MASSACHUSETTS REPORT ON NURSING

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Do you know this nurse?
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ANA MASSACHUSETTS
AMERICAN NURSES ASSOCIATION

September 2018

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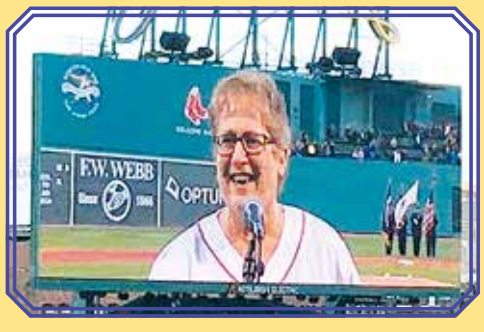

PRESIDENTIAL MEMORIES
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It's Not Too Soon to Think About Nominating a Colleague for an ANA MA Award

You work with or know nurse colleagues whose commitment to nursing and to patient care is exemplary. Yet in the rush of today's world, there is often little time to acknowledge them and their professional contributions. ANA MA Awards provide you the opportunity to honor their remarkable, but often unrecognized, practice.

Most ANA MA Awards are not restricted to ANA MA members. Nominees can be a member of ANA MA or a non-ANA MA member who is nominated by a member of ANA MA. These awards can be peer- or self-nominated.

For more information on and applications for the various scholarships and awards offered by ANA MA please visit the ANA MA web site: www.anamass.org

Mary A. Manning Nurse Mentoring Award

This award was established by Karen Daley to support and encourage mentoring activities. This monetary award in the amount of $500 is given annually to a nurse who exemplifies the ideal image of a mentor and has established a record of consistent outreach to nurses in practice or in the pursuit of advanced education. **(ANA MA membership not required)**

Excellence in Nursing Practice Award

The ANA MA *Excellence in Nursing Practice* is presented yearly to a registered nurse who demonstrates excellence in clinical practice. **(ANA MA membership not required)**

Excellence in Nursing Education Award

The ANA MA *Excellence in Nursing Education Award* is presented yearly to a nurse who demonstrates excellence in nursing education in an academic or clinical setting. **(ANA MA membership not required)**

Excellence in Nursing Research Award

The ANA MA *Excellence in Nursing Research Award* is presented yearly to a nurse who has demonstrated excellence in nursing research that has had (or has the potential to have) a positive impact on patient care. **(ANA MA membership not required)**

Loyal Service Award

This award is presented annually to a member of ANA MA who has demonstrated loyal and dedicated service to the association. **(ANA MA membership required)**

Community Service Award

This award is presented annually to a nurse whose community service has a positive impact on the citizens of Massachusetts. **(ANA MA membership not required)**

Friend of Nursing Award

This award is presented annually to a person or persons who have demonstrated strong support for the profession of nursing in Massachusetts. **(ANA MA membership not required)**

Future Nurse Leader Award

The Future Nurse Leader Award was established to recognize nurses who have demonstrated leadership potential during nursing school or in their first nursing position. It is designed to encourage recent nursing graduates to become active in ANA Massachusetts and to develop their leadership skills. Nominees for this award must be graduating in the year nominated or have graduated from any pre-licensure nursing program within two years of the nomination deadline.

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ANA Massachusetts Fall Conference

*October 19, 2018 * Sturbridge, MA*
Hot Topics in Massachusetts Nursing:
Domestic and Sexual Violence Training
Staffing Ballot Question
More information and to register TODAY: www.anamass.org

President's Message

Donna M. Glynn, PhD, RN, ANP

This November, citizens of the Commonwealth of Massachusetts will be asked to vote on a controversial ballot question of mandated nurse-patient ratios. ANA MA opposes this proposal for mandated nurse-patient ratios. ANA MA supports optimal staffing as essential to providing excellent nursing care with optimal patient outcomes, but believes that nurse staffing is more complicated than mandated ratios. Mandated nurse-patient ratios take this decision away from nursing professionals with specific understanding of the patient's needs. In addition, passing legislation without sufficient evidence is dangerous and once passed into law is difficult to change even if research disproves its effectiveness. ANA MA joined the Organization of Nurse Leaders, Massachusetts Association of Colleges of Nursing, Infusion Nurses Society New England Chapter and Western Massachusetts Nursing Collaborative in opposition to this ballot question.

Let's take a closer look at the ballot question and highlight the critical concerns which will affect professional nursing practice. First, the ballot question is based on "number-centered" and not "patient-centered" care. Patients have different needs and even the same patient will have different needs day to day. Mandated ratios ignore patient acuity and other critical criteria required to make safe staffing decisions. In addition, the proposal does not take into account nurse education, skills, knowledge and experience.

California is the only state with mandated nurse-patient ratios. Since the passage of Bill 394 in 1999, several studies found no significant impact on nursing effectiveness (Bolton et al., 2007; Donaldson et al., 2005; Greenberg, 2006). In addition, California hospitals have reported delays in access to care, reduced hiring of ancillary staff, and recruitment of agency and "traveling" nurses and cross training nurses to cover other units (Douglas, 2010). Based on the California data, if passed in Massachusetts, this will result in changes in nurses' work schedules and increases in floating to other units. Bedside nurses may be forced to rotate to off shifts more frequently and due to unpredictable census, this law may eliminate 12-hour staffing shifts.

If passed, the implications of this ballot initiative may restrict access to healthcare. Hospitals that are not able to hire the required number of nurses will be forced to close beds and community hospitals may be forced to close completely. Wait times in emergency departments may increase. In addition, this ballot question has the potential to drain nursing resources from vital non-hospital based services. Healthcare has shifted from the in acute care to the community setting. Length of stay has decreased and patients receive increased care in their homes, sub-acute facilities and long term care. As acute care hospitals recruit to meet mandated nurse–patient ratios, who will care for patients in community settings?

Where will the extra funding to support this mandate come from? Consumers of healthcare in the Commonwealth may be paying more. An independent study was performed by two research groups, Mass Insight Global Partnerships and BW Research Partnership, who concluded that the staffing proposal would cost an additional $1.3 billion in the first year and over $1 billion each year after that. This may result in increased taxes, copays, out-of-pocket spending and other insurance increases for families and small businesses. California hospital administrators used a variety of measures to fund the staffing mandate. These included decreased funding of supplies and equipment and decreased educational programs and tuition reimbursement for nurses seeking advanced degrees (Buerhaus, 2010).

ANA MA endorses a legislative solution which recommends guidelines for establishing nurse staffing based on census, patient acuity, nursing experience and knowledge. ANA MA supports the Federal legislation which was filed in February of this year. "Safe Staffing for Nurse and Patient Safety Act of 2018" calls for a hospital-wide staffing plan for nursing services based upon input from the registered nurse staff who provide direct patient care and be based upon the number of patients and the acuity of the patients. This legislation takes into account the level of education, training and experiences of the professional nurses and takes into account the staffing levels and services provided by other healthcare personnel including certified nurse assistants, licensed vocational nurses, aides and orderlies. In addition, this legislation holds the hospitals accountable under the Department of Health and Human Services. Hospitals will be required to develop a detailed written description of the hospital wide staffing plan and face penalties for noncompliance.

However, if the ballot question passes, we will be mandated by law to have no voice in our professional practice and patient care. I challenge all RNs in the Commonwealth to become more knowledgeable about the best option for our profession. Do we want the government mandating our clinical decision practice? Do we want our practice to be decided by government mandates when we can work together to develop committee based nurse staffing plans which will improve patient outcomes and increase nurse satisfaction? Please review the ANA Safe Staffing White Paper at https://www.annanurse.org/article/ana-releases-white-paper-optimal-nurse-staffing-november-25-15 and the ANA Safe Staffing Model Legislation at https://www.nursingworld.org/news/news-releases/2018/ana-applauds-nurse-staffing-legislation/.

Vote "NO" this November and leave the staffing decisions in the hands of experienced nurses at the bedside! We CAN work together to improve staffing, improve patient outcomes and improve professional practice.

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It's Not Too Soon continued from page 1

Nomination must be made by an ANA MA member. An additional letter of support from another ANA MA member is required. At least one letter of support must come from the Dean or a faculty member of the nominee's nursing program.

The nominee selected must plan to live in Massachusetts for one year after receiving the award and serve on one of ANA MA's committees for one year.

The recipient of this award will receive a one year ANA MA membership and will attend the annual ANA MA Awards dinner free of charge.

The nomination process for all awards is easy:

- Access the applications at the ANA MA website: www.anamass.org
- Complete the application and submit electronically or by mail by the deadline of January 12, 2019
- If you have any questions or need help, call ANA MA at 617-990-2856

Professional Scholarships

Ruth Lang Fitzgerald Memorial Scholarship

This scholarship was established by the Fitzgerald family in memory of Ruth Lang Fitzgerald, a long time member of ANA MA. The monetary award of up to $1,000 is given each year to a member of the ANA MA to pursue an area of special interest or a special project that will be beneficial to the member and/or the association. The scholarship can be used to attend an educational conference or some other educational activity. It may also be used for participation in a humanitarian aid project. **(ANA MA membership required)**

Arthur L. Davis Publishing Agency Scholarship Is for an **ANA MA Member** to pursue a further degree in nursing **or** for a **child or significant other** of an ANA MA member who has been accepted into a nursing education program. The $1,000 scholarship can *only* be applied to tuition and fees.

Application Process for Scholarships

- Access the application for either scholarship at the ANA MA Website: www.anamass.org
- Complete the application and submit electronically or by mail **(postmarked by January 12, 2019 for Fitzgerald Scholarship; March 15, 2019 for Davis Scholarship)**
- If you have any questions or need help, call ANA MA at (617) 990-2856.
- The selected recipients will be notified by January 25, 2019 for Fitzgerald Scholarship and by April 1, 2019 for Davis Scholarship.

Living Legends in Massachusetts Nursing Award

The prestigious Living Legend in Massachusetts Nursing Award recognizes nurses who have made a significant contribution to the profession of nursing on a state (Massachusetts), national or international level.

Living legends in Massachusetts Nursing Awards are presented each year at the ANA MA Awards dinner ceremony. **Candidates for this award should be a current or past member of the American Nurses Association Massachusetts (ANA MA) or a member of the Massachusetts Nurses Association (MNA) when it served as the state affiliate for the American Nurses Association (ANA) and be nominated by a colleague.**

Nomination Process

- Access the application at the ANA MA website: www.anamass.org
- Complete the application and submit electronically or by mail by the **deadline of January 12, 2019**
- If you have questions, need help? Call ANA MA at 617-990-2856

EDITORIAL

Words Matter

Susan A. LaRocco PhD, MBA, RN, FNAP

As a nurse, do you follow doctor's orders? Or do you implement the medical care plan? Do you say to a patient: "Do you want your pain medicine?" Or do you ask "Do you have pain?" While on the surface these slight nuances may seem irrelevant, in fact these words convey a vastly different scenario. If the public (and physicians) see nurses as following orders rather than making independent judgments and incorporating them into the medical care plan, we will continue to appear to be caring technicians rather than the thoughtful professionals that we know we are. Offering pain medicine without ascertaining if the patient actually has pain opens the door to patients using the medication for the wrong reason. It also indicates that pain medicine is the only option. Inquiring about the patient's pain allows for alternatives to administering an opioid.

Do not resuscitate (DNR) is a common order. But how harsh it sounds. It also implies that if we resuscitate, the patient will live when in fact we know that many codes do not revive the person. At the least it should be 'do not attempt resuscitation' (DNAR). But why not frame it another way? Allow natural death (AND) essentially means the same as do not resuscitate. It means that if the person ceases to breathe and her heart stops, we recognize that life has come to an end. Wouldn't it be easier for a family member to decide to allow a loved one to die naturally than it is for that person to decide not to resuscitate their loved one?

Do you have an emergency button to summon security? How often has it been called a panic button? Again words matter. A panic button implies that the person activating it is panicking. An emergency button implies that the situation has been assessed and a judgment has been made that an emergency situation exists.

Are our decisions data driven or data informed? Data driven implies that the numbers rule, while data informed implies considering numbers and utilizing critical thinking to make a decision.

I am sure that you can think of many other examples where careful selection of your words makes a subtle difference. I encourage you to remember that words matter. Use them carefully and precisely. Think of the impact of your words – on our patients, on our colleagues, and on the public that still doesn't really understand all that we do.

Dear Colleagues,

I have enjoyed being the editor of the ANA Massachusetts official publication. Recently I moved to New York State as I have accepted the position as Dean of the School of Nursing at Mount Saint Mary College in Newburgh NY. Beginning with the December 2018 issue, Jean Solodiuk, RN, PhD, will become the editor.

Clio's Corner

Janet Wilson James: Nursing's Historian

Mary Ellen Doona

Nursing was fortunate to have been in the orbit of Janet Wilson James' (1918-1987) for she treasured the profession's story and brought its historiography into history's mainstream. This celebrated historian had credentials galore. Long before the late 1960s resurgence of the Women's Movement, James had sought an interpretation of history broader than the grand narratives that had overlooked the contributions of women. She ventured into the then predominantly male academy to study with Harvard's Arthur Schlesinger, Sr. By 1954 she defended her dissertation: *Changing Ideas about Women and the United States: 1776-1825* that opened with, "Ever since Eve was formed from Adam's rib the female sex has been a bone of contention." In subsequent work she traced women's equal partnership with men in creating a family's economy as the United States became a nation. She showed how that equal economic partnership ended when the United States changed from an agrarian society to an industrial power. Instead of men and women working together on farms, men went off to work places and women stayed at home. Separated from contributing to the economy and in a constricted space, women's once significant influence dwindled to dependence. Before long it was assumed that women were weaker by nature.[1]

From 1965-1969, James served as Director of Radcliffe's Women's Archive founded in 1943 at the 23rd anniversary of women getting the vote in 1920. In 1965, the Women's Archives, then only two small rooms, expanded into the Elizabeth and Arthur Schlesinger Library on the History of Women in America. By that time, Radcliffe's development of a scholarly biographical dictionary was already underway having received the go ahead from the advisory committee. The names of 4000 women from the founding of the American colonies in 1607 to those who had died no later than 1950 were gleaned from various sources. Of these, 1337 women met the criteria of being significant public figures who had gained distinction in their own right and had special knowledge in their field.

James spent more than a decade working with others on the project that became the three volume *Notable American Women: 1607-1950*, *A Biographical Dictionary* (1971). Stella Goostray (1886-1969), who led nursing at Children's Hospital, the National League for Nursing Education and as vocal promoter of nursing's history served as a member on the Committee of Consultants. She influenced the selection of 15 exceptional nurses and contributed biographies on: Linda Richards (1841-1930), Sophia Palmer (1853-1920) and Julia Stimson (1881-1948). In doing so she ensured that nursing's origins and development as a consequence of the liberating effect of the Civil War (1861-1865), as James claims, was well represented. Nurses were no longer unnoticed or disregarded as they had been along with other women in usual histories.[2]

Janet W. James, box 17, folder 196-97, Boston College Faculty and Staff Photographs (BC.2000.005). John J. Burns Library, Boston College

Given that nursing is a predominantly female profession it is not surprising that James would devote considerable energy to its history. She stated that nursing was the only woman's profession that was founded by women for women. Such was the case of the Boston Training School (precursor of Massachusetts General Hospital Training School for Nurses (1873-1973). Women of social prestige and power feared for the safety of girls relocating from rural areas to the city during America's economic transition. If they failed in establishing themselves, unprotected girls might fall victim to crime and prostitution. Providing nurses training would prepare these young women to be self-supportive as private duty nurses in people's homes. Wealthy people did not go to hospitals.

James recounts the male-female dynamics of the early days of nurses training at MGH. The men running the hospital were not much interested in the new idea. They were content with scrubwomen caring for its charity patients. Reluctantly they gave in to the pressure from the BTS founders-many of whom were their wives, daughters and other kin. Their access was necessary before Linda Richards, the nursing superintendent, was able to gain two additional scrubwomen to do the scouring so that pupil nurses could care for patients. Subordinate to the all-male hierarchy and distant from the decision making process, nurses were expected only to be womanly, that is, gentle and submissive. Ironically nursing care was especially labor intensive in that pre-technological era requiring nurses who were strong and vigorous. Several years passed before the hospital conceded that pupil nurses gave better care than scrubwomen. The moment marked one small step nursing took towards professional status.

Nurses took broader steps during the Progressive Era (1890-1920) that James claims was a sort of Golden Age in women's history. Nurses were among a generation of women who chose a single life for a career outside the home where they were free to exercise their intelligence and managerial skills. Sophia Palmer, a native of Milton, was among these women who "went out" rather than "stayed at home" much to the disapproval of her family. Her family did not visit her while she was Linda Richards' pupil at the BTS but the family's displeasure would be nursing's gain. Palmer's gift for leadership put her at the forefront of the professionalization of nursing. By 1900 nurses had collected the diaspora of graduates into alumni associations; gathered these into state nurses associations (ANA Massachusetts began in Faneuil Hall February 26, 1903) and then created what is now called the American Nurses Association.

By October, 1900, these leaders had lost hope that hospital hierarchies would respect the young profession as evidenced in the inaugural issue of their professional journal. Nurses were told how the law could protect professional boundaries and kicked off the quest to register who could call themselves a trained nurse. The opposition was fierce but nursing prevailed in its state-by-state campaign. Palmer's editorials in the *American Journal of Nursing* kept nurses informed and energized while they also called medicine to task for its quackery, and state government for its faulty oversight of medical practice. Some nurses enjoyed the contest seeing it as moving the quest for women's legal rights forward even as nurses gained the legal status as Registered Nurse. During this same time nursing education began its long trek from hospitals to colleges starting with such courses at Teachers College at Columbia. These nurses added more luster to the Golden Age of Women, and says James, their Golden Age lasted longer.[2]

Dear to James' historian's heart among this generation of leaders was Lavinia Lloyd Dock who gave the new profession a history that James praised as a long sweep from ancient times to the founding of the training schools at the end of the nineteenth-century. Although M. Adelaide Nutting and Dock planned the history together, Dock did the archival research in France, Germany and what became the National Library of Medicine. The *History of Nursing* appeared in four volumes: two in 1907 and the other two in 1912. Dock did all the writing except for two chapters although Nutting is given first author status.

Nurses more accustomed to Dock's *Materia Medica* manual on drugs first published in 1897

Who is the Nurse in the Masthead?

Lillian Rachel Goodman

Lillian Rachel Goodman (May 20, 1923 - January 24, 2018) graduated from the Peter Bent Brigham Hospital School of Nursing and then journeyed on with others leading nursing education out of hospitals and onto college campuses. Goodman earned baccalaureate, masters and doctoral degrees at Boston University and left direct nursing care to shape education of nursing's next generation. As Founding Dean of the Department of Nursing at Worcester State College in 1973, she educated registered nurses of Central Massachusetts at the baccalaureate level. Since May 6, 2011 that Department is the Lillian R. Goodman Department of Nursing at Worcester State University. Goodman left her mark on nursing in the Commonwealth: in the Department of Mental Health, as interim Dean at UMASS Amherst, as Dean at Worcester State University and as Dean of the Graduate School of Nursing at UMASS Medical School. She and the students she educated promoted the common weal, that is, the people's well-being.

were startled by her 1910 *Hygiene and Morality* that dealt with venereal diseases, prostitution and the double standard, that is, male promiscuity seen as a physical necessity and the promiscuous female seen as a fallen women. Dock's feminism was more militant than that of her colleagues but most of them agreed with her on the necessity of nursing's self-determination. That women's right to vote was twenty years in the distance and gives some context of their struggle for autonomy.[2]

Nurses' earning power remained a factor as nursing's Golden Age continued even as they confronted the classism that had risen with the industrialization of the United States and its culture of corporate greed. They created settlement houses in the midst of severe poverty providing education, socialization and access to health care. Mary Eliza Mahoney benefitted when the New England Hospital for Women and Children refused to accept a woman into their intern program because she was colored (contemporaneous term). Reminded that the NEHWC had been founded to deal with the discrimination against women in medicine, and decrying discrimination of any kind, the aspiring intern was admitted. A place was made for Mahoney in the nurses training program. Years later when America's First Afro-American nurse welcomed the National Association of Colored Graduate Nurses to Boston, she praised her School for not being selfish. Mahoney had been able to earn a better living because she was a trained nurse.

James knew from its absence in her early career how important mentors were. She encouraged feminist historians as they eschewed the Great-Man-and-dramatic-events theories of history in favor of ordinary people and everyday life. Similarly she was an energetic member of the executive committee of the *Lucy Lincoln Drown Nursing History Society* (1984-2001) that Richard Tierney, Executive Director of the Massachusetts Nurses Association, had shepherded into being. She helped the committee create needed guide for preserving nursing's documents as more diploma schools closed following ANA's Position Paper on Nursing Education (1965). The executive committee gave James their best thinking on whether Hildegard E. Peplau was a significant enough nursing figure that the Schlesinger Library should collect her papers. Later the committee members attended the reception when Schlesinger accepted Peplau's papers and listened as she recounted her pioneering journey in psychiatric nursing.

Committed to the integration of the sexes, James carefully noted its progress. She was part of the change herself when she joined the all-male history department at Boston College in 1971 where only a year before women were admitted to its College of Arts and Sciences. She watched as interactions between men and women in the classroom and on campus became easier and anticipated the lessening of gender stereotyping. More men were also choosing nursing though the 2% rise in their number in 1970 made little dent in the female dominated profession. All the same by 2013 the percentage of men in nursing had risen to 9.6%. Gender integration will be valid, James asserted, only if each sex is judged and rewarded for their participation in the same way. She concluded that nursing's significance depended on nurses' full participation in making decisions about the health of society.[2]

James was born one hundred years ago in December 1918 as nurses returned home from the Great War. After a career, marriage and motherhood replete with success, James became a recipient of nursing care. As her life neared its end, a young nursing student told her, "You are not my patient today, Professor James, but I wanted to tell you I heard about you in class yesterday." Precious moments such as this one are part of nursing's history.

Works cited

Janet Wilson James, *Changing Ideas About Women in the United States: 1776-1825*. New York: Garland Press, 1981

Janet Wilson James, Preface and Introduction, *Notable American Women, 1607-1950*: *A Biographical Dictionary*, Cambridge, MA Belknap Press of Harvard University Press, 1981

Checklist to Determine if a Continuing Education (CE) Program Satisfies Board Requirements

The Board of Registration in Nursing defines CE as planned, organized learning designed to augment the knowledge, skills, and attitudes for the enhancement of nursing practice with the goal of improving health care to the public.

A Continuing Education (CE) program satisfies Board requirements at 244 CMR 5.00: Continuing Education if "Yes" to all **SECTION A** questions **AND** "Yes" to questions for the appropriate CE program in **SECTION B**

Section A

1. Does the CE program describe learner objectives that are specific, attainable, measurable, and describe expected outcomes? Yes O No O

2. Does the CE program content contribute to your professional growth and development? Yes O No O

   Examples of what CE content may include:
   a. research findings in nursing science, nursing practice, or nursing education;
   b. health care delivery management;
   c. social, economic, political, legal aspects of health care;
   d. patient teaching and consumer health education; and
   e. topics which improve competency.

3. Does the CE program provide sufficient time to meet its stated objectives? Yes O No O

4. Does the CE program provide an opportunity to evaluate faculty, learning experiences, instructional methods, facilities and educational resources used for the program? Yes O No O

Section B

If the CE program was a Live Program or Webinar, does the program provide all of the following:

- opportunity for you to provide feedback? Yes O No O
- an authenticated record of attendance specifying provider, title of program, date of program, and number of contact hours awarded for successful completion of the program? Yes O No O

If the CE program was a Self-Study or Correspondence Course, does the program provide all of the following:

- opportunity for you to provide feedback? Yes O No O
- a bibliography? Yes O No O
- a test to indicate progress and verify completion of the CE? Yes O No O
- an authenticated record of attendance specifying provider, title of program, date of program, and number of contact hours awarded for successful completion of the program? Yes O No O

If the CE program was an Academic Course, is the content:

- part of a curriculum to meet the educational requirements for a formal nursing program or related field? Yes O No O

If the CE program was a Planned, Supervised Clinical Experience, does the program provide all of the following:

- content beyond your basic educational level of preparation? Yes O No O
- a clinical setting appropriate for the program? Yes O No O
- an authenticated record of attendance specifying provider, title of program, date of program, and number of contact hours awarded for successful completion of the program? Yes O No O

Important Information

Calculating Contact Hours

A contact hour is equal to 50 minutes of attendance and participation in a program. By example, the following assist in calculating contact hours (CH):

- Lecture - One CH for each 50 minutes of didactic instruction
- Self-Study course - One CH for each 50 minutes of participation
- Planned, supervised clinical experience - One CH for each 100 minutes of clinical instruction
- One (1) semester college credit = Fifteen (15) CH
- One continuing education unit (CEU) = Ten (10) CH

Record Keeping Responsibilities

You must keep CE program completion documents for a period of two license renewal cycles. The Board may request at any time to review the documents.

https://www.mass.gov/service-details/mandatory-continuing-education-for-nurses

Bulletin Board

Regis College Educational Offerings for Fall 2018

Co-Sponsored with Harvard Pilgrim Health Care

October 17, 2018

Title: Personalized Medicine: Our New Reality

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

Description: This panel presentation brings together unique perspectives on personalized medicine and its challenges. Drawing on the knowledge and experience of experts in the field - a biomedical engineer, a pharm D, the director of a genetics counseling program, and a consultant and advocate for the industry, attendees will leave with a deeper understanding of its potential and reality.

Online Registration:
www.regiscollege.edu/personalmed

November 14, 2018

Title: Confronting Hepatitis C and HIV among the Homeless

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

Description: New drugs are available for treating or curing Hepatitis C and HIV, but what is the reality of their use among the homeless? What challenges do providers face in caring for those among whom these diseases are most prevalent, including IV drug users and unstably housed persons? Don't miss this opportunity to hear from experts who face these challenges every day, and have engaged in extraordinary efforts in caring for and meeting their unique needs.

Online Registration:
www.regiscollege.edu/homeless

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

ANA MA Past President Myra Cacace received the Distinguished Nurse Practitioner of the Year Award from the Massachusetts Coalition of Nurse Practitioners. Congratulations Myra!

ANA MASSACHUSETTS
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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
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- Financial Planning Offered by Edelman Financial Services
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We hope you enjoyed this edition of the Massachusetts Report on Nursing, sent to every RN in the Commonwealth.

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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.

Bulletin Board

Massachusetts Regional Caring Science Consortium Conference Announcement

Please note there will be no Massachusetts Regional Caring Science Consortium (MRCSC) conference this Fall 2018. The next MRCSC Conference will be in April 2019. Please visit the MRCSC website (mrcsc.org) for future details and dates. Further details will also be in the ANA Mass *Report on Nursing* December 2018 issue. Thank you for your continuing interest in the Consortium, which brings nurses together to explore caring practices and renewal of the heart of nursing. Please email Lynne Wagner at alynnewagner@outlook.com for further information.

Are you a practicing RN?

If so, we invite you to participate in the 2018 *American Nurse Today* Nursing Trends and Salary Survey, developed in collaboration with ANA.

This isn't your usual "salary survey." In addition to salary questions, we want to know more about your work environment, including challenges such as bullying and patient/family violence.

Data from the survey will provide the editors of *American Nurse Today* with a snapshot of nursing practice in 2018 and will be the cornerstone for developing an article to be published in a future issue of *American Nurse Today.*

Take the 2018 *American Nurse Today* Nursing Trends and Salary Survey and be entered for a chance to win a $25 gift card. https://www.americannursetoday.com/

Innovation Awards

ANA is proud to launch the ANA Innovation Awards™, powered by BD, a global medical technology company. The purpose of these awards is to highlight, recognize and celebrate nurse-led innovation that improves patient safety and/or outcomes. The ANA Innovation Awards are presented to a nurse and a nurse-led team who best exemplify nurse-led innovation in patient safety and/or outcomes, whether it is a product, program, project, or practice. The ANA Innovation Awards include a $25,000 individual nurse award and a $50,000 nurse-led team award. BD's contribution to the American Nurses Foundation supports the ANA Innovation Awards program for the next three years. Applications close December 31.

To learn more about the awards and apply, visit www.nursingworld.org/aia.

Why I *Chose* Health Policy?

Christina Saraf, MSN, RN, CNL
Co-Chair, ANA Health Policy Committee

As my extended family would drop in over the weekends, we would find ourselves sitting around the small kitchen table discussing the ongoing news and issues surrounding our lives. I was the youngest but felt energized to learn and develop my views with understanding. Times were turbulent with marginalized groups protesting against the inequalities, remnants of war, along with inflation leading to many out of work. We needed to make sense over the politics and policies shaping our lives. Sometimes heated arguments would give way, as there are so many sides to an issue. However, with family we learned early to move on and come back next time with a stronger argument.

Early in my adulthood, my military and business background provided for very conservative views. When everyone was listening to music, I was listening to the AM radio talk shows, a format for lively discussion on many topics. I soon discovered I am an idealist at heart. Although, my views may not be realistic at times, I do believe idealism brings a sense of fairness to any topic. I am one who tries to be fair with everything. Naturally defending those who are vulnerable. Over the years, the issues have become more complex with surging technology leading to greater access of information or misinformation. Trying to discern what is real has become more of a challenge.

Being in the healthcare profession, we see the inequalities in life. We are entrusted to provide guidance. We assume the role of advocacy, on many levels, to ensure the best for our patients. As healthcare continues to transform, legislation has become more important as it influences how healthcare is paid and delivered while ensuring higher quality of service. Having a voice in legislation allows us to make positive changes for our patients and in general the healthcare industry. As we are on the frontlines, we need to be part of this decision making process. Our insight as nurses is invaluable. I find myself sitting with the ANA Health Policy Committee making sense of healthcare is not so far from my days at the kitchen table with the common goal of making a positive change.

Health Policy…have no fear!

Arlene Swan-Mahony, DNP, MHA, BSN, RN

Three values, integrity, vulnerability and commitment comprise the foundation for which I identify as a nurse professional. These values have been the mainstay of how I interact with patients, families, staff and co-workers throughout my 30+ years as a nurse. To have a responsibility to our patients, families, profession and self to "do the right thing" is a core value that requires diligence on my part each and every day.

I have always been a pediatric nurse working with children, adolescents and young adults who are "typically" developing, those with significant disabilities and those who fall somewhere in between. From the tiniest of babies to the innocence of childhood and through the tumultuous teen years, each child brings a unique view of themselves and the world and for the most part a resilience that perseveres through whatever illness or injury they are faced with. This is what has fed my soul in all of my years as a nurse. My advocacy efforts revolved around issues within the different settings in which I worked…until three years ago.

My involvement in ANA Massachusetts and Health Policy came much later in my career and I owe it to a professor in my DNP program, Dr. Lisa Summers. Though always interested in current events, politics and health care issues, I was always timid when it came to committee work. In my health policy class, we were charged to identify a health policy issue, attend our state ANA meetings and become involved. I attended a Massachusetts Nursing Advocacy gathering, became energized by the presenters as well as the work happening in Massachusetts on behalf of our nursing profession. I realized that becoming involved on a larger front would benefit not only the settings in which I worked but the nursing profession as a whole. Joining the health policy committee has been a wonderful experience - learning, sharing ideas, discussing issues and affecting change is energizing. I urge my nursing colleagues to become involved much earlier in your career than I did - you will be glad you did so, and we will as well!

Caring for Forensic Patients in the Hospital

Amber Soucy, MS, RN

With crime shows like CSI, NCIS, and Law & Order broadcasting on all major cable networks, more and more of a spotlight is on the forensic patient population. For this article, a forensic patient is an individual in law enforcement custody requiring an admission to an outside healthcare facility. These patients need to be carefully monitored by both hospital and law enforcement staff to maintain the safety and security of all those involved in the provision of care.

In researching Massachusetts hospitals' policies and protocols, all include guidelines directing the admission of forensic patients, the use of restraints, and the roles and responsibilities of forensic officers. Although this policy information is crucial in coordinating safe care, little information is provided for guiding best practice for direct care staff.

How can we, as healthcare professionals, provide optimal care while maintaining safety and security? We cannot simply rely on forensic officers to educate us on security protocol and enforce safety measures; we need to have detailed practice guidelines to be more knowledgeable and more situationally aware to keep ourselves and our patient populations safe.

As a former Massachusetts correctional nurse and current staff nurse in Boston, I have had the opportunity to learn and integrate safety and security protocols within my practice. Safety is of the utmost importance in nursing, and when caring for forensic patients, safety extends into maintaining security. Nursing care of this population requires more guidance in hospital policies, and more information must be provided to positively impact future nursing practice.

If a patient is admitted to the hospital and is verbalizing suicidality or exhibiting self-injurious behaviors, they will be placed on suicide precautions. The patient will be under constant observation and room modifications will be made. For example, the patient will likely receive a dietary safety tray, and curtains and excess equipment will be removed for safety. So when a forensic patient is admitted, shouldn't similar precautions be put into effect?

I cared for a forensic patient with the admitting diagnosis of "ingestion of foreign objects" because he swallowed pieces of soda cans while in his correctional facility. When I walked into the patient's room, there were four ginger ale soda cans on the bedside table. If someone is specifically admitted for ingesting soda cans, soda cans should be **prohibited**. In this case, no order for a dietary safety tray was entered because no forensic patient precautions were entered or even existed within the hospital.

In conclusion, here are suggestions gathered from current research and personal experience that may be beneficial in modifying both hospital policies and improving practice:

ENVIRONMENT	• Forensic officer must maintain constant observation of the forensic patient. • The forensic patient must have a private room and bathroom. Bathroom use requires supervision with door open at all times. • Remove all unnecessary lines, curtains, cords, equipment from patient room. • No staples, safety pins, paper clips, lanyards, scissors, pens, or potentially harmful materials given directly to patient or left in patient's room without approval from forensic officer.
DIETARY CONCERNS	• Forensic patients must have a safety tray (disposable tray, plates, bowls, cups, no metal utensils, no aluminum cans or foil). • An order for a safety tray must be placed by a physician/nurse practitioner for acknowledgement by food/nutrition department as well as direct care staff. • Verify security level for further tray modifications; if patient is on finger food restrictions in their law enforcement facility, this should continue while they are hospitalized.
COMMUNICATION	• Visitors and phone calls must be pre-approved by both law enforcement agency shift commander and direct care staff. • The forensic patient must have confidential status within the electronic medical record; • No patient names posted on unit communication boards, patient data monitors, census, etc. • Hospital security must be in constant contact with the forensic officers. Perform rounds routinely to ensure communication and to plan patient movements.
DIRECT CARE AND SITUATIONAL AWARENESS	• Forensic officers must be present when all direct care is provided. • Forensic officer escort is required for all patient movement. • Direct care staff should not notify patient of procedure times, hospital movement, or discharge plans; giving specific times can increase likelihood/risk of planned violence, escape attempts, etc. • The hospital should adopt law enforcement restraint policy; inconsistencies between hospital and law enforcement policies should be addressed before patient admission to hospital and physician order should be placed to guide direct care staff practice. • Direct care staff should: § Stand arm's length away from patient whenever possible § Never stand with back to patient § Never bend down within arm's reach of patient § Maintain a position near closest exit point

Excerpt from: The Ethical Responsibility to Manage Pain and the Suffering It Causes

Effective Date: 2018
Status: Position Statement
Written by: ANA Center for Ethics and Human Rights
Adopted by: ANA Board of Directors

Purpose

The purpose of this position statement is to provide ethical guidance and support to nurses as they fulfill their responsibility to provide optimal care to persons experiencing pain. The national debate on the appropriate use of opioids highlights the complexities of providing optimal management of pain and the suffering it causes. While effective in treating acute pain and some types of persistent pain, opioids carry significant risks. This causes a tension between a nurse's duty to manage pain and the duty to avoid harm.

While there are many important topics related to pain management, this document will not attempt to address many of the specific terms, including suffering and the definitions and management of drug tolerance, dependence, or addiction. Additionally, the term "complementary health approaches" (CHA) is used throughout even though we recognize that the term "integrative therapy" or "complementary alternative medicine" may also be used (National Center for Complementary and Integrative Health, 2016).

Statement of ANA Position

American Nurses Association (ANA) believes:

- Nurses have an ethical responsibility to relieve pain and the suffering it causes
- Nurses should provide individualized nursing interventions
- The nursing process should guide the nurse's actions to improve pain management
- Multimodal and interprofessional approaches are necessary to achieve pain relief
- Pain management modalities should be informed by evidence
- Nurses must advocate for policies to assure access to all effective modalities
- Nurse leadership is necessary for society to appropriately address the opioid epidemic

Biases

Nurses' biases and prejudices influence their approach to collaboratively managing pain with patients. Prejudices and biases are preconceived and not based on reason or fact. The range of biases regarding patients includes but is not limited to gender expression, sexual orientation, disability, culture, societal influences, economic circumstances, race, geographic locality, hierarchy, age, values, religious or spiritual beliefs, lifestyle, and social support. In order to minimize these influences, nurses must identify biases and intentionally set the biases aside.

By reflecting on their own experiences or background regarding pain and the suffering it causes, nurses can minimize the influence of biases by first identifying these biases. This might include the nurse's own experiences with pain, personality, values, or accompanying family or friends throughout a pain trajectory. Efforts to eliminate biases or ignore them are futile and may reduce success in achieving the goal of relief of pain and the suffering it causes. Instead, nurses should recognize, acknowledge, and set aside or bracket their biases so they can better understand the patient's experience.

Nurses can use the following questions, among others, to reflect on their own experience, background, or biases. To what extent:

- Do I worry about causing addiction in my patients?
- Do I feel some people are more likely to *game the system* to obtain medications?
- Do I feel anxious about discussing pain management with colleagues or other members of the healthcare team?
- Do I ever feel guilty about too much or too little pain relief?
- Do I recognize that *pain is whatever the person who has it says it is* but really feel the patient sometimes is not right?
- Do I impose my own experience with addiction, opioid misuse, and drug-seeking behaviors?
- Do I resist the idea that some patients may require more aggressive pain management than prescribed? For example, patients undergoing minor procedures, children or adolescents, Emergency Department patients, patients with substance use disorder who undergo surgery, etc.

Summary

Nurses have an ethical responsibility to relieve pain and the suffering it causes. The national response to the opioid crisis poses constraints for nurses in every role and practice setting. Recognizing biases, preventing moral disengagement, creating ethical practice environments, and addressing financial inequities are tactics for minimizing constraints and approaching better relief of pain and suffering. In concert with other organizations and associations, nursing will collaborate to provide excellent patient care through research, policy, and education. Guidance from the *Code* supports these and many other activities in order to meet the desired ends articulated in this position.

Did you know...

according to the Board of Registration in Nursing

- CPR courses cannot be applied as Continuing Education
- Initial certification of ACLS and PALS may be applied, but not re-certification
- Required in-services held by your work place provide necessary information for performing your job safely and effectively. In-services are not accepted as CE for license renewal

https://www.mass.gov/service-details/mandatory-continuing-education-for-nurses

Celebrating the 75th Anniversary of the United States Cadet Nurse Corps: Mary Schofield Maione

Dr. Barbara Poremba

Photo Credit "Barbara Poremba Collection"
1st Row Kathy Adee (Salem State University) Seated Honorees L-R
Mary Schofield Maione (Hamilton), Irma Canzanelli Adams (Medford),
Elizabeth "Betty" Damon Beecher (Weymouth)
2nd row Barbara Poremba (Salem State University),
Ann Sheridan (UMass Amherst)
3rd row Mary Grant (ANA MA), Ruth Flumerfelt (Hamilton)
Karen Johnson, Winona Moeller (Army Veteran),
Judy Beal (Dean, Simmons College), Susan Orsini (Betty's daughter)
Linda Perry (Public Health Museum), Janet Ross (ANA MA)
Not pictured Matt Goulet (VA Boston Healthcare System),
Donna White (Boston City Hospital)

In the dark days of the Second World War, Mary Schofield was a young woman of 20 years living with her family in Ipswich, MA. Each day, she took a train then a bus to the General Electric Plant in Lynn where she worked for the war effort by assembling airplane parts. One day in 1944, she took a different bus route, which stopped at Lynn Hospital. Since everyone else was getting off at that stop, she decided to go in and was greeted by the nursing supervisor who gave her a tour.

Mary had long been attracted to nursing. As a young girl, she contracted scarlet fever and spent a month at the Contagious Disease Hospital in Salem, MA. She recalled that when visiting her mother in Cable Memorial Hospital in Ipswich, her father called the nurses the "white angels" who would make her mother better just as she had "gotten better." Her father also told her that nurses magically gave babies to families. The ladies in all white looked like angels to me. They made my mother better, I got better." Then she giggled and said, "I thought, I want to be one so I can give babies too!" Then in high school, Mary helped care for an 84 year old woman who had a broken hip from a fall. "I found it rewarding. I wanted to be a nurse but money was scarce and nursing school was not an option for me."

During her visit to the hospital that day, she found her opportunity. After talking with the supervisor, she filled out the required documents to apply for the United States Cadet Nurse Corps (UNCNC). Luckily, she had five dollars in her purse to cover the application fee and submitted it immediately. Shortly thereafter, she received her letter of acceptance and enlisted in the Corps for thirty months of intensive, accelerated training at Lynn Hospital, Lynn, MA.

Mary was one of 124,000 Cadet Nurses who voluntarily answered the country's desperate call for trained nurses so that more experienced nurses could go abroad to care for wounded soldiers. The Cadet Nurses were responsible for providing 80% of the nursing care in civilian hospitals and are credited with preventing the collapse of the nation's health care system.

Mary recounted many stories about her education and experiences. "Every morning, we had inspection," she recalled. "We had our grey cadet uniform that we wore when we were out and about. In the hospital, we wore our white uniforms [from Lynn Hospital] with our cadet patch on the sleeve. We worked 12 hour days Monday through Saturday and half a day every other Sunday. Lights off at 10PM so we would study in the closets with flashlights."

For the last six months as Senior Cadet Nurses, students were assigned as needed by the United States Public Health Service. "I wanted to work on an Indian reservation in Alaska, but I was sent to McGuire military hospital in Richmond, Virginia" where she cared for returning soldiers. "The soldiers were very badly injured" she said, "lots of traumatic amputations that had to be surgically repaired once they were back in the States. It took a long time for them to get better. Some didn't want to go home because they didn't want people to feel sorry for them."

The soldiers had witnessed "a lot of rough things." She explained that many suffered from what was then called "shell shock" (now known as PTSD) which was evident in their "attitude and response." "One of the vets told me a story that I still remember. He drove an ambulance in the Battle of the Bulge. Apparently there was no roof over the driver area. The enemy put thin wires across the road. The soldier who was in the passenger seat was taller and the wire cut through his neck and he was bleeding so badly. The soldier was very upset about what he had seen. I don't know what happened to him. That is all that the soldier told me. I think he must have died."

Although the Cadet Nurse Corps had a non-discrimination clause, the military was still segregated. Black soldiers, called "Negro" in those times, were confined to a separate ward. "One day I went to go there with clean linens." 'No, no nurse', a soldier said, 'don't come in here, I'll take it'. When it was time for medications, we didn't go there, they brought them to us, stretchers first, then wheelchairs, then ambulatory. All the medications were administered at the doorway. It made me sad."

While a Cadet Nurse, Mary performed all the skills of a Registered Nurse and more. For example, Senior Cadet Nurses routinely inserted IV's, but when working at Cable Hospital in Ipswich, after the war, she was told "No, no, nurses cannot do IV's. That is for the doctors to do."

Although WWII ended September 2, 1945, the USCNC continued until December 31, 1948. The Cadet Nurses fulfilled their pledge to service the country for the duration of the war (no matter how long that may have been) in military and civilian hospitals wherever needed. For example, Senior Cadets answered the emergency call for nurses during a polio epidemic in

Minnesota in 1946. Upon discharge, Cadet Nurses were urged to continue to meet the nursing needs of the nation. The Cadet Nurse Corps News pleaded, "Civilian hospitals and health agencies are counting on you even more as young graduate nurses" (Cadet Nurse Corps News, Vol 1 No 10, September 1946).

After the war, "they begged me to stay in Virginia. But I was very young, I said I'm too homesick…I want to go home." So instead she went to work at Cable Hospital where she nursed for 46 years before retiring in 1992. For many years, Nurse Maione was an active volunteer in her community of Hamilton, MA where she served on the Board of Directors for the Council on Aging and Unit President for the District of the American Legion. On her retirement from these positions in 2012, the town of Hamilton honored her many achievements and contributions by designating September 5th of that year as "Mary Maione Day."

"It is important that people know about what we did," she explained, "that we did something of importance for the country, that the program was very successful and that if a problem should occur where they need nurses in such a similar situation, it would be an ideal thing to do again. It produced a good group of nurses. It was something that my family could not pay for, it did a lot for the poorer class. I think that the Cadet Nurse Corps started a movement for women. There were few opportunities for women then."

"When I left the corps, it never crossed my mind that we were not veterans. We were in the service. We had military uniforms," she recounted. "We went where we were needed and did whatever we were told. It is the only time in our history that a uniformed service has not been recognized as veterans. I was very proud to be in the Cadet Nurse Corps," Mary nodded as she spoke. But like other members of the United States Cadet Nurse Corps, she thinks that once they are all gone, they will be forgotten.

Mary Schofield Maione's story validates the experience of thousands of young women who willingly served our country throughout the duration of the Second World War. As uniformed nurses in an all-female Corps, they are truly heroines deserving of veteran status. Since 1995, there have been at least 10 Bills introduced in Congress seeking to recognize Cadet Nurses as veterans. These nurses are not trying to make anyone else's service less meaningful. Mary explained, "We just want to be recognized as a valued war worker." Currently, HR 1168 the United States Cadet Nurse Equity Act to confer veteran status is in the US House of Representatives. It has yet to receive support from any of the nine Representatives from Massachusetts. Please contact your US Representative and urge support of this bill. It is time to honor the service of the Nurses of the Corps in the same way we do for all other uniformed veterans who have served our country on the home front or abroad in wartime.

Dr. Barbara Poremba welcomes hearing from Cadet Nurses and can be reached at bporemba@salemstate.edu

Next time:
Cadet Nurse Elizabeth Damon Beecher, RN
How the USCNC advanced the nursing profession.

A Proclamation

Whereas, The U.S. Cadet Nurse Corps, administered by the U.S. Public Health Service, provided for the training of some 180,000 nursing students nationwide during World War II, of whom some 124,000 became registered nurses; and

Whereas, Cadet Nurses were devoted to care of patients in stateside hospitals during World War II, thereby preventing the collapse of the nation's healthcare delivery systems; and

Whereas, In addition to providing up to 80% of a hospital's skilled nursing service in the United States, Cadet Nurses provided for the healthcare of the nation's citizens, thereby making it possible for graduate nurses to serve in the military during World War II; and

Whereas, The U.S. Cadet Nurse Corps began operation on July 1, 1943, and Cadet Nurses celebrate the 75th anniversary of this important program in 2018; and

Whereas, The U.S. Cadet Nurse Corps is the precursor of the Nurse Corps of the U.S Public Health Service; and

Whereas, Cadet Nurses have left an enduring legacy on the nursing profession through their continued service as nurses and leaders in the decades after World War II,

Now, Therefore, I, Charles D. Baker, Governor of the Commonwealth of Massachusetts, do hereby proclaim July 1st 2018, to be,

U.S. CADET NURSE CORPS DAY

And urge all the citizens of the Commonwealth to take cognizance of this event and participate fittingly in its observance.

Given at the Executive Chamber in Boston, this first day of June, in the year two thousand and eighteen, and of the Independence of the United States of America, the two hundred and forty-first.

BY HIS EXCELLENCY

CHARLES D. BAKER
GOVERNOR OF THE COMMONWEALTH

KARYN E. POLITO
LT. GOVERNOR OF THE COMMONWEALTH

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

God Save the Commonwealth of Massachusetts

Is OR Nursing Real Nursing?

Carol Hayes, MSN, RN, CNOR, Staff Nurse, West Roxbury VA Hospital

Beyond the doors of the Surgical Services Unit work nurses who rarely leave the sanctum of this secluded area of the hospital. Being isolated from the other units makes OR nursing seem mysterious and strange. I have heard many times that OR nurses aren't real nurses but perhaps that is because no one really knows what we do inside the Operating Room walls.

Undeniably, OR nursing is very different from floor nursing. We only work with one patient at a time and that patient is asleep for most of the period we care for them. Our patients rarely remember us, but we give comfort and reassurance as they go off to sleep and when they wake up from anesthesia. We care for their physical needs throughout the procedure. And most importantly, we protect our patients from harm while they are anesthetized, when they are at their most vulnerable and unable to protect themselves. The OR nurse is ever vigilant about safety, surgical sterility and infection prevention measures. We ensure the patient is positioned in a manner that will not cause harm to the nerves, tendons and vessels during long procedures and protect their pressure points to prevent pressure ulcers because we can't turn our patients during surgery.

Having one patient at a time might seem like an easy role, but we are constantly running in the OR. Before the patient is brought in, the nurse prepares the room for surgery by helping set up the sterile field with the instruments and supplies the surgeon will need and getting equipment, positioning devices, monitors, and a multitude of electronics ready. We coordinate with the anesthesiologist and the surgeon(s) while responding to the needs of our surgical technician, who is also performing their own role in setting up for surgery, all the while under a time pressure to get the patient into the room at the scheduled time. Interdisciplinary collaboration and strong communication skills are vital to ensure success in the operating room.

Every instrument and piece of equipment used in the operating room must be familiar to us, as nursing provides the means for the surgery to proceed. This knowledge extends from just knowing the name of and what the hundreds of surgical instruments look like to knowing how they are used and in what specialty procedures. We must know not only the ins and outs of the numerous complicated electronic devices and specialty equipment used in various surgical procedures but also know how to trouble shoot it in an instant. The OR nurse knows every step to every procedure performed in their OR out of necessity so they can meet the needs of the surgical team in real time, provide the proper equipment and supplies, and respond to emergency situations. Many of us can also perform the job of the surgical technician and can step into this role as well when called upon to scrub into the surgery. The OR nurse is continually learning as surgical techniques change and different surgeons may come with different methods and preferences.

The OR nurse is also the guardian of their OR room, overseeing every action and event like a surgical referee. We are the last fail-safe for surgeries, ensuring we have the correct patient for the correct surgeon to perform the correct surgery, and that surgery is occurring on the correct side. Everyone that enters the OR must follow the principles of sterile technique or the nurse must intervene on the patient's behalf. Every piece of equipment or instrument used must be carefully checked, transferred and utilized all while protecting its sterility to prevent surgical site infections. And we must ensure every single item used during the surgery is accounted for to prevent accidental retention of a surgical item.

Are OR nurse's real nurses then? The ANA defines nursing as the "protection, promotion, and optimization of health and abilities, prevention of illness or injury, facilitation of healing, alleviation of suffering … and advocacy in the care of individuals…" An OR nurse does all of these things for their patients, but in a highly specialized and technical field of nursing. I am a real nurse.

CONTINUING EDUCATION

Making a Difference: Continuing Nursing Education

Sandra Reissour, MSN, BS, RN

Professional nursing and life-long learning go hand in hand. Every year, Approved Providers of educational programs submit an Annual Report to the ANA Massachusetts ANCC Accredited Approver Unit. The report gathers information from the previous year in terms of programs offered, contact hours awarded and so forth. Perhaps the most interesting information garnered from these reports comes in response to the question *How do you know that the educational activities that you provide make a difference?* After all, the reason for planning, implementing and evaluating continuing nursing education (CNE) is to fill an identified gap: a gap in knowledge, practice and/or skills. Making a difference validates the time and effort required in this educational process. The responses are always interesting. The results are impressive. Here are a few we would like to share:

MelroseWakefield Healthcare (formerly Hallmark Health System), Medford, MA

The formation of a pain management task force at Hallmark Health System (HHS) in 2014 explored the knowledge gap related to non-pharmacological pain management modalities and nurses' understanding of pain management strategies. As a result, a comfort cart was designed and implemented within HHS in 2015. The comfort cart contained non-pharmacological pain management interventions such as aromatherapy and music therapy, as well as items such as sleep masks, tea lights, and stress balls which are easily available to clinical nurses.

An audit was conducted to determine the use of the comfort cart. The audit results revealed extremely low usage of the comfort cart, thus it was identified that nurses required additional education on the function of the comfort cart. Nursing research regarding non-pharmacological pain management was presented in the 2017 continuing educational activity entitled *9th Annual Christine Cameron Symposium on Evidence-Based Practice and Quality Care.* The nursing research which was presented validated the use of comfort carts and encouraged nurses to explore other non-pharmacological methods to improve patients understanding and perception of pain. As a result, the comfort cart has been individualized for each unit and contains items, identified by the clinical nurses on that unit, geared toward that patient population. Clinical nurses now individualize the care provided to their patients, have expressed greater understanding of non-pharmacological pain management, and feel empowered to introduce additional evidence-based modalities in order to improve patient satisfaction in relation to pain management.

Lahey Hospital and Medical Center, Burlington, MA

On March 16, 2017, Lahey Hospital and Medical Center (LHMC) offered a live 7 hour course entitled A New Look at the Old. The target audience for this program was all RNs who serve in the Geriatric Resource Nurse (GRN)/Geriatric Champ role, as well as those interested in learning evidence based practice when caring for the older adult population. The unique role of the GRN/Geri Champ allows the RNs to function as resources, mentors and experts for their patients, as well as their peers, in the area of geriatrics. A cross-system collaboration between Lahey Hospital & Medical Center and Newton Wellesley Hospital was a key factor in the success of this program, allowing for exposure to alternative workflows and organizational processes, ultimately resulting in strengthening the Nurses Improving Care for Healthsystem Elders (NICHE) program at both institutions. The class had 37 participants. Program content included:

- Why Geriatric Nursing
- Age Related Changes
- Nutrition, Hydration and Oral Health
- Pain in Older Adults
- Pressure Injury in Older Adults
- Function, Mobility and Balance
- Urinary Incontinence
- Elder Mistreatment/Abuse/Healthcare Decisions
- Geriatric Resource Nurse/Geriatric Nurse Champion Panel

Description of Current State - Older Adults suffer from hospital associated deconditioning and have higher length of stays and readmission rates (NICHEprogram.org, 2017). The number of older adults is expected to double in size by 2030, yet nurses lack geriatric specific knowledge required to provide age competent care. (Retooling for an Aging America: Building the Health Care Workforce, Retrieved February 9, 2017).

Description of Desired/Achievable State - Nurses will be knowledgeable about best practice and incorporate evidence based strategies and tools into their nursing practice to improve care and outcomes for older adults.

Identified Gap - Although a high percentage of patients in acute care hospitals are 65 or older and require specialized care, nurses lack knowledge about evidence based strategies and tools which can be implemented in improving care and outcomes for older adults.

Program Purpose/Outcome - Upon completion of this program, participants will be able to articulate and incorporate evidence based strategies and tools into their nursing practice, and provide the highest quality age sensitive care for older adults. Interdisciplinary clinicians and thought leaders from each institution joined the group as guest speakers. Existing GRNs also joined the group as guest speakers. Each educational day included a pre and post program quiz and use of case studies, interactive teaching technology tools, small group discussion and experiential learning opportunities.

Description of evaluation method

Knowledge:

Pre-Program:

1) A pretest compiled of multiple choice questions was administered
2) A self report preprogram knowledge rating was completed by participants

Post-Program

1) The same multiple choice questions administered prior to the program was given post program, and the scores were compared for knowledge gain
2) A self report post program knowledge rating was completed by participants

Skills:

Case studies were discussed throughout the program allowing for evaluation of knowledge application

Summary of Findings

Class Date	Pretest Score Average	Posttest Score Average
March 16, 2017	67.9%	86.7%
Total Class Average Increase in knowledge = 18.8%		

In addition to pre/post self-assessment, the program evaluation included an open-ended question asking participants to describe how the knowledge from this program would impact their practice. The participants described an increase in knowledge and a perceived significant positive impact on their practice with the intent to provide evidence based practice with an anticipated improvement in patient outcomes. Overall themes included: Care for older adults related to urinary incontinence, wound care/pressure injury prevention, pain management, impacts of age related changes, adequate nutrition and hydration need for increased ambulation and the role of elder protective services. In summary, quantitative and qualitative data indicated successful program outcomes in addressing the identified gap, thus advancing nursing professional development and improving patient outcomes through attention to the increased knowledge necessary to provide age sensitive care.

Beth Israel Deaconess – Plymouth, Plymouth, MA

During the spring of 2017, all educators began monthly "Cardiac Rhythm of the Month" education, which was tied to supporting the new Basic Cardiac Dysrhythmia Interpretation course. These discussions reviewed the cardiac rhythm types as well as assessment skills and interventions. Staff reviewed the rhythms and demonstrated their use of critical thinking in the interpretation of the specific rhythm and care provided for their patients. Feedback from staff each month was encouraging, as they would indicate learning in real time. This process also enabled educators to identify staff struggling with concepts during the review sessions, and encourage enrollment in the full Basic Cardiac

Dysrhythmia Interpretation course. This process continued for six months and in the fall, all the staff were required to complete a test during the annual nursing competency fair. A remediation process was implemented with successful re-testing for staff that was unsuccessful initially.

As of 12/31/17, 98.5% of the nursing staff has successfully completed this competency. The remaining staff are currently on leave and will complete the competency upon return to work. In addition to this formal test result, feedback from the Nurse Practice Council was positive about this learning process and their increased comfort in caring for patients requiring telemetry monitoring. They asked that additional training be incorporated into the 2018 calendar on this topic/skill so that they can maintain their current level of competence in this area.

Exeter Health Resources, Inc, Exeter, NH

A laser focus on patient safety is critical to excellent patient outcomes; tracking and trending quality data is a continuous process. This is especially true in a Magnet organization. Through shared governance, unit-based practice councils (UBPCs) review quality metrics to ensure continuous quality improvement at the unit level. In order to affect positive outcomes, it is imperative that clinical nurses understand their individual role in quality and patient safety and assume accountability and ownership for their practice.

Exeter's Nurse Residency program was built on the *Quality and Safety Education for Nurses* (QSEN) framework. Preparing new nurses to transition to the professional role requires in depth education about a variety of clinical topics. It also necessitates preparing them with the knowledge, skills, and attitudes necessary to continuously improve quality and patient safety. NPD Specialists developed the class, *Linking Quality and Patient Safety to Practice,* aimed at helping the new nurse make the connection between practice and patient outcomes and understand that "data is the autograph of the nurse."

The class focuses on the driving forces behind quality and patient safety (IOM, public reporting and regulatory agencies, and the alarming numbers of medical errors) and creating context for tracking quality metrics (value-based purchasing and Magnet). Participants have an opportunity to review, discuss, and interpret unit-level data (i.e., falls, wounds, patient satisfaction) with a quality expert. The importance of benchmarking data against other like organizations is also emphasized.

Following the January 2017 class, Nurse Residents were asked to rate their confidence level interpreting quality metrics. On a five-point Likert scale, nurse residents rated their confidence level a full point higher after taking the class (pre-class average score = 2.6; post-class average score = 3.6). Anecdotally, nurse residents are taking a more active role in collaborative rounding – where quality metrics are reported on and integrated into a patient's daily plan of care.

Since the implementation of the *Linking Quality and Patient Safety to Practice*, two former nurse residents have moved into leadership positions. Critically analyzing unit-level data and developing actions plans around the data is a major responsibility of these leaders. During a recent DNV visit in January, clinical nurses reportedly interacted confidently with appraisers regarding unit dashboards and metrics. Reviewing quality data has become embedded into daily work throughout the organization.

These are but a few examples that solidly depict that Continuing Nursing Education positively impacts the life-long learning of a professional nurse.

The Need for Price Transparency in Health Care

Gerri-Lyn Boyden, BSN, RN,
MSN student at UMASS Dartmouth

As both a nurse providing health care services, and a consumer, I assert that the lack of transparency in health care is a growing issue. As healthcare expenditures rise, accounting for a greater portion gross domestic product (GDP) in the United States (U.S.) each year, "there has been increasing pressure for greater transparency regarding health care costs, with the presumption that greater transparency will foster greater accountability" (Knickman & Kovner, 2015, p. 25-26). Identical health care services are sold to different buyers at different prices (depending on type or lack of insurance). Economists call this "price discrimination" (Reinhardt, 2014). When compared to the economics of health care around the world, the lack of transparency in healthcare in the U.S. is an outlier. Reinhardt (2014) states, "physicians, hospitals, and other clinicians and entities that provide health care within most systems outside the U.S. are paid on common fee schedules uniformly applied to all clinicians, health care organizations, and insurers" (p. 1642).

The net effect of this lack of price transparency can be viewed in terms of patients, health care systems, providers, insurance companies, and the overall U.S. economy. The lack of transparency puts patients at a disadvantage, leaving them unable to make value based choices. Unger (2016) states that consumers need both price and outcome information "to make informed value decisions." In their article on transparency and value, Hostetter & Klein (2012) note that "Prices for health care services vary significantly among providers, even for common procedures, and it's often difficult for patients to determine their out-of-pocket costs before receiving care." Even when prices are available for patients, they are not understandable. Technical terms used by hospitals in "charge masters" (schedules of price lists) to negotiate prices with insurance companies are difficult for average patients to understand, with 15,000 distinct items (Reinhardt, 2014).

Factors contributing to lack of cost transparency among hospitals and providers are numerous. Hospitals have survived by relying on volume to drive profitability, Unger (2016) states, but this is no longer working as "declining inpatient volumes, decreasing reimbursement, evolving payment models, and a push for price transparency are going to force this change." Fragmented care, or receiving different pieces of care from different providers, makes determining total cost difficult for providers (Unger, 2016). Data governance, the "overall management of the availability, usability, integrity, and security of data used in an enterprise" (Tech Target, 2017), like cost of delivery of health care services, hinders price transparency (Unger, 2016). Providers struggle to sort out political, technical, and change management issues within their systems in an attempt to deal with data governance issues that are "deeply embedded in healthcare organizations" and must be resolved to provide accurate cost information (Unger, 2016).

Despite the complexity of this problem, solutions are possible. According to Unger (2016), "With data available, solid costing processes, and some simple statistics we should be able to tell someone 25th, 50th, and 75th percentile cost for a specific procedure or diagnosis with reasonable accuracy." The All-Payer Claims Database (APCD) is mandated by state governments to collect data from multiple sources, which includes private insurers, Medicaid and Medicare, and health benefits programs (Petrov, 2017). However, state implementation varies from governance and funding to the data, structure, and access (Petrov, 2017). A July 2016 "Report Card on State Price Transparency Laws" gave 43 states an "F" (Petrov, 2017). Hospitals are starting to post prices for common services and procedures on websites, give estimates for out-of-pocket expenses, and offer payment plans to improve cost transparency for patients (Petrov, 2017).

Insurance companies need to improve customer education and provide better customer tools to improve cost transparency. Consumers' education, such as what the terms deductible, co-payment, co-insurance, out-of-pocket maximum, and in-network provider mean and when they apply, would enable patients to better understand insurance products (Petrov, 2017). A 2013 survey showed that 86% of people surveyed had difficulties with these terms (Petrov, 2017). Improving consumer tools, like websites and mobile apps, would also aid in cost transparency.

The U.S. government and individual states, are working to counter the lack of cost transparency in health care with legislation. The Massachusetts legislature has taken steps to make health care systems more transparent, passing the Medical Price Transparency Law. "As of Jan. 1, 2014, physicians and hospitals in Massachusetts are required to provide patients with cost information on services and procedures if they request it" (Hardwick, 2017). In addition, "health insurers have also been required to provide cost information to patients on office visits, procedures, and tests" (Hardwick, 2017). On the national level, three Republican representatives introduced a bill to the U.S. Congress in May, 2017 called: "The Transparency in All Health Care Pricing Act of 2017." "This bill requires entities that offer or furnish health care related products or services to the public, including health insurers and government agencies, to disclose the price for those products or services at the point of purchase and on the internet" (Congress.gov, 2017). This bill is still in being considered for passage by three committees of the House of Representatives (Congress.gov, 2017). Legislators in more than 30 states have proposed or are proposing legislation to promote price transparency, with most efforts focused on publishing average prices for hospital services (Hostetter & Klein, 2012).

As nurses, and health care consumers, I urge you to support health care transparency legislation on the state and national level. My hope is that greater accountability in health care pricing will result in improved patient care services and outcomes.

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Embracing Technology into our Nursing Care Delivery

Tiffany Kelley, PhD, MBA, RN

As nurses, one of the first pieces of technology we learn how to use is the stethoscope. Think back to nursing school when you received your first stethoscope. Then, during your physical assessment class, you learned to use it. You learned how to listen to heart, lung, and bowel sound and to measure blood pressure. For many, that stethoscope is on your person at all times during your nursing shift. That stethoscope is an essential to delivering high quality care. You may not have thought of the stethoscope as a piece of technology. I certainly hope you will now going forward.

Technology, like the stethoscope can enhance and improve patient care. A major example of technology that has forever changed the patient care environment is the electronic health record or 'EHR'. While there will always be areas for improvement and advancement with EHR technologies, we depend on these tools in much the same way that we depend on our stethoscope. As a profession, nurses must recognize both the positive aspects of this technology for patient care and our role in advancing this technology.

The first step in this effort is to embrace new technology into our nursing care delivery process. Embracing technology refers to a willingness to view technological advancements as resources to support our care delivery environments. Beyond the EHR, technology can be something as simple as leveraging email as an effective communication method for your teams or as complicated as more advanced diagnostic screening tools for earlier disease and condition identification inside and out of the formal health care environment.

I can speak from experience that my work in this field began with a very limited understanding of technology. Now today, I look for ways in which we can improve on care through technological tools that help support and enhance the patient's care delivery. These tools can take on a variety of forms whether through a hardware device (e.g., computer, smartphone), or software applications (e.g., mobile apps, websites). Where nurses have an advantage in improving on health care technologies is in sharing their nursing knowledge and expertise to either develop or support the development of new tools and address some of the opportunities we see today that remain in our health care environment. Each of you have the opportunity to make a positive impact with your knowledge and interest in helping shape the future tools we will rely on day to day, in much the same way as that of the stethoscope.

Reflections from Past Presidents

Past President Myra Cacace singing the national anthem at Fenway Park

Presidential Memories

Myra F. Cacace GNP-BC
April 2015 – April 2016

Hello to all ANA Massachusetts members! On April 10, 2015, I became the President of a great professional nursing organization. I was the 8th in a line of excellent nurse leaders who continue a long tradition of affiliation with the American Nurses Association (serving nurses in the United States since 1908). I had big shoes to fill but worked hard with the help of a great Board of Directors and Committee Chairs to represent ANA Massachusetts as the nursing organization with the reasoned voice of nurses in the Commonwealth.

Exciting times! Under the leadership of President Tara Tehan, and with the help of our great lobbyists, Patricia Lynch and Benjamin Fierro, ANA Massachusetts filed our first ever legislation: An act relative to the governance of the Health Policy Commission. I carried the ball forward and gave testimony in support of our bill and for nurse practitioner and nurse anesthetists: An Act to Remove the Restrictions on the Licenses of NPs and CRNAs as Recommended by the Institute of Medicine and the Federal Trade Commission. I testified about the opioid crisis, and worked on task forces to help modernize MassHealth, Safe Patient Handling, increase awareness of Pre-diabetes and a variety of topics in mental health. With our lobbyists and Executive Director, Diane Jeffery (now O'Toole), I met with all key legislators and hosted community gatherings to facilitate meetings between nurses and their own local legislators to advocate on behalf of our profession and the patients we serve. We were an important voice in the discussion about the regulations for nurse staffing in the ICU after the June 2015 law was passed that gave the nurse to power to decide how the right number of patients/nurse in that setting.

We continued the tradition of celebrating National Nurses Day at Fenway Park, and I even had the opportunity to sing the National Anthem before the 2017 game. Our conference planning committee planned and implemented fun and educational networking events and our membership grew! And the organization continues to grow and add more great experiences and activities…I encourage everybody who reads this to become more active and engaged members!

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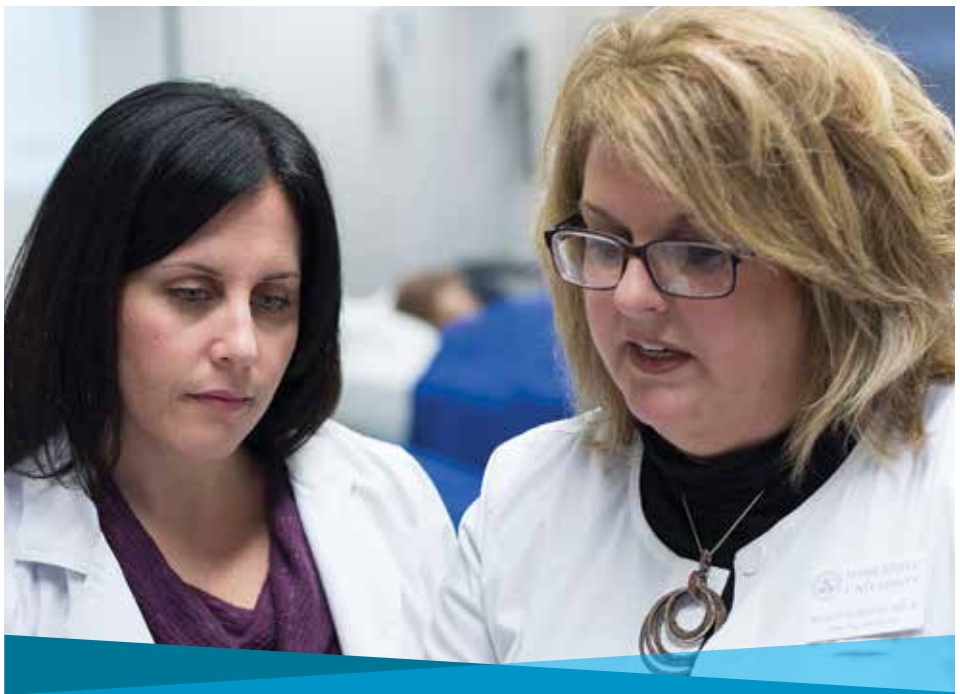

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