MASSACHUSETTS REPORT ON NURSING

Quarterly Circulation 131,000 | Volume 17 Number 3 | September 2019

The Official Publication of ANA Massachusetts • PO Box 285 • Milton, MA 02186 • 617.990.2856 • newsletter@anamass.org

Who is this nurse?

AMERICAN NURSES ASSOCIATION MASSACHUSETTS

www.ANAMASS.org

In this issue:

ANAMASS Awards

Someone said **"Every nurse deserves an award."** We can't agree more! I am sure you work with or know a nurse whose commitment to care and the profession is exemplary. The American Nurses Association Massachusetts Awards program provides an opportunity to honor a nurse for their remarkable, but sometimes unrecognized contribution.

You do not have to be an ANAMASS member to be nominated or to nominate another unless noted below. Awards can be peer or self-nominated unless noted below. ANAMASS is committed to the advancement of nursing and quality care. With the exception of the Loyal Member Service Awards, nominations are open to all Massachusetts nurses. Awards will be presented at Spring Awards Dinner. For details visit: www.anamass.org.

The award nomination process is easy:

- Access the application at www.anamass.org
- Submit the application electronically or by mail by **January 12, 2020**
- If you have any questions, or need help, call ANAMASS at 617-990-2856

Rebecca and Jessica McCann

Award	Presented to:
Excellence in Practice	RN who demonstrates excellence in clinical practice
Excellence in Education	RN who demonstrates excellence in nursing education in an academic or clinical setting
Excellence in Research	RN with research that had (or has the potential to have) a positive impact on care
Community Service	RN whose community service has a positive impact on the citizens of Massachusetts
Mary A. Manning Nurse Mentoring	RN mentor with outreach to nurses in practice or the pursuit of advanced education *(Established by Karen Daley- monetary award of $500)*
Loyal Service	RN with loyal and dedicated service to the association **(ANAMASS membership required)**
Friend of Nursing	A person or persons who have demonstrated support for the profession of nursing in Massachusetts
Future Leader	RNs with leadership potential during nursing school or in their first position. The recipient will receive a one year membership in ANAMASS and attend the awards dinner free of charge. • Nominees must be graduating in the year nominated or have graduated from a pre-licensure nursing program within two years of the nomination deadline. • The nomination must be made by an ANAMASS member with an additional letter of support from a second ANAMASS member. • One letter of support must come from a dean or faculty member of the nominee's nursing program. • The nominee must plan to live in Massachusetts after receiving the award AND serve on an ANAMASS committee for one year.
Living Legends	• Recognizes RNs who have made significant contributions to the profession and society. • Candidates must be a current or past member of the ANAMASS or a member of the Massachusetts Nurses Association (MNA) when it served as the state affiliate for the ANA. • Nominated by a colleague.

ANAMASS Awards continued on page 7

president's message

ANA Massachusetts: Listening to you

Julie Cronin, DNP, RN, OCN

I was recently asked the question "Is ANA Massachusetts in touch with all nurses, not just those in "leadership"? This question made me think long and hard- is ANA Massachusetts hearing from and responding to all our members? And what does "leadership" truly mean? Here are my thoughts:

1. Nurses are at the forefront of healthcare in all its many settings.
2. Nurses lead small, large, interdisciplinary and other health care related teams.
3. Nurses understand the complexity of delivering safe and quality care.

Being a leader does not necessarily equate to someone working in a management role, academic appointment or in the C-suite. There is a major difference in "leading" and "managing." There are managers who are not necessarily leaders. There are leaders who are not managers.

I see leadership every single day in the nurses around me. On a large ambulatory infusion unit, nurses provide exceptional oncology care at the bedside and lead patients and families through incredibly challenging times. Resource and triage nurses maintain the pulse for the happenings of a busy and complex unit. Clinical specialists lead the education of staff and influence the practice of a unit. Directors lead their teams and positively affect the culture of a unit. There is leadership everywhere in nursing, not just at a "management" level.

As I write this message to you, I am holding my seven-week-old baby who is asleep in my arms. I think back to the months leading up to my daughter's arrival. I think about every time I called the nurses in my Obstetrician's office with the many "first time mom to be" questions. I think about the time the nurse in the office spent leading me through next steps, test results and what to expect on the big day. Then there were the exceptional nurses on the Labor and Delivery unit that were there with my husband and I through every painful, joyful, emotional and beautiful minute of the night we entered the hospital as a couple and left as a family of three. The night nurses that stayed an hour past their shift into the morning to be with me as my daughter was born. The post-partum nurses who took the time to educate us on all the aspects of being new parents, from diapers, swaddling, feeding, sleeping (or not!), bathing and taking care of a newborn and ourselves. The patience, kindness, caring and understanding was exceptional. I relied on their leadership for that experience. The nurses that cared for me and my family led us through an extraordinary experience that I will never forget.

What I love about ANA Massachusetts is that our mission is to represent and advocate for ***all*** nurses who lead care in their respective roles each day. From new graduate nurses to experienced nurses. Nurses working in acute and long-term care, to hospice and public health. Nurses working in oncology to labor and delivery, psychiatry, and every specialty in between. Nurses with advanced degrees and those without. Nurses on boards and committees. Nurses leading innovations in care delivery. Nurses confronting bullying and lateral violence. Nurses advocating for our profession at the State House and Capitol Hill. Nurses leading care teams, like mine.

In fact, our very own ANA Mass Board of Directors is comprised of nurses working in a variety of settings, from staff nurses in acute care, mental health, and veterans' affairs, to those in education, management, and nurse practitioners.

I believe regardless of your practice setting or membership status in ANA Massachusetts, you are already a leader. I want to hear your voice and how you lead, so please share your thoughts, ideas and experiences with me. I would love to engage more you with opportunities to others your leadership: Join us at the State House as we offer testimony on legislation that affects you. Join a committee or attend an open Board meeting. Email us your questions and thoughts. **We want to hear from you, our nursing leaders.**

For our next issue of the Massachusetts Report on Nursing, I would like to answer some questions and hear from our members. Please email me at President@anamass.org. I look forward to hearing from you!

AMERICAN NURSES ASSOCIATION MASSACHUSETTS

Receiving this newsletter does not mean that you are an ANA member. Please join ANA Massachusetts today and help promote the nursing profession.

Board of Directors

President
Julie Cronin, DNP, RN, OCN

President-Elect
Tiffany Kelley, Ph.D. MBA, RN

Past-President:
Donna Glynn, PhD, RN, ANP-BC

Secretary:
Jim Kernan, RN, MPIA

Treasurer:
Christina Saraf, RN, MSN

Directors

Myra F Cacace, GNP-BC
Kate Duckworth, BSN, RN
Lynne Hancock, MSN, RN, NE-BC
Silda Melo, BS, RN
Janet Monagle, PhD, RN, CNE
Janet E. Ross, MS, RN, PMHCNS
Deniece Waruinge, RN, BSN

Executive Director:
Carmela A. Townsend, DNP, MS/MBA, RN

Committee Chairs

Awards and Living Legends Committee
Maura Fitzgerald, RNC, MS

Bylaws Committee
Mary McKenzie, EdM, MS, RN

Conference Planning Committee
Cynthia LaSala, MS, RN

Approver Unit
Jeanne Q. Gibbs, MSN, RN

Health Policy Committee
Arlene Swan-Mahony, DNP, MHA, BSN, RN
Christina Saraf, MSN, RN

Membership Engagement
Tiffany Kelley, PhD, MBA, RN
Janet Ross, MS, RN, PMHCNS-BC

MA Report on Nursing Committee
Jean C. Solodiuk RN, CPNP, PhD, Editor
Barbara Belanger RN, MSN, CNOR
Inge B. Corless RN, PhD, FNAP, FAAN
Gail B. Gall RN, PhD
Anya Peters, PhD, RN, CNE

Nominating Committee
Donna Glynn, PhD, RN, ANP-BC

~ ANA Massachusetts Staff ~

Executive Director
Cammie Townsend, DNP, MS/MBA, RN

Office Administrator
Lisa Presutti

Nurse Peer Review Leader
Judy L. Sheehan, MSN, RN

Massachusetts Report on Nursing is published quarterly every March, June, September and December for ANA Massachusetts, P.O. Box 285, Milton, MA 02186, a constituent member of the American Nurses Association.

editor's message

Listening to *The Scream*

Jean C. Solodiuk

A theme that runs through this edition of the *Massachusetts Report on Nursing* is listening. Listening to our bodies, minds and souls to ensure we administer self-care. Listening to our patients to ensure they receive necessary care. Listening to each other so that we can grow together in understanding. Listening to the evidence to improve care. Listening to our history to improve our future. This fall, I am rededicating myself to both listening more and to better articulating my thoughts and feelings so that others are more inclined to listen. Although I sometimes consider these opposite tasks, both have the same goal of understanding.

Listening to the scream

I am drawn to the open eyes, flared nostrils and long fingers tenderly holding their skeletal head in Edvard Munch's *The Scream*. Judging from how often I see this figure on T-shirts, ties, book bags, inflatables and socks, I believe many others are also drawn to this anguished figure standing beneath the blood red sky.

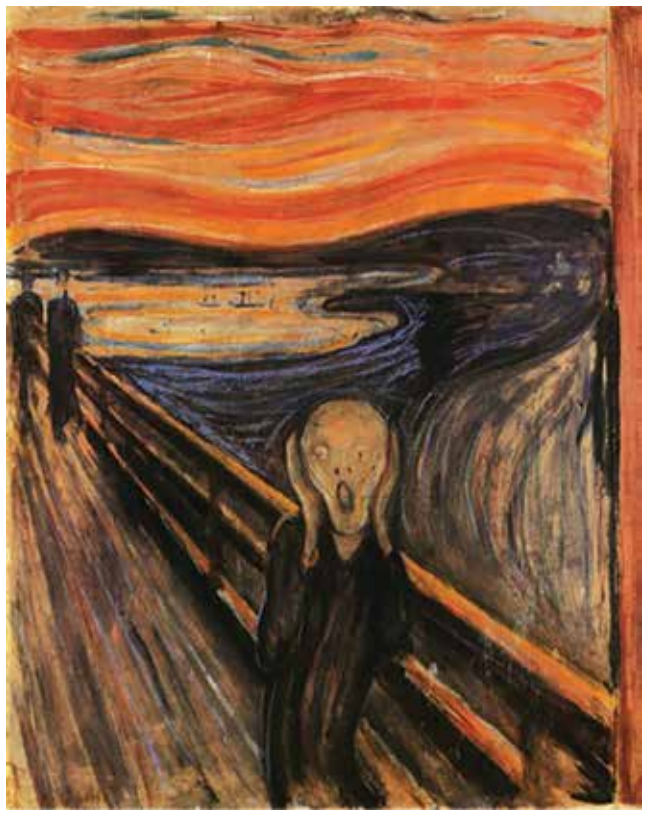
As a pain management nurse practitioner, I tend to interpret the figure's expressions of distress as physical pain. The way the figure is tenderly grasping his head with a look of surprise, the cause of the pain may be trigeminal neuralgia, an often abrupt onset of severe, shooting facial pain caused by nerve irritation or damage of the trigeminal nerve. But it could also be a headache, toothache or any other type of pain. Since the art form is a painting, Munch leaves us wondering what the actual *Scream* sounds like. Is the voice high pitched or thundering or silent? Is the desperate figure calling out for a specific someone or for anyone who will listen?

Nurses are often the first person at the bedside to witness a patient's pain behaviors, or to listen to the patient's self-reported pain. Pain assessment tools (like all measurement tools) are not perfect nor do they capture the entire experience of pain. But a tool validated for a similar patient group has the best chance of accurately measuring pain within that subgroup.

However, measuring pain intensity using a valid and reliable tool is only part of the process of pain assessment. Experiencing pain is a complex bio-psycho-social experience. This is why people perceive and express pain differently even when exposed to the same stimulus. Therefore, in addition to measuring pain intensity, it is important to observe both the patient's emotional and physical responses to pain. It is also important to know that pain responses are influenced by many factors including the stimulus, medical condition, past experiences, learned expressions, physical abilities, developmental age and level of anxiety and stress. Because pain expression is varied based on many factors, each self-reported pain score must be compared with that individual's trend of pain scores. But even an individual patient can have different responses to the same pain stimulus based on how stressed, sleep deprived, anxious, etc. they are feeling at that time.

When pain is managed based on pain intensity scores alone, then some patients will be overmedicated and others will be undermedicated.[1] For example, not every patient will respond in the same way after the same surgical procedure. Some report low pain scores, "It only hurts when I breathe," while taking shallow breaths and splinting. Others report consistently high scores but their pain does not impact their function. Instead of medicating based on pain intensity alone, consider the pain intensity score within the context of your behavioral observations (how does the patient look especially during movement); vital signs; and the patient's previous responses to analgesics and other pain interventions. These clinician observations can be documented in the medical record to help with subsequent assessment of pain. Additionally, routine pain assessment is necessary to ensure that pain is recognized so that the appropriate intervention can be initiated. This is important for all patients but especially for those that do not express pain as clearly as that anguished figure in *The Scream* such as patients with intellectual disability or those with difficulty communicating verbally.

The evolutionary reason for pain vocalization and expression is to receive assistance from another in the form of comfort, acknowledgement, treatment of the pain source and eventual pain relief. As I look at *The Scream*, I am inevitably frustrated with the two distant pedestrians who in my imagination, seemingly passed by the figure without recognizing or acknowledging the obvious expressions of considerable suffering! In this painting, the pedestrians may be distracted by conversation, the beautiful sky and waterfront. Sadly, we all have the potential to be distracted and miss someone's pain and suffering. When I look at the two pedestrians, in Munch's painting, they are reminders of why we as nurses must listen, hear and attend to the needs of *The Scream*.



***The Scream* by Edvard Munch**
Courtesy of www.EdvardMunch.org

Reference

Vila H, Smith R, Augustyniak M, et al. The efficacy and safety of pain management before and after implementation of hospital-wide pain management standards: is patient safety compromised by treatment based solely on numerical pain ratings? *Anesth Analg*. 2005; 101(2):474-480.

Jean Solodiuk is a nurse practitioner at Boston Children's Hospital and the editor of the Massachusetts Report on Nursing.

introductions

Cynthia LaSala interview

Labor Day always arrives before I'm quite ready, having once again failed to soak up enough soft breezes, snug harbors, sounds of children shooting hoops, riding bikes and pushing curfews. Even on a writer's schedule I feel the pressure to make checklist. Reluctantly I swap out flip flops for flats. The aroma of hot apple cider donuts wafts over drying cornstalks. School buses crowd the streets; college students occupy sidewalks; and reminders to get the flu shot surface.

As fall comes knocking, June graduates settle into new roles as veteran nurses cope with new student groups. Many embark on endeavors or enroll for further formal learning. Professional nursing development programs are essential to bridging transitions, identifying key growth areas, and strengthening nursing practice.

Gail Gall

Cynthia LaSala

In this issue, we'd like to introduce Cynthia LaSala, MS, RN, an ANAMASS member, chair of the Conference Planning Committee who has a had a stellar career in acute care nursing and professional development. Ms. LaSala never strayed from caring for patients at the bedside and supporting direct care nurses even as she pursued higher nursing degrees and honed her expertise in ethics and leadership, both on the job and as a volunteer with ANA Mass, our state organization.

Late last spring Ms. LaSala readily agreed to an interview for this edition of *Massachusetts Report on Nursing*. Within a few minutes of our initial contact she shared her values about nursing practice. I hope you will enjoy these insights into present-day nursing and professional development from a thoughtful, accomplished, and refreshingly candid nursing practice expert.

Core values and roles.

Reflective practice and caring ethics are integral to modern nursing practice. Reflective practice is based on the theory that nurses are at ground zero in witnessing, reacting to, and protecting patients and families in order to ameliorate or prevent harm. Caring ethics comprise the awareness, respect, and response to patients' experiences. Based on these constructs, Ms. LaSala identified three important aspects of being a nurse:

- Provide the best possible care: Be well-prepared to meet role expectations as clinician and educator of patients, families, colleagues and executive leadership. Learn the requirements to fulfill each nursing role. Remember that patients know what competency and caring look and feel like.
- Give back to the profession: Follow in Nightingale's footsteps by responsibly updating skills, knowledge and by helping others do the same.
- Participate in nursing's professional organization: Whether at the state, regional, national or even international level, involvement with professional nursing groups builds skills and infuses confidence to assume leadership.

Influences on patient care:

- Technology: New developments in communications, treatments, and documentation affect personal interaction with patients, families, and colleagues. Nurses experience frustration, sadness, and fatigue as they balance documentation requirements that widen distance from direct patient care.
- Changing work environments: Increased patient acuity and staffing changes create urgent demands to provide more complex care by thinly stretched nurses. They need to know that nursing leadership is aware of their needs and will provide support, resources, and avenues for nurturing, allowing room to process feelings, explore ethical issues, and provide appropriate care for patients and themselves.
- Nursing leadership: Leaders need to keep close to reach out to the entire team of care givers including licensed and non-licensed care givers. Clinical nurses appreciate knowing that leaders are present and supportive.
- Teamwork model: Both team cohesion and evidence-based data are essential when planning practice improvements. Interactions between newcomers and experienced nurses that show respect and regard for one another; being present and helpful when someone is NOT having a good day; and engaging diplomatically rather than dismissively are effective strategies.
- Professional organizations: Professional organizations need to expand membership, engage nurses, and offer educational opportunities that address nurses' needs to feel safe and supported in practice. Interaction between the professional organizations and nursing education is crucial to actively engaging nursing students and new nurses.

Ms. LaSala feels honored and privileged to be a leader and founding member of ANA Mass which has emerged as a voice for nursing in the Commonwealth, solidified the relationship with ANA, and continues to grow. ANA Mass has set a goal to build its leadership component with opportunities for internships and committee seats to promote and nurture career advancement. Volunteerism and professional practice intertwine to assist in this process. In retirement Ms. LaSala will continue to stay involved, as she says, "It's part of who I am. Its filled with wonderment, excitement and challenge."

On career development she offers these words of advice:

"Know yourself and when it's time for a change. Maintain respect and regard for one another. Create an environment of responsibility, trust, and shared values. Take care of yourself as you do others."

Recently Globe writer Dan Aucoin interviewed award winning actress Faye Dunaway who was in Boston to portray Katherine Hepburn in the pre-Broadway run of "Tea at Five." A graduate of Boston University's theatre program, Dunaway looked back on her early days of stage acting and reflected that she chose live theater because…

"I was doing what I needed to do at that moment: Learning my craft. You have to know what you're doing. You can only do that, I think, by working in the theater. You are forced:

You have to make the performance realer and deeper and as alive as it has ever been before. It's an important — an essential — part of growing as an actress." [1]

If you substitute "actress" and "theater" for "nurse" and "hospital," the sentence becomes universally true for our profession. Practice that involves reflection and a caring ethic can reach perfection or come pretty close.

Many thanks, Cynthia LaSala, for service and wisdom.

Gail B Gall, PhD, RN

June 28, 2019

Aucoin, Don. (June 13, 2019, 6:37 PM), For Faye Dunaway, a return to Boston — and her roots on the stage. Boston Sunday Globe. N1, N6. Retrieved from: https://www.bostonglobe.com/arts/theater/dance/2019/06/13/for-faye-dunaway-return-boston-and-her-roots-stage/Gy6UMtbL1m44NjPorPs7sN/story.html.

#NoJournalsNoEBP: Nurses advocate for access to evidence

Jane Lawless, MLS, BA

Public health nurses, visiting nurses, school nurses, and nurses not affiliated with major medical institutions – all may share the same problem when trying to access research articles: the paywall. Nurses who are not part of a hospital or university system, or who recently graduated from a nursing program, are often frustrated to find that they are asked to pay for access to articles that support their evidence based practice. If you belong to this category, you are not alone.

Recently, discussion of this topic has exploded on Twitter, thanks to Melanie Rogers, RN, MPH, a public health nurse in Colorado, who started the #NoJournalsNoEBP thread in March 2019. In May 2019, I spoke with Ms. Rogers about ways in which unaffiliated nurses can access articles, and support wider access for all nurses. We discussed several approaches that nurses could take.

First, be aware of resources that are available to you, without hitting a paywall. Here are a few:

- *PubMed Central* https://www.ncbi.nlm.nih.gov/pmc/, developed by the National Library of Medicine (under the National Institutes of Health), has 5.5 million freely available articles in the biomedical and life sciences – including nursing and public health. This resource can be accessed from any computer, and has numerous tutorials available on YouTube.
- Sigma Theta Tau's *Virginia Henderson Global Nursing e-Repository* https://www.nursingrepository.org/ provides nurse authors a place to host their publication pre-prints, open access articles, and dissertations – and nurse researchers a place to access them, free of charge.
- *The Directory of Open Access Journals* https://doaj.org/ provides access to 13,457 high quality, open access, peer-reviewed journals from 131 countries. A search for the term nursing, with full-text articles in English, returned 53,270 results.
- *Open Science Foundation* https://osf.io/ provides open access to registered article preprints with details about any corrections made before the final publication stage. [1]

Second, be willing to advocate for access to research journals for yourself and your profession. Many articles found in *CINAHL*, and published through major publishers like Elsevier, Sage and Wiley, will not be available through the resources above, but together we may be able to improve access through vocal and persistent advocacy.

- Reach out to your nursing program alumni associations, and ask them if your previous institution can offer access to program graduates. Be ready to explain why this is important to your practice, and how such access will strengthen alums professionally.
- Ask your employers if they can support subscriptions to specific journals or resources. Whenever possible, back up your requests with evidence of how you will use these resources, and why they are important to your work.
- Encourage your professional organizations and unions to explore whether they can provide access to electronic databases/journals for members at a reduced rate – or supported through membership dues.
- Advocate with your political representatives, for state-level resource support. A great example of this is the HEALWA program https://heal-wa.org/ a collaborative effort of Washington State Department of Health and the University of Washington, partnered to make available multiple nursing and health databases and journals. Could Massachusetts make this happen, too? Gather your colleagues and add your voices to such efforts.

Learn more about evaluating open access journals, so that you can identify predatory journals, which may use questionable practices and omit meaningful peer review. Many college and university libraries have guides (LibGuides or resource guides) with sources about predatory journal identification. Reach out to your local public librarian for more assistance.

In addition, think local:

- Form writing, research and supportive partnerships with nurses in your community.
- Become familiar with local resources, such as the *Access to Resources in Community Health (ARCH)* program https://library.massgeneral.org/arch/ which is associated with Mass General Hospital's Treadwell virtual library. ARCH program personnel have expressed their willingness to help community health nurses, in any community, access resources they need.
- Watch this publication space for articles on this and related topics.

And finally, follow *#NoJournalsNoEBP* on Twitter. This is an active feed where you can find inspiration and information from nurses – and concerned professionals from other disciplines – who want to improve access to the evidence that, in turn, improves practice. Melanie Rogers and her colleagues will be glad to welcome you there. If you are a podcast fan, consider following *Nurse Nation*, which recently interviewed Ms. Rogers. You can find *Nurse Nation* on iTunes or Spotify.

Nurse Nation podcast #8: #NoJournalsNoEBP (May 30, 2019). https://podcasts.apple.com/us/podcast/nurse-nation/id1454833150

Jane Lawless, MLS, BA is the Electronic Resources Librarian and Liaison to the School of Nursing at Curry College.

Pain in children with complex needs

McKenzie K. LaLumiere

Recently, I had the opportunity to work as a student nurse researcher. I worked on a study that involves interviewing parents about their child's expression of pain in children with complex needs (for example, cerebral palsy, brain injury, profound developmental disability, or other special healthcare needs). In addition, we asked these same parents about the experiences they had talking to nurses and other care providers about their child's pain.

Pain in children with complex needs occurs more frequently as compared to typical children, since children with complex needs are more susceptible to painful experiences and undergo many medical procedures. Children with complex needs often cannot clearly express verbally whether they have pain, where or when they are hurting or how bad it hurts. In addition to the communication deficits, these children can also have heightened or reduced pain sensitivity or underlying chronic pain that can complicate diagnosing the cause of the pain. While neuro typical children might display behaviors such as withdrawing from touch or seeking comfort, these pain-related behaviors are different for each child with complex needs.

When children with complex needs present to medical offices or emergency rooms with concerns about pain, there are often many potential causes of pain. Because of children's medical complexity, and limited communication skills, identifying the source of pain can be challenging. Sometimes, however, children with complex have an ear infection or constipation just like typical children. A difference for children with complex needs is that it takes some time to determine the source of the pain, and parents are the ones describing the pain.

As part of the research project, I have been able to listen to and transcribe the parent interviews. Some parents do not feel heard by providers especially when pain goes unrecognized in their children. For example, many parents expressed feeling ignored or not taken seriously by healthcare providers. One parent shared an experience of seeking care for her son, who has reduced pain sensitivity. With the reduced sensitivity to pain, any pain behaviors her son displayed indicate severe pain. The mother shared her observations of her son's discomfort with providers; however, the providers did not seem to believe her description. The providers performed a physical assessment with negative findings and attempted to evaluate his pain reaction to the abdominal assessment. Unfortunately, since he had reduced pain sensitivity the providers initially ruled out conditions requiring intervention. By the time a scan was ordered he had become septic secondary to pancreatitis and needed life support. This was a distressing experience for the family. Researchers and clinicians are working to find best practices surrounding pain diagnoses for these children.

No one wants children to be uncomfortable, or for the source of pain to fester into something that requires surgery or other invasive interventions. Therefore it is essential for nurses and other care providers to understand steps we can take to best support children with complex needs and their families. Some parents appreciated when nurses would speak directly to their children (even though they are nonverbal) instead of speaking over or across them to the parents only. This small gesture of including the children in the conversation helped parents build trust with the nurses, and helped demonstrate that the nurses would make comfort a priority for the child. Additionally, parents felt that nurses and other providers needed to trust their judgment. After all, parents are the experts on their children, know when their child is in pain, and can help us know what their child looks like when they experience pain. Parents appreciated when providers asked parents to share observations of pain and non-pain behavior. Asking for parent input is another way providers can get to know the unique pain behaviors of children with complex needs.

We should continue to identify ways to support stronger, more collaborative partnerships between parents, nurses, and other caregivers. In the future I hope to specialize in pediatrics. I know it will be important to consider how to not only treat the patient, but also their families. It is important to remember that parents are our partners in pain care.

McKenzie K. LaLumiere is a Student, at the University of Massachusetts, Lowell.

clio's corner

MGH nursing history committee receives prestigious Austen award

Our camaraderie is fostered by our shared love of history; by the recognition that nursing's unique history is under-reported; by the many discoveries that we have shared to this point and by the knowledge that there are many more to be made.

Mary Ellen Doona
Susan Fisher

Everyday thousands of people pass the elegant Paul S. Russell MD Museum of Medical History and Innovation at Grove Street as they travel along Cambridge Street. Some are headed to Massachusetts General Hospital (MGH) while the destination of others is City Hall Plaza, Boston Common and beyond. Enlarged photographs of pivotal moments in MGH history, artifacts of once state of the art technology and posters announcing upcoming events and lectures are only a few of the visuals mounted at the glass fronted museum. These exhibits might catch the attention of passersby while at the same time offer a tacit invitation to enter the Museum.

Those arriving at the Museum Wednesday evening 6:00 pm May 29, 2019 strode decisively across its threshold moving towards an event that had been on their calendar for months and perhaps had been anticipated for a year. That event was the Patricia R. Austen RN MGH History Award ceremony. At the creation of the Award in 2017, Peter L. Slavin MD, MGH's President praised Austen's "remarkable efforts to promote and preserve the history of the hospital." Austen, a 1960 graduate of the five-year nursing program at Simmons College first entered MGH for her student clinical experiences. From that moment, Austen recalls, MGH filled her with awe that increased when she joined the nursing staff following graduation, and later served with the Ladies Visiting Committee. It remained a force that energized her helping young professional families acclimatize to Boston and MGH, and later, supported families of patients as they awaited the outcome of treatments. With MGH's Bicentennial (1811-2011) looming in 2000 MGH asked Austen to focus on identifying art and artifacts around the hospital. She and her colleague Ellie Hackett more than met the request as they discovered, identified and documented items of historical value. Austen is justifiably proud of bringing a nurse's sensibility to her interactions with administrators on MGH's History Committee. With what she calls her strong nurses voice, she made sure that nursing would have a prominent place as MGH celebrated its history of healing, discovery and care.

Now twenty years later Austen was in the prominent place. Seated with her family she listened as Dr. John Herman opened the Award ceremonies. He remarked on the number and excellence of the submissions for the Patricia R. Austen RN MGH History Award. This year nursing's history at MGH would be in the spotlight. Marianne Ditomassi RN, DNP, FAAN, Executive Director of Nursing and Patient Care Services Operations, proposed the MGH Nursing History Committee for the 2019 Austen Award. She cited its efforts to preserve MGH nursing history, including the publication of the bicentennial book, *Massachusetts General Hospital: Nursing at Two Hundred.*

Dr. Paul Russell, the former Chief of Transplant Surgery and a major force in creating the Museum that bears his name, spoke of nurses who served during the Crimean War (1854-56) and the American Civil War (1861-64). Then, he recounted a scene he must have witnessed often during his 70-year MGH career - seeing nurses chatting happily together as they left the hospital after having spent hours caring for patients. The image conjured up a sense of nurses as a life force. Russell's remarks led smoothly into those of Susan Fisher RN, a member of the MGH Nursing History Committee and Editor of the MGH SON Alumni Association's *Quarterly Record.*

Thank you, Dr. Russell. And thanks to the selection committee for acknowledging the work of our Nursing History Committee over the past decade. Special thanks also to Patient Care Services for their leadership and support, and to the MGH Nurses' Alumnae Association for their commitment to preserving MGH nursing history. I speak for the Committee when I say that we are grateful for the opportunity to have been given the time, space and tools to do this work.

And the work has been fruitful so far, especially considering our size and diverse points of view. Members include individuals from inside and outside of the MGH community. There are eight alumnae of the MGH SON from the classes of 1953-1976, a number of retired and current employees, a nurse historian, a research librarian, two nurse educators, representatives of the Russell Museum and several administrators. When everyone's favorite meeting comes around each month, the energy around the table is palpable. Our camaraderie is fostered by our shared love of history; by the recognition that nursing's unique history is under-reported; by the many discoveries that we have shared to this point and by the knowledge that there are many more to be made. And there is the "MGH factor." As our colleague Dr. Oliver Wendell Holmes observed in 1850, "This hospital has always inspired the fervid attachment of those holding any relationship to it whatsoever." The genesis of the current committee was the book, Massachusetts General Hospital: Nursing at Two Hundred, begun in late 2009 and published in 2011 for the Hospital's bicentennial (1811-2011). The handout at the first book meeting asserted, "There exists only a minimal amount of written history about nursing at Mass General during the Hospital's earliest years, making a substantial or detailed 'history' book a challenging enterprise." And indeed, the work was challenging, but not because there was so little material, rather because there was so much. From the founding minutes in 1873 to the day the school closed in 1981, materials were saved and then carefully catalogued, packaged and stored away. The archive (43 boxes plus) remained essentially unknown until our work began. The breadth and depth of this preserved history gradually revealed itself and through the work we began to understand the significance of this treasure. The book was a great success, both in the MGH community and beyond, and has won several awards and many accolades.

Our major projects over the past five years have included a tribute to Linda Richards to coincide with the unveiling of her portrait during nurses' week 2014. Richards, America's first trained nurse (1872), was superintendent of our school during its formative years of 1874-77. She set a standard of excellence that continued throughout the life of the school. Her seminal contributions and importance to the MGH had been brought to light during the researches for the book.

Our next major initiative brought a focus to the MGH nurses who served during WWI, over 200 of them. For well over a year, we read, researched and documented source materials from our own archives and beyond. During 2017, the group produced a year-long series of eight articles for the Patient Care Services newsletter, Caring Headlines, featuring stories and photos of individual nurses and accounts of their experiences abroad. Our research also helped to provide context for the WWI displays at the hospital throughout that centennial year.

Another major project was the centennial commemoration of the 1917 Halifax explosion, a disaster to which clinicians in Boston, MGH nurses among them, responded. Through a series of serendipitous connections made through the committee, the anniversary was marked with two days of events honoring first responders and culminating in the lighting of the Halifax tree on Boston Common. We discovered a bright star among our own alumnae, Beth Thompson, class of 1953, whose parents had survived the blast and whose story she shared at ceremonies both in Boston and Halifax and who has become an active member of our committee.

Ongoing projects include the digitization of some of the important materials residing in the school of nursing archives; supporting the gathering of oral histories of MGH nurses. Through various initiatives we continue to uncover and articulate the rich history contained in the lives and careers of nurses who have touched and been touched by MGH.

We are beginning work on preparations to mark the 150th anniversary of the founding of the school in 2023. And there is even talk of a movie.

Finally, I want to say personally it makes me very happy that our Nursing History Committee's name will be right up there under that of Patty Austen, the person who's been such a force in all of the hospital's history efforts for more than twenty years. We thank you.

Fisher accepted the 2019 Patricia R. Austen RN MGH History Award etched on a pane of mariannglass from an original Bulfinch Building window, amid the applause, especially that of her fellow members of the MGH Nursing History Committee. In 2011 MGH SON AA conferred honorary membership on Austen with Fisher saying, "You are one of us." Then she added that the AA was making "official what has been true in fact all these years." The Award and the honorary membership-one she shares with Linda Richards (1841-1930) only adds to Austen's continuing sense of awe of MGH. When everyone gathers for the 2020 ceremonies, the MGH Nursing History Committee's name will already be inscribed on the Patricia R. Austen RN MGH History Award plaque that hangs in the Putnam Gallery of the Paul Russell MD Museum of Medical History and Innovation.

Susan Fisher accepts the Patricia R. Austen MGH History Award with Austen at her right and surrounded by MGH Nursing History Committee members: Roberta Nemeskal, Barbara Dunderdale, Marianne Dittomassi, Georgia Peirce, Sarah Alger, Lucy Ross, Beth Thomson, Martha Stone, Mary Ellen Doona, Mary E. Larkin, Barbara Poremeba. Not pictured are: Ann Collins, Ann Queally, Joanne Hyde and Patricia Beckles.
Credit: Jeff Thiebauth Photography.

who is the masthead nurse?

Mary Macdonald

In 1942 Mary Macdonald (1918-2000), a Worcester MA native, added a diploma from Massachusetts General Hospital School of Nursing to her degree in the sciences from Emmanuel College. She was in demand in the post WW II (1941-1945) transformation of nursing education serving on the faculty of Boston College (opened in 1947) and then at UMASS Amherst (opened in 1953). She continued her own education during this time earning a graduate degree and pursuing doctoral studies. BC President Michael Walsh SJ and MGH's John Knowles MD, both sought Macdonald to lead nursing at their institutions. Macdonald chose MGH and after analyzing its nursing services, instituted the profession's refocus on its primary function: patient care. Direct care is now so obvious an absolute that it is hard to realize a time when it was not. On May 1, 1973 Macdonald led 5000 nurses at Faneuil Hall objecting to Governor Francis Sargent's plan to abolish the Board of Registration of Nursing (BORN). Seventy years before on February 26, 1903, Macdonald's fellow MGH alumna, Mary E. P. Davis (c1840-1924) Class of 1878, rallied nurses to create the Board and on that day nurses founded the Massachusetts States Nurses Association now known as ANA Massachusetts.

ANAMASS Awards continued from page 1

Scholarships

Ruth Lang Fitzgerald Memorial	• Established in memory of Ruth Lang Fitzgerald, a longtime ANAMASS member. • Up to $1,000 awarded for: A humanitarian aid project, a special interest or attendance for a conference. • ANAMASS membership required
Arthur L. Davis Publishing Agency	• $1,000 given through the generosity of our publishing partner for tuition and fees. • ANAMASS membership required. • Pursuing a degree in nursing or a child or significant other of member accepted into a nursing program. • Deadline is March 17th.

Scholarship Application Process

- Access the application at www.anamass.org
- Submit the application electronically or by mail by **January 22, 2020** for Fitzgerald Scholarship; **March 17, 2020** for Davis Scholarship
- If you have any questions, or need help, call ANAMASS at 617-990-2856

Save the Date

Spring Awards Dinner

Friday, May 8th 2020

at the Royal Sonesta Boston

Health policy committee update

Christina Saraf, RN, MSN, CNL &
Arlene Swan-Mahony, RN, DNP, MHA, BSN
Co-Chairs, Health Policy Committee

The ANAMASS Health Policy Committee has been quite busy this spring. As this is the beginning of the new legislative calendar, our committee has the responsibility to identify bills that will affect the healthcare concerns of all in the Commonwealth as well as the nursing profession. So what does this entail? In partnership with our lobbyists from Lynch & Fierro, the committee reviewed over 40 bills that were filed in January and selected twelve key bills for ANAMASS to focus our efforts. Each bill requires thorough analysis, with discussion to support or oppose, tracking the movement of the bill and monitoring dates of hearings. Both written and verbal testimony will be prepared for each bill and involvement with our membership and partners in determining strategies for testimony. Testimony has already been presented for three bills, including (1) representation of a registered nurse on the Health Policy Commission and (2) Nurse Licensure Compact and (3) Act strengthening the penalty for assault and battery on an emergency medical personnel or health care providers. Below are the legislative priorities for 2019-2021. We are always looking for new members who are interested in health policy to join our committee. Please reach out to Christina or Arlene to find out more.

ANAMASS Legislative Agenda 2019-2021

HB2664/SB701

An Act relative to the governance of the Health Policy Commission

This bill governs the makeup of the health policy commission, to add a new twelfth member, the fourth to be appointed by the governor, who is to be a registered nurse licensed to practice in Massachusetts in a patient care setting, appointed for a term of five years. Also adds a new thirteenth member to be appointed by the attorney general, who is to be an individual having an advanced degree in public health who has expertise in implementing strategies to eliminate health care disparities, appointed for a one-year term.

HB1941/SB1345

An Act establishing a commission on quality patient outcomes and professional nursing practice

This bill establishes a 17-member Commission on nurse staffing in hospitals to review and make recommendations regarding best nurse staffing practices designed to improve the patient care environment, quality outcomes, and nurse satisfaction; locates the Commission within, but not subject to the control of the Executive Office of Health and Human Services; articulates the qualifications and terms of Commission members; identifies several areas of examination for the Commission relative to nurse staffing levels; requires the Commission to file an annual report with the Legislature by March 1.

HB1944/SB103

An Act relative to nurse licensure compact in Massachusetts

This bill increases public access to safe nursing care, provide for the rapid deployment of qualified nurses in response to a state of emergency, address the emerging practice of nursing through telecommunications technology, support spouses of relocating military members, and build effective interstate communication on licensure and enforcement issues.

HB3487/SB1213

An Act relative to safe patient handling in certain health facilities

This bill adds new provisions that regulate the lifting of patients in both acute care and long-term care facilities. In particular, the bill defines a lift team as health care facility employees specially trained to handle patient lifts, transfers and repositioning using lifting equipment when appropriate and precluded from performing other duties, and establishes 35 pounds as the maximum recommended weight lift limit established by the National Institute for Occupational Safety and Health. The bill further requires each health care facility to establish a safe patient handling committee to design and recommend the process for implementing a safe patient handling program. By December 30, 2020, health care facilities must complete the acquisition of safe patient handling equipment. In addition, the development of architectural plans for constructing or remodeling a health care facility or a unit of a health care facility must incorporate patient handling equipment and the construction design needed to accommodate such equipment.

HB1867

An Act to support access, value and equity in health care (SAVE Act)

This bill expands the authority of nurse practitioners to dispense, administer or conduct research on controlled substances by removing the requirement that they do so under the supervision of a physician; gives the Board of Registration in Nursing the sole authority for regulating the practice of nurse practitioners by removing the requirement that the board of registration in medicine concur; removes certain restrictive time limitations on writing prescriptions by nurse practitioners; updates the Nurse Practice Act to reflect that nurse practitioners are authorized not only to order tests and therapeutics, but also to interpret them.

HB1578/SB838

An Act strengthening the penalty for assault or assault and battery on an emergency medical technician ambulance operator, ambulance attendant or health care provider

This bill increases penalty to include imprisonment in a state prison up to five years and strikes out "treating or transporting" to make more universal i.e. not just during those times.

SB683

An Act establishing Medicare for all in Massachusetts

This bill establishes a new chapter 175L, the Massachusetts Health Care Trust, in the General Laws, which would create a single-payer system for health care in Massachusetts. The bill establishes a Massachusetts Health Care Trust, which will be the single-payer body responsible for the collection and disbursement of funds required to provide health care services for every resident of the Commonwealth.

HB1976/SB1093

An Act requiring health care facilities to develop and implement programs to prevent workplace violence

This bill relates to the safety of healthcare employees; directs the department of public health to develop statewide standards for evaluating and addressing known security risks in different healthcare settings; requires health care employers to develop and implement programs to minimize the danger of workplace violence in accordance with the DPH standards; requires health care employers to designate a senior manager to oversee the development of such programs and an in-house crisis response team for employee victims; establishes criminal penalties for committing assault or assault and battery on emergency medical technician, ambulance operator, ambulance attendant or a health care provider; requires health care facilities to allow employees who were victims of violence to take unpaid time off to seek or obtain victim services, legal services, obtain a protective order or participate in legal proceedings; directs EOHHS to coordinate with EOPSS to develop a system allowing the sharing of records to facilitate patient care, security risk assessments and planning and healthcare operations.

HB1902/SB1279

An Act regulating flavored tobacco products

This bill prohibits the sale and distribution of flavored cigarettes to any consumer or any flavored tobacco products to any consumer, except in a smoking bar.

"Flavored cigarette," any cigarette, or any component part thereof that contains or imparts a characterizing flavor.

SB589

An Act relative to limits on insurers' retroactive clawbacks for mental health and substance use disorder services

This bill regulates the use and coverage of step therapy protocols in medical treatment; defines step therapy protocols as a specific sequence in which prescription drugs for a specified medical condition and which are medically appropriate for a particular patient are provided; establishes and regulates the membership of a special commission to study and assess the implementation of step therapy process reforms; requires submission of findings and recommendations within nine months; regulates the evaluation of step therapy

Health policy committee update continued on page 12

Let's put the mouth back into the body…

Flor Piedrasanta

It is well known among dental professionals that Early Childhood Caries (ECC) is the most common chronic childhood disease in the United States and that half of the adult population has some form of periodontal disease. This, however, is not common knowledge among all healthcare professionals. Physicians, nurse practitioners, registered nurses, licensed practical nurses, physician assistants and medical assistants are essential members of the healthcare team with a combined wealth of knowledge who often are unaware of the importance of oral health as it relates to overall health.

As a registered dental hygienist in Massachusetts I often see the devastating effects of poor oral health, especially in young children. Poor oral health has been linked to uncontrolled diabetes, heart disease and pre-term labor in adults and ECC has been linked to failure-to-thrive in young children. Signs of systemic illness can be visible inside the mouth and oral infection and periodontal disease can negatively affect someone with an existing illness making symptoms worse. It is very important that oral health is not forgotten. Given that it is a significant contributor to a patient's overall health regardless of age, prevention and education efforts need to start early.

Routine preventative care and early intervention are important for maintaining good oral health. The American Dental Association recommends that a child's first dental visit be within six months of the first erupted tooth or by the age of one. Unfortunately, I have heard, time and time again, from caregivers that they did not know to bring their child in for a dental exam or dental prophylaxis, until it was too late and there were already problems. Medical professionals are typically the first providers that children see for care, and do so with more frequency especially during infancy, approximately eight times by the age of one. Therefore, medical professionals are in a unique position to refer a patient to a dental professional for preventative oral health care or early intervention by providing anticipatory guidance and current recommendations.

Some recommendations include:

- Brushing two times a day starting at eruption
- Caregivers should brush the child's teeth until about eight years old
- After brushing, spit out only, do not rinse with water
- Children under three years of age should use a smear (or size of a grain of rice) amount of fluoridated tooth paste
- Children over three years of age should use a small pea size amount of fluoridated tooth paste
- Establish a dental home by the age of one

Currently there is an effort in the state of Massachusetts to implement an oral health component such as the application of fluoride varnish during 'Routine Child Health Check' visits. As an Outreach Coordinator for the MassHealth Dental Program, I travel across the state and conduct trainings on oral health and fluoride varnish application for pediatric and family physicians and provide support in their efforts to implement an oral health component in their office. During this training, the entire staff has the opportunity to learn more about the oral and systemic link that exists so they too can direct patients to a dental home and establish good oral health habits for both themselves and their patients, contributing to overall wellness. Additional resources are provided to include printed material and an online module that awards continuing education credits through smilesforlifeoralhealth.org.

Medical practices also benefit from the integration of dental into medical. The application of fluoride varnish is reimbursable by MassHealth Medicaid program at $26 for eligible members under the age of 21. The cost of purchasing fluoride varnish ranges from $1.00 to $2.50 per dose. This is considered a medical reimbursement and does not affect dental benefits. The low cost of fluoride varnish and the little time needed to apply the material on teeth makes this treatment not only a great service for the patient, but also financially sound for the practice.

As members of the healthcare team, nurses and medical assistants spend a great deal of time with patients; they are often the ones that caregivers and patients ask questions to, before and after, the physician leaves the room. Being prepared with appropriate oral health information, having the ability to apply fluoride varnish and feeling comfortable with discussing current oral health recommendations is beneficial to the patient and the practice. If your medical practice is still not providing fluoride varnish please encourage them to do so. It's time to put the mouth back into the body.

For information about oral health and fluoride varnish trainings for health care professionals contact me, Flor Piedrasanta, RDH at 617-886-1797 or via email at flor.piedrasanta@greatdentalplans.com

References

American Academy of Pediatrics, Bright Futures. (2019) Recommendations for Preventative Pediatric Health Care. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

American Academy of Pediatric Dentistry. (nd) Oral Health Policies and Recommendations. https://www.aapd.org/research/oral-health-policies--recommendations/

American Dental Association. (2000) Statement on Early Childhood Caries. https://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/statement-on-early-childhood-caries

Chapple ILC, Genco R, and on behalf of working group 2 of the joint EFP/AAP workshop. (2013) Diabetes and periodontal diseases: consensus report of the Joint EFP/AAP Workshop on Periodontitis and Systemic Diseases. J Clin Periodontol (Suppl. 14): S106–S112. doi: 10.1111/jcpe.12077.

Colak, H., Dülgergil, C. T., Dalli, M., & Hamidi, M. M. (2013). Early childhood caries update: A review of causes, diagnoses, and treatments. Journal of natural science, biology, and medicine, 4(1), 29–38. doi:10.4103/0976-9668.107257

Elice C E, Fields H W. (1990) Failure to thrive: review of the literature, case report and implications for dental treatment. Pediatric Dent 12:185–189.

Linda L. Humphrey,L.L., Fu, R., Buckley, D.I., Freeman, M., Helfand, M., Periodontal Disease and Coronary Heart Disease Incidence: A Systematic Review and Meta-analysis. J Gen Intern Med (2008) 23: 2079.

Saini, R., Saini, S., & Saini, S. R. (2010). Periodontitis: A risk for delivery of premature labor and low-birth-weight infants. Journal of natural science, biology, and medicine, 1(1), 40-2.

Sheiham, A. (2006) Dental caries affects body weight, growth and quality of life in pre-school children. British Dental Journal volume 201, pages 625–626

U.S. Department of Health and Human Services. (2000) Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

Flor Piedrasanta, RDH is a registered dental hygienist and the Outreach Coordinator for the MassHealth Dental Programs.

Leaping from RN to NP

Rachel Mortell

Nursing is a versatile career, and for me, as a bedside nurse in a Pediatric Intensive Care Unit, the next goal was to become a nurse practitioner (NP). After the excitement of completing school and boards, the adventure continued as I started in my first NP position about one year ago. In my novice assumption, as a bedside nurse with years of experience, I expected a smooth transition in what seemed to be the next logical step from my current position. But let me tell you, the struggles were real!

Struggle 1: "You do what with this?" (The learning curve)

NP school teaches us the basics of safe practice and provides us with the tools and skills of advanced practice such as assessment and pharmacology. But in an acute care hospital with many specialties, most of the training is done on the job. In my case, I learned something new every day, and continue to do so a year later. The initial feelings of overwhelming unknowing and "feeling my way through the dark" was rather unsettling in a new environment. My patients were no longer right next to me while I worked at the bedside. Rather they were scattered throughout the hospital. I see my patients in snapshots throughout the day or through the electronic record. My trust is in their nurses. Luckily my fellow NP's and physicians are my beams of light, leading me to the right answers and guiding me through procedures or the thought processes needed to be successful in this new NP role.

Struggle 2: "Here comes the expert!" (Portraying and building confidence)

The shock hits when you are starting out again in a new role. You are being consulted to help manage patients that are in distress. You are making decisions about patients and their care. You have to learn to say "no" in a sensitive way. All of these scenarios require some form of confidence - in the decision you ultimately make, in the way you explain rationales to patients, families, or multidisciplinary teams. What I had to do was re-learn my environment and elevate my skills in order to rebuild confidence in this new role. It is something that definitely takes some time and is ongoing.

Struggle 3: "Tell me that again?" (Communicating effectively)

As an RN, I felt like I talked all day long, filling the silence, keeping patients company, speaking with multiple teams, educating, supporting, comforting, joking, etc. The talking continues, but I find myself using my words differently. Nurses have much power and purpose in their words. As a new NP, I had to find that stronger voice (back to confidence again), and provide very clear, concise, and direct content. Each verbal interaction requires careful attention. I have found that my communication skills have improved, as NP's are held to high standards and expectations. Like Don Miguel Ruiz says, "be impeccable with your word."

Struggle 4: "Help!" (Managing expectations)

As in all healthcare scenarios, managing patients' and multidisciplinary teams' expectations is an ongoing process. Families and medical teams expect efficacy and results. As both RNs and NPs, we often have to be the problem solvers, strategizers, or navigators through challenging situations. In the NP role, there feels like there is a different level of expectation, trust and knowledge demanded from our patients and peers. Asking for help and offering assistance is crucial in supporting one other. This is an ever long and ongoing process in each individual NP, and in this new role it is something I am eagerly adapting to.

Conclusion

As you may imagine, the RN to NP role transition can be rather stressful. However the wealth of new knowledge and experience makes the transition valuable and exciting. In alignment with Patricia Benner's Stages of Clinical Competence, transitioning into a new NP basically results in a period of what she describes as "novice" and "advanced beginner" proficiency stages again (Benner, 1984). I've had to accept this and move through these four aforementioned struggles, but it is not impossible with adequate encouragement and support! It's a challenge and a great accomplishment to realize you can become a competent and productive new NP if you do the work to improve your skills and knowledge. Of course, it is comforting to be that proficient or expert nurse at the bedside, but why not throw some challenges at yourself and take the leap into advanced practice nursing?

Reference:

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park: Addison-Wesley, pp.13-34.

Rachel Mortell is a nurse practitioner at Boston Children's Hospital, Anesthesia Department, Pain Division.

Understanding Addiction

Kate Genovese

My name is Kate Genovese. I have been a registered nurse for over thirty years in many different areas, mainly hospitals then the Visiting Nurse Association (VNA) to case management and school nursing to name a few.

I was brought up in a large catholic family west of Boston. As a little girl I was use to seeing alcohol being served, so it seemed normal to me when I got older-people drink. Some are alcoholics. Others drink only socially. When I took care of patients as a student, none of this seemed foreign to me and if a patient told me he had five cases of beer a week, I didn't judge, but wondered why he needed so much alcohol and if it was killing his liver? As the years went on, I realized a lot of illnesses were arising from people's lifestyles such as cirrhosis of the liver, Hepatitis C, and pancreatitis.

At that time, most health care providers were uneducated about substance abuse. It wasn't looked at as a disease but a choice. I would get frustrated with patients when they promised me they would go to an Alcoholics Anonymous (AA) meeting but a month later they were back, vomiting up blood from too much drinking. They couldn't seem to stop. I would hear comments from nurses such as "he did it to himself, I don't feel sorry for him." I would hear that statement more often than not.

My eyes became wide open about addiction when my son Christopher, better known as Geno became addicted to Oxycodone in 2012 after taking Oxycodone from numerous hockey and football injuries and surgeries. Then I realized addiction was a disease. When Geno was taking Oxycodone, he was a different person; he would never say and do some of the things he did if he was straight. In his early twenties he stopped using, cleaned himself up and got a good job, great girlfriend and I thought the days of addiction were over. Unfortunately he relapsed, this time with stronger drugs; heroin mixed with Fentanyl. He died of an accidental overdose in May of 2016 from inhaling the drugs.

When I finally was able to go back to work, I couldn't help but notice that not much had changed with nurses' views on addiction. I could feel their anger and frustration when they had to take care of a substance abuser and this was his fourth overdose. One particular nurse simply thought this was a choice-once again, he could stop if he wanted to.

That was three years ago. I am no longer working in patient care and wondered if my colleagues still feel the same way after the addiction crisis has become an epidemic. I wanted to know. So, I put it on Facebook. I wanted to hear their stories and opinions of this latest epidemic. Two hundred men, women and teenagers die every day from overdoses. I got an amazing response and I was very proud of my profession. They were educating themselves on this disease of substance abuse. "How could I not learn about it" one nurse said. Her 26-year-old brother died of an overdose; his story was similar to my sons. Another nurse told me; four young men died in his town in one week.

After reading over one hundred responses, I knew nurses and other caretakers were not "labeling" the addict, but relating to the person with a disease. A friend who works in a detoxification center said "it's the worst disease I have ever seen; the patient comes to our facility after overdosing and straighten up for two weeks, then before you know it they're being readmitted because they just can't stay sober."

My son tried to heal himself but he just couldn't seem to stop-but there were demons he was fighting and they won in the end. He was a wonderful son and friend who had a bad disease that took his life. I was told the emergency room staff did everything possible to save him; tears flowed in some of the nurse's eyes as they hugged his friends.

It's a tough disease-a frustrating one for health care workers but times are changing as our country watches more deaths everyday from substance abuse and deaths.

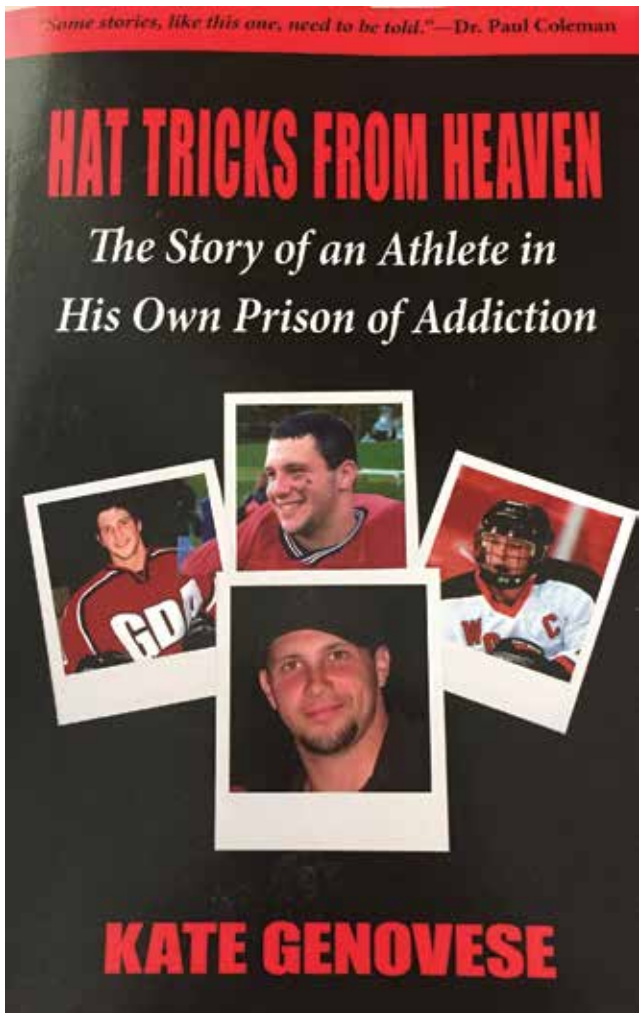
Nurses can be a valuable resource to the abuser when they are hospitalized. Often times they are the ones who can sit and talk to them, or just listen to their story. Our profession is needed now more than ever as they are changing their attitudes about addiction and treating the person with respect and dignity and helping them not to feel shame.

I recently watched the show ADDICTION that was on NOVA channel 2. It was a documentary that every health care worker should be mandated to watch. It shows what happens to the brain with alcohol and drugs and why the substance abuser has a craving so intense that makes them steal from their families, rob banks even kill for money.

I hope someday there will be a cure for this disease. Where there is life there is hope.

Kate Genovese is a nurse and the author of HAT TRICKS FROM HEAVEN- the story of her son, Christopher John Genovese, known as "GENO."

Book Review: Hat Tricks from Heaven



Gail Deterling

Hat Tricks from Heaven, The Story of an Athlete in His Own Prison of Addiction, is a story told with straightforward honesty, simple clarity and raw human emotion. Author, Kate Genovese, speaks from the heart as a mother, and with the authority of a nurse, as she unveils her life story and that of her son, Geno.

Christopher John Genovese, who preferred to be called Geno, was a popular, handsome star athlete, a private high school and college graduate, surrounded in life by friends and family, who became the victim of an accidental drug overdose at the age of thirty. This story is very timely, given the toll that the opioid epidemic has had on so many young people and those who love them, particularly in our home State of Massachusetts.

Geno suffered several injuries to his shoulders and knees, which led to multiple surgeries over many years. Percocet® would be legitimately prescribed for post-operative pain, but Geno continued to play football and hockey through the chronic pain and got to the point where he would self-medicate before games, and at intervals during them. His mother eventually began to notice that her own narcotics, which had been prescribed for her own post-operative pain, began to disappear, despite having hidden them. Over time, Percocet® became too expensive, so Geno moved on to cheaper heroin.

Like his older sister and brother, Geno was raised by parents who were attentive, loving and very much involved in their children's lives. They participated in sports and volunteer activities, and were taught to put their best effort forth, in whatever endeavors they chose to undertake. Like any good parents, Mr. and Mrs. Genovese made sacrifices, and invested time and hard earned money, in order to provide for their children and to give them the best opportunities for success.

They spoke to their children about the very real danger of drugs and alcohol, knowing from personal experience in their younger years before children, where that involvement could potentially lead. The author reveals a great deal of personal history, as she allows the reader into her life and that of her immediate and extended family. In doing so, she shares the ups and downs of caring for and loving an addicted child.

Early signs that something was amiss occurred during freshman year of high school, when Geno's football coach and mother independently noticed that he was acting differently. He wasn't as attentive on the playing field, was less communicative with his parents, and at times, appeared sad. When asked about this, his response was that he would work things out on his own.

Mrs. Genovese discussed the means by which her son had access to, as well as the ability to purchase drugs, which began as experimentation with alcohol and marijuana in grade 8. Geno had a cousin who used drugs and they often spent time together. Despite having money from various odd summer jobs, Geno still asked his parents for money. During college, he would take money from his joint account with his mother, who because she trusted him, didn't keep that close of an eye on it. Mrs. Genovese frequently asked surgeons to stop prescribing Percocet®, informing them that addiction ran in the family. She tells of an incident in which her concern was once responded to with the comment that Geno wasn't an addict, and she should stop hovering over him.

While none of this is unusual in the life of someone who is drug dependent, it is the author's revelation of how the medical profession may have inadvertently contributed to her son's addiction during the span of years when Geno had six surgeries that makes us as nurses, take pause and reflect.

During his junior year at Governor Dummer Academy, an English teacher contacted Mrs. Genovese to express his concern about an essay that Geno had written about a family in which three children had been sexually abused by an uncle. As we later learn, this was a demon with which Geno struggled greatly. He confided to his mother that playing sports, despite pain and injury, was how he dealt with the memory and resulting anger. It was during a conversation about this that Geno talked of needing more narcotics for knee pain, because it not only alleviated his pain, but also helped rid of the memories of abuse.

The lack of access to an adequate supply of treatment programs, the months long waiting period when one is found, the time it takes for an addict to agree to submit to treatment, and the restrictions placed by insurance, made it difficult for Geno to access the treatment he needed, once he agreed to it. Kate Genovese recounts in vivid detail the effort she expended in her attempt to seek the help Geno so desperately needed. In addition to researching programs, she took the unusual steps of contacting the DEA (Drug Enforcement Agency) and the Middlesex Sheriff's Office for any assistance they might provide. The end result, however, was disappointment.

Hat Tricks from Heaven is a very personal account of a life lost to drugs, and the effect it has on the user, as well as those who care for and love that individual. It informs us of the warning signs that one might be using drugs and the problems that result from doing so. In the case of Geno, it was loss of jobs following college, loss of relationships with an older brother and caring and responsible girlfriends, incarceration, house arrest, and probation.

The author provides clear illustrations of the various behaviors a user might resort to- including lying, stealing, manipulation, angry outbursts, denial, and broken promises to stop using. Through it all, Kate Genovese never places blame on anyone for her son's addiction, and is careful to appropriately refer to addiction as an illness. Her story is one of humility, compassion, courage and above all else, love.

Gail Deterling is a nurse at Boston Children's Hospital that cares for children with chronic pain conditions.

caring corner

Exploring self care

Pam Cormier, MSN, RN, AHN-BC

Nursing as a profession can be tremendously rewarding and fulfilling but nurses also know the job can take a toll on our own health and wellness. Nurses provide amazing care for others yet often struggle to do the same for themselves. There is growing research which shows burnout and compassion fatigue are an all too common phenomena among nurses, yet to many nurses, the concept of putting yourself first and practicing self-care feels selfish and almost wrong. The American Nurses Association Code of Ethics states that nurses "owe the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth." [1]

Nursing Theorist Jean Watson writes "My work on the Theory of Human Caring is founded on the principle that practicing kindness, compassion and equanimity toward yourself is an important process to go through before you can be caring, loving and compassionate — or caritas — toward another person. Self-care is integral to a nurse's job." [2]

A little over a year ago, I had the opportunity to immerse myself in Watson's Theory of Human Caring. This theory, often recognized by the 10 Caritas Processes, which facilitates healing, honors wholeness and contributes to the evolution of humanity (Watson 2008), is the framework I have built my nursing practice around. As a Caritas Coach and a certified advanced holistic nurse, I am passionate about nursing care which promotes health and wellness and enables people to reach their fullest potential. In my work as a professional development manager, my "patients" are typically nurses. I see my role as promoting and providing care for the people who care for patients.

The first Caritas process is "Cultivating the practice of loving kindness and equanimity toward self and others."[3] Watson is intentional in placing self first; if you do not take care of yourself and your own wellness, you cannot effectively care for patients. Equanimity refers to balance and, in this process, Watson is referring to the balance of your mindbodyspirit in all aspects of your life. When talking about self-care, equanimity and wellness will look different for each unique individual. Activities or practices that nourish my mind-body-spirit may be irritants to someone else. Personal reflection is helpful in identifying ways to rebalance and reconnect with yourself and what brings you joy. I want to share with you a 5-step "nursing process" to evaluate your own self-care habits and develop a plan to implement a new practice to nurture you.

1. ***Complete a self-care assessment*** (see page 11) by considering the following:
   - What types of activities do you regularly engage in that contribute to your well-being, enjoyment and health?
   - How do you care for your emotional life?
   - Do you pay attention to your spiritual needs?
   - Are you exercising, eating well, going on vacation, or otherwise doing things that move the wellness needle in a positive direction?
   - Take a few minutes and rate your self-care using an assessment tool. (There are many self-care assessment tools easily found on the internet you can use to assist you with this.)
2. **Diagnose a self-care deficit:** Honestly and transparently examine the items in the self-care tool where you scored. This will help you target your self-care plan to areas where you may need some work.
3. **Plan a course of action:** Think about what could bring a neglected aspect of your life into balance. No matter where you choose to start, there are actions you can implement to improve your overall health and happiness. However, I caution you to be thoughtful and reasonable about the plans you make. No one can sustain numerous lifestyle changes all at once.
4. **Implement the plan:** Choose one or two things on your list that are meaningful and enjoyable to you. Develop a plan to increase that activity (or even start doing it at all). Be specific but reasonable with your self-care goals. For example, if your self-care goal is to have more time in nature, you could set an achievable and measurable goal, such as: "I will hike in one of my favorite nearby hiking spots twice weekly over the next three months." The specificity of the plan is crucial; make it specific, measurable, achievable, action-oriented, and time-sensitive.
5. **Evaluate your progress:** Finally, when you've initiated your interventions, evaluate your progress and how you're doing overall. If your goals were too lofty, adjust your plan. Perhaps two hikes a week was too much right now, so you cut back to one and feel absolutely thrilled if you sometimes manage to do more. The key is not to judge yourself when you need to adjust your plans. Evaluating effectiveness and making changes to your plan is what you do when working with patients, this is no different. Watson states "When nurses are practicing self-care, they have more compassion, are less judgmental of themselves and are, therefore, less likely to judge others."[2]

The practice of loving kindness and equanimity toward self and others is the first process and cornerstone of Watson's Human Caring theory. Taking time to explore new activities or renew old habits is a great way to nourish yourself and ensure you will have plenty of compassion to care for your patients who need your unique gifts and talents.

References:
1) https://anacalif.memberclicks.net/assets/Events/RNDay/2016%20code%20of%20ethics%20for%20nurses%20-%209%20provisions.pdf
2) https://www.nurse.com/blog/2018/06/11/caring-science-starts-with-self-care/
3) Watson, J. (2008). Nursing: the philosophy and science of caring. Boulder: University press of Colorado

Pam Cormier is a Professional Development Manager for Primary Care Nursing at Brigham and Women's Hospital.

Decreasing nurse's stress and burnout

Barbara Belanger

The impact of stress and burnout on nurses is enormous:

- 98% nurses reported their work is mentally and physically demanding
- 85% nurses reported their work makes them fatigued
- 63% nurses noted that their work causes burnout
- 44% nurses reported being worried that their fatigue will impact patient care
- 41% nurses considered changing hospitals due to burnout (Dekeyrel, 2017)

Causes of stress and burnout in the nursing work environment include:

- Incivility
- Exclusion as part of the team
- Group dynamics and hierarchical stratification and bullying behavior
- Lack of work-life balance
- Inadequate distribution of acuity in patient care assignment leading to fatigue
- Self-sacrificing nature
- Poor self-esteem secondary to fear of rejection and devalued by leadership (AORN, 2018; Blum, 2014; Bowles, 2019; Sadler, 2018).

The Institute for Healthcare Improvement developed the Quadruple Aim to promote a healthy work environment and work-life balance for providers with a goal to reduce stress, burnout and turnover (Bodenheimer & Sinsky, 2014). Self-care is a central strategy with multiple approaches. Meditation and stress relaxation methods have been piloted as class, lecture, and technology (app for self-care) approaches with intergenerational clinical nurses (Blum, 2014). Success to reducing stress and create a healthy nursing work environment may be sustainable using Kaizen to implement effective self-care initiatives at the point of care (Brown, 2013). Several organizations advocate for the endorsement of resources/tools that promote the health and professionalism of nurses in all practice areas:

- American Nursing Association (ANA) initiative for *Healthy Nurse, Healthy Nation Grand Challenge* initiative (2019).
- "The Quadruple Aim aligns with the American Nurses Credentialing Center's Magnet standards in the components of leadership, structural empowerment, professional practice, and innovation described 35 years ago…" (Bowles, et al., 2019).
- Since 2001, the American Association of Critical-Care Nurses (AACN) has advocated for an evidence-based healthy work environment that promotes excellence in nursing practice and positive patient outcomes (2005).
- Association of periOperative Registered Nurses (AORN) recognizes the presence of burnout and harm from not coping (2018).

Change will not be easy. It requires an inclusive team effort.

References
American Association of Critical-Care Nurses (AACN). (2005). AACN standards for establishing and sustaining healthy work environments: A journey to excellence. Retrieved from www.aacn.org/
American Nurses Association (ANA). (2019). Healthy Nurses, Healthy Nation. Retrieved from https://www.nursingworld.org/practice-policy/work-environment/health-safety/healthy-nurse-healthy-nation/
Association of periOperative Registered Nurses (AORN). (2018, May 23). Burnout: Managing nurse/life balance. Retrieved from https://www.aorn.org/about-aorn/aorn-newsroom/periop-today-newsletter/2018/2018-articles/burnout-managing-nurse-life-balance
Blum, C. A. (2014). Practicing Self-Care for Nurses: A Nursing Program Initiative. *OJIN: The Online Journal of Issues in Nursing.* 19 (3), Manuscript 3. DOI: 10.3912/OJIN.Vol19No03Man03
Bodenheimer, T., and Sinsky, C. (2014, November). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine,* 12(6), 573-576. doi: 10.1370/afm.1713
Bowles, J. R., Batcheller, J., Adams, J. M., Zimmermann, D., and Pappas, S. (2019, April-June). Nursing's leadership role in advancing professional/practice work environments as part of the Quadruple Aim. *Nursing Administration Quarterly;* 43(2). 157-163
DeKeyrel, A. (2017, April 13). Is Nurse Burnout on the Rise? Startling Statistics on Nurse Well-Being. [Post] Retrieved from https://www.mededwebs.com/blog/
Institute for Healthcare Improvement (IHI). (2019). Retrieved from http://www.ihi.org/
Sadler, D. (2018, November). Burnout and bullying. *OR Today.* 18 (1), 44-47.

Barbara Belanger is an operating room nurse at Massachusetts General Hospital.

Self-Care Assessment Worksheet

The following worksheet for assessing self-care is not exhaustive, merely suggestive. Feel free to add areas of self-care that are relevant for you and rate yourself on how often and how well you are taking care of yourself these days. When you are finished, look for patterns in your responses. Are you more active in some areas of self-care? Do you tend to ignore others? Are there items on the list that hadn't even occurred to you? Listen to your internal responses and dialogue about self-care, and take note of anything you would like to prioritize moving forward. Using the scale below, rate the following areas in terms of frequency:

Physical Self-Care	5 Frequently	4 Occasionally	3 Rarely	2 Never	1 Never occurred to me
Eat regularly (e.g. breakfast, lunch and dinner)					
Eat healthfully					
Exercise					
Get regular medical care for prevention					
Get medical care when needed					
Take time off when you are sick					
Get massages or other body work					
Do physical activity that is fun for you					
Take time to be sexual					
Get enough sleep					
Take vacations					
Wear clothes you like					
Take day trips or mini-vacations					
Get away from stressful technology e.g pagers, telephones, email					
Psychological Self-Care	5	4	3	2	1
Make time for self-reflection					
Have your own personal psychotherapist or counselor					
Write in a journal					
Do something at which you are a beginner					
Take a step to decrease stress in your life					
Read literature that is unrelated to school					
Let others know different aspects of you					
Notice inner experiences—thoughts, dreams, judgments, imagery, feelings					
Engage your intelligence in a new area, e.g. museum, performance					
Practice receiving from others					
Be curious					
Say "no" to extra responsibilities sometimes					
Spend time outdoors					
Emotional Self-Care	5	4	3	2	1
Spend time with others whose company you enjoy					
Stay in contact with important people in your life					
Treat yourself kindly e.g. supportive inner dialogue or self-talk					
Feel proud of yourself					
Re-read favorite books, see your favorite movies again					
Identify comforting activities, objects, people, relationships, places and seek them out					
Allow yourself to cry					
Find things that make you laugh					
Express your outrage in in a constructive way					
Play					
Spiritual Self-Care	5	4	3	2	1
Make time for prayer, medication and/ or reflection					
Spend time with nature					
Participate in a spiritual gathering, community or group					
Be open to inspiration					
Cherish your optimism and hope					
Be aware of intangible (nonmaterial) aspects of life					
Try at times not to be in charge or the expert					
Be open to mystery and not knowing					
Identify what is meaningful to you and notice its place in your life					
Have experiences of awe					
Sing					
Express gratitude					
Listen to inspiring music					
Read inspirational literature (talks, music, etc.)					
Workplace/professional Self-Care	5	4	3	2	1
Take time to eat lunch with co-workers					
Take time to chat with co-workers					
Make time to complete tasks					
Identify projects, tasks that are exciting, growth promoting, rewarding					
Get regular supervision or consultation					
Negotiate for your needs such as benefits and pay raises					
Develop a peer support group					

Adapted by BWell Health Promotion from: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

Based on this assessment, develop a self-care plan

List self-care habits you are using to manage stress and stay healthy

- i.e. I get at least 8 hours of sleep at night
-
-

List self-care habits you would like to use but are not currently practicing:

- i.e. Practice yoga regularly
-
-

Identify the obstacles keeping you from practicing these habits:

- i.e. I don't practice yoga regularly because I don't have time
-
-

What solutions can you come up with to address the obstacles you listed:

- i.e. Replace watching TV with Yoga
-
-

Reread the self-care habits you wrote down for item 2. Select one of the habits you would like to begin practicing and complete the sentences.

Today, I commit to…

I want to do this because…

I will accomplish this by...

Massachusetts Action Coalition receives funding for innovative work to help nursing build a healthier America

Pat Crombie

The Massachusetts Action Coalition (MAAC) is among 12 organizations in the United States that will receive up to $25,000 each for work addressing nursing's role in building a Culture of Health and promoting health equity, the Future of Nursing: *Campaign for Action*, an initiative of AARP Foundation, AARP, and the Robert Wood Johnson Foundation (RWJF), announced. The Innovation Fund winners were selected based on submissions of replicable strategies that help nurses build a Culture of Health and promote health equity and well-being, while highlighting the importance of collaboration with diverse stakeholders.

The competition was limited to the *Campaign's* state-affiliate "Action Coalitions," or organizations designated by Action Coalitions. Applicants were required to raise matching funds to be considered. The MAAC received those matching funds from the National Network of Libraries of Medicine New England Region as a Community Engagement Award.

In addition to the award in Massachusetts, the *Campaign* announced that Action Coalitions or their designees in Florida, Indiana, Maryland, Missouri, Montana, Nebraska, Pennsylvania, Rhode Island, Virginia, Washington, and West Virginia also received awards. Of note, Massachusetts and four other states also received this award last year. The goal for this two-year award is to assist in the creation of replicable strategies that sustain Action Coalition work while highlighting the importance of collaboration with diverse stakeholders. "We are proud to be selected and look forward to building on our work to create replicable strategies that help nurses build a Culture of Health and promote health equity and well-being," said Amanda Oberlies, PhD, MBA, RN, CENP, CEO of the Organization of Nurse Leaders which serves as the co-lead organization of the MAAC.

MAAC's Culture of Health-School Wellness Team lead by Glynnis LaRosa, Maureen Sroczynski, Karen Rousseau and Pat Crombie will build on and expand the outcomes of their initial Innovations Fund award in which a new partnerships with the National Libraries of Medicine (NLM), Massachusetts Health Council (MHC) Massachusetts Association of Public Health Nurses (MAPHN) and the Massachusetts School Nurses Organization (MSNO) were developed to implement an initiative with the primary goal to promote health literacy and overall health and wellness of students in selected communities by increasing the nursing representation on School Wellness Committees (SWC) throughout the state to facilitate information, resources and knowledge sharing. The School Wellness Committees are responsible for promoting school policies addressing nutrition, physical activity and related health issues that impact student health as identified by the community. The target population was school age children (K-12) in communities across the state and prioritized by the 2018 County Health Rankings Report for Massachusetts of those communities with low ranking in the Health Outcomes and Health Factors categories. Nurses who live or work in those communities were recruited as Nurse Facilitators, educated about resources available from the NLM and MHC and were supported in their outreach and connection to their local School Wellness Committee.

The next phase of this work will include a new partnership with the Massachusetts Association of School Superintendents (M.A.S.S.) and collaboration with representatives of School Wellness Committees (SWC) statewide to create an evidence-based, adaptable, developmentally appropriate curriculum for grades 6-12 on the impact of vaping on student health and wellness. In this expansion project, we will increase the support and resources provided to the cohort of nurse facilitators developed in our first award and expand our connection to statewide School Wellness Committees through multi-stakeholder Advisory and Curriculum Development Committees that will utilize the resources of the National Libraries of Medicine, Massachusetts Health Council and other statewide and national groups that are working to address vaping to deliver a comprehensive curriculum that addresses what has become a statewide public health issue and a national public health issue. The focus of the expanded award has emerged from information provided by our nurse facilitators and confirmed by School Wellness Committees in many areas of our state and from the input from a variety of stakeholders across the Commonwealth.

For more information or if you would like to help with this work, please contact Pat Crombie at pmcrombie@gmail.com. Learn more at www.campaignforaction.org. Follow the Campaign for Action on Twitter at @Campaign4Action and on Facebook at www.facebook.com/CampaignForAction.

Pat Crombie is the Project Director of the Massachusetts Action Coalition (MAAC).

Patient advocacy and teach-back

Inge B. Corless

My first semester nursing students are devoted to being patient advocates and that makes me very happy. When our patients are not in a position to speak for themselves and/or we are aware of a change in status or an untoward response to a medication or some procedure, it behooves us to initiate an immediate response within our scope of practice and to alert the appropriate colleague even when that means the dreaded 3:00 AM call. Our doing so, may mean the difference between life and death and/or additional impairment of one sort or another.

Patricia Benner's (1984) book *From Novice to Expert* is replete with exemplars of nurses pursuing the appropriate professional colleague and/or intervention when a patient's welfare and indeed life is in peril. Nurses also advocate for their patients for less dire issues and that is as it should be or should it?

Many nurses now use an approach termed teach-back to be assured that the patient understands the information that has been provided to them. This is a major reversal and revision to the stance of a professional rattling off instructions and asking the patient whether what was conveyed was understood. And who among us, whether a medical professional or not, wants to appear ignorant to the professional conveying the information. Consequently, all too many of us benignly shake our heads in the affirmative.

With Teach-Back the onus is on the professional. Have we conveyed the information in such a way that it is comprehended by the listener? The proof is when the patient is asked to repeat in their own words what they have heard the nurse say. And we invite this response by saying we want to be sure that we provided the information in an effective way. The point is the onus is on the provider to convey information in a way that the patient can understand.

What you may have surmised by now, is that I'm going to link advocacy with teach-back. While the incorporation of such modalities as teach-back have been used to assess the understanding of a patient as to discharge orders or other information, it could be used in other ways as well.

In those non-critical situations where patients simply shake their heads as to understanding a message conveyed by a colleague, a message we often explain once the colleague has gone off to some other activity, what if we introduced the patient to teach-back?

We could help our patients learn some phrases to the effect of asking the colleague to repeat the message in non-medical terms after which the patient could use teach-back and say "let me be sure I understood what you are saying" and then proceed to convey the information they heard. That skill would help the patient in not only that situation but in others as well. And the nurse would not be doing the work of a colleague but using the time for other activities including listening to the patient's response to the information conveyed.

Teach-back is another form of advocacy for the patient. And in the many roles we play with patients, may have the most durable effect. So, should we advocate for patients? Of course! However, if our patients learn to advocate for themselves, their long-term well-being may be enhanced. And who knows, they may ask us to repeat what we heard them say!

Reference

Benner, P. (1984). *From Novice to Expert - Excellence and Power in Clinical Nursing Practice.* Menlo Park, CA.: Addison Wesley Publishing Company nursing Division.

Health policy committee update continued from page 7

protocols, and requires use clinical data to determine their effectiveness; requires insurance companies which restrict the use of a particular drug included in step therapy to establish a clear readily accessible and convenient process to request a step therapy exception; requires insurance companies and MassHealth to grant the exception in the listed circumstances, including when the required drug is known to be contraindicated with other drugs in the protocol or when the patient has tried and failed on the required drug.

S.997/HR 2056

United States Cadet Nurse Corps Service Recognition Act of 2019

Amends GI Bill to recognize that service in the US Cadet Nurse Service Corps between 7/1/1943 and 12/31/1948 constituted active military service and those who served receive honorary veteran status including only burial benefits (headstone) and medals or other commendations.

S.2178

An Act relative to the United States Cadet Nurse Corps Day

Amends Chapter 6 of the general laws to add a new section "The governor shall annually issue a proclamation setting the apart the fifteenth day of June as the United States Cadet Nurse Corps Day."

ce corner

Frequently asked questions about disclosures

Judy Sheehan

Questions: What needs to be disclosed to the participants prior to the start of a program? What are acceptable ways of disclosing this information?

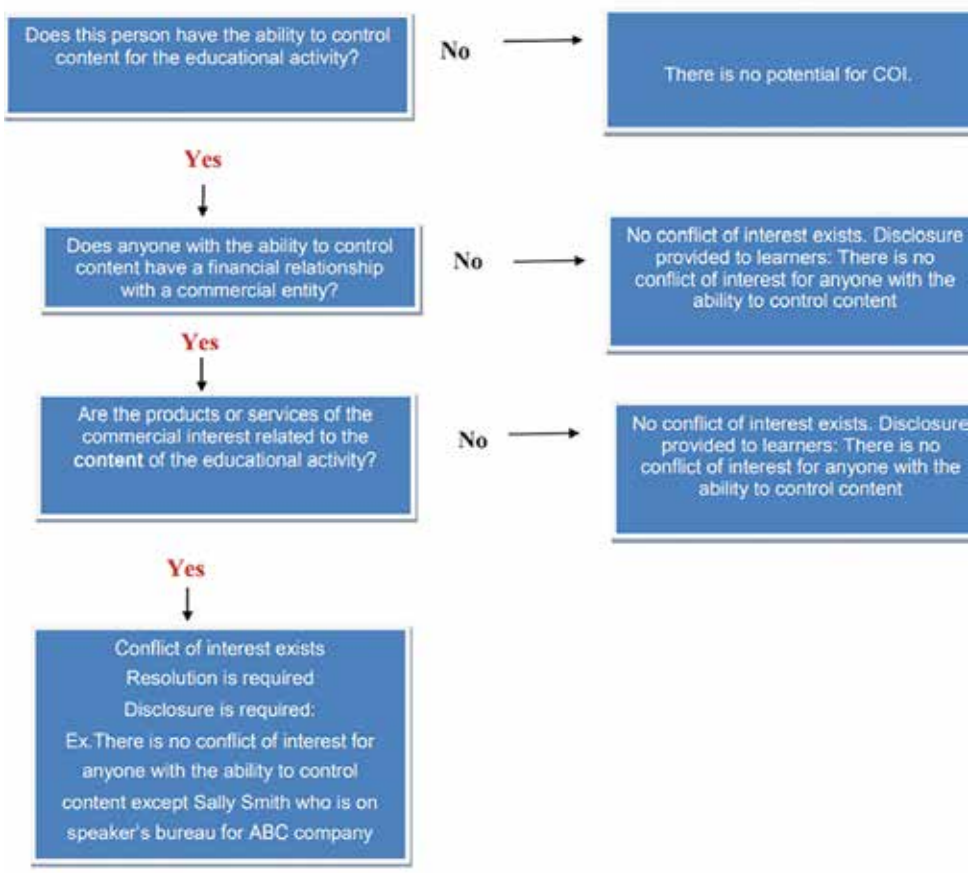
Answer: Disclosures to participants must include:

- The **requirements necessary to obtain contact hours**
- The **presence or absence of conflict of interest**
- The **official approval statement**
- If conflicts of interest are present, the resolution of those conflicts must be disclosed to the participants.
- If commercial support has been provided, it is necessary to state this **and** identify the party providing the support
- If it is a joint-provided program, it must be clear who **the provider is** and who is the joint provider.
- The expiration date must be disclosed if it is an enduring or blended activity.

Question: How do you determine if a conflict of interest exists?

Answer: A conflict of interest exists when:

- A person in a position to control the content of the program has a financial relationship with a commercial entity AND
- The commercial entity's products are related to the content of the educational activity.
- The following decision tree was developed by ANA Ohio and may be a useful guide for determining if conflict of interest exists.



Question: Whose responsibility is it to determine if a conflict of interest exists?

Answer:

- It is the nurse planner's responsibility to determine if a conflict of interest exists for both the planners and the faculty.
- In addition, someone other than the nurse planner must evaluate and determine if the nurse planner has any conflict of interest.

J. Sheehan is a Nurse Peer Review Leader for ANAMASS.

CNE hot topics and water cooler solutions

Judy L. Sheehan

The ANAMASS Accredited Approver Unit holds a fall and a spring symposium each year. The 2019 spring conference "Hot Topics and Water Cooler Solutions" was held at Curry College in early June and generated many great ideas and discussions. The program included a review of the ANCC criteria, conversations about applying the criteria and allowed opportunities for participants to problem solve, share expertise and build an ever stronger nursing continuing education community. Participants engaged in both large and small group discussion where cases were discussed, best practices acknowledged and many possible solutions to common problems identified. Dialogue around topics such as gap analysis, program design and methods of evaluation challenged the group and many "water cooler solutions" were analyzed. The small group discussion was facilitated by committee members; Jeanne Gibbs, Peggie Bretz, Pamela Corey, Stephanie Wakim, Carmela Townsend, Arlene Stoller, Jean Mellot, allowing direct connections and conversations to occur between nurse planners and peer reviewers.

Some of the best practices brought forward included:

1. When conducting a **gap analysis** ask the potential target audience to answer the following question: "What problems are you having in your practice/care team that needs to be addressed and how will you know it has been solved?" These questions form the framework for your gap analysis, evaluation and program planning.
2. Maintain **content Integrity** by reviewing the speaker slides prior to the program if bias is a concern.
3. Ensure the program is **based on best available evidence** by ensuring a variety of references from the speakers include items from peer reviewed sources that are no older than five to seven years. It is also advantageous to utilize expert speakers and Quality Improvement experts when program planning.
4. Engage participants using updated techniques such as escape rooms, video conferencing, clickers and games.
5. Evaluation can be accomplished in many ways; survey monkey, clickers, pre/posttests, electronic gaming, simulations, direct observation of discussion, combined CME and CNE evaluation forms, formative evaluation as well as summative evaluation.

At the request of the participants, the format of the symposia will be maintained for the fall program to be held in November and repeated (with different areas for dialogue) next spring. In addition to the symposia the Accredited Approver Unit has been asked to provide webinars, enduring and blended programming going forward. The requests have become part of the planning committee's current gap analysis

Judy L. Sheehan MSN, RN-BC is a Nurse Peer Review Leader, ANA Mass Approver Unit.

WWII Cadet Nurse: Mary Lorraine "Rainy" Baldwin Kench

Barbara Poremba

Cadet Nurse Mary Lorraine Baldwin Kench, Lynn Hospital SON

Mary Lorraine Baldwin Kench was a proud WWII Cadet Nurse. "Rainy" shared with me many documents and letters that she had written to members of Congress since 1995 when the first bill for veteran status was filed. Sadly, she died of a sudden illness in May at the age of 95 years. Up to the very end, she was actively working on passing our new legislation for Honorary WWII Veteran Status by getting her Florida Representative and Senators to sign on as cosponsors of S997/HR2056 the United States Cadet Nurse Service Recognition Act of 2019. In fact, in her final days, she was still talking about it and the lack of response from any of her congressional delegation.

We are sad that she did not live to see this bill pass but we are grateful to the local chapter of the VFW for acknowledging her service and wish for a military funeral. This is what all WWII Cadet Nurses deserve and our bill for Honorary Veteran Status will make this possible for all who wish to be so honored for their service to country in wartime.

Here is her-story in her own words, to her granddaughter Allison.

Allison from Nana Oct 10, 2009

I will attempt to recall my remembrances of World War II.

I was a senior in High School in 1941. I attended Lynn Classical High School in Lynn, MA. Same school that you went to - only more than 50 years earlier,

Senior year 1941 was a fun year. We were all graduating and going on to colleges. No cares!

And then came December 7th. It was a Sunday. I was in Central Square, Lynn at about 1 P.M. heading for the movies with a friend. All of a sudden the square was filled with loud sirens and whistles and vehicles with loud speakers turned on announcing that we as a country were at war! It was December 7, 1941 and Japan had bombed Pearl Harbor.

Four days later Germany declared war on the U.S.

As I look back I remember that we were excited about going to war. We didn't have any idea what it meant and felt since it would only last a few days and the U.S. would be victorious.

As time went on some of the male students were given an early graduation to enter the service. Our attitude changed and we became more concerned.

When I graduated in June 1941, I tried to get a job at the General Electric Company who was involved in doing War work. In order to become employed a manual dexterity test had to be taken and passed. It involved putting blocks together to form a cube and secondly to pick up three pins with a small forcep-like thing and put them together in a hole. And I flunked the pin part - my hands (fingers) were too clumsy. So I didn't get a job there. And to be "Rosy the Riveter" was the ambition of all the young girls who didn't get to college.

So it cost $5.00 to take a "Psychometric" exam for admission to Nursing school which I passed and so I spent the next three years at Lynn Hospital School of Nursing.

We - as did everybody - received Ration Books, butter, sugar & gas were all rationed and available only with a coupon.

Butter was almost not available. It was substituted by a product called oleomargarine. It was a white fatty substance (looked like lard) that we allowed to soften. It had an orange colored capsule in it that had to be broken and then mixed well with the white fatty stuff until it looked like butter. When it was shaped into a block resembling a pound of butter and kept in the refrigerator. Most people had ice-boxes (not electric) and purchased blocks of ice to place in them to keep foods cold. I don't remember when we got our first electric one.

The city operated "black-outs" where you kept your shades closed and lights lowered as a safety-practice against possible invasion or air attacks. We were fortunate to never experience either.

War bonds were a big item. Some purchases would give out stamps to be saved and placed in a book. When the book had $25.00 saved then you could turn it in for a U.S. Savings Bond.

I wrote frequently to your grandfather who was my "boyfriend" at that time to keep him up with news from home. He wrote back (I have four years of WWII letters saved) but only once during the time he was serving was he able to say where he was. And that was three days after the Invasion of Normandy. All mail was censored but he was able to say that his ship had taken part in the action.

I joined the U.S. Cadet Nurse Corps in 1943. We signed to "serve for the duration of the conflict and for the reconstruction period." We were not assigned to overseas duty but our last six months in nurses training we could be assigned to a [military] service hospital - Army, Navy or Marine.

We had official uniforms- ours were grey with red epaulets on the shoulders and silver buttons. We even had an official song denoting that we were "In the Corps."

When I graduated in September of 1945 I was unable to enlist in the regular Army or Air Force as the quota was filled at that time. War was officially over as the Japanese had surrendered on Aug 15, 1945.

One last note - President Franklin D. Roosevelt died on April 12, 1945. He was the one who stated that the bombing of Pearl Harbor was "a day that will live in infamy." He did not live to see the end of the war, but what he said will never be forgotten.

Honorary WWII Veteran Status for our Cadet Nurses

The bill S997/HR2045 has made progress! The U.S. Cadet Nurse Corps Service Recognition Act was added to the NDAA, the National Defense Authorization Act for 2020, as an amendment. Although the amendment did not pass in the Senate, it passed in the House. That means that we have a 50/50 chance that this makes it on the final bill that must be voted on, passed and signed into law before the year's end.

With the support of the VFW, ANA and 61 other organizations in the Nursing Community Coalition, we are working with the House and Senate NDAA conferees to ensure that this is included in the final bill and signed by the President. We are grateful for the support of our Massachusetts congressional delegation including: Senator Elizabeth Warren, sponsor; Senator Ed Markey, cosponsor; Congressman Jim McGovern, original cosponsor of House bill and Chairperson of the House Rules Committee that successfully shepherded the bill as an amendment on the House version; all other MA Representatives, cosponsors.

If it does not pass this year on the NDAA, it would go back to the committees where, given a nearly 25-year history of never getting out of any committee, it could languish. If it does make it out of committee and passes in the House, its fate is uncertain in the Senate where sadly, we have little Republican support.

Honoring Our Massachusetts WWII Cadet Nurses

Given such uncertainly of federal recognition, it is important to make sure that our 9,000 Massachusetts WWII Cadet Nurses will not be forgotten for their service to country in wartime. State Legislation is moving forward to assure that July 1, the founding date of the USCNC in 1943, is designated in perpetuity as United States Cadet Nurse Day in Massachusetts. To commemorate the corps, plans for a plaque in Nurses Hall of the State House are underway.

It was from the steps of the State House on May 13, 1944 that 900 WWII Cadet Nurses representing 26 MA hospital schools of nursing marched with the Army band to the Parkman Bandstand on the Boston Common. They took part in a national radio broadcast from Washington D.C. where they raised their right hands and pledged to serve their country for the "duration of the war."

Their contributions to the war effort were highly regarded as they were responsible for 80% of all nursing care in military and civilian hospitals on the home front. Without them, the health care system would have collapsed due to lack of trained nurses.

C/N Betty Beecher (Massachusetts Memorial School of Nursing) and Mary Maione (Lynn Hospital SON) pointing to permanent plaque location in Nurses Hall.

As read to the State House Art Commission, Cadet Nurse Mary A. Schofield Maione stated: *I joined the USCNC to serve my country and to fulfill a lifelong dream of becoming a nurse. I took care of wounded soldiers that were sent home injured from the war to a military hospital in Richmond, Virginia. Like all of us nurses that joined, we signed on to serve for the duration of WWII not knowing how long that would be. I left my home, my family and my friends to serve my country. To honor me and my fellow Cadet Nurses with this plaque would touch me deeply.*

Remarks read on behalf of Cadet Nurse Betty Beecher were also well received: *In speaking for all Cadet Nurses past and present, a plaque in Nurses Hall would ensure our sacrifices and contribution to WWII success will not be forgotten. In the three years we served, we prevented a total collapse of the health care system. We elevated the status of nursing by assuming greater responsibility than ever thought possible. We elevated the status of women. Yet, we are unknown to today's generation. What better way to preserve our legacy! A plaque in Nurses Hall would be most welcome and appreciated. Our story needs to be told.*

USCNC served our country with honor from the inception date July 1, 1943 to VJ Day in 1945 and [in the three years post war] to December 1948. It met effectively the most vital needs of the military in wartime and fought a silent war against [deadly] disease. A plaque in Nurses Hall and a day of recognition in our great state of Massachusetts to honor the USCNC would preserve our legacy for future generations. I hope this will happen quickly so I may see it in my lifetime."

Nationally, the Veterans of Foreign Wars endorsed the bill and locally, WWII Veterans have personal reverence to the Cadet Nurses. One Army Veteran wrote: *"I served in the 3rd Infantry Division and took part in the landing at Anzio where I was First Ammunition Carrier. There I was wounded and finally transferred back for the States for continuing treatment and rehabilitation at Cushing General Hospital in Framingham, MA. I spent almost two years having surgeries and treatment and know I was cared for by Cadet Nurses during my long period of hospitalization at Cushing. It is hard to think what that care would have been like if it hadn't been for the US. Cadet Nurse Corps members who cared for me and my returning, wounded brothers..."*

Given the age and fragility of our living WWII Cadet Nurses, we are asking for help in moving these efforts forward with urgency."

Please follow us on Facebook at Friends of the United States Cadet Nurse Corps WWII for the most updated information on how to help. Email: FriendsofUSCNC@gmail.com; Facebook: Friends of the United States Cadet Nurse Corps WWII; Website: https://www.nursingandpublichealth.org/cadet-nurses.html

Dr. Poremba is Professor Emeritus, Salem State University and Director of Friends of the United States Cadet Nurse Corps WWII. She welcomes hearing from Cadet Nurses, all Women who served in WWII and those who want to help preserve their legacy. If you know of a nurse who trained 1943-1948, they may have been a Cadet Nurse

bulletin board

Tuesday, October 1, 2019

Health Policy Legislative Forum
Massachusetts State House (Great Hall)

Medicare for All: An Alternative Health Financing Program With Implications for All

October 9, 2019

7th Massachusetts Regional Caring Science Consortium Conference, October 9, 2019, 7:30 am - 12 noon

Inviting nurses to attend the 7th Massachusetts Regional Caring Science Consortium (MRCSC) Wednesday, October 9, 2019, UMass Worcester Graduate School of Nursing, 7:30 am- 12 noon.

- The MRCSC is a forum for nurses to reclaim the heart of nursing by sharing and exploring caring practices that foster and sustain personal and professional well-being, healing relationships with colleagues and patients, healthy work environments, and best outcomes in patient care.
- The conference features a keynote speaker and presentations by a panel of nurse Caritas Coaches®, graduates of the Watson Caring Science Institute's Caritas Coach Education Program® (CCEP), which prepares nurses and other health care providers to coach, teach and implement caring-healing philosophy and practices. These coaches will present caring-practice projects, based on Caring Science concepts, that they launched in their acute care and outpatient care settings with healing outcomes.
- There will be time for interactive questions and discussion and some take-home handouts.
- Join the presentations and conversation on October 9, 2019 to renew your caring practices and heart of nursing. Continental breakfast, parking, and contact hours will be provided.
- Conference details will be posted on the MRCSC website (mrcsc.org) as they are finalized. Registration is required by October 4, 2019. You can register on the MRCSC website at mrcsc.org or by contacting Lynne Wagner directly for information and registration at alynnewagner@outlook.com.

October 16, 2019

Regis College Educational Offerings, Co-Sponsored with Harvard Pilgrim Health Care, October 16, 2019, 6:15 – 8:30 pm, Health Care by Zip Code: So What?

Contact Hours: 2
Location: Regis College, Casey Theater, Fine Arts Center, 235 Wellesley Street, Weston, MA 02493
Fee: None
Registration: Call 781-768-8080; Email: presidents.lectureseries@regiscollege.edu; Online Registration: http://www.regiscollege.edu/HealthByZip
Description: Yes, your Zip Code does matter! One's life is affected not only by genetics, lifestyle, and risk-taking behaviors, but by social and environmental factors as well. In fact, these factors account for nearly 70 percent of health outcomes, and actually contribute to the inequities in health that some populations experience. Come learn about these factors and the innovative ways in which health professionals are partnering with their communities in actively decreasing their impact.
Location: Regis College, Casey Theater, Fine Arts Center, 235 Wellesley Street, Weston, MA 02493

Friday, November 8, 2019

Hot Topics: Water Cooler Solutions
Mercy Medical Center/Springfield, MA

ANAMASS Accredited Approver Unit Annual Symposium - Western Workshop

November 13, 2019

6:15 – 8:30 pm, Vaping, Vanity and Victims

Contact Hours: 2
Location: Regis College, Casey Theater, Fine Arts Center, 235 Wellesley Street, Weston, MA 02493
Fee: None
Registration: Call 781-768-8080, Email: presidents.lectureseries@regiscollege.edu; Online Registration: http://regiscollege.edu/Vaping
Description: Are you vaping for pleasure? Is it about vanity, or are you using it as an alternative to smoking? Is vaping ever a responsible choice? Whatever your answer, you need to know the facts. You might be surprised to learn who is vaping, what their vaping, and if in fact, we have an epidemic on our hands. Attend this panel and hear experts on the topic give you the evidence-based information you need.

March 11, 2020

Save these dates for Regis College 2020 Spring Panels!
March 11, 2020 – The Fate of Health Care Reform
April 22, 2020 – Gambling and other Behavioral Addictions

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.

Friday, April 17, 2020

ANAMASS Spring Conference, The Good, the Bad, and the Ugly: Beyond the Hand Sanitizer
The Conference Center at Waltham Woods

Call for Posters and Exhibitor/Sponsorship Opportunities information at www.ANAMASS.org

Friday, May 1, 2020

Call for Abstracts - Boston University, Florence Nightingale's Influence on the Evolution of Nursing

In celebration of the bicentenary of Florence Nightingale's birth, the Nursing Archives Associates of the Howard Gotlieb Archival Research Center at Boston University is accepting abstracts for presentations focused on Florence Nightingale's influence on the evolution of nursing, both historical and contemporary.

Please submit two copies of your abstract electronically to Nicole Williams at nmwill@bu.edu by December 1, 2019. One copy should not contain any identifying information and the other copy should include name, credentials, and contact information. Limit the abstract to 250 words.

Each presenter will have 45 minutes (including question and answer period).

Abstracts are due by December 1, 2019; notification by January 15, 2020.

Friday, May 8th 2020

Save the Date for the Spring Awards Dinner: Friday, May 8th 2020 at the Royal Sonesta Boston

AMERICAN NURSES ASSOCIATION MASSACHUSETTS

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
- ANA Meetings & Conferences/ ANA Annual Nursing Quality Conference™
- Navigate Nursing Webinars
- 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
- Emmanuel College – Tuition reduction scholarship
- 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.

Go to www.ANAMass.org for more information

Like us on Facebook -
http://www.facebook.com/pages/ANA Massachusetts/260729070617301

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.

Nurses: Take the next step.
RN-to-BSN

Labouré's RN-BSN was created by nurses to be flexible, 100% online, and one of the most affordable in Massachusetts at just $350/credit.

Accelerated · Online · Affordable
For you, the working nurse

GET STARTED TODAY!
More information at laboure.edu
or (617)322-3575

Labouré College

OUR NURSES CREATE our greatness

New Rates • Enhanced Benefits • Shared Governance
Free Healthcare Option for you and your family
Professional Growth and Development opportunities

For detailed information please visit
jobs.bmc.org
or email
nursingcareers@bmc.org

CENTER
BOSTON MEDICAL

EARN YOUR MASTER OF SCIENCE IN NURSING ONLINE

WHY CHOOSE US?

ADVANCEMENT THROUGH SPECIALIZATION

Specifically designed for working professionals like you to enhance your career—without putting it on hold—by specializing in one of three distinct concentrations:

- **Nursing Education**
- **Nursing Management**
- **Public Health**

MEANINGFUL CONNECTIONS

A collaborative network of experienced peers and faculty who create a vibrant community valuing integrity, excellence, and diversity

DESIGNED TO FIT YOUR SCHEDULE

- Fully online coursework with no required login times, or choose our on-campus hybrid courses, held in the evening
- Part-time options, with three starting points each year
- A no-pressure, consultative admission process
- Financial aid available to those who qualify

EXPAND YOUR OPPORTUNITIES

To learn more, go to hartford.edu/msnonline

UNIVERSITY OF HARTFORD
COLLEGE OF EDUCATION, NURSING AND HEALTH PROFESSIONS