety, but will instead remove nurse autonomy and put our patients, and our health care system at risk.

As you know, nurse staffing is more than numbers. Our membership needs a care environment that provides enough flexibility to allow nurses at the bedside to decide how they provide care after thoughtful consideration of the acuity of the patient, the experience level of the nurse, and the resources available on the unit.

In stark contrast, MNA's petition works against these objectives. It requires that hospitals across the state, no matter their size or specific patient needs, adhere to rigid nurse staffing ratios within all patient care areas. The petition would create an unfunded mandate that requires our state's acute care hospitals to meet these ratios "without diminishing the staffing levels of [their] healthcare workforce."

The measure will cost more than $800 million each year to implement, costs that will be felt across our healthcare system. This financial burden will severely limit hospitals' ability to support the required additional nursing workforce, and endanger the viability of smaller community hospitals, likely forcing financially vulnerable hospitals to completely close.

Our patients will also suffer. The additional costs will be passed on to them through higher premiums, deductibles and taxes. Care will be hindered by dramatically increased emergency room wait times and delays in other lifesaving care services. Even worse, it would force our hospitals to send patients to other hospitals or prevent us from admitting patients in crucial times of need. The crippling cost of implementation will divert precious resources away from important healthcare priorities like providing opioid treatment and mental health services.

The ballot initiative as presented will negatively impact the professional role of the nurse. We are a central part of the healthcare team. But this mandate would undermine the vital role we play, replacing our professional judgement as qualified health care professionals with government regulations. Further, nurses will not have the ability to participate in shared governance, professional committees, residency programs, or professional development opportunities due to the burdens caused by this rigid and costly initiative.

Lastly, there are no scientific studies or reports that demonstrate the effectiveness of this government forced, one-size-fits-all policy. California is the only state that has imposed such a mandate and there has been no evidence that it has improved quality of care.

With these considerations weighed, we have joined the Coalition to Protect Patient Safety, which includes the Organization of Nurse Leaders, the Massachusetts Health & Hospital Association, the Massachusetts Council of Community Hospitals, and the Conference of Boston Teaching Hospitals, among other healthcare leaders.

I look forward to your partnership and collaboration as we move forward together. Please do not hesitate to contact me with any questions or concerns that you may have regarding this initiative.

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SAVE THE DATES

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

Tuesday, March 20, 2018
ANA Massachusetts Lobby Day
State House, Boston, MA
See article on page 1

Thursday, March 1, 2018 in Chicopee, MA
Thursday, March 22, 2018 in Bourne, MA
ANA MA Political Advocacy Program: How Nurses Can Influence Policy
There are many legislative issues that affect YOUR nursing practice. Come learn about what they are and how YOU can make a difference.

Friday, April 6, 2018
ANA Massachusetts Celebration of Nursing Awards Dinner and Spring Conference
Dedham Hilton Hotel, Dedham, MA
Join your nursing colleagues at our 17th Anniversary Spring Convention as we learn from the experts at the Annual Spring Conference and celebrate the best of the best in nursing at the Annual Awards Dinner.

Conference
(7:30 a.m. - 4:00 p.m.)

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

Join us as we hear from Nursing experts concerning the assessment, diagnosis, treatment, current evidence, and practice implications for patient care in Stroke, Diabetes, Heart Failure, Psychiatric Response in the Medically Ill Patient and Oncologic Implications in Acute and Chronic Illness.

Featured speakers: Mary Guanci, MSN, RN, CNRN; Judy Sheehan, MSN, RN-BC; Myra Cacace, MS, GNP/ADM-BC; Mary Beth Harrington, PhD, RN, ACNS-BC, ANP-BC, CCRN-E and Susan Finn, RN, MSN, AOCNS

Check our website for speaker updates, www.anamass.org.

ANA Massachusetts Annual Business Meeting
(4:30 p.m.)

ANA Massachusetts Annual Awards Dinner
(cocktail reception begins at 6:00 p.m.)

Celebrate the Past, Present and Future of Nursing in Massachusetts!

Check website for list of award recipients.

Sponsorship Opportunities and **Call for Posters** at www.ANAMASS.org.

Friday, May 18, 2018
ANA Massachusetts Night at Boston Red Sox
Fenway Park, Boston, MA

May 4-11, 2018
Rhode Island SNA's Earn and Learn CE Cruise to Bermuda
7-day Bermuda, round-trip Boston
Call 401-828-2230/donna@travelplusri.com for details

Friday, June 1, 2018
ANA Massachusetts Approver Unit Provider Symposium
Curry College, Milton, MA
Registration Open - Early Bird through March 30th
ANA Massachusetts Accredited Approver Unit Annual Spring Symposium: *The Nuances of Evaluation*
Join
ANCC Program Director Jennifer Graebe, MSN, RN, NEA-BC & ANA MA Nurse Peer Review Leader Judy Sheehan, MSN, RN-BC

Understanding a multi-level evaluative approach to planning nursing continuing education to meet ANCC criteria.

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

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

EDITORIAL

A Just Culture: What it is and Why it is Important

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

Errors – we have all made them. As nurses, we have made clinical judgment errors, medication errors, and treatment errors. Although I have not provided direct patient care for a long time, I still remember and reflect on an error that I made years ago. I also remember other nurses' errors, especially those that came to my attention when I was a nursing administrator. When the Institute of Medicine (IOM, now the National Academy of Medicine) published *To Err is Human: Building a Safer Health System* (2000), we were all shocked that "as many as 98,000 Americans die in hospitals each year as a result of medical errors" (p. 26).

The IOM taught us a whole new vocabulary: error, adverse event, preventable adverse event, negligent adverse event, near miss. We learned to speak of sentinel events. Quality and safety became infused throughout nursing education and became a major focus for all health care organization activities.

However, perusing the index of *To Err is Human*, it is notable that the terminology "just culture" does not appear. In 2001, the IOM published *Crossing the Quality Chasm*. This report "focuses more broadly on how the health care delivery system can be designed to innovate and improve care" (p. ix). Again, 'just culture' does not appear in the index. In *Introduction to Quality and Safety Education for Nurses: Core Competencies* (2014) by Kelly, Vottero, and Christie-McAuliffe, 'just culture' is not in the index.

So if three important books on the topic of quality and safety do not include just culture, is it an important topic? The answer is a resounding YES.

Just culture "seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues" (ANA Position Statement on Just Culture, http://nursingworld.org/psjustculture). Rather than the "shame and blame" culture that penalizes people for reporting their errors, just culture recognizes that systems problems often contribute to errors. In a just culture, the emphasis changes from errors and outcomes to system design. Near misses are analyzed to determine what went wrong, as well as events that actually caused harm.

A just culture does **not** give a pass to negligent or reckless behavior or conscious disregard of clear risks to patients. Ignoring policy, such as skipping the required patient identification for medication administration, is still unacceptable and can result in blame and punishment. What just culture does do is seek to identify "what went wrong" rather than "who is to blame." A just culture looks to find a balance between a blame free environment and a punitive environment.

According to the ANA position statement (2010), "the Just Culture model addresses two questions: 1) What is the role of punitive sanction in the safety of our health care system and 2) Does the threat and/or application of punitive sanction as a remedy for human error help or hurt our system safety efforts?" These two questions should help to frame the discussion and subsequent practice in health care institutions as well as the practice related to student errors and near misses in nursing education.

I encourage you all to read the ANA position paper and to embrace the concept and look for ways it can be applied in your workplace.

References available on request from slarocco0603@curry.edu.

Clio's Corner

75th Anniversary Memorial of the Cocoanut Grove Fire

Mary Ellen Doona

Seventy-five years have passed since the Thanksgiving weekend of 1942 when on Saturday night a thousand people jammed into the popular Cocoanut Grove. A night of dining, dancing and drinking within its tropical décor of palm trees, bamboo and rattan offered a brief respite from the cold outside and the war in Europe and the Pacific. Some were celebrating family milestones; others were saying goodbye to friends and relatives going off to war; and still others were enjoying another night on the town. Among the crowd were Boston College fans absorbing the unexpected loss to Holy Cross earlier that day that had also eliminated the Eagles chance of a bowl game. All were packed into Boston's "in place to be" their numbers far exceeding the Grove's capacity of 460.

And then fire broke out in the Melody Lounge. Within two to four minutes it had raced up stairs that acted like a chimney drawing the fire and its toxic gases into the street level foyer. From there it continued through the Caricature Bar aided by a ventilating fan into the dining room and then into the new Broadway Lounge. The Fire Commissioner estimated only twelve minutes had elapsed from the start of the fire in the Melody Lounge at the lower level to its arrival at the Broadway Lounge.

Patrons rushed as if by instinct towards the revolving door through which they had entered the club. The onrush of people intent on escape quickly jammed the slow revolving door. Other exits were locked to prevent patrons from leaving the club before they had paid their bills. Tables, chairs and decor blocked still other exits that were hidden behind decorative walls. Even if unlocked, according to post fire thinking, the intense heat of the fire would have made these exits impassable. Waiters and entertainers who knew the layout of the building led the lucky few-about 220-through the darkened club to unlocked exits.

Firefighters, fortuitously nearby, rushed to the scene to knock down the blaze but its intense heat at first delayed entry. Once inside, they found bodies stacked on bodies by the exits, other bodies eerily still sitting at the bar, and some others slumped on the settees in the dining room. Only a few were still alive among the hundreds that were dead. Many had been extensively burned while others only had faces blackened from exhaled smoke, and still others had cherry red faces signifying carbon monoxide poisoning. Toxic gases released from the tropical décor had anesthetized some victims as they scrambled for an exit lulling them into a final sleep.

Saturday night partiers, men and women in military uniform and passersby rushed to help. Trucks, taxis and cars became ambulances to transport most of the victims to Boston City Hospital, the usual destination for emergency cases. During one seventy-five minute period victims arrived there at the rate of one every eleven seconds. One hundred and eighty died in transit and ten to fifteen died within a few minutes of arrival. One hundred and thirty-four were admitted to wards that had been reserved for war victims. Seventy-five of the one hundred and fourteen victims that arrived at Massachusetts General Hospital died on arrival. The thirty-nine still alive were admitted to the White unit. Eventually ambulances were directed to other hospitals and military hospitals in the area.[1]

The Cocoanut Grove Fire, labeled the deadliest nightclub fire in history, is the legacy Dr. Ken Marshall's mother, Mary Creagh left to him. The native of County Clare, Ireland was on duty the night of the fire. She never recovered from the trauma, says Marshall, often screaming herself awake from flashbacks of seeing so many bodies still dressed in their evening finery laid out in the BCH parking lot. Marshall continues to honor his mother and the lessons she taught him as a boy. On Saturday November 25, 2017 he presided over the 75th Anniversary Memorial of the Cocoanut Grove Fire at the Revere Hotel. Speaker after speaker recounted the good that has risen from the ashes of the catastrophe not only in Boston but throughout the nation as well. Fire codes and their enforcement have made places of public assembly safer. Illuminated exit signs visibly point the way out. Other doors that open out into the street flank revolving doors. Burns are now treated as systemic injuries requiring plasma and blood to prevent shock. Penicillin, then under wartime secrecy, was used for the first time with civilians. The study of psychological trauma yielded important insights that four decades later would be labeled PTSD.

The catastrophe remained front-page news until May of the following year. The club itself was demolished in 1945 but not forgotten. Paul Benzaquin's Fire in Boston's Cocoanut Grove was published in 1959 and reissued in 1969 two years after the twenty-fifth anniversary of the fire. At the fiftieth anniversary in 1992, the seventy-year-old Anthony P. Marra, a fifteen-year-old busboy the night of the fire, memorialized the deaths of 492 people. With the help of the Bay Village Neighborhood Association Marra's small plaque was imbedded in the sidewalk at 17 Piedmont Street once the revolving door entrance to the Grove.

Ken Marshall, MD and Barbara Poremba, EdD, RN

Credit: Leland Hussey

More time passed and memories began to fade as new buildings rose on the site with Marra's "Phoenix out of the Ashes" becoming less and less prominent. Then, one day over "a good cigar and a cup of coffee" Marshall and Michael Hanlon of former Mayor Kevin White's administration chatted about their being the last generation with a direct connection to the fire. With that realization came the command: "If we didn't do anything, nothing would be done, nothing would happen."[2] With the help of survivors, families of the victims, fire and police personnel, and especially Mayors through the years: Raymond Flynn, Thomas Menino and in 2013 Mayor-elect Martin Walsh something happened. On November 30, 2013 the Shawmut Ext street sign that intersected with Piedmont Street, was renamed Cocoanut Grove Lane. Providing the backdrop to the crowded dedication were three large posters with the names of everyone who had died because of the fire. Marra's plaque that had migrated during construction in the area has come to rest at the base of the Cocoanut Grove Lane sign. Plans are afoot for a more significant monument to be erected in the future. (See https://www.youtube.com/watch?v=eMKtlWwvWxw).

Two of the dwindling number of survivors attended the 75th Anniversary Memorial. Joyce Spector Mekelburg and Marshall Cole, both nonagenarians, recounted their escape from the Grove as well as spoke of the psychological scars they still bear. Nurses who cared for the Grove victims are also declining in number. Barbara Poremba, EdD, RN, Professor Emeritus of Salem State University, presented excerpts from her ongoing study of these nurses. Anne Montgomery, for one, was a nineteen-year-old nursing student at BCH when Margaret Bushe, the Director of Nursing, exclaimed, "This is it!" It was not the enemy invasion the hospital had been preparing for but victims from the fire at the Grove. Montgomery left the dance in

the nurses home for duty in the accident room where she said the dead "were flowing in faster than they could bring them over to the morgue across the street…. They sent me to guard the bodies," and was directed, "Make sure no one robs them of their valuables." Montgomery added, "I was only a kid, I was scared…. See[ing] all of these dead bodies."

The arrival of victims occurring at it did at the change of shift provided a double complement of nurses for a staff severely depleted because so many graduates had enlisted in the military. Yet even that did not meet the demand. Helen Berman, another nurse in Poremba's study, recounted her experience. "Everything was happening so fast. You did what you were told," she recalled. "You didn't think, you just did…. And we did it for days." At one point the then twenty-one-year-old graduate found herself nursing supervisor by virtue of being the only nurse on the spot. Grief over the deaths of a first cousin and two BCH doctors had to be set aside as a much lesser priority than the crisis and the urgent care that followed.

Fifty years later, Dr. Stanley Levenson credited intensive nursing care with keeping patients going. The one respirator on each ward, the only pulmonary device then at the BCH, could not meet the overwhelming demand. Levenson remembered nurses keeping patients breathing, getting them to cough and clearing their airways. Remembering the care that became medical history, Levenson cited doctors, interns and medical students. "And most of all," he added, "We had wonderful nurses." Their encouragement and moral support were as vital as their physical care.[3]

The nursing care at the MGH was no less exemplary as Mary Larkin, the President of the MGHSN Alumna Association has discovered in the MGH Alumnae Association Oral History Project. Among nurses she has interviewed was Marion Bates, a 1934 graduate of the MGH School of Nursing who in 1942 was night supervisor when the fire's victims arrived. The nonagenarian who has since died said that the sight of so many bodies of those who were dead on arrival lined up in the corridor was "a sight [she] would never forget." Indeed as Donna White, the President of BCH School of Nursing Alumni Association told attendees at the 75th Anniversary Memorial, the lessons nurses learned as they cared for the Coconut Grove victims, became the lessons they taught to the next generation of nursing students.

[1] See Mary Ellen Doona, Clio's Corner: Seventy-one years ago: The Cocoanut Grove Fire (Part One) March 2014 and Cocoanut Grove Fire: Nursing Care (Part Two) December 2014, In *The Massachusetts Report on Nursing*: and reprinted in Mary Ellen Doona, *Clio's Corner: The History of Nursing in Massachusetts. American Nurses Association Massachusetts,* 2016, 182-189.

[2] *The Boston Globe*, November 28, 2013, 1, 12.

[3] Stanley Levenson, "Recalling Cocoanut Grove," *The Boston Globe*, May 5, 1991, 34. See also Lauren Ellis *The Alumni Bulletin [Massachusetts Memorial Hospitals Nursing Alumni Association* [Ed. Emily Feener], vol. 84 no. 1 Fall 2002 6-7.

SEEKING INFORMATION

on nurses who cared for the victims of the Cocoanut Grove Fire on November 28, 1942.

Barbara Poremba, EdD, RN, Professor Emeritus, Salem State University, seeks nurses and/or information about nurses who cared for Cocoanut Grove Fire victims on November 28, 1942 for her study "Celebrating Nurses: the Unsung Heroines of the Cocoanut Grove Fire."

Dr. Poremba would also welcome hearing from anyone who has direct knowledge about victims or survivors of the Cocoanut Grove Fire.

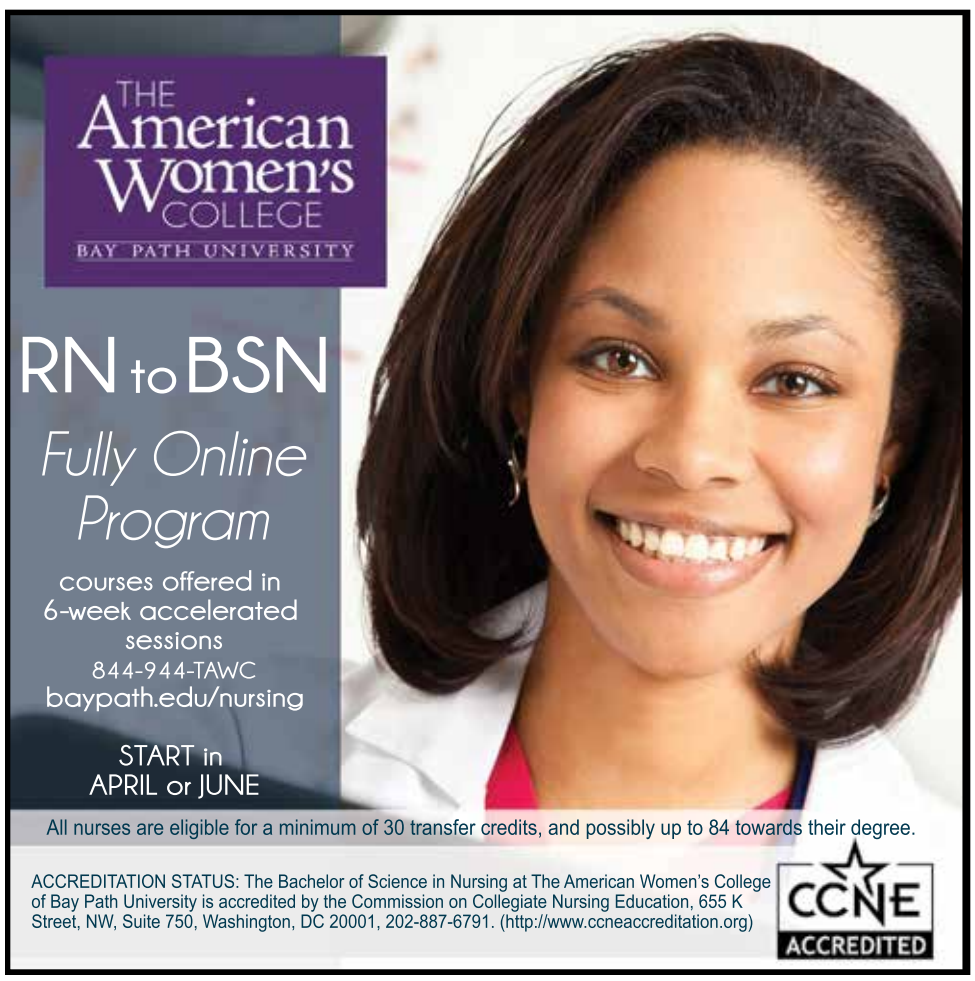
Contact her at bporemba@salemstate.edu.

Who is the Nurse in the Masthead?

Mary Creagh

Boston City Hospital nurse, Mary Creagh (Anglicized from the Irish *craobh* meaning branch) was a native of Ennis, County Clare, Ireland. She epitomizes the branch of nursing's history that is filled with nurses awaiting discovery and inclusion in the profession's narrative. Creagh was on duty in BCH's emergency room the night of November 28, 1942 when the victims of the Cocoanut Grove Fire arrived. Creagh never forgot the horrors she saw that night and for many days after. That was the legacy she left her son, Ken Marshall MD, who has spent his inheritance making sure that the Cocoanut Grove catastrophe is remembered. In doing so, he has also ensured that Mary Creagh is not forgotten. Rescued from obscurity, she represents all those other nurses still to be discovered and included in nursing's history.

Photo Credit: Ken Marshall



Reflections from Past Presidents

Nurses Leading Practice and Work Environment Redesign

Karen Daley, PhD, RN, FAAN
ANA MA Past President and ANA Past President

Much has been written about factors that contribute to safe, quality health care for patients. One factor – work environment – was highlighted in a 2004 IOM report entitled: *Keeping Patients Safe: Transforming the Work Environment of Nurses*, as playing a dominant role in nurses' ability to provide safe, quality patient care. Based on their findings, the IOM committee recommended that significant changes be made to the way all health care organizations were structured, including: management and leadership; workforce deployment; work processes; and organizational cultures. In the years since that IOM report, numerous other studies have followed that have consistently reaffirmed the importance of nurses' work environment relative to the provision of safe, quality care and its impact on related factors such as nurses' surveillance capacity, errors, injuries, adverse patient events, missed care, and role satisfaction and engagement.

Given the almost constant state of reform and transformation across the health care industry, opportunities exist for innovation of current nurse practice models and work environments. As providers who understand the unique knowledge and competencies they bring to patient care safety and quality, nursing needs to lead this aspect of health care reform. Imagine you have the freedom to determine how your time as a nurse caring for patients is best spent and to redesign the care environment in which you practice. What would be different?

Think about how you currently spend your time on an average shift and ask yourself a few important questions: *Is your time being expended engaging in activities that best utilize your unique nursing knowledge and competencies? What would those activities include? Do you often find yourself leaving your shift mindful of missed care with the potential to cause avoidable harm to your patients because you didn't have enough time? What are you currently spending your time doing that could be safely delegated – with proper training and supervision – to another member of the health care team? Given your knowledge and clinical competencies, how would your time be best spent to the benefit of your patients?*

In addition, you might consider: *Is your time used getting to know your patients and their families and developing an understanding of their care and quality of life preferences? Do you have the time and resource capacity to adequately monitor your patients, conduct ongoing assessments, critically think and reflect, and conduct discharge teaching? Do you have the time to engage with your patients and their family members in conversations directed towards helping them maintain their health, manage chronic disease and prevent future complications and illness? As their direct care provider, are you part of the team helping to coordinate their care? What factors within your current practice environment seem to impede safe, timely and efficient care delivery?*

Finally, ask yourself: *Do you ever challenge the day-to-day status quo when you know your work environment might be made more efficient and safe? Do you use your voice and engage with others to identify system issues that pose barriers to quality care? Is your practice environment collegial and supportive - one in which you experience open, respectful and transparent communications?*

As professionals, we have the knowledge and capacity to contribute to improvement and innovation of care delivery and our work environments. Nurses need to be the ones to lead that change.

BSN in 10: The New York Experience Continues

Barbara Zittel, RN, PhD

WE HAVE A SIGNED BILL! WE HAVE A SIGNED BILL! WE HAVE A SIGNED BILL!

That is the message that was sent to the nursing profession in New York State and to our colleagues and friends across the nation and throughout the world. **On December 18, 2017, Governor Andrew Cuomo signed the BSN in 10 bill** (S6768/A1842) sponsored by Senate Majority Leader John Flanagan and Assembly Majority Leader Joseph Morelle. This legislation establishes an evidence-based educational mandate to meet increasingly complex health care needs of the residents of New York State. At the same time, the legislation continues to permit RN licensure after completion of a diploma or associate degree nursing program. The legislation recognizes that the diploma and associate degree in nursing are appropriate entry points into the nursing profession with academically demanding and clinically challenging courses of study. The newly enacted legislation also recognizes that additional education makes a difference in the skill and competence of RNs, just as it does for other licensed health professionals.

Given the enhancements to articulation between associate and baccalaureate degree nursing programs and the ever-increasing options for advanced placement and distance learning, we believe that the legislation can be implemented without disadvantaging future newly-licensed RNs.

The law specifies that future graduates of diploma or associate degree nursing programs have up to ten years to obtain their baccalaureate degree, with the possibility of extensions for extenuating circumstances. RNs not meeting the requirement will have their licenses placed on 'HOLD' a policy currently used by the State Education Department for licensees not meeting the continuing education requirement in many other licensed professions.

All presently licensed RNs, as well as nursing students currently enrolled in diploma or associate degree programs or applicants on a waitlist for a nursing program, would be "grand parented" and their licenses forever protected from this mandatory additional educational requirement.

We wish to extend our sincere gratitude to all of the many persons who made this law a reality. And now we challenge every state and jurisdiction, every organization of nurse executives, every nurses association, and every board of nursing to begin your own journey to advance nursing education. We humbly offer our assistance in that process.

Tri-Council for Nursing Issues Proclamation on Nursing Civility

Civility Considered Key to Promoting Healthy, Inclusive Work Environments and Safeguarding Patient Safety

Nurses are ethically obligated to care for each other and those we provide care with civility regardless of race, ethnicity, socio-economic status, gender, physical ability, religious affiliation, language, sexual orientation, age, political orientation, veteran status, occupational status, geographical location and any other cultural diversities

Washington, DC – September 26, 2017 – In an effort to emphasize how critical civil behavior is to excellence in nursing practice and to outstanding congruent care for all patients, the Tri-Council for Nursing (American Association of Colleges of Nursing (AACN); American Nurses Association (ANA); American Organization of Nurse Executives (AONE); and the National League for Nursing (NLN)), today issued a bold call to advance civility in nursing.

The resolution calls upon "all nurses to recognize nursing civility and take steps to systematically eliminate all acts of incivility in their professional practice, workplace environments, and in our communities." Tri-Council urges that nursing civility be practiced throughout the US "to establish healthy work environments that embrace and value cultural diversity, inclusivity, and equality." It makes a point of noting that people of all racial, religious, ethnic, sexual orientation, socio-economic, political, geographic and other differences are to be treated respectfully.

"It's no secret that acts of disrespect, and other overt or subtle negative emotional behavior create a toxic work environment which contributes to burnout, fatigue, depression and other psychological stresses. Eliminating assaults to anyone's self-esteem is essential to providing a healthy work and learning environment," noted G. Rumay Alexander, EdD, RN, FAAN, president of the NLN and Associate Vice-Chancellor/ Chief Diversity Officer and Professor at the University of North Carolina at Chapel Hill. "The Tri-Council recognizes that instilling an ethic of civility from the very beginning of a nurse's education and throughout the profession will begin to eliminate the dangers that inevitably arise when it is lacking."

"Manifesting civility is key to enhancing the patient care experience and ensuring quality team-based care," said Juliann Sebastian, PhD, RN, FAAN, and chair of the American Association of Colleges of Nursing. "As the most trusted healthcare provider, registered nurses understand the connection between treating patients with respect, establishing open lines of communication, and realizing positive care outcomes."

"AONE is committed to providing nurse leaders with the tools and resources to prevent workplace violence and ensuring the safety of all health care workers and patients. Through its work with the American Hospital Association, AONE is partnering to increase awareness of the issue and support AHA's Hospitals against Violence initiative," stated Joan Shinkus Clark, DNP, RN, NEA-BC, CENP, FACHE, FAAN, AONE's president and SVP, THR Chief Nurse Executive at Texas Health Resources.

"Civility forms the foundation of a culture of respect for one another and is non-negotiable for a healthy, safe and ethical work environment," Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association, commented. "The ANA has zero-tolerance for any form of incivility, violence, or bullying in the workplace in order to safeguard patients, nurses, and other healthcare team members."

The Tri-Council identified other potential measurable hazards to health care of incivility, intolerance, and disregard for emotional health: difficulty in nurse recruitment and retention, aggravating the persistent shortage of nurses, and poor communication and teamwork giving rise to preventable errors that risk patient safety. Noting that nurses currently enjoy a reputation as the most ethical and honest profession in the country, the council's statement articulates a nurse's ethical obligation to care for others and themselves.

View the full text of the proclamation on the Tri-Council's website, http://tricouncilfornursing.org.

About the Tri-Council for Nursing

The Tri-Council for Nursing is an alliance of four autonomous nursing organizations each focused on leadership for education, practice and research. The four organizations are the: American Association of Colleges of Nursing; American Nurses Association; American Organization of Nurse Executives; and the National League for Nursing. While each organization has its own constituent membership and unique mission, they are united by common values and convene regularly for the purpose of dialogue and consensus building, to provide stewardship within the profession of nursing. These organizations represent nurses in practice, nurse executives and nursing educators. The Tri-Council's diverse interests encompass the nursing work environment, health care legislation and policy, quality of health care, nursing education, practice, research and leadership across all segments of the health delivery system.

Continuing Education

ANA Massachusetts Approver Unit News

The annual spring symposium for nursing continuing education will be held on June 1, 2018 at Curry College in Milton, MA.

As a special treat, Jennifer Graebe, MSN, NEA-BC, the Director of the Primary and Joint Accreditation program at ANCC will be joining Judy Sheehan MSN, RN-BC, Nurse Peer Review Leader, to discuss the "Nuances of Evaluation." The program will have the same learner outcome and structure as the Holyoke program held last November, however, as always the questions from participants and discussions will drive the program focus. As one participant said at last years' meeting "I come to all of the programs, because the questions are always different and I always learn something new." ANCC recognizes that adult learners can learn new things when repeating programs and thus contact hours can be obtained if you attend both.

For more information and to register for this program go to http://www.anamass.org/.

ANA Massachusetts Approver Unit Frequently Asked Questions

Judy L. Sheehan, MSN, RN and
Sandra Reissour, MSN, RN

SUMMARY REPORTS

Source: The summary question comes from nurses who plan individual educational activities and from primary nurse planners who are responsible for ensuring adherence to ANCC criteria within their Approved Provider Unit.

Q: A summary report is required for every activity provided. What should be reported and to whom?

A: A summary report should be developed after each educational activity and reviewed by the nurse planner. The purpose of this report is to allow an evaluation of the program, provide evidence for needed changes in any repeats of the same program, provide data for future programs and verify how many participants attended the program. Summary reports from both individual activity providers and approved provider units must be submitted to the ANA Massachusetts Approver Unit. The difference between the two is: the Individual activity provider submits a report every time the activity is run and the Approved provider unit submits a report once a year, addressing all programs run during a given year. In turn, the ANA Massachusetts Accredited Approver Unit reports the collected data to ANCC annually and may be asked to provide a narrative answer to a focused question determined by the Approver Unit.

Reporting requirements as described by ANCC:

- Date/Range of Activity.
- Title/Name of Activity.
- Type of activity.
- Target Audience (RN's, Interprofessional).
- Total Number of Activity Participants/Total Number of Nurses (Registered Nurses).
- Number of contact hours offered/offered upon activity completion.
- Whether the Activity was Directly or Jointly Provided.
- If the Activity Received Commercial Support.
- Amount of Commercial Support Received.

Reference: 2015 ANCC Primary Accreditation Approver Application Manual, p 36

MULTIFOCUS ORGANIZATIONS

Source: Many nurses who submit applications to become an Approved Provider of continuing nursing education through ANA Massachusetts demonstrate difficulty describing their Provider Unit from a demographic perspective.

Q: How do I know if my organization is a multifocused organization or not?

A: The best way to determine whether your organization is single focused or multifocused is to examine why the organization exists. Look at the big picture. Does the organization itself exist for the sole purpose of providing continuing nursing education? Or, does the organization exist for more than the purpose of providing continuing nursing education? An example of a multifocused organization is a medical center which obviously exists for the primary purpose of providing various levels of health care as well as other purposes such as medical and nursing education.

Reference: 2015 ANCC Primary Accreditation Approver Application Manual, p 56

Testimony to Remove Artificial Barriers to NP Practice

November 7, 2017

Re: H2451/S1257 – An Act to contain health care costs and improve access to value based nurse practitioner care as recommended by the IOM and FTC

Dear Senator Lewis, Representative Hogan, and members of the Joint Committee on Public Health:

My name is Myra F. Cacace and I have been a nurse practitioner since 1994. I am also the Past President and present Co-chair of the Health Policy Committee of the American Nurses Association Massachusetts. ANA Massachusetts is the constituent organization of the American Nurses Association (ANA). We are the largest voluntary professional organization representing professional nurses, including Advanced Practice Nurses in Massachusetts. On behalf of our nurse members, I would like to thank you for giving me the opportunity to submit testimony regarding H2451 and S1257 An Act to contain health care costs and improve access to value based nurse practitioner care as recommended by the IOM and FTC.

ANA Massachusetts is in full support of any legislation that allows nurse practitioners full practice authority. ANA's Principles for APRN Full Practice Authority provides policy-makers, advanced practice registered nurses (APRNs), and stakeholders with evidence-based guidance when considering changes in statute or regulation for APRNs. "Full practice authority" allows the APRN to utilize knowledge, skills and judgment to practice to the full extent of their education and training. The ANA agrees with the American Association of Nurse Practitioners (AANP)'s definition of full practice authority as, "the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments – including prescribe medications – under the exclusive licensure authority of the state board of nursing" ("Issues At-A-Glance: Full Practice Authority," 2014).

I earned my license to practice as a nurse practitioner in 1994, after working as a RN for 17 years, completing a course of study in a certified NP program and passing a nationally recognized certification exam. My license enables me to practice and obligates me to provide excellent care to my patients as part of the health care team. My experience and training give me the expertise to thoroughly assess a patient, develop a care plan and provide the necessary care and education to meet the needs of the person, family and community.

Massachusetts leads the nation in health care reform initiatives; however, we are in a health care delivery crisis in Massachusetts. There is uncertainty about the future of affordable health care in America and more people than ever are seeking good reliable health care. Unfortunately, there is a shortage of primary care providers in the Commonwealth. Ironically Massachusetts, a leader in health care reform, lags behind other states in the area of allowing APRNs to practice to the full extent of our license and experience. Arbitrary rules that limit my scope of practice or mandate that the physician must see a patient for the first time "to set up the care plan" lead to delays in access, inefficient care and a waste of time, money and resources. It is time to remove these barriers to patient care!

There is over 40 years of evidence showing safe and cost-effective provision of care by APRNs. This evidence based research demonstrates that Advanced Practice Nurses excel in delivering high quality care. In addition, there is no data to substantiate that current Massachusetts' licensure framework either enhances patient safety or reduces health care costs.

The Institute of Medicine, the American Association of Retired Persons (AARP), the National Governors' Association (NGA), the Bipartisan Policy Center, the Veteran's Health Administration and many national organizations all are calling for the removal of all barriers to full practice authority for advanced practice nurses. In fact, the Federal Trade Commission (FTC) issued an opinion letter to the Massachusetts Legislature in January 2014 supporting the IOM recommendations to remove such barriers.

As a NP, I am accountable for the care I provide, carry my own malpractice insurance and work in a collaborative practice with physicians to care for our patients. As my experience grew and I acquired a certification in Advanced Diabetes Management, the relationship between the members of the health care team shifted and my physician colleagues frequently sought my advice about caring for their diabetic patients. In fact, when the area endocrinologist moved out of Massachusetts, physicians from other practices referred their diabetic patients to me.

There is also a mandate that a "supervising" physician must retrospectively review a sub-set of the prescriptions issued to patients by NPs and CRNAs. This is not meaningful supervision, since chart and prescription reviews are often done days or weeks after the care is provided. Not to mention the challenge of getting the physician to make the time to fit a medication review into an already insane schedule.

Advanced practice nurses caring for patients understand their scope of practice and regularly seek out opportunities to collaborate to provide the best patient care. We want to practice as part of multidisciplinary teams that encourage and rely upon true collaboration, but with the "individual authority" to provide our own expertise consistent with national standards. This legislation brings the balance of accountability, safety and flexibility that Massachusetts needs to successfully meet workforce demands and gaps in access to care that will meet patients' needs.

There are physicians who will tell you that I can't be trusted to practice and must have not just one Board but TWO boards overseeing my license. No other licensed disciplines making up the health care team, such as psychologists, social workers, physical therapists, podiatrists or optometrists have this arrangement. Why should this arrangement exist for advanced practice nurses? A better question is: Why should the Commonwealth pay for double oversight?

Massachusetts is the only New England state that has not yet removed these restrictive and artificial barriers to our practice.

Advanced Practice Nurses can and MUST be allowed to be part of the solution. Now is the time to eliminate inappropriate, redundant physician oversight that exists in today's Nurse Practice Act and to stop the misuse of scarce resources during a time when quality and cost are the focus of statewide attention. We continue to welcome any opportunity to discuss this further with you and your committee.

Sincerely,

Myra F. Cacace, MS, GNP/ADM-BC
Co-Chair, Health Policy Committee, Past President

Nurses and the Centennial of the Halifax Explosion

Mary Ellen Doona

Special thanks to Susan Fisher, Director, MGH School of Nursing Alumni Association

December 6, 1917 is a date deeply etched in the memory of Alumni of Massachusetts General Hospital School of Nursing. In Halifax that morning at 9:05 the *SS Imo* collided with the *SS Mont Blanc* igniting its cargo of six million pounds of munitions meant for the war in Europe.[1] The explosion and the shock wave and 35 foot tsunami that followed made no distinction among the Mi'kmaq people who were native to Halifax, the military who had recently arrived and all those in between who had long made the port city their home. In a flash two thousand people were killed, 9000 were injured, 25,000 people were made homeless and thousands of children became orphans.

Twelve hours after receiving the news that Thursday morning, Massachusetts' Committee on Public Safety's Abraham C. Ratshesky, a prominent banker and civic leader, was sending two Pullman cars, one baggage car and a buffet car to Halifax filled with nurses, doctors, workers and medical supplies. The relief train left Boston that night at 10:00 pm, plowed its way through a blizzard and arrived Saturday morning at 6:30 am. Although somewhat delayed, the relief train was the first response from outside the Halifax area providing a respite to the local nurses and doctors who had been working non-stop since the explosion. On seeing the devastation, Ratshesky wired Boston to send a trainload of building supplies, especially panes of glass, to the devastated city.

With the help of American sailors and Canadian soldiers the Bellevue Building in the center of town was cleared of shattered glass, ice and debris. Supplied with equipment from the British military depot, the new emergency hospital was receiving injured people by 12:30 pm. Similarly cleaned and organized, St Mary's College became a hospital where MGH nurses cared for 150 inpatients. Many more people would receive care on an outpatient basis.

The people of Halifax have never stopped saying thank you to the people of Boston for their wholehearted response. MGH nurses, mindful of their past, know the full significance of the tree that arrives every November from Halifax to grace Boston Common for Christmas. They know that at a time when MGH nurses were in Bordeaux France caring for sick and injured soldiers, other MGH nurses rode the relief train to Halifax and into history. Not only did their care of the Halifax people create a bond with the Canadian people, it also reinforced the bond they already had with Canadian-born alumni in MGHSON's long white line.

In June 2015 Charlene Day, then the President of the Victoria General Hospital SON Alumnae Association in Halifax, sent an email to MGH seeking information about her great aunt Mabel Mariette, Class of 1907. Patty Austen alerted Susan Fisher, her fellow member of the MGH Nursing History Committee. "By lucky circumstance," remembers Fisher, Day was to be in Boston the following week. A visit to the MGH SON Archives ensued during which time Mabel Mariette's record was retrieved verifying than she had graduated from McLean (1905) and MGH (1907) Hospitals Schools of Nursing, and had been among the many MGH nurses who cared for soldiers in Europe during World War I. Mariette continued as a nurse with the Army following the Armistice of 1918 returning to Canada at the end of her career.

Susan Fisher, Member of the MGH Nursing History Committee and Charlene Day, Past President of the Victoria General Hospital School of Nursing Alumnae Association in Halifax

Photo credit: Larkin Photo

Day mentioned that she and some nurses would be in Boston in 2017 for the tree lighting on the Common that would mark the centennial of the Halifax Explosion. Again by lucky circumstances, the MGH Nursing History Committee was engrossed in the history of MGH nursing during World War I and the Halifax explosion. The Committee was more than receptive to Fisher's report of her meeting with Day and considered whether the upcoming Centennial was an opportunity for a closer connection with the nurses from Halifax. "If they're coming for the tree lighting," Georgia Peirce, the Committee's chair added, "I think we'll want to do some planning to welcome them properly." For the next eighteen months the Committee bent its best efforts to creating that proper welcome.

A town crier alerted Boston as the tree arrived on Boston Common early in November. Several weeks later, on November 29th the commemoration began with state and municipal dignitaries welcoming their counterparts from Halifax at the State House. Beth Thomson (MGHSON 1953), the last person on the opening program, spoke of her mother and father, both of whom were Halifax natives, only 12 and 11 at the time of the explosion. The little girl was late for class and anxious as she grasped the doorknob to her classroom. At that moment the Mont Blanc exploded. She thought that her being late had made God angry with her. The little boy was at another school in the classroom waiting for his teacher. As lucky survivors of the catastrophe and later residents of the United States, they taught the lesson they had learned – take care of others. As petite as Beth is, she became a giant as she paid homage to her parents and Halifax roots. Nurses from Halifax led the standing ovation that swept over Beth as the program concluded.

Beth spoke again as the Centennial celebration continued the next morning on Boston Common. She lined up with Canada's first responders as Boston and Halifax dignitaries dedicated a plaque describing the long relationship between the two cities. Following the ceremony everyone boarded busses for the trip from the Common to MGH's Paul Russell Museum. There, its Director and MGH Nursing History Committee member, Sarah Alger, toured attendees through the extensive exhibit that highlighted Boston's response to the disaster. Then Deborah Ann Sampson, PhD, APRN presented an excerpt from her on going research on nurses' involvement in the relief efforts during the Halifax Disaster. After the formal part of the program, Haligonians and Bostonians relaxed for a while as they mingled over lunch.

The festivities continued later at the Canadian Consulate Reception at the Omni Parker House and once again, Beth was part of the formal part of the program. By this time nurses from Halifax and Boston were well advanced in forming bonds with one another. Then with traffic stopped and guided by mounted police the celebrants left the Omni Parker House and crossed Tremont Street for Boston Common for the tree lighting ceremony. At 8:00 pm Boston's Mayor Martin Walsh and Halifax Premier Stephen McNeil flipped the switch. The Centennial tree exploded in a blaze of color amid a cacophony of cheers commemorating the relationships created one hundred years before.

Thanks to one nurse's search for her ancestor and another nurse's response, the MGH Nursing History Committee prepared a proper welcome for the nurses from Halifax. In doing that, the Committee ensured that nurses would have a prominent place in the Centennial ceremonies. What's more, the Committee members and the nurses from Halifax shone a light on how the past influences the present.

http://www.cbc.ca/beta/news/thenational/halifax-explosion-100-years-later-1.4436889

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1 John U. Bacon. *The Great Halifax Explosion: A World War I Story of Treachery, Tragedy, and Extraordinary Heroism*. New York: William Morrow, 2017, 106.

Beth Thomson (front row center) with Nova Scotia nurses and Premier Stephen McNeil at State House

Photo credit: Barbara Poremba

Diversity and False Comfort

Deborah Washington, PhD, RN
Director, Diversity
Nursing and Patient Care Services
Massachusetts General Hospital

I recently met a close friend for brunch. Lisa is not a woman of color. We typically cover a range of topics over good food. Of course, a conversation about diversity is part of our list of topics. We move from specific examples based in personal experience to any diversity related *hot* topic trending in the news. During our most recent discussion it was she who mentioned the phrase "false comfort" to describe what happens when people avoid a deep dive into our debatable progress with diversity. We agreed that facing the lack of diversity in nursing faculty, leadership and workforce requires great patience and skill, especially if there is doubt or questions about cause.

Carrying out the vision of bringing more diversity to nursing seems to have us stumped. Not an unusual situation when the vision is ambitious. Still, we need something more. So far that mysterious "more" is the reason we cannot speak about progress without the use of ifs, ands, or buts as qualifiers. We have evidence based understanding of the problems, e.g. facts, figures, and statistics. We have approaches to the problems, e.g. personal stories, mentoring programs, scholarships, academic progression initiatives, etc. But healthcare organizations seem unable to produce the desired long-term solutions. We fall short. However, this dissatisfaction may be in and of itself our most significant progress to date. We, nevertheless, need an ongoing lineup of achievements. So, where are we stumped? The answer is that diversity interventions are not yet norms incorporated into business strategies and tactics. Here, some might say, "But we include those strategies in our organization." Counter to such a response is "The number of those that do are not sufficient." Reasons for this sit between nursing's past and its future. The diary of nursing includes stories from the past indicating how our organizations acted in accordance with the race based social barriers that were once the dictates of the larger society. The demographics of our profession are a legacy of those times. Today sincere efforts are at work to make things different from what they would be if what was handed down from the past was left alone. Keeping that in mind, nobody wants political correctness to be the main motivation for change. Such an approach neither inspires nor does it unmute the dialogue we so badly need. The change in direction we say we want has a strong stop at a line that if we were to cross over would take us to the "something different" we seek. For example, models for change may be widely known but, sadly, not commonly encountered. Diversity is set apart as a special project within the profession and tends to be hampered by limited funds. When financial resources run dry so does engagement and attention to the issues. For the most part, we neither advance nor fall back from our diversity agenda but instead remain in neutral. It feels like we're spinning our wheels.

People of color affected by microaggressions and stalled careers grow increasingly restless with the pace of progress. They are unsure if the pace results from passive opposition or a genuine search for answers to a complex issue. Hope and optimism is placed in the latter idea. Without question, there has been progress. But we must not take false comfort in what has been done and let that soothe us into missing the work that remains unfinished. What we give to and receive from one another in this important effort requires that we add a deeper note to our discourse. Explanations and determinants that go unrecognized or believed unlikely cannot continue unacknowledged. Until this step is taken the response to diversity will not be fully executed. Here is the clincher for nursing and its related issues. We have already shown the will to succeed.

Making Every Day Meaningful

Remembering Joe Woodman: Guest Lecturer at Boston College, 1981-1984

Eleanor Vanetzian, PhD, RN, CS

Boston College School of Nursing's affiliation with New England Sinai Rehabilitation Hospital (NESRH) in Stoughton Massachusetts provided a highly valued clinical learning site for senior students. Orientation to the agency included not only their introduction to the team of rehabilitation therapists, but also to Jewish cultural traditions that influenced nutritional and religious activities for those requesting them. Introduction of each student to each patient/resident assigned for their care during the two day weekly clinical rotation each semester was a priority. Joseph Woodman, the second son in his family and the first to be diagnosed as a school aged boy with Duchene's Muscular Dystrophy (MD) was hospitalized for care due to organ failure and functional disability. Joe's older brother was healthy; his younger brother also inherited the neuromuscular disorder, which only appears in a child at a time when his peers are growing and developing normally. Joe's family had raised the roof of their minivan to accommodate a wheel chair, which allowed Joe the mobility to attend events and activities outside of NESRH with friends and family. After knowing him for some time and during orientation, I introduced him to students as my friend, Joe Woodman.

Joe attended a special school for handicapped children before being hospitalized at the NESRH. Early on I realized there was much to be learned from this young man who resided in a single bed hospital room, was dependent on a ventilator for respiratory function, and dependent on an electric wheelchair for mobility in addition to nursing care in all areas of functioning. His dependence on the ventilator did not prevent him from communicating, something he was eager to do. It became clear that Joe was an astute observer of all that was going on around him, in his room, in his life, and in the world. Joe's care required a nurse's time and while providing activities of daily living, respiratory care, transferring and positioning him in his wheelchair, one could have a conversation with him that revealed the remarkable person he was.

Although speaking wasn't easy for him, he persevered by listening and when he had something to say, he would wait for the ventilator to deliver a pre-set volume of air and then, on exhalation, verbalize his thoughts. This activity was tiring, but not for Joe because he had a lot to say and he looked forward to having someone there to listen. Each day, before report and before students arrived at the agency, I visited each resident assigned a student to confirm their agreement and to prepare them for the day. One morning, Joe offered "I like that you introduced me to students as a friend." Another morning, I asked Joe how he slept. He told me that he had a dream. I asked if he remembered the dream: "Yes, I dreamed I was running." Another time, he described a shopping trip with his mother while he was much younger and attending the special school for disabled children. Joe was in a wheelchair and a young boy came over to him. Joe thought the boy wanted to say 'Hello'. But the boy's mother interjected, "Stay away from him. You'll get what he's got." To which Joe thought, but did not say, "He's already got it."

After getting to know Joe and realizing how important his contributions were to individual nursing students I asked him if he would be a Guest Lecturer for the senior rehabilitation course at Boston College. He and his family agreed. Each semester, fall and spring, I reserved the handicapped space closest to the classroom where his family and a nurse would bring him in his wheelchair equipped with a portable ventilator. He addressed the students and answered questions candidly about his life and his nursing care and his concern with healthy people he knew who, through their own actions, caused wounds that tended to appear as though they were "throwing their lives away." Most vividly, he expressed his sincere gratitude for the students, the nurses and his family. This tribute is to Joe and his family whose challenges were met with grace and love. Joe was a symbol of all that is right with providing supportive care in an environment that values life and appreciates all that life brings to those around us. The following were inscribed on the card at Joe's funeral:

In Loving Memory of
Joseph A. Woodman
February 2, 1987
Prayer

May the angels lead you into Paradise,

May the Martyrs receive you at your coming,
and take you to Jerusalem, the holy city.

May the choirs of Angels receive you, and with the once poor Lazarus, have everlasting peace. Amen

Do any 1982 to 1986 BC graduates remember Joe? If so please send your remembrance to me at newsletter@anamass.org and we will share it in a future issue.

Delirium in the ICU – A Patient's Perspective

Carol Bradley, RN

Upon awakening – probably more of not being totally unconscious rather than really awake – I had no idea where I was or why. I am sure that many people told me that I was in the ICU, but it was not what was expected and therefore, at the time, these words meant nothing to me. My family was there but that did not register either. As things started to fall into place, I remembered that I had gone to surgery for a possible small malignancy in my lung, and yes it would be painful, but the hospital stay would probably be 3 to 4 days. If ICU had been mentioned, it was as a remote possibility. I do remember someone saying yes it was malignant.

The next few days are a complete blur. There was severe pain as my surgeon had warned me, but it was treated promptly and during the times when I was somewhat alert I always felt well taken care of. At some point I discovered a bear in scrubs tucked in with me, and knew it was my sister's way of telling me I was being taken care of. My family and former coworkers were supportive and, despite some complications such as air leaks requiring a second chest tube, I felt I was making progress. Then came the nights … a completely different story.

As background, I am an RN, retired after 42 years of direct patient care, 15 in various med-surg positions with the last 27 in a maternity setting, primarily labor and delivery at the hospital where I was now a patient. I am no stranger to surgery. My past history includes 4 C-sections and a complicated exploratory laparotomy resulting in removal of my gall bladder. In no way did any of these things prepare me for a week long ICU stay with delirium.

The positioning of my bed in my room prevented me from seeing the one small window. Although winter in New England does not produce much daylight, it was still very disorienting, not to see out. With the nights came the hallucinations. One night I was sure I was in the basement with the pipes and electrical boxes. That night I somehow convinced my nurse to use my phone and call a friend who came in at 4AM in a blizzard; she talked me through the night. Another night was spent in an all stainless steel room with no doors or windows and I frequently told people coming into my room not to step on the little black cat with white paws.

One of what must have the worst nights (because I remember the number of staff around me) became okay when most of the staff left the room and one wonderful nursing assistant named Diane held my hand and said, "I won't leave you alone." I was able to fall asleep. I will never forget her.

Despite all this, my healing progressed well. A physical therapist got me walking, the dietician found food I could eat, my chest x-ray and blood studies improved, tubes were removed and I was able to transfer to a (thankfully) private room. I continued to heal and with my determination and good nursing care, was able to go home in 3 days, albeit with continuous oxygen therapy.

By seven weeks post discharge I had been weaned off my oxygen, and my surgeon, an oncologist, and a pulmonologist had assured me there was no metastasis and no chemotherapy or radiation were needed. Why then did the nightmares and general anxiety continue? I thought seeing the room and the fact that it was just a hospital bed, nothing frightening, would help, so I called the ICU and asked to visit "my" room when it was empty. They agreed and for the first time I learned about the PTSD that often occurs after periods of delirium. A nurse and an intensivist spoke at length with me and gave me material to read. They recommended melatonin to aid in sleeping and extended the invitation to come back if I needed to talk further. It helped tremendously to simply know that I was not going crazy. I was sleeping better, but still not well, so my primary care provider prescribed Trazadone which solved the sleep problem. The cognitive deficits began to subside. I continue to have mild problems with word recall but once again I can balance my checkbook and do puzzles as well as the usual activities of daily living.

Almost a year after the surgery I was invited to speak with a focus group that was hoping to start a diary project for ICU patients. I truly believe this would have helped me to know and understand what happened during the week that I could not remember. I strongly encouraged them to pursue this initiative. I also recommended that they consider comfort touch of some kind. Everything hurts in ICU and so many procedures increase the pain temporarily. Seeing the respiratory therapist made me want to hide, rather than be made to cough although I knew that it was necessary. Even family members need to be educated on touch. The sight of so many tubes and monitors makes them afraid to come close because they might disturb something. They can't know how much a foot rub or gentle hair patting would mean. Of course this can be taken to a higher level such as Reiki, but any gentle touch would help. Perhaps my years of comforting labor patients, and now volunteering as a cuddler in the NICU where the need to touch these babies is well understood, has helped me to verbalize this need for kind touching in the ICU.

I always thought of myself as a compassionate and caring nurse and still believe I was, but this experience, bad as it was, would have brought a new dimension to my nursing career.

See "Bedside Journals in the ICU: One Strategy to Reduce Post Intensive Care Syndrome" on page 13

2018 National Sample Survey of Registered Nurses

HELP!

Nurses play a critical role in the lives of patients across the country. That is why the U.S. Department of Health and Human Services is dedicated to providing you, policy makers, and researchers with the most comprehensive data on U.S. registered nurses and nurse practitioners. To accomplish this, **we need your help.**

Please support and encourage participation in the **2018 National Sample Survey of Registered Nurses (NSSRN).** This vital national survey is the primary source of data on the nursing workforce, the largest group of healthcare providers.

The Purpose of the Study

The NSSRN will gather up-to-date information about the status of registered nurses in the U.S. These data will be used to describe the registered nurse population at both the national and state level, so policymakers can ensure an adequate supply of registered nurses locally and nationally.

Data Collection

The NSSRN will be sent to over 100,000 registered nurses in March of 2018. Nurses will be able to fill out the survey electronically or through a paper questionnaire. It is imperative that nurses participate and send back as soon as possible.

The Survey Contractor

HRSA has contracted with the U.S. Census Bureau, the leading statistical federal agency in the United States. Census has assembled a team of expert survey methodologists responsible for gathering the lists of licensed RNs, constructing the national sample, and administering the survey by mail, and on the internet.

Did you Know?

Did you know…employment settings change as nurses age? The vast majority of registered nurses under 30 years old work in hospitals, but over 50 percent of registered nurses 55 years or older work in non-hospital employment settings. Information like this from the NSSRN survey helps policymakers and healthcare leaders plan for future staffing needs.

The Survey Results

We plan to release the public use file from the 2018 study by January 2019. A report from the 2008 study is available at http://bhw.hrsa.gov/healthworkforce.

Endorsements

The following nursing organizations have endorsed this survey. The National Council of State Board of Nursing and individual state boards of nursing have generously provided mailing lists for the survey.

HRSA Health Workforce

United States Census Bureau

American Academy of Ambulatory Care Nursing

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American Nurses Association

American Organization of Nurse Executives

National Association of Hispanic Nurses

National Black Nurses Association, Inc.

National Council of State Boards of Nursing

National League for Nursing

National Organization of Nurse Practitioner

Faculties

Bedside Journals in the ICU: One Strategy to Reduce Post Intensive Care Syndrome

Victoria Greymont, RN; Kathryn Harper, BSN, RN; Sara Landry, BSN, RN; Amanda Watkins, BSN, RN, CCRN; Adam Castagno, BSN, RN

From left to right: Adam Castagno, BSN, RN; Vicki Greymont, RN; Nurse Educator, Colleen Ryan, MSN, RN, CCRN; Sara Landry, BSN, RN; Amanda Watkins, BSN, RN, CCRN.

Kathryn Harper, BSN, RN.

Imagine yourself being so sick that you are sedated, intubated and admitted to the Intensive Care Unit (ICU). While you are sedated, doctors, nurses, and other staff members are in and out of your room taking care of you. Your family and friends are sitting by your bedside, talking to you and perhaps praying for a speedy recovery. You experience periods of wakefulness during repositioning. You may travel off the unit for diagnostic testing and procedures. You can hear alarms and voices but aren't quite aware of where you are, what day it is, what time of day it is, or what is happening. Titration of sedating medications for spontaneous awakening trials may produce anxiety. Then the big moment comes and you are extubated. Now you are left to wonder what happened.

Many intubated patients develop a Post-Intensive Care Syndrome (PICS), which refers to the "new or worsening mental health, physical, and cognitive outcomes that linger past the ICU stay" (Davidson & Harvey, 2016, p. 185). According to Locke et al (2016), "The prevalence of this syndrome is variable but can be high, occurring in 15% to more than 50% of ICU survivors" (p. 213). As you can imagine this can be a scary time for patients and their families. Patients are often left with few and distorted memories from this time.

The Newton Wellesley Hospital ICU Nursing Practice Council utilizes evidence-based practice to improve quality of care and nursing practice. Our literature review suggested that bedside journals could be beneficial in reducing PICS in patients and their families. We implemented bedside journals for intubated and sedated patients and had similar findings. These journals help to bridge the disconnect between the periods of intubation and extubation. These periods may include medical care or current events such as a Patriot's win!

The use of bedside journals was introduced in our ICU in December of 2015. Education on the journals was required for our staff, the patients' loved ones, and eventually the patient. Champions assisted staff with writing journal entries. Instructions were included inside the journal cover suggesting ideas of how the journals could be used. We encouraged all disciplines to write in the journals. Entries include feelings, news events, milestones, and are written in layman's terms. The patient's loved ones are also invited to write in the journal as their involvement has shown to help with their own coping and healing. We would like to share a few positive experiences of families and patients.

A substance use disorder patient in our ICU was intubated to protect his airway after overdose. The patient's wife was angry at the patient for his actions that brought him to our ICU. She shared her frustrations and sadness, eventually coming to forgive her husband in that journal. Their children utilized the journal by sending in pictures and notes from home. In this situation, the journal also served as an efficient tool that allowed the children to communicate with their father.

A patient was designated comfort measures only and died in our unit. The family had used the journal to grieve during the patient's illness and during their decision process. They left the journal behind after the patient's death. When they realized it, they called, upset, hoping to obtain the journal to keep. They were relieved when they heard that we had saved the journal for them.

One of our most memorable entries came directly from our nursing staff.

1/17/2016 9:30PM

Today is a seasonably cool, cloudy winter Sunday. You were brought to the ICU because of difficulty breathing and needing support, so you are now on a ventilator. Your strong body is responding beautifully to our/your treatments. Amazingly, you are answering yes/no questions consistently and very clear in your responses. Your lovely sons were in to visit you today and left a beautiful blue crystal rosary that we/you keep in your hand. I hope you can feel it and that Our Blessed Mother and Jesus bring you much comfort during this challenging time.

Your nurse,
Katy

I forgot to mention... A most exquisite and poignant moment/event today... Your son Christopher and his bride to be recited their wedding vows privately at your bedside here in the ICU. It was you and them, together; just the three of you, but the room was bursting with LOVE. You are so loved.

The feedback we've received from families has been very positive. Our staff have been impressed with how a simple intervention can make such significant impact in patient care. Moving forward, we anticipate that the journals will help our unit decrease the incidence of PICS in our patients.

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See "Delirium in the ICU: A Patient's Perspective" on page 12

Pharmacological Treatment of Binge Eating Disorder

Jana Ambrogne, PhD, PMHNP-BC
Associate Professor
Curry College

Binge eating is characterized by eating a significantly large amount of food in a discreet period of time coupled with a sense of a lack of control over eating during the episode (American Psychiatric Association [APA], 2013). Historically, binge eating has been included in the Diagnostic and Statistical Manual of Mental Disorders [DSM] under the diagnoses of "eating disorders not otherwise specified." However, the most recent, fifth edition of the DSM-V includes the diagnostic category of "binge eating disorder" (BED).

Epidemiological data on BED is limited. However, it is thought to be the most common eating disorder, affecting an estimated 2.8 million adults (Masheb, White, & Grilo, 2013). Typically, eating disorders such as BED are thought to primarily afflict females. However, males account for as many as 36% of those with an eating disorder, with BED being the most common (Woolridge & Lemberg, 2016). Further, BED is often considered to be limited to the overweight and obese. However, not all overweight individuals have BED and in some cases, people of average weight meet the diagnostic criteria for BED.

Individuals with BED are at a higher risk for concurrent psychiatric disorders including: (a) mood and anxiety disorders (Becker & Grilo, 2015; Cossrow et al., 2016; Swanson et al., 2011), (b) attention deficit and hyperactivity disorder (ADHD) (Cossrow et al.,) and (c) post-traumatic stress disorder (PTSD) (Mitchell & Wolf, 2016). Individuals with BED are more likely to use marijuana and other drugs and to have a comorbid substance use disorder (SUD) (Becker & Grilo; 2015). Further, BED is strongly associated with obesity and associated medical comorbidities including (a) diabetes (Olguin et al., 2016; Woolridge & Lemberg, 2016), (b) hypertension and other cardiac problems (Kessler et al., 2013; Olguin et al., 2016; Woolridge & Lemberg, 2016), (c) dyslipidemias (Olguin et al., 2016; Woolridge & Lemberg, 2016), (d) sleep problems (Olguin et al., 2016), (e) pain conditions (Kessler et al., 2013; Olguin et al., 2013) (f) gallbladder disease (Woolridge and Lemberg, 2016), (g) osteoarthritis (Woolridge & Lemberg, 2016), and (h) ulcers, respiratory, and GI problems (Woolridge & Lemberg, 2016).

Successful treatment of BED will almost always improve comorbid psychiatric and medical conditions. In addition to a reduction/elimination of binge episodes, treatment outcomes may include weight loss, improved self-esteem, improved quality of life, and a reduction of symptoms related to associated comorbidities. The stimulant lisdexamfetamine dimesylate was approved by the Food and Drug Administration (FDA) in 2015 for adults with moderate to severe BED. To date, this is the only medication approved to treat BED. Lisdexamfetamine dimesylate is approved to reduce the number of binge eating days per week, but is not indicated for weight loss or obesity. Efficacy and safety studies have found lisdexamfetamine to be superior to placebo in reducing binge eating days, with safety results consistent with the known safety profile of the drug (McElroy et al., 2016).

Selective serotonin reuptake inhibitors (SSRI) have also been used to treat BED. Fluoxetine and sertraline, in particular, have been found to be effective in reducing episodes of binge eating (Arnold et al., 2002; Milano, Petrella, Capasso, 2005). Compared to placebo, bupropion, another antidepressant, has been associated with a modest, but significantly greater amount of weight loss in women (White & Grilo, 2013)

Topirimate, an anticonvulsant drug used for the treatment of epilepsy, prophylaxis of migraine and mood stabilization in bipolar disorders has well documented efficacy in binge eating disorder and obesity (Guerdjikova, Fitch, & McElroy, 2015), significantly reducing both binge eating and weight (Reas & Grilo, 2015). An extended release formula combining topirimate and the appetite suppressant phentermine is approved as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management of obesity in adults. This drug has been found to be effective in the cessation of binge eating behaviors and weight loss (Guerdjikova, Fitch, & McElroy, 2015).

Data from controlled trials provide support that some medications alone are effective in reducing binge eating and in some cases, facilitating weight loss over the short term. However, combination therapy, particularly cognitive behavioral therapy and medication may yield the best outcomes in reduction of binge frequency. Overall, there is a paucity of data related to BED, and more research on this debilitating condition is warranted.

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Save the Date

Monday May 7, 2018, 5:30 PM

The Annual Meeting of the Nursing Archives Associates – Howard Gotlieb Archival Research Center at Boston University

The Nursing Archives Associates of Boston University will commemorate the 100th Anniversary of the Influenza Pandemic of 1918 with a presentation by Board member, Barbara Poremba, EdD, MPH, MS, RNCS, ANP, CNE, entitled "10,000 Grip Cases in Lynn: Nurses Needed."

The lecture and reception are free and open to the public. They will be held in the Trustee Ballroom, One Silber Way, Ninth Floor, Boston University.

For more information call 617-353-3696 or go to www.bu.edu/archives.

Bulletin Board

Dare to Dream

In the last issue, we asked you to dream about the future of nursing. Here are some of the responses that we received.

1. That the nursing workforce grows to reflect the diversity of the US population. Currently, nursing remains a very homogenous profession which limits our potential to provide safe and effective care to all. This will require changes in public policy including expanding funding for nursing education and restoring support for practicing in areas of greatest need.
2. Ensure that all nurses practice to the fullest capacity of their licensure.
3. ANA continues to be a strong voice for supporting access to health care with increased membership and political clout.
4. Growth in professional self-awareness and respect for our nursing colleagues and aspiring students.
5. Leadership development and collaboration with all members of the health care team.
6. Resurgence in the role of public health nursing to broaden access to preventive and primary health care services.

– Gail B. Gall, PhD, RN

I envision nursing to be an independent professional service that patients seek to manage and provide care of a loved one or oneself in a holistic manner. Nurses will care, treat, and refer as needed in the community and in acute care settings. "Caring" remains at the center.

– Janet Monagle, PhD, RN, CNE

I continue to have the same wish I had when I graduated from nursing school in 1974 – that is to see more diversity in nursing education with the recruitment of men and ethnic minorities.

– Don Anderson, EdD, RN

My dream for nursing is a "back to the future" scenario. Nursing has come so far over the 50 years since I became a nurse. The recognition that scientific evidence is essential for optimal care, along with the much deserved respect for our profession, has been very gratifying to see, and makes me proud to be a nurse. However, what I think we have somewhat lost along the way is the basic value on which nursing was based – caring – for others and ourselves. In my opinion caring should once again be the primary focus of nurses and nursing. If caring is not first and foremost, much of what we do could eventually be replaced by artificial intelligence. So, even though caring is a hard concept to teach, my dream is that it once again be evident in all of what we do.

– Susan R. James PhD, RN

I dream that nurses' voices are heard and that their input is sought when operational changes in health care agencies are implemented.

– JBK

THANK YOU

A special thank you to everyone who wrote for the *Massachusetts Report on Nursing* in 2017. You willingly shared your knowledge and thoughts with our colleagues throughout the Commonwealth. We look forward to hearing from more of our readers in 2018. Address inquiries or ideas for articles to newsletter@ANAMass.org.

ANA Declares 2018 the Year of Advocacy

Each quarter will have a dedicated theme.

- First quarter: Nurses advocating locally
- Second quarter: Nurses influencing elected officials and other key decision makers
- Third quarter: Nurses get out the vote!
- Fourth quarter: Global impact and making every year a year of advocacy

How will you be an advocate this year?

ANA MASSACHUSETTS
AMERICAN NURSES ASSOCIATION

JOIN ANA Massachusetts and ANA TODAY!

Professional Development - Advance your knowledge through ANA's Continuing Education Opportunities

- Online CE Library - discounted on-line independent study modules, a solid library of education offerings to meet your practice and career needs
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- Gain and Maintain Your ANCC Certification
  (Save up to $125 on ANCC initial certification and up to $150 on ANCC certification renewal)
- American Nurse Today
- The American Nurse—ANA's award-winning bi-monthly newspaper
- OJIN—The Online Journal of Issues in Nursing
- ANA SmartBrief—Daily eNews briefings designed for nursing professionals
- Nursing Insider—Weekly e-newsletter with ANA news, legislative updates and events
- Discounted Nursing Books!
- ANA Leadership Institute - enhance and extend your leadership skills
- ANA MA Career Center
- Network and Connect with Your Fellow ANA Member Nurses
- Valuable Professional Tools
- Leadership opportunities/professional development
- Discounted ANA Massachusetts conference fees
- Access Valuable Professional Tools to enhance your career development

Advocacy

- Protecting Your Safety and Health
- ANA's HealthyNurse™ program
- Strengthening nursing's voice at the State and National Levels
- 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
- ANA-PAC demonstrates to policymakers that nurses are actively involved in the issues that impact our profession and patients
- ANA Mass Action Team
- ANA's Nurses Strategic Action Team (N-STAT)

Personal Benefits

- Professional Liability Insurance offered by Mercer
- Auto Insurance offered by Nationwide
- Long Term Care insurance offered by Anchor Health Administrators
- Term Life Insurance offered by Hartford Life and Accident Insurance Company
- Financial Planning Offered by Edelman Financial Services
- Savory Living Eating – discounted program offerings
- Walden University Tuition Discounts
- Tuition Savings at Chamberlain College of Nursing
- Scholarships for you and your family members
- Free Research Recruitment Notices placed on ANA Massachusetts Website and sent to the ANA Massachusetts Email Distribution

Join today at www.ANAMass.org

We hope you enjoyed this edition of the Massachusetts Report on Nursing, sent to every RN in the Commonwealth.

Please join ANA Massachusetts today and become an active member of the world renown and most respected professional nursing organization. Go to: www.ANAMass.org to complete the application.

The **ANA Massachusetts Action Team – MAT** cordially invites you to join this exciting team, when you join you will be lending your voice to those matters affecting all nurses in Massachusetts.

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ADDRESS CHANGE? NAME CHANGE?

ANA Massachusetts gets mailing labels from the Board of Registration in Nursing. Please notify the BORN with any changes in order to continue to receive the Massachusetts Report on Nursing!

ANA Massachusetts Mission

ANA Massachusetts is committed to the advancement of the profession of nursing and of quality patient care across the Commonwealth.

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.

Regis College Educational Offerings for Spring 2018

Co-Sponsored with Harvard Pilgrim Health Care

March 21, 2018

Title: The Future of Health Reform: What Happens Next?

Contact Hours: 2
Location: Regis College, Casey Theater, Fine Arts Center

Description: This panel presentation brings together perspectives on the future of the Affordable Care Act, Medicare, and Medicaid. Come hear the experts present on the impact of politics and policies to alter the role of government in reducing the number of uninsured Americans and ensuring access to high quality care.

Online Registration:
www.regiscollege.edu/aca

April 18, 2018

Title: Defying the Dementias: Breakthroughs in the Diagnosis and Treatment of Alzheimer's and Other Dementias

Contact Hours: 2
Location: Regis College, Casey Theater, Fine Arts Center

Description: Every 66 seconds, someone in the United States develops Alzheimer's dementia. Alzheimer's kills more than breast and prostate cancer combined and is estimated to cost the country $259 billion in 2017. On the horizon are exciting breakthroughs in the diagnosis and treatment of Alzheimer's and other dementias, which hold promise for millions. Don't miss this opportunity to learn from the experts.

Online Registration:
www.regiscollege.edu/alzheimers

These activities have been submitted to ANA Massachusetts for nursing contact hours. The American Nurses Association Massachusetts is an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Time: 6:30 – 8:30 pm | **Fee:** None | **Registration Information:** Call 781-768-8080
Email: presidents.lectureseries@regiscollege.edu

Regis College | 235 Wellesley Street | Weston, MA 02493

The Commonwealth of Massachusetts

Executive Office of Health and Human Services Department of Public Health
Division of Health Professions Licensure Board of Registration in Nursing
239 Causeway Street, Suite 500, Boston, MA 02114

Tel: 617-973-0900 | TTY : 617-973-0988 | http://www.mass.gov/dph/boards/rn

December 21, 2017

To: Massachusetts Nursing and Professional Healthcare Organizations
From: Board of Registration in Nursing
Re: Update to required training for Sexual and Domestic Violence Prevention

The Board of Registration in Nursing (Board) must comply with the law that requires training for health care providers on the issue of domestic and sexual violence as a condition of licensure (M.G.L. c. 112, § 264). DPH's Division of Sexual and Domestic Violence Prevention and Services continues its work developing an e-Learning tool that will be housed on its DPH's Domestic and Sexual Violence Integration Initiatives web page. Once the e-learning tool is completed, the Board will issue a new update and post information regarding it on the Board's website.

The Board will not hold a nurse responsible for the required training until it is available. After the training information is posted on the Board's website, nurses who have not yet renewed in 2018 will have an additional six months to complete the training. Nurses who have renewed prior to the posting must complete the training prior to their next renewal.

A nurse participating in a currently approved in-person training program will be considered to have met the requirement and does not need to take the online course by DPH.

Please continue to refer to the Board's website for training updates.

Please note: The Board of Registration in Nursing (Board) no longer issues paper license renewal reminders or paper licenses. The Board will use email to communicate renewal reminders and important changes in statute, regulations and policies related to nursing. **FAILURE TO PROVIDE A WORKING EMAIL ADDRESS WILL PREVENT YOU FROM RECEIVING THESE IMPORTANT UPDATES.** Log onto the Online Services link at www.mass.gov/dph/boards/rn to add or change your email address. The data base does not work w/iPhones, iPads, Safari or Google Chrome. Please use a compatible web browser.

SAVE THE DATE

5th Massachusetts Regional Caring Science Consortium Conference

The Intersection of Caring Science and Current Health Care Challenges: Building Resiliency Through Healing Relationships and Environments

Thursday, April 26, 2018, from 7:30 am to 12 noon

The 5th Massachusetts Regional Caring Science Consortium (MRCSC) half-day conference will be held on **Thursday, April 26, 2018 at Simmons College, School of Nursing and Health Sciences, Boston, MA from 7:30 am to 12 noon.** MRCSC is a venue for nurses to share caring nursing practices, renew the heart of nursing, and promote a shared wisdom to restore the ethic of compassionate caring in health care systems. The Consortium and the conference are open to all nurses, other health care providers, and students. Breakfast will be provided, as well as parking (for small fee). Contact hours are pending. **There is no fee to attend, but registration is required for planning.** Please register at website www.mrcsc.org or contact Lynne Wagner directly for registration or information at alynnewagner@outlook.com. Registrations will be confirmed and further conference details of parking and meeting room sent.

The keynote speaker, **Annie Lewis-O'Connor, PhD, NP-BC, MPH, FAAN**, will present *Shifting the Paradigm: Trauma-Informed Care Promoting Transpersonal Healing Relationships.* Dr. Lewis-O'Connor is a Senior Nursing Scientist, Founder and Director of the C.A.R.E. Clinic at Brigham and Women's Hospital, Boston, MA. The C.A.R.E. Clinic (Coordinated Approach to Recovery and Empowerment) models a trauma-informed and patient-centered collaborative framework to care for women and men who have experienced domestic and sexual violence and human trafficking. She has served as Co-Chair for the Partners Trauma-Informed Steering Committee for the past 6 years. In addition, she is the past Chair of the National Health Collaborative on Violence and Abuse and the Principal Investigator on a Department of Health Services funded grant that is exploring best practices for domestic and sexual violence screening and intervention. Well published in peer-reviewed journals and academic books on the topic of violence against women and children, her work has reached Haiti, China and Taiwan. In 2017 she was recognized as a Distinguished Fellow with the International Association of Forensic Nurses. In 2012, she was recognized by the Boston Business Journal as a Champion in Health Care. Dr. Lewis-O'Connor holds a Faculty Appointment at Harvard Medical School. She received her MSN from Simmons College, a MPH from Boston University, and a PhD from Boston College.

The April 26 gathering will also feature presentations by an interactive panel of Massachusetts Caritas Coaches, graduates of the Watson Caritas Coach Education Program, which prepares nurses and other health care providers to coach, teach and implement caring-healing philosophy and practices. Topics will explore practical projects of infusing caring science into nursing curriculum, changing workplace cultures to healing environments, building resiliency through compassionate and relational care for self, colleagues and patients. Come and join the presentations and conversation on April 26, 2018 to renew your caring practices.

Northeast Region VA Nursing Alliance (NERVANA) received the 2017 New Era for Academic Nursing Award from the American Association of Colleges of Nursing (AACN) This award recognizes AACN member institutions that have successfully implemented recommended strategies from AACN's report Advancing Healthcare Transformation: A New Era for Academic Nursing.

The Poor State of Mental Health Care for Children

Gail Grammatica, MS, RN, CNE
Senior Lecturer, Curry College

It is unusual to hear nursing students say their passion is mental health nursing. More often, I hear pediatric or maternity nursing. Forty years ago, I was not very different from most of my current students. I knew well before entering nursing school that my passion would be pediatric nursing. After years of personal and professional experience I have come to realize that physical problems are often more comfortable for nurses to address than mental health problems, particularly in children.

When a child's behavior becomes violent, families are initially taken by surprise and feel at a loss on how to proceed to get care for their child. There is stigma and lack of understanding about mental health issues. Some resources are available but are often difficult to access, which may lead to a cycle of chronic emergency room visits. The Parent Professional Advocacy League (PPAL) (2017) notes 79% of children aged 6 to 17 with mental disorders do not receive appropriate care.

According to the National Alliance on Mental Illness (NAMI), 1 in 5 children between the ages of 13 to 18 have, or will have, a serious mental illness (2017). The prevalence of mental health disorders among children ages 8 to15 is 13%. Mental health conditions such as attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), post traumatic stress disorder (PTSD), anxiety disorders, mood disorders and repeated suicide attempts are at the top of the list (NAMI, 2017). Most of us know a family that is affected by these conditions. Yet, as professionals have we taken the time to understand the stress and trauma these families experience daily?

Early identification and treatment leads to better outcomes. Without intervention mental illnesses may increase the risk of a child being involved in the juvenile justice system. According to PPAL (2017) 66% of boys and almost 75% of girls in juvenile detention have at least one mental disorder.

Mental Health America (MHA) (2017) ranked Massachusetts first among all states for access to care for adults with mental health. The ranking for Massachusetts drops to fourth for children (MHA, 2017). However, talk to any parent of a child in Massachusetts with mental health issues and you will hear a different story. In reality, availability of services for children in Massachusetts is bleak. Children exhibiting unsafe behavior are in Emergency Department (ED) settings for days or weeks, awaiting a hospital bed. When a bed is eventually found, the facility may be a long distance from the family's home. Hospital stays are typically short term and limited by insurance coverage. Children may be discharged without adequate community support, leading to additional ED stays and a cycle of repeat hospitalizations. Be sensitive to families in this situation. Emergency department episodes are stressful and traumatizing for parents and siblings whether it is the first or one of many stays in the ED.

It may be less demanding for nurses to provide support for chronic physical diseases such as diabetes, asthma or cancer. Chronic mental disease is invisible, yet no less stressful for families. Making efforts to offer simple gestures of kindness and compassion will go a long way with families. Moreover, the role of advocacy for these families is so important. Become familiar with resources and be an advocate for families to get these resources.

Caregivers and professionals may view the child's behavior as who they are as a person. It takes effort to make the separation between behavior and the child. Nurses who are witness to violent outbursts can also become traumatized and may need to seek support for themselves. There should be support services available for nursing staff. It is also important that nurses keep themselves updated on mental health issues in children through continuing education.

Unfortunately, children may end up in emergency departments due to a lack of outpatient and community mental health services. Serkin, Olsho, Sheedy, McClellan & Walsh (2017) completed a study of wait times for out-patient mental health services. Parents were asked to report on wait times for an initial out-patient appointment. The study findings indicated,

> "In most instances, individuals and parents reported waiting several months for an initial outpatient mental health visit. These findings are broadly consistent with findings from a 2016 online survey conducted by the Parent Professional Advocacy League (PPAL) with a convenience sample of engaged Massachusetts parents in their advocacy network. Fewer than 20 percent of parents in the PPAL survey reported being able to get an appointment with a new mental health provider within three weeks, and 82 percent reported waiting more than a month for an appointment" (p. 3).

The authors suggest that wait times for child and adolescent psychiatry services were particularly difficult due to a lack of providers with this specialty. Other barriers included geographic availability, insurance coverage and expertise to make a good "fit" with the child and family (Serkin, et. al, 2017).

An additional barrier for families is that mental health services in the community are only available for children with Mass Health through the Children's Behavioral Health Initiative (CBHI) Community services available through CBHI include mobile crisis intervention, in home therapy and care coordination. Families with commercial insurance cannot get coverage for community services (Executive Office of Health and Human Services, 2017.) Therefore, they must go without or obtain additional insurance through MassHealth. Recently, a representative from PPAL testified in a hearing to the Massachusetts state legislature in support of House Bill 488 regarding the need for access to community services regardless of insurance (The General Court of the Commonwealth of Massachusetts, 2017). Nurses can also advocate for policies that support this bill and others that address mental health services for children.

Regardless of the practice setting, nurses should become familiar with current mental health issues for children and adolescents. Nurses should learn about available resources, be supportive, make appropriate referrals, advocate for services and seek support for themselves.

Advocacy is the most important role for nurses working in any setting. Begin by supporting the Substance Abuse and Mental Health Services Administration (2017) promotion of children's mental health awareness day on May 10, 2018. Do what you can as a professional to advocate for children's mental health services and support families!

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Pediatric Pain Assessment

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Many clinicians have questioned whether routine pain assessments are beneficial to medical care (Voepel-Lewis, 2011). Some have suggested that pain assessment contributes to patients' expectations of receiving opioids when seeing a provider for pain (Friedman, 2016). We are not aware of any studies that describe the benefits or risks of assessing pain. We maintain that especially while caring for children or people that have difficulty communicating, routine pain assessment is a necessary part of compassionate medical care.

Pain management is a crucial component of compassionate care. The first step in pain management is communicating (verbally or nonverbally) the pain experience to someone who can help with pain management. Not everyone has the ability to communicate pain, an abstract physical and emotional experience. For those who are preverbal, nonverbal, have a limited vocabulary, a communication disorder or those who are simply shy when talking to health care professionals, routine pain assessment improves the chance of communicating the pain experience to someone who can help.

Trying to understand a child's pain experience can be challenging. Pain is a multidimensional experience. Pain assessment in children is confounded by the child's: 1) developmental stage; 2) ability to comprehend and; 3) communicate (verbally and nonverbally) his/her pain experience. The experience of pain is influenced by mood, environment and the meaning of the pain to the individual. For simplicity, most pain assessment tools measure one dimension of pain: Pain intensity. Since pain is a subjective experience, some children may consistently report higher (or lower) than expected for the source of pain. For this reason, when using a pain assessment tool, it is important to compare the child's responses to previous responses of that child NOT between different children. Pain assessment tools (like all measurement tools) are not precise. No pain tool is ideal for every clinical situation, but a pain assessment tool that has been psychometrically tested for a certain patient subgroup has the best chance of measuring pain intensity well within that subgroup.

The gold standard of measuring pain intensity remains self-report whenever possible. Examples of self-reported pain assessment tools are the Wong-Baker FACES scale (Morain-Baker & Wong, 1987) or Numeric Rating Scale (NRS) (von Baeyer, 2009). The FACES scale can be used in children older than three years. The FACES tool is comprised of six black and white cartoon faces that portray increasing levels of pain. The scale consists of faces that score 0 (smiling face), 2, 4, 6, 8 and 10 (crying face). The NRS scale is scored from 0 (no pain) to 10 (worst pain imaginable) and is typically reported verbally. The NRS is used for children 7 years and older.

For children unable to self-report, behavioral pain assessment tools can be used. For example, for infants and children up to age 7 years old, the FLACC (Face, Legs, Activity, Cry and Consolability) is a commonly used behavioral pain assessment tool. The FLACC scale is composed of 5 items, face, legs, activity, cry and consolability. Each item is scored from 0 to 2. Items are added together to result in a total score from 0 to 10 (Merkel et al, 1997).

Pain assessment is comprised of a thorough assessment of a child's facial expression of pain, pain behaviors, emotional response to pain, physical function and physiological measures of pain. When assessing pain using self-report, observe the child to ensure that other aspects of pain are consistent with the self-reported pain intensity. For example, a child may report a score of 0/10 if he believes that it will get him discharged from the hospital.

Certainly, there is a need for health care professionals to reeducate the public on the use of opioids to manage pain. Not all pain requires an opioid for treatment. In order for the pain treatment plan to be safe, effective and appropriate, the treatment plan must be based on the source and intensity of pain and how the pain affects the patient.

Pain assessment and development of a safe and effective pain treatment plan can be challenging for any population. There is no ideal pediatric pain assessment tool but rather many components that go into the development of a complete pain assessment. In doing these assessments routinely, conceivably the healthcare provider's assessment may be more sensitive to each specific child. Furthermore, pain treatment plans may be optimized, as not all pain responds to opioid management.

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