MASSACHUSETTS REPORT ON NURSING

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Who is this nurse?

ANA MASSACHUSETTS
AMERICAN NURSES ASSOCIATION

www.ANAMASS.org

In this issue:

living legends

Dr. Anne-Marie Barron has spent her long and highly distinguished career as an advanced practice nurse, educator, academic leader, and scientist committed to elevating the role of the nurse in providing compassionate care. She has done so by combining an active clinical practice in psychiatric nursing and oncology with academic leadership. Her teaching, practice, leadership and consultation have influenced nursing practice and education regionally, nationally, and internationally. Her significant contributions to the profession of nursing have been in illuminating the power of nursing to transform suffering and promote healing. Dr. Barron's impact is extensive and occurs in the classroom, her clinical practice, and in consultation in Bangladesh.

In her role as Associate Dean of the College of Natural, Behavioral, and Health Sciences (CNBHS) at Simmons University, she has created a welcoming and inclusive culture and community of caring scholars where faculty are supported in their teaching of the science and

Dr. Barron continued on page 4

Dr. Jean Steel is a respected nurse leader whose influence and dedication to the health of populations has inspired and impacted the nursing profession and, in particular, advanced nurse practitioner practice and education across the world. Her pioneering work helped establish the current US model for nurse practitioner (NP) collaborative practice and informed NP reimbursement policy, both of which have been sustained over several decades. Her leadership and service on the ANAMASS Leadership Council and the National Joint Practice Commission were integral to the establishment of the pathway to greater NP practice autonomy and helped lay the groundwork for collegial and collaborative advanced nursing and physician practice.

Jean has lived her nursing philosophy in many capacities throughout her illustrious career. In recognition of her many contributions as a distinguished educator, clinical leader and outstanding mentor throughout the US and abroad, she has received numerous

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Dr. Antoinette M. Hays is a well-respected nurse leader committed to improving the discipline of nursing. Dr. Hays is a prominent voice in global health policy, gerontology, and interdisciplinary higher education.

Dr. Hays is the tenth president of Regis College. Prior to her appointment as president in 2011, Dr. Hays spent two decades educating nurses at Regis College. Dr. Hays was the founding Dean of the Young School of Nursing at Regis College. Through her leadership, Regis College has pursued cutting-edge technological innovation, launched nursing graduate programs including the Doctor of Nursing Practice and offers a rapidly expanding fully online suite of nursing programs. Under her guidance, Regis was recognized as a National League for Nursing (NLN) Center of Excellence in Nursing Education, a designation that Regis has continued to be recognized for three consecutive terms. Her energy and compassion have also driven the successful development and funding of the Regis

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Responding to rising challenges in nursing and healthcare

Join us at the 18th annual **Spring Conference** to share knowledge and celebrate nurses. This year's conference discusses responses to rising challenges in nursing and health care including violence against nurses, nursing resiliency, the opioid crisis, concussion management and weight stigma. Immediately following the conference and the business meeting is the **ANA Massachusetts Annual Awards Dinner** that honors the remarkable, but often unrecognized work of ANA Massachusetts members. To register go to www.anamass.org.

Responding to Rising Challenges in Nursing and Healthcare
Friday, March 29th 2019 8:30 am – 4 pm
Royal Sonesta Cambridge/Boston

The State of the State…An Update on the Opioid Crisis.
Keynote Speaker Susan L.W. Krupnick MSN, PMHCNS-BC, ANP-BC, C-PREP
Jill M. Terrien PhD ANP-BC

The Truth About Concussions
Rebecca M. Stevens, MSN, RN, CPNP
Alex McLean Taylor, PsyD

Violence Against Nurses: Current Trends and Interventions
Sheila Wilson RN, MPH

Resiliency in Nursing: Myth or Achievable Reality?
Michele Carley Jacobo PhD

Weight Stigma - Physical and Psychosocial Impact
Lisa DuBreuil LICSW

Interactive Poster Session (with prizes)

Followed by
Business Meeting for ANA Massachusetts members

Please join us in celebrating the Living Legends and other Excellence in Nursing Awardees and Scholarship Awardees at the ANA Massachusetts Annual Awards Dinner starting at 6 pm.

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president's message

Donna M Glynn, PhD, RN, ANP, President ANA Massachusetts

What a year!

As my term as President of ANAMASS comes to an end, I am reflecting on the year, professional nursing practice and our remaining challenges. Professional nursing practice is a challenging career. We work with patients and families during vulnerable moments and juggle the interdisciplinary team to meet patients' goals. We make a difference in the lives that we touch.

The past year was a challenge. The ballot question initiative divided nurses, confused the public and left us with ongoing questions. In connection with several professional nursing organizations, ANAMASS recently co-led a Nursing Summit to bring nurses from across the Commonwealth together to discuss the issues affecting practice. This initial step will help to determine our future efforts.

ANAMASS continues to work in the legislature to address our professional practice issues. With our Health Policy Committee, we filed legislation to establish a commission to evaluate patient care outcomes and professional nursing practice. We proposed that the commission is comprised of nurses, representatives from health care organizations and the public. We are hopeful that by bringing many to the table, we can identify issues and work together for a solution.

ANAMASS has re-filed our legislative efforts related to the appointment of a Registered Nurse on the Health Policy Commission. Nursing needs to be represented on this Commission. I ask that all nurses support our legislative efforts and contact your elected officials and voice your support of both of these bills.

This year our organization suffered a great loss. Sandra MJ Reissour passed away unexpectedly in November. For almost twenty years she co-chaired the ANCC Accredited Approver Unit for ANA Massachusetts, and was a mentor to so many in educational design and interpretation of ANCC criteria. In 2009, Sandra received the President's Award from ANA Massachusetts, and in 2018 was recognized with the Loyal Service Award for her dedication. She will be missed. Donations to a scholarship in her memory can be made at www.anamass.org.

Our annual meeting on March 29, 2019 will begin with an educational program. Topics include **opioid crisis, concussion protocol, resiliency, weight stigma, and violence against nurses.** Afterwards, we will honor the accomplishments of specific nurses. I encourage all nurses to participate in this event.

ANAMASS will be recognized at Fenway Park as part of National Nurses week. National Nurses Day is celebrated on May 6th to recognize the role nurses play in our society. It marks the beginning of National Nurses Week, which usually ends on May 12th, Florence Nightingale's birthday. This year, Red Sox Nation is bringing over 4,000 nurses to Fenway on Tuesday, May 15th. Bring your friends and colleagues to celebrate nurses and the World Champion Red Sox with ANAMASS. Buy your tickets soon because we expect a sold out crowd!

I would be remiss if I did not thank the ANAMASS Board of Directors, Awards Committee, Bylaws Committee, Conference Planning Committee, Health Policy Committee, Membership Engagement Committee, Newsletter, Nominating, and Accredited Approver Unit for their amazing work. It takes many to accomplish our goals. A special thank-you to our Executive Director, Cammie Townsend and office manager Lisa Presutti. Their dedication to our organization is amazing.

Please continue to support ANAMASS. I look forward to seeing you at upcoming events.

Cadet nurse Dorothy "Dottie" Harrington Hall

Barbara Poremba, EdD, MPH, MS, RNCS, ANP, CNE

Dorothy "Dottie" Harrington had just turned 18 years old when she was accepted to Massachusetts General Hospital School of Nursing. Coming from Wendell, a tiny town in northwestern Massachusetts, Dottie connected the Cadet Nurse Corps with the military. She hadn't decided to join the Corps until she arrived at MGH. "I remember seeing the recruitment posters and since everyone else was in the Cadet Nurse Corps, I decided I should join too. I liked the uniforms we got to wear when we were out and about. They made us look patriotic. I felt like I was doing my part for the war."

MGH had a stellar nursing program but it became more intense when the government required the training period be shortened from three to two and a half years. This was so that Senior Cadet Nurse was available for full time service in military and civilian hospitals six months earlier.

Dottie recalled that there was little time for anything but studying and working. MGH was far from her home and transportation was difficult in those days. "We didn't have cars so we had to take buses and trains. I didn't go home often, until my mother was sick with cancer. Then I tried to go home once a month." Because of her mother's terminal illness, Dottie did her six months of service as a Senior Cadet at MGH working in the operating room as a scrub nurse. "I loved it!" she said.

Unlike many Cadet Nurses who eventually ended up in the military, Dottie returned home to care for her mother until she died two years later. She explained, "Those of us who didn't go into the military had other reasons for not going. I would have entered the military had my mother not been ill and the war had not ended. I had to go back home and take care of mother because in those days they didn't have nursing homes and you couldn't keep her in the hospital forever. And when my mother died in 1948, the war was over." So instead, Dottie left for Washington D.C. for her first RN position as an OR nurse at the now D.C. General Hospital. After a year, she moved to NYC and took a job at Cornell University Medical Center.

In 1952, Dottie returned to Massachusetts to work as a school nurse in Amherst, Mass. This allowed her to spend summers at NYU where she completed a BS in 1959. Two years later, she completed a MA at Columbia University while supporting herself working per diem at University Hospital in NYC. Had she been eligible for GI benefits which paid for tuition, Dottie would have completed her studies much sooner.

Dottie returned to Massachusetts where the rest of her meritorious nursing career focused on public health. In 1988, she retired from the top position as District Health Officer for the Northeast Region of the Massachusetts Department of Public Health where she was responsible for 62 communities. Her commitment to public health continues to this day as she serves on the Executive Board of Directors for the Public Health Museum in Tewksbury.

Cadet nurse: Dorothy Hall continued on page 10

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editor's message

Dear Readers,

I hope you like the new look of the *Massachusetts Report on Nursing*, the official publication of ANA Massachusetts. Although it looks different, it still has the same distinguished name, and writings by nurses or about nursing. This newsletter is sent to nurses in the Commonwealth. Therefore, receiving this newsletter does not mean that you are an ANA member. If you are not a member, please consider joining ANA Massachusetts today to help promote the nursing profession. For more information, go to www.ANAMASS.org.

Micro-Narratives: A Challenge

"Prose, Narratives, Etcetera, can carry healing. Poetry does it more intensely"
Ted Hughes, writer, poet

Stories, both the listening and telling, are an integral part of caring for patients. Each workday and sometimes on our days off, nurses listen, bear witness and at times are characters in the stories of people who are sick, suffering and healing. Like many nurses across the Commonwealth, I have cared for many patients whose stories remain with me, some for decades. I have cared for those with robust spirits and failing bodies, and those who respond with grace and love to debilitating illnesses. I have cared for those who inspire with their courage and persistence against all odds and those who make regretful decisions time and time again with eventual tragic consequences.

Narratives about clinical care are often laden with emotions. Some are joyous and I find myself laughing aloud, whenever the narrative comes to mind. Unfortunately, many are not joyous. Often, these narratives stay with us as long as our memories endure. I can visualize the bright blue eyes and red hair of the sweet infant that I watched die during an unsuccessful code during my first weeks as a nurse. I recall times when the sadness of having an intimate acquaintance with the suffering and death emanated from my thoughts and dreams until I had to tell the story. I still ask my husband, "Do you want to hear a [*insert adjective such as heartbreaking, tragic, grotesque*] story?" Thankfully, he still always says yes to this question. During these sad remembrances, the process of storytelling, especially when the right person is listening, can provide healing.

Sometimes the process of storytelling helps the storyteller to change the trajectory of the narrative by identifying a different solution or option that they did not think they had before. Occasionally, and these are my favorite stories, storytelling helps the teller to achieve the Frank Capra-esque ending that they were striving for.

Before and after each shift, nurses listen and tell narratives during report. The narrative arc: exposition, rising action, climax, falling action and resolution is repeated over and over again for the number of patients you are covering that day. In addition, nurse write concisely in progress notes and sign out sheets. For this reason, I believe that nurses are good at writing micro-narratives.

Some of you may have read Earnest Hemingway six-word micro-narrative: *"Baby shoes for sale: Never worn."* In six words, Hemingway was able to communicate the sorrow of the greatest loss a parent can endure. Inspired by Hemingway, I challenge you to write one or more micro-narratives about nursing. As nurses registered in the Commonwealth of Massachusetts (13 letters), write a 13-word story about nursing within the below general categories. If you prefer to avoid the number 13, then use 12 words. The stories can be funny: *Linda's orange flavored Metamucil brownies eradicated rounding teams from devouring the nurses' food*. Or the stories can be not funny: *Before death, he willed his sister his prized possession: A red fire truck*.

The Newsletter Committee will choose stories to be published in the next newsletter. Send them to me at newsletter@anamass.org with your name, email address, and below category by April 5th, 2019. If the stories are patient related, please do not include identifiable information.

As a nurse, I know that listening to and being a part of the stories of my patients and colleagues have influenced my life in every way. Some of the stories have inspired me to persist or to grow. Many inspire me to appreciate my life, my health and the problems that I do have. I hope that sharing these stories will help each of us to grow and learn together.

Categories of Micro-Narratives

- **Human connections**: Describe a nursing moment that changed the way you see the world.
- **Between us nurses**: Share a moment where you relied on your fellow nurses (funny or otherwise).
- **Professional hopes and dreams**: Describe why you became a nurse or what makes you want to grow.
- **Hopefully never again**: Describe a difficult moment as a nurse.

So what IS climate change?

Barbara Sattler, RN, DrPH, FAAN, and Cara Cook, MS, RN, AHN-BC

At a recent nursing meeting that I attended, I asked nurses to pair up and role play the following: "Your neighbor has just asked you - so what IS climate change?" Each nurse had to take a turn with a partner and answer that question, as though she/he were telling her neighbor the answer. After completing the role play, I asked how many of the nurses were able to answer that question with a high level of confidence and only about 10% raised their hands. When I ask how many could answer with reasonable confidence only another 10% raised their hands. How about you, would you feel confident answering the question? What everyone discovered from this activity was how unprepared many nurses are to talk about what climate change is. While nurses are more familiar with what climate change seems to be causing, such as more extreme weather events, sea level rise, and extensive wildfires, a large portion are unable to explain what climate change is in simple terms.

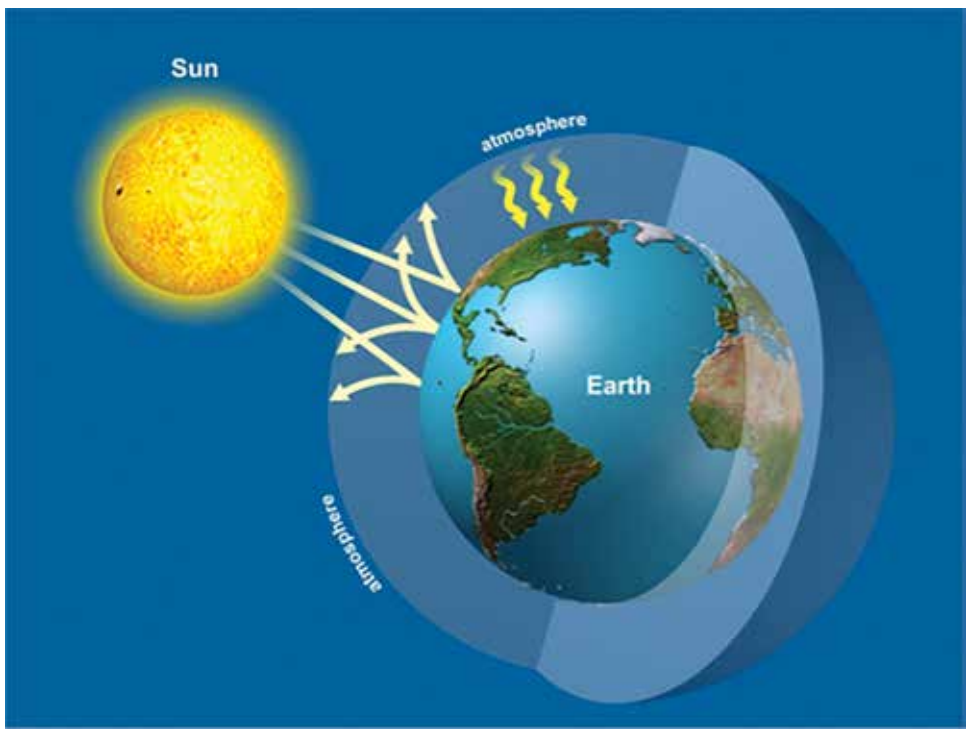
So here is a little primer: The earth's temperature has historically been modulated by the sun's rays beating down, warming the land and water, and then radiating heat back out beyond the earth's atmosphere. This process has kept the earth at a livable temperature for humans and other lifeforms to flourish.

However, we now have a "blanket" of gases that are surrounding the earth, gases created substantially by human activities such as transportation, energy production, industry, cooking/heating, and agriculture. These gases are called greenhouse gases because they create the same warming effect as a greenhouse and are slowly warming the earth – both the land and particularly the oceans. And in the process they are changing our climate. Climate is distinguished from weather in that weather is what occurs from day to day or week to week, but climate is what occurs over longer periods of time, month to month and year to year.

The process is a bit like what happens to your car when you leave it outside in the sun with the windows up. The sun's rays heat the inside of the car and that heat cannot adequately escape, so the car heats up.

Just as there is a small range of body temperatures at which humans can be healthy, the same is true for all species on earth. When human temperatures rise from 98.6 to 100.4 degrees it means the difference from feeling fine to having a fever and not feeling well. When our temperatures get even higher we begin to see bodily system distress and damage. What happens when the earth has a fever?

So what IS Climate Change? continued on page 5



Gases surrounding the earth are slowly warming the earth.

Congratulations, nurses, for maintaining #1 spot in Gallup's annual honesty and ethics poll

For the 17th consecutive year in a row, nurses were rated as having very high or high honesty and ethical standards (84%), earning the top spot among a diverse list of professions. This same sample rated 4 other professions as having very high or high honesty and ethical standards: medical doctors (67%), pharmacists (66%), high school teachers (60%) and police officers (54%). Members of congress received the lowest ratings on honesty and ethics in the same survey with nearly 58% of those surveyed saying they have low or very low ethical standards.

Some background information about the Gallup poll:

- The Gallup Poll Social Series are a series of public opinion surveys designed to monitor long-term trends on social, economic and political topics (in total, there are several hundred questions). Some of these trends date back to the 1930's.
- The latest results of the Gallup Poll Survey are based on telephone interviews conducted between December 3-12, 2018 with a random sample of 1,025 adults, ages 18 years and older, living in the 50 U.S. states and District of Columbia.
- Each sample includes adults with a minimum quota of 70% cell phone and 30% landline respondents, with additional minimum quotas by time zone within region. Both landline and cell phone telephone numbers are selected using random digit dial methods. Landline respondents are chosen at random within each household on the basis of which member has the next birthday.
- The question about honesty and ethics was asked as follows: "Please tell me how you would rate the honesty and ethical standards of people in these different fields" followed by a list of fields:
  - ◊ Very high
  - ◊ High
  - ◊ Average
  - ◊ Low
  - ◊ Very low
  - ◊ No opinion

It's not invisible

Martha Curley

To my nursing colleagues:

It's Not Invisible

Today, I saw you . . .

Make room for more than 20 family members at the bedside all at once, so that everyone could be together with Billy one last time.

Ask Billy's grandfather to plug the extension cord in; you knew he needed to do something-anything.

Give options to Billy's parents about "being there" during resuscitation attempts and help them choose words to talk with him, considering he was only 8 years old.

Speak very softly to Stephen while removing the tape from his eyelids only to find his pupils blown and unequal . . . , you didn't even change your facial expression-you didn't want to upset mom . . . , not any more . . . not just then.

Ask Stephen's mom what she was thinking as she stood near his bed looking out the window just before support was withdrawn. . . . "He was always very quiet, but I knew something was wrong; I should have taken him to the hospital but, he didn't want to go" . . . , wipe your tears as you listened and convincingly say that she did the best that she could.

Take a deep breath before you spoke up at team conference . . . "We ought to be more vigilant about the conversations we hold at the bedside- we don't know what Stephen's level of consciousness is under the sedation and chemical paralyzing agents". . . , whisper in Stephen's ear that the new ventilator might be scary because of the noise it made, then dry his tears.

Take the time to sit with Rachel's mom while others resuscitated her daughter, your patient, because you knew she was alone-her husband was on his way in.
Resuscitate Rachel because you knew that Rachel's mom needed your colleague right then.

Care enough to take the time to "orchestrate" death . . . , to make the worst-thing-in-the-world-anyone-could-ever-experience . . . , a little more tolerable.

It may be very hard for others to hear what we do . . . it can just be so sad. We eventually stop telling them. Eventually, we might think that our caring becomes invisible. But, it is not invisible not to Billy, not to Stephen, not to Rachel, or their parents, or to one another.

With Permission from Martha A.Q. Curley, RN, PhD, Ruth M. Colket Endowed Chair in Pediatric Nursing, Children's Hospital of Philadelphia, Professor, University of Pennsylvania School of Nursing, Anesthesia and Critical Care Medicine - Perelman School of Medicine

As published in Curley, M.A.Q., & Moloney-Harmon, P. A. (2001). *Critical care nursing of infants and children*. 2nd ed. Philadelphia: WB Saunders Co.

Dr. Barron continued from page 1

art of healing practice and students are held in high regard as they learn the skills and beauty of their professional pathways whether as nurses, physical therapists, dieticians or scientists. In her practice as a psychiatric clinical nurse specialist on the inpatient oncology and bone marrow transplant (BMT) unit at the Massachusetts General Hospital (MGH), she consults with nurses on the meaning of their caring presence in addressing suffering and promoting healing. Her program of research is focused on the meaning of illness, suffering, and caring. In her role as consultant to leaders in Bangladesh she leads the many nursing education initiatives there focused on building and staffing a BMT unit, training Bangladeshi nurses, and leading the work to offer the End-Of-Life Nursing Education (ELNEC) Train the Trainer Curriculum to over 200 Bangladeshi nurses, pharmacists and physicians.

Dr. Barron received her BSN and PhD from Boston College and her MSN from the University of Massachusetts Amherst. She is a fellow in the National Academies of Practice and in 2018 was inducted as a Fellow in the American Academy of Nursing for her sustained and impactful contribution to the profession of nursing.

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awards, including being inducted into the American Academy of Nursing in 1994. As a nurse visionary who pushed the boundaries of advanced nursing practice regulatory standards and interdisciplinary practice, she has established herself as someone who is incredibly deserving of recognition by ANAMASS as a Living Legend.

Dr. Hays continued from page 1

Haiti Project to educate Haitian nursing faculty. Since its inception in 2007, Regis has graduated 37 Haitian faculty with graduate degrees in nursing.

Dr. Hays received her nursing degrees from Boston College and Boston University and a doctorate from the Heller School for Social Policy and Management at Brandeis University. Dedicated and passionate about nursing, Dr. Hays maintains her certification as a registered nurse. In addition, she volunteers her time on many boards including Partners In Health, Health eVillages and Trinity Catholic Academy.

A tribute to Gellestrina "Tina" DiMaggio: Teacher, mentor, leader

Gellestrina "Tina" DiMaggio was a leader and innovator in nursing practice and education. From the beginning of her career in pediatric nursing, Tina was a trailblazer. She was in the vanguard of research focusing on the nursing care of children. She applied knowledge and understanding to the needs of hospitalized children, emphasizing the importance of parent-child-nurse relationships, growth and development, therapeutic play and less restrictive visitation policies into practice.

Learning was an integral part of her life. She earned a bachelor's degree from Connecticut College for Women (1944), a master's degree from Yale University (1947), and a master's degree from Columbia University.

In 1955, the University of Massachusetts opened the first baccalaureate nursing program in public higher education in the Commonwealth. Founding Dean Mary A. Maher recruited Tina along with Mary A. Gilmore Helming (former president of ANA MA) and Mary Macdonald (Director of Nursing, Massachusetts General Hospital). Together, they were pioneers in nursing education in Massachusetts. Tina was an inspirational teacher who faculty and former students fondly called "my teacher and my mentor."

Tina served as both the Associate Director of Nursing and Acting Director of Nursing, at MGH, one of the first women to serve in these positions. She continued to guide young nurses, supervisors and researchers until they became leaders in nursing in their own right. She was influential in the inauguration of the MGH Institute of Health Professions.

Throughout her career, Tina was active in the American Nurses Association. As Chair of the Maternal-Child Division of ANA, she initiated the development of the certification examination for Pediatric Nurse Practitioners. In 1978, for this leadership and commitment to excellence, she received the ANA "Nurse of the Year Award." She received other honors such as a Distinguished Alumni Award from the Yale School of Nursing and was appointed to the Massachusetts Board of Registration in Nursing.

After retirement from MGH in 1985, Tina continued to pursue her interests in nursing. She traveled to India to develop nursing services for a new hospital. To the delight of her friends and colleagues, she told the stories of this unique venture and demonstrated the proper way to wear a sari!

For several years, Tina was a member of the Board of Directors of the History of Nursing Archives Associates at the Gotlieb Archival Research Center, Boston University. Colleagues described how she "brought the richness of her extensive professional nursing background to Board deliberations" and how "her vibrant personality and sense of humor were always evident and appreciated."

Living on Beacon Hill was a joy for Tina and there, together with friends and neighbors, she formed a community of scholars and travelers. She attended the Harvard Institute for Learning, taught English to international students, traveled to Europe and the Greek Islands and engaged in cultural events. Being true to her adventurist spirit and ingenuity, she was a founder of the "Village Concept for Seniors" which has been replicated as a model for many retirement communities throughout the United States. Her zest for living and learning, her leadership and ingenuity and love of family and friends were the hallmarks of her life.

On December 21, 2018, Gellestrina "Tina" DiMaggio died at the age of 95. Her beautiful life was honored at "her church," the Paulist Center in Boston. She will be remembered not only for her contributions to nursing history, education and practice but also for her kindness, generosity and friendship. The words on her memorial card best define the life she lived and how she will be remembered by those who knew and loved her:

"To laugh often and much;
To win the respect of intelligent people and the affection of children.
To earn the appreciation of honest critics and endure the betrayal of false friends.
To appreciate beauty;
To find the best in others;
To leave the world a bit better whether by a healthy child, a garden patch, or a redeemed social condition;
To know even one life has breathed easier because you have lived.
This is to have succeeded." *Ralph Waldo Emerson*

E. Ann Sheridan
Barbara Poremba
Sarah Pasternack

Yale School of Nursing 1947, Tina is in the last row, 3rd from right (Photo credit B. Poremba collection)

We gathered together

Mary Ellen Doona

Once called the Missionaries of Mainstreet, the Paulist fathers presided over Tina's funeral. Christmas was still in evidence in wreathes that graced the lofts on either side of the aisle and in two large Christmas trees small white lights. Readings from Ecclesiastes reminded us that this was a time of sadness while those from Timothy stressed that Tina had fought the good fight, finished her race and kept the faith. Eulogies from clergy and family reviewed Tina's long contributions to this world as a lively member of a large immigrant family; as one of the first faculty at University of Massachusetts, Amherst; as assistant director of nursing and then acting director of nursing at Massachusetts General Hospital and; as a member of the Board of the Nursing Archives Associates while in retirement. Tina enjoyed her long life with family, friends, colleagues and fellow members of the Beacon Hill Village. Those gathered at her funeral added their thoughts as they completed the clergy's prompt: "My Tina was..." with "mentor", "generous", "loyal," "an inspiration," and other heart felt words. Testimonials concluded with the clergy reading from a poem that directed that when love was all that was left of a person, then it should be given away to float among those who remain.

So what IS Climate Change? continued from page 3

As the earth warms, we are beginning to see shifts in climate which are resulting in some areas seeing much more rain and others much less, some colder winters, some hotter summers.

As we encounter more extreme heat days and extended heat waves, we are going to see many more heat-related illnesses and even deaths in humans. People who work outside in agriculture, utilities, construction, gas/oil, and many other fields will be at higher risk for hyperthermia. And, of course, extreme storms and wildfires have been taking an enormous toll on human and ecological health

Changes to the earth's climate can have irreversible effects on plants, including our agricultural food crops. Rising ocean temperatures is affecting plankton which is the foundation of the food chain for fish and sea mammals. An estimated billion people are dependent on fish as their main source of protein. In addition to interrupting the world's food supply, there are a great many other health threats that are associated with the changes we are seeing. For an extensive list of how climate change affects human health, visit https://bit.ly/2qNLNtW.

While there are some natural sources of greenhouse gases, the ones that we have the most capacity to reduce are those that are manmade. As individuals we can assess our household's contribution to greenhouse gases by using a "carbon footprint calculator," such as this one from the U.S. Environmental Protection Agency: https://bit.ly/1XIc9pa. As nurses, we can help promote climate healthy purchasing and practices in our health care facilities, K – 12 schools, faith-based organizations, universities, and any other settings in which we have influence.

The new International Council of Nurses (which ANA is a member of) announced its new position statement on climate change in September, 2018 and calls on all nurses to help address climate change (https://www.icn.ch/sites/default/files/inline-files/PS_E_Nurses_climate%20change_health.pdf). It calls for us to know the evidence which, in the case of climate change, is abundant.

We must be able to talk about this issue with a degree of confidence and we must engage both individually and as a profession to advocate for policies and practices that will decrease greenhouse gas production from a wide range of its sources. The truth is climate change is a health issue and that's what we nurses are all about. For more resources on climate change and health, including nurse-focused guides and webinars, visit the Alliance of Nurses for Healthy Environments Climate and Health Toolkit: climateandhealthtoolkit.org. To join our free monthly calls on Climate Change and Nursing please email the authors.

For more information email Barbara Sattler, Professor, University of San Francisco, bsattler@usfca.edu and Cara Cook, Climate Change Program Coordinator, Alliance of Nurses for Healthy Environments, cara@enviRN.org.

CPR Training: An every two year opportunity

Jon Gorman

It happens every two years, the renewal of CPR Certification. Unfortunately, some nurses approach this training with a negative perspective. "I can't believe I have to do this again," "I have better things to do with my time," "I have done this so many times," and "This is a waste of my time" are a few of the comments I hear. These comments are very disappointing to say the least.

CPR (Cardiopulmonary Resuscitation) is one of the most important lifesaving skills a person can receive. CPR takes over for the non-beating heart and pumps blood to the two most important organs – the heart and brain.

Responding to victims in a timely manner is essential for all health care professionals and lay rescuers. Being prepared to respond during a life threatening event is of the utmost importance. During an emergency is not the time to stop and think "Ok what do I do". Studies have shown that several months after a CPR class, if students have not used what they have learned, the knowledge begins to diminish.

There are many healthcare professionals that have the opportunity to practice their CPR skills frequently such as those who work in an emergency room or intensive care unit. However, there are areas where the skill are used infrequently such as an outpatient physician office or some medical/surgical units and lay rescuers. It is important for all health care professionals to remain up to date with the skills learned in a CPR class. This is especially true for nurses as we are usually the first to respond to a medical emergency.

So when two years rolls around again, and it is time for the renewal of your CPR Certification, please think of it as an opportunity. CPR Certification is an opportunity to perfect your recollection of this (literally) life-saving skill. CPR training is the opportunity to reflect on the impact CPR can have for a person to survive a cardiac arrest, no matter the cause.

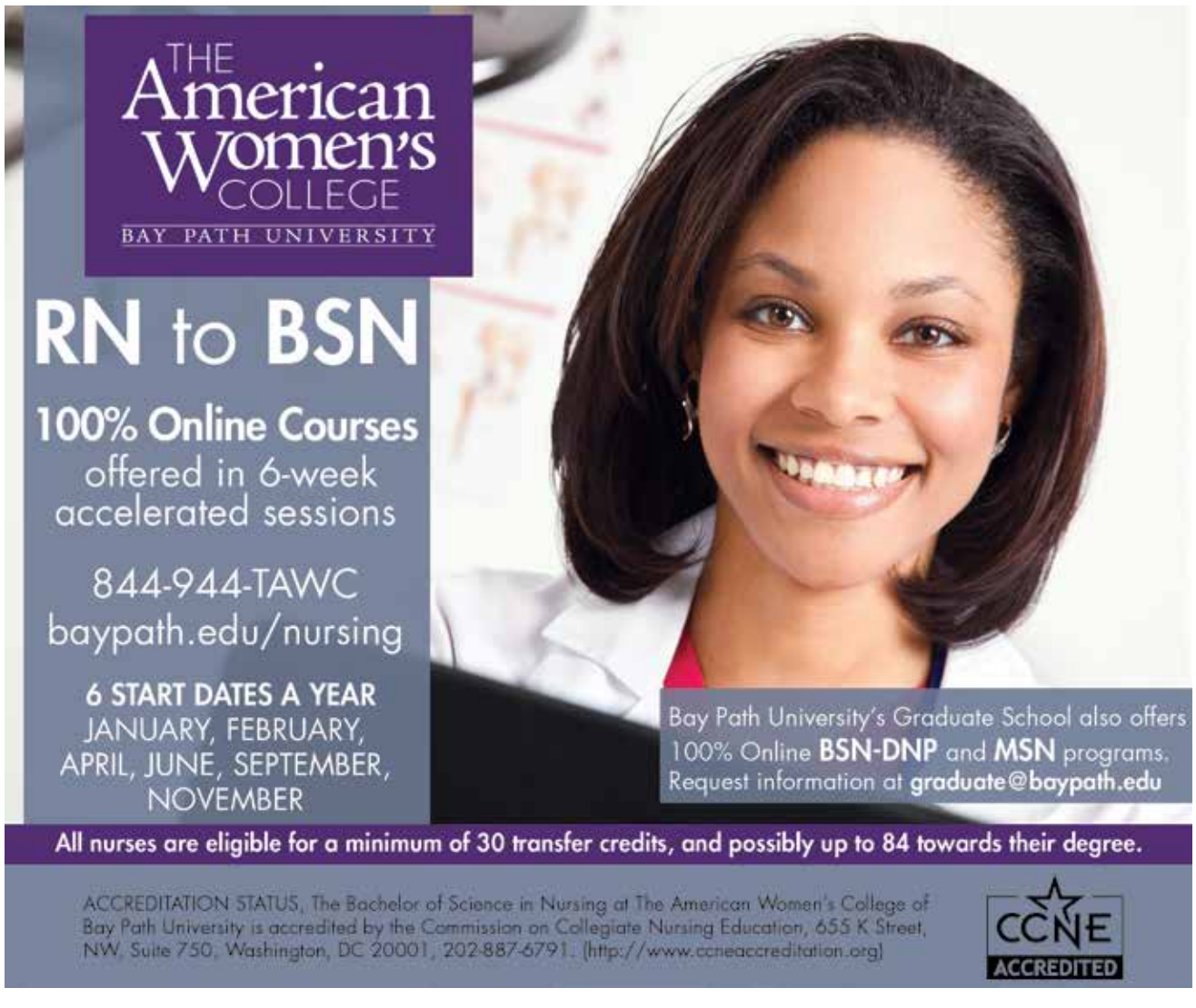
Facts about Cardiac Arrest:

- There is a very small window of opportunity for CPR to be effective. Every minute that goes by without CPR being performed on a person who is suffering cardiac arrest, there is a 7-10% drop in the chance of survival.
- Per the American Heart Association "In one year alone, 475,000 Americans die from a cardiac arrest. Globally, cardiac arrest claims more lives than colorectal cancer, breast cancer, prostate cancer, influenza, pneumonia, auto accidents, HIV, firearms, and house fires combined."

Highlights of the history of CPR from the American Heart Association (see the AHA website for a complete timeline www.heart.org):

Year	Highlights
1960	Cardiopulmonary resuscitation (CPR) was developed. The American Heart Association started a program to acquaint physicians with close-chest cardiac resuscitation. This became the forerunner of CPR training for the general public.
1966	The National Research Council of the National Academy of Sciences convened an ad hoc conference on cardiopulmonary resuscitation. The conference was the direct result of requests from the American National Red Cross and other agencies to establish standardized training and performance standards for CPR.
1979	Advanced Cardiovascular Life Support (ACLS) is developed after discussions held at the Third National Conference on CPR.
1981	A program to provide telephone instructions in CPR began in King County, Washington. The program used emergency dispatchers to give instant directions while the fire department and EMT personnel were en-route to the scene. Dispatcher-assisted CPR is now standard care for dispatcher centers throughout the United States.
1988	AHA introduced the first pediatric courses, pediatric BLS, pediatric ALS and neonatal resuscitation, cosponsored with The American Academy of Pediatrics (AAP).
2000's	Information added regarding Opioid Overdoses. These happen within medical care settings as well as in the community at frightening rates. According to the CDC, more than 30,000 people died of an opioid overdose in 2017 numbers for 2018 are still being compiled.

American Heart Association https://cpr.heart.org/AHAECC/CPRAndECC/AboutCPRECC/WhatIsCPR/UCM_499896_What-is-CPR.jsp



ce corner

Engaging the adult learner

Judy L. Sheehan MSN, RN-BC

The ANCC criteria states that "as part of the educational design process the nurse planner and the planning committee develop ways to actively engage the learners in the educational activities" (ANCC 2015 criteria). Although participants might celebrate being saved from "death by power point," planners and speakers are sometimes left wondering how to "actively engage participants" when delivering a lecture or preparing an online learning module. Appropriate activities must be efficient as well as effective and this will challenge the planner to identify different strategies for large groups, small groups as well as varying spaces and time frames. Gaming, case studies, share and pair, small group discussions, large group discussions, role plays and simulation exercises all offer benefit as well as risks for the speaker. Some speakers might be uncomfortable outside the lecture format or perhaps the content does not lend itself to gaming; the audio visual components might not be available or may be sabotaged by broken links; the participants might not be interested in participating or the energy of the room is low. How does the nurse planner/ planning committee plan for the various scenarios? Speakers and planners benefit by being flexible, creative and always having a backup plan in place.

When selecting engagement strategies, it is always important to look at the intended learning outcome and be sure the strategies for engagement support your program goals. Skill based outcomes may require different techniques from knowledge based outcomes. For example role play and simulation work well in smaller groups and are especially well suited for skill based outcome whereas case examples and voting might work better for larger groups and support knowledge based outcomes. Share and pair might work well in a large group but perhaps not when developing an online program. Gaming can be useful in online learning and small group programs and although it may be difficult to co-ordinate in a large lecture hall it is possible that a skilled presenter would be successful. Clicker systems can engage a large or medium size group, but so can voting cards.

The planning committee should discuss the intended learning outcome and possible related engagement strategies with potential speakers prior to speaker commitment as part of the planning process and consider the effectiveness of the strategies as part of the evaluation. In addition, a nurse planner or a member of the planning committee can be present at the program and undertake some formative evaluation in between sessions or inject some activity before or after breaks to keep the participants involved in the learning. In this way, the educational design comes full circle and linking the design with the outcome and the evaluation.

Memorial

It is with profound sadness that we announce the unexpected passing of Sandra Reissour MSN, RN.

Sandra was the co-chair of the ANCC Accredited Approver Unit for ANA Massachusetts, and mentored many nurses across the state and throughout the country in educational design and interpretation of ANCC criteria. In 2009 Sandra received the President's Award from ANA Massachusetts, and in 2018 was recognized with the Loyal Service Award for her dedication to the association. Sandy was highly respected, valued for her opinion, and loved for her attention to detail and "eagle eye."

Her kindness and willingness to share her expertise with novice educators was a gift to the profession. She will be missed by all who knew and worked with her. Donations* for a scholarship fund may be made in memory of Sandra Reissour to the American Nurses Association Massachusetts, P.O. Box 285 Milton, MA 02186 or online at www.anamass.org.

We are all better from having had the honor to know and work with her.

**Donations are not tax deductible as ANA Massachusetts is a 501c6 corporation. Please consult a tax professional if you have any questions.*

2018 ANEC national magnet nurse of the year award

Sandy Quigley, MSN, RN, CPNP-PC, CWOCN, won the 2018 ANCC National Magnet Nurse of the Year Award: New Knowledge, Innovations, and Improvements award.

A clinical specialist in Wound, Ostomy & Continence Care at Boston Children's Hospital, Quigley is a universally respected nurse leader in the assessment, prevention, and management of pediatric hospital-acquired pressure injuries (HAPI). Her innovative research identified evidence-based, nurse-led practice changes that fundamentally transformed care of HAPI in infants and children worldwide. Most recently, she worked with Dr. Martha Curley and other nursing colleagues from Boston Children's Hospital and five other pediatric hospitals to develop the Braden QD (D is for Device) scale to address pressure injuries from devices, a significant cause of injuries in pediatric patients. The Braden QD Scale was developed from data derived from a broad, diverse sample of hospitalized pediatric patients pre-term to 21 years old, including cardiac patients, and predicts both immobility and medical device-related pressure injuries. It provides acute care pediatric clinicians with one instrument to predict both immobility- and device-related pressure injuries across diverse age and clinical populations.

Searching for evidence: Overcoming barriers

Jane Lawless, Electronic resources Librarian and Liaison to the School of Nursing, Curry College

Not all nurses work in settings that are affiliated with academic or hospital libraries, and therefore some nurses may struggle to access current research and evidence-based information.

Consider this scenario: Monica is a home health nurse with several elderly patients. Some of her patients have recently been hospitalized with urinary tract infections (UTIs). Monica relies on her professional experience, the advice of her supervisor, and her organization's procedure manual for guidance in helping her patients avoid recurrent UTIs, but her curiosity leads her to research the topic on the internet, where she finds an overwhelming amount of information. A recent graduate of a baccalaureate nursing program, Monica remembers that both CINAHL and Dynamed were good sources for evidence-based research. But her Visiting Nurse organization has no access to these resources. In an attempt to find reliable information, Monica turns to PubMed, and is glad to find there some tutorials that help her construct a search. She finds a recent article that is of great interest to her, which speaks directly to the problem her patients are facing – but it would cost $35.00 to download! While in her nursing program, she could use her college's interlibrary loan service, but that's no longer available.

What are Monica's options? Monica has several options:

- She can pay for that article.
- She can contact her local public library – either where she lives, or where she works - and speak with the reference librarian about obtaining it through interlibrary loan, at no cost.
- She can register for Loansome Doc, https://docline.gov/loansome/login.cfm which allows unaffiliated health professionals to select a Massachusetts health sciences library through which to make requests.

Once Monica obtains and reads her article, she can discuss with her supervisor any evidence-based practices she thinks her organization might consider to improve health in patients with recurrent UTIs.

There are many barriers that prevent nurses in the community, who have no access to hospital or academic libraries, from accessing evidence-based research articles. Among the most frequently documented barriers are lack of time and lack of access to resources. Community health nurses who research topics of concern, as Monica does, are likely doing so on their own time, and with little support. What resources are available?

- Use freely available resources that search reliable internet health literature, including PubMed https://www.ncbi.nlm.nih.gov/pubmed/ and Google Scholar https://scholar.google.com. Tutorials for searching both resources can be found on Youtube https://www.youtube.com/. PubMed and Google Scholar provide access to peer reviewed articles, but in some cases (like Monica's) only a citation is provided, or you are asked to pay for journal access. You too can use public library interlibrary loan services, or Loansome Doc, to request articles which are "behind the paywall."
- The National Institutes of Health website https://www.nih.gov/health-information includes health resources for consumers and health professionals, including guidelines for treatment, which cite evidence based research.
- The Center for Disease Control and Prevention https://www.cdc.gov/ includes extensive information about diseases and conditions, including references to peer-reviewed and evidence-based resources.
- Some major research hospitals, like the Mayo Clinic https://www.mayoclinic.org/ and Johns Hopkins Health Library https://www.hopkinsmedicine.org/healthlibrary/ offer diagnosis and treatment guidelines endorsed by those institutions.

In addition to accessing information resources, it's important to form alliances with people who can support your research interest. Find an ally within your organization - or outside of it - with whom you can discuss your topic of interest. Resist the impulse to wrestle alone with your computer results.

- Make use of all libraries and librarians available to you. Along with your public library, most community college libraries, and some colleges and universities will allow visitors to search for materials, and help with their queries. Call and ask the reference librarian.
- Create an account with the New England Regional office of the National Libraries of Medicine https://nnlm.gov/user/join or sign up for their newsletter https://news.nnlm.gov/ner/newsletter/ to learn about online classes that will help you identify available resources.
- Watch for new initiatives – like the Public Health Digital Library https://nnlm.gov/nphco/about. This national initiative hopes to make subscription resources available to health professionals, including the unaffiliated, through public health departments.

Monica might feel somewhat isolated with her questions, but there are supportive connections available to her, and to you. Professional curiosity matters greatly. Following it to find reliable resources will improve your practice, knowledge and satisfaction.

clio's corner

The fiftieth anniversary of nursing education

Mary Ellen Doona

In June 1923 the National League of Nursing Education (formerly the American Society of Superintendents of Training Schools for Nurses) convened at the New Ocean House in Swampscott, Massachusetts. Founded thirty years before at the 1893 World Columbian Exposition in Chicago, the Society focused on nursing education. Nurses attending the convention hoped that the just released Rockefeller Foundation study of nursing education would reform nursing education as the Flexner Report (1911) had reformed medical education.

The Foundation had rejected nursing's proposal as had other foundations until nursing's philanthropist, Gertrude Weld Peabody, contacted family friend, John D. Rockefeller. Once he called the Foundation, nursing's application got underway. Sara Parsons who headed nursing at Massachusetts General Hospital persuaded the Foundation to expand its focus beyond public health nursing to include hospital nursing. After Harvard declined implementing the study's recommendations, Yale accepted the task effectively establishing the Yale School of Nursing in 1923 with Annie Warburton Goodrich as its dean.

Little wonder that the convention erupted in enthusiastic applause when Goodrich was introduced at the convention's banquet. The Goldmark Report, as the study is still commonly called, and Goodrich's conspicuous status augured a "new era in nursing education." Nursing education's new era, however, was secondary for the banquet's program aimed to shine a light on nursing education's founding era of fifty years before. Guests of honor at the banquet were nursing education's founders: Linda Richards, Mary E. P. Davis and Lucy Lincoln Drown. Except for her sudden death three years before, Sophia French Palmer would have made the trio a foursome.

First, of course, was Linda Richards (1841-1930). Long before she became the frail 82-year-old guest of honor, Richards had accepted nursing's first diploma. In 1873 she was the first of five students to complete Dr. Susan Dimock's one-year training program at the New England Hospital for Women in Children (now Dimock Community Health Center. The Smithsonian in Washington D.C. preserves the diploma).

Goodrich was fulsome in her praise exclaiming that Richards' story was already in nursing students' history books; her photograph was on the walls of almost every school; and, her name was connected with general nursing, mental health nursing and nursing in Japan. Although her *Reminiscences of Linda Richards: America's First Trained Nurse* (1911) was not mentioned those in attendance probably owned a copy. The 400 nurses who rose in tribute, said Goodrich, were "a small proportion of the vast throng of nurses now scattered all over the world."

Anna Maxwell (1851-1929) reminisced saying, "Miss Richards trained me [at the Boston City Hospital] in the early ways to bright living and briskness, for you know in those days, as I remember it, we had fifty nurses for six hundred patients. But though difficult, we felt we learned from Miss Richards' standards more than we could ever impart to our future students. She gave us an inspiration; she showed us how in every possible way to care for the sick."

Richards responded to these and other tributes that followed:

> I did not expect to make a speech, but may I say that I feel very insignificant in receiving all this praise, which to me does not seem right. When I look forward and see the work that is accomplished by the nurses today and look backward on my own little beginning, the very small part of the work I have been able to do, I feel as though the praise should not be mine, but should be for the workers of today. I appreciate all you say and I am very, very happy to meet you and thank you for the kind words and kind thoughts.

One of Richards' first students at the Boston Training School, Mary E. P. Davis (c.1840-1924), along with her classmate Sophia Palmer, who did what all good teachers wish and as all good students do. They far surpassed their teacher. Davis labored to make nursing a profession, spoke at the Chicago fair, served as the Society's second president, launched the *American Journal of Nursing* in 1900 and got laws to regulate who might call themselves a trained nurse. She rallied nurses and their colleagues in Faneuil Hall in 1903 during which time the Massachusetts State Nurses Association was created. That the MSNA continues in an unbroken thread from its beginning that day to the American Nurses Association Massachusetts of 2019 speaks to the strength of the foundation she built.

Carrie Hall (1873-1963), Superintendent of Nursing at the Peter Bent Brigham Hospital and fellow MGHSON alumnus read the letter Davis sent to the assembled nurses. She "would gladly accept the honor if it were within bounds of possibility, which from the slow and uncertain progress I am making towards normal I know is not to be considered." The 83 year-old Davis continued: "I have not been able to ride…and have walked out two or three times round the block. I have to lie down two or three times during the day and I retire between 6 and 7 p.m. My ears buzz yet and my eyes are not as keen as usual." Then Davis addressed the convention saying:

> I send my best wishes to the old comrades who will be there and tell how the society was formed and how many are left to tell the tale, and to the late members who have so vigorously overcome obstacles which seemed almost insurmountable and who still see difficulties, my message is 'The cause is just,' and if continued along the lines as heretofore of self-immolation and loving service must result in victory. Again thanking the M.S.N.A. and voicing my regrets, I am, Very truly yours, M. E. P. Davis."

Sophia French Palmer (1853-1920), Davis' classmate, was at the beginning, in fact created many beginnings, of nursing's long and troubled journey to full professional status. To Palmer belongs the insight that it was futile to expect doctors and hospitals to recognize nursing students as learning professionals. Women's status at the time and the hospital's economic need for nursing students' cheap labor took precedence. She reminded nurses they were citizens and had access to the law. As editor of the *AJN* she directed and encouraged nurses in their quest for laws and chastised and exposed doctors who would stand in the way of nursing's progress. Palmer's "wise thought protected and advanced all the interests of nursing, especially in her journalistic work," Lucy Lincoln Drown said as she addressed the convention.

Many are Palmer's contribution to nursing but perhaps the least known is her establishing the nurses' training school at St Luke's Hospital in New Bedford. That school accepted Frank Bertram and when he completed the program in 1886, he became the first man to graduate from a nursing program in a general hospital. Since 1882 men had graduated from specialty hospitals such as the McLean Hospital's program. Its graduates could not meet the Board of Registration in Nursing standards set in 1910 due to their lack of general hospital training. During her much more vigorous days, Davis was a one nurse accreditation force protecting nursing's hard won standards.

The fourth of the honorees, Lucy Lincoln Drown (1847-1934), came to nursing after graduating from Salem Normal School and teaching in Newton Lower Falls and Pennacook, New Hampshire. Immediately on graduating from Boston City Hospital Training School in 1884, Drown became Richards' assistant and then her successor when she left for Kyoto, Japan. The banquet lauded the 76 year-old Drown as "a conscience, an incentive, a person who gave opinions with very calm and deliberate judgment." She addressed the convention:

Lucy Lincoln Drown

> I still seem to be one of the links between the distant past and the present. In accepting this invitation my mind has gone back many times to that coterie of women, profound earnest women, who met together so many years ago to consider the problems that are familiar to you. They came so fast that we hardly knew which one to choose first. The proper admission qualifications for the candidates and for the training schools, the length of the course, the curriculum of study, the better character of the nurses, the better preparation of the teachers-all these and many more had to be met as best we could. And I look back on all the pictures on memory's walls there come before me some of the faces that I wish could assemble here tonight and see you all gathered together.

Mary Margaret Riddle (1856-1936) was also a teacher before enrolling at Boston City Hospital Training School and became Drown's assistant at graduation in 1889, and remained in that position until 1904 when she became nursing superintendent at Newton Hospital until 1921. Ever a leader, Riddle became MSNA first president (1903-1910), president of ANA from 1903-1905 and of NLNE in 1910. From 1910 to 1926 she was the senior nurse of the doctor-led Board of Registration of Nurses. In all that she did she emphasized that nursing must educate or perish.

As Drown concluded her remarks she said: "Years have gone; the little company has gone; the nurses have come up from North and South, the East and West; and progress thus has become manifest; and as years go on we begin to look to you its leaders to a higher sphere." The next year Davis was gone to become yet another picture on "memory's wall." In spite of infectious diseases that were the leading causes of illness and death in the pre-antibiotic 1920s all the honorees lived beyond the fifty-five years that was then a woman's life span. Sophia Palmer was sixty-seven years old when a stroke suddenly claimed her life. Other honorees lived into their eighties with Linda Richards living for eighty-nine years before she, too, became a picture on "memory's wall."

In four more years, 2023, nursing education will mark its one-hundredth year. Nursing students are no longer staffing nursing departments. They are on college campuses with other young people as they earn degrees. There were many twists and turns in nursing's long journey to the academic setting. Linda Richards, Mary E. P. Davis, Sophia Palmer and Lucy Lincoln Drown started nurses on that journey. Their story from the "distant past" provides inspiration for nurses of the "present" as they step into nursing education's next hundred years.

Source for quoted material:
Proceedings of the Twenty-ninth Annual Convention of the National League for Nursing Education, Baltimore, MD: William & Wilkins Company, 1923, 153-161.

who is the masthead nurse?

Anna Caroline Maxwell

New York native, Anna Caroline Maxwell (1851-1929), served as assistant matron at the New England Hospital for Women and Children from 1874-1876 and while there took a three month course in obstetrics. She then enrolled in Linda Richards' program at Boston City Hospital graduating in 1880. From 1881-1889, Maxwell headed the Boston Training School (precursor to Massachusetts General Hospital School of Nursing). Thus prepared, she returned to New York first to lead nursing at St Luke's Hospital (1889-1891) and then to found the Presbyterian Hospital School of Nursing (1891-1921). After caring for soldiers felled by a typhoid epidemic during the Spanish American War (1898), she joined with others to persuade Congress to create an Army Nurse Corps (1901).

Honoring cadet nurses

Barbara Poremba, EdD, MPH, MS, RNCS, ANP, CNE

For 22 years, efforts to grant veteran status to the United States Cadet Nurse Corps (USCNC) have failed. Currently, there are two NEW BILLS in the Congress for the United States Cadet Nurse Corps Service Recognition Act. Senator Warren introduced the bill in the Senate on Pearl Harbor Day. The companion bill followed in the House. If passed, it will grant the USCNC honorary veteran status. It will mean that the 124,000 members will be eligible to receive an American flag and gravesite plaque marking their service. There is precedent for this. In 2017 Congress passed into law The Honor Our Merchant Mariners Act which provided the same burial benefits to this all-male civilian WWII group.

Please consider reaching out to your U.S. Senators and U.S. Representative to COSPONSOR the bipartisan bicameral bill, the United States Cadet Nurse Corps Service Recognition Act. Call or use the ANA link provided on the website. It literally takes two minutes!

Preserving Nursing History

The USCNC is a significant part of our nursing history that must not be forgotten. It was the nation's first and only integrated uniformed corps that admitted African, Native and Japanese American females for service. It was passed by an Act of Congress and signed in to law by FDR to meet the nation's critical shortage of nurses for the military and civilian population.

The USCNC was essential to the success of the war effort. The government recruited our teenage girls and enlisted them to serve for the "duration of the war". Although the war ended, the Cadet Nurses fulfilled their three years of service, including six months deployment as far away as Alaska. Yet they were never recognized as veterans.

Let's change his-story and tell her-story too!

But why stop there? Symbols of the contribution of our female nurses to the success of WWII should be as important as the many statues honoring the contributions of men. A statue of a Cadet Nurse or a suitable monument to the USCNC on the Boston Common would honor these young women who answered our country's call for service during wartime while educating about this amazing all-female corps and serving as a visual role model for which our girls may aspire.

Dr. Barbara Poremba is Professor Emeritus of SSU and Founder and Director of the advocacy group Friends of the USCNC WWII

She welcomes hearing from Cadet Nurses, organizations and individuals at FriendsofUSCNC@gmail.com

For more information please go to https://www.nursingandpublichealth.org/cadet-nurses.html

Follow us on Facebook: Friends of the USCNC WWII

Cadet nurse: Dorothy Hall continued from page 2

What is the Legacy of the USCNC?

"I don't think that the Cadet Nurses were ever recognized for their true value for what they did for the war effort." Dottie explained, "We increased the number of nurses, relieved trained nurses for war and staffed the hospitals. Without us, there would have not been nurses for the front lines or in military and civilian hospitals. We were recruited by the federal government and were used in many instances to enhance the war effort." Many Cadet Nurses eventually ended up in the military, veteran, or government hospitals. They provided 85% of the nursing staff in civilian hospitals.

Dottie went on to explain, "I think it is important to recognize the USCNC as a military branch. They served a purpose that was outlined for them by the federal government. Cadet Nurses contributed to the war effort and humanity at large. There has been nothing in the last 75 years that has supplanted what it did. It was a one-time deal and there hasn't been anything like that again. There is no question that it was the exact solution to the problem" at that time.

"I remember seeing the recruitment posters."

Why does the USCNC deserve veteran status?

"Well," she sighed, "I think it's a little late but we are certainly well-deserving. I feel that I served my country because I stood up and responded to a need at the time."

She sat back and went on. Cadet Nurses "filled a void back in the days of war. We were established by the President [Franklin Delano Roosevelt] and an act of congress. We served our country and did our part for the war effort."

In looking at what qualifies a person as a war veteran, Dottie explained slowly, "you have to differentiate intent, interest and willingness to participate. If you were in the Army, it didn't make a difference if you were facing a gun or not. Many soldiers didn't serve overseas. Many stayed on the home front to work. And they were all treated the same." Those who serve in the military are given the same veterans benefits under the GI bill, such as VA medical, higher education and military burial rights, without differentiation of role or function.

For example, Dottie clarified, "My kid brother was in the Korean war. He didn't go overseas. He was in the Air Force. He trained in Texas and was stationed in Kansas. And he is treated the same as any other veteran of the war."

I asked Dottie if she thought that things would be different had they been an all-male corps. She answered without hesitation, "Yes, I think that if the Cadet Nurses were all male, we probably wouldn't be sitting here today thinking about getting recognition. They would have had it from the beginning."

Impact of DNP education

Barbara Belanger, RN, MSN, CNOR

Nurses exemplify characteristics and practice approaches that are key in the achievement of sustainable healthcare reform. Nursing's experiential clinical skill to recognize areas for performance improvement generates from a patient-centered focus to promote safety and quality. Nurses demonstrate leadership ability to promote success from an interdisciplinary and interprofessional perspective. Education and an evidence-based practice approach supports nursing's influence to promote healthcare reform. Nurses have an option for two terminal degrees. The research focused PhD degree and practice focused Doctor of Nursing Practice (DNP) (Chism, 2019, p. 11-13).

The growth of the DNP degree was reinforced by the Institute of Medicine (IOM) reports on the state of healthcare in the United States and the Robert Wood Johnson Foundation (RWJF) reports on nursing. The American Association of Colleges of Nursing (AACN, 2006) *Essentials of Doctoral Education for Advanced Nursing Practice* provide the foundation that supports strategic development of DNP program curriculums. Skills and competencies demonstrated by DNP prepared nurses reflect the impact to promote performance improvements and innovation in healthcare delivery practices and patient health outcomes. Advanced Practice Registered Nurses (nurse anesthetists, nurse midwifes, nurse practitioners and clinical nurse specialists) and executive nurse leaders are the major specialties for DNP prepared nurses (Chism, 2019, p. 11-21).

The role of the DNP prepared nurse includes administrative, executive and leadership roles. The impact from DNP prepared nurses to guide systems-based change with the delivery of healthcare comes as a result of advanced education and mentoring "…in several key areas, such as quality, service, process assessment, and improvement, making him or her a valuable asset to address these challenges and transform the healthcare landscape" (Sherrod & Goda, 2016, p. 13).

Roles that DNP prepared nurses assume influence healthcare policy development, prevention, population health and wellbeing, and informatics. Skills that promote success for DNP prepared nurses include an ability to collaborate with interprofessional and diverse teams to meet multiple stakeholder interests. At the core of a DNP strategic practice is an evidence-based practice approach that links theory with science (Chism, 2019, p. 11-21; Grace, 2018, p. 2). Nurses seeking to collaborate on performance improvement initiatives to promote quality care, patient safety, positive patient outcomes, efficiency, and access can evaluate the DNP education as a professional path with a connection to nursing practice (Sherrod & Goda, 2016, p. 15).

American Association of Colleges of Nursing. (2006, October). *The Essentials of Doctoral Education for Advanced Nursing Practice*. Retrieved from https://www.aacnnursing.org/

Chism, L.A. (2019). *The Doctor of Nursing Practice: A guidebook for role development and professional issues*. Burlington, MA: Jones & Bartlett Learning.

Grace, P. (2018, January 31). Enhancing nurse moral agency: The leadership promise of Doctor of Nursing Practice preparation. *The online Journal of Issues in Nursing*; 23(1), Manuscript 4. DOI:10.3912/OJIN, Vol23No01Man04

Sherrod, B., and Goda, T. (2016, September). DNP-prepared leaders guide healthcare system change. *Nursing Management*; 13-5.

What do nursing faculty really do?

Susan A. LaRocco PhD MBA RN CNE FNAP

Perhaps you have precepted new graduates? Or maybe you have worked as a clinical instructor, supervising a group of nursing students in a health care setting? Now you are thinking that you would like to be a full time faculty member. You are a clinical expert and really enjoy working with students. So, what do faculty really do? Sure they teach in the classroom, but that might only be 9 to 12 hours a week. What else do faculty do?

Typically faculty are expected to be active in three areas: teaching, scholarly work, and service. Depending on the college or university, there may be more emphasis on one area than on the others. A research intensive university will have high expectations for scholarship. To become tenured, faculty will need to obtain grant funding for a program of research, with expectations for frequent scholarly publications. Other settings may be more teaching intensive, with heavier course workloads and less emphasis on (or time for) scholarly work. All educational settings will expect faculty to participate in college service by participating on committees and advising students.

Faculty governance and peer review are central tenets of the college environment. While this provides for input into the policies and practices of the work setting, it is also time-consuming and, at times, frustrating. There are seemingly endless meetings and lengthy discussions before decisions are made. This can be annoying to nursing faculty who are used to making critical decisions in a fast paced environment. As English faculty quibble over a word, and philosophy faculty ponder some obscure point, nursing faculty have been known to roll their eyes. Personally, I like it. I love the opportunity to make a coherent argument for a curriculum or policy change, and to consider other perspectives. While there are many aspects of a nursing program that are unique, it is important to remember that it is a school or program within a college structure.

Within the nursing program, one of the most important areas is curriculum development. Reviewing and revising the curriculum to keep it relevant is essential. This involves keeping current on topics such as the NCLEX, white papers from professional organizations, research findings, and government regulations.

Service to the profession is also a key component of a faculty role. This can include serving on a committee or board of directors of a professional organization, organizing a team for a charity event, or volunteering in a health care facility. Often there are opportunities to include students in these activities.

Of course, students are (or should be) a major focus. Advising students (formally and informally), working with students in the Student Nurses Association, planning and participating in events such as pinning or the blessing of the hands, and taking students on study abroad experiences are some of the varied expectations for faculty.

It is important for nursing faculty to remember that they are also professional role models. Students and other faculty are observing. How we treat our peers and students shows our students how professionals should behave. Respectful conversations, thoughtful listening, and openness to new ideas and evidence help our students to value the professional demeanor that is essential to teamwork in the health care setting.

Even in a college that is not research intensive, scholarly work is essential. This primarily means publications and presentations. Publications do not need to be based on original research. As a clinical expert, there are opportunities to write for the clinically focused journals. Presentations at educational conferences are typically focused on teaching and learning topics, including ideas that have been implemented in the classroom or simulation and skills labs.

Many faculty also serve as clinical course coordinators. This involves supervising and supporting the clinical faculty and students. Making sure that students have an excellent clinical experience while providing safe patient care can be challenging.

Still think that you want to be a nursing professor? If so, it is essential that you begin a doctoral program if you have not already obtained a terminal degree. This is the expected credential for faculty. Before making a commitment to a doctoral program, be sure to do your research and give careful consideration to whether you want to pursue a DNP, an EdD or a PhD. But that is a topic for another day.

How to be an ally for transgender and gender diverse patients

Katharine Thomson, PhD and Sabra L. Katz-Wise, PhD

Imagine an adolescent patient is admitted to the hospital. She has limited family support so her friends are eager to visit her. When her friends check-in at the information desk they are told there is no patient by that name admitted to the hospital and turned away. The patient is a transgender girl named Alexis whose medical record indicates only her assigned sex (male) and birth name, Jacob. Since her family is not supportive and her friends could not get past the information desk, Alexis does not have a single visitor during her multiple-day hospital stay. How can institutions and clinicians improve care and prevent scenarios like this in the future? Step 1: Educate yourself and become a transgender ally!

First, Gender 101. Everyone has a gender identity. Regardless of a person's sex assigned at birth, a person may identify as a woman, a man, both, neither, or they may be gender fluid (moving between two or more genders). Some people identify as *cisgender* — when one's gender corresponds with their sex assigned at birth. Others identify with a gender that is different than what was assigned to them at birth and may identify as *transgender* and/or *gender diverse* (see vocabulary for more terms). Never assume that you know a person's gender identity from the way they talk, dress, or act (i.e., "gender expression").

Second, let's talk pronouns. In a healthcare setting, respecting a patient's gender identity and asking about the name and pronouns they use is a crucial element of good clinical care and is an important sign of respect. Proper pronoun use can also increase communication and trust with patients. Always make sure to ask for someone's affirmed pronouns and name in a respectful and private setting. Don't ask about gender or pronouns to be "nosy" – ask because you are striving to be a respectful clinician. You might start the conversation by introducing yourself using your own pronouns; for example, "Hi, my name is José, and I use the pronouns she/her/hers." You can follow with: "Feel free to let me know your pronouns if you would like to share; I don't want to make any assumptions." Keep in mind: 1) pronouns do not signal gender identity (i.e., even if someone tells you their pronouns, this does not tell you about their gender identity) and 2) again, never assume you know a person's pronouns from the way they talk, dress, or act.

One way to assure proper name and pronoun use is to collect this information on intake forms. If (and that's a big IF) the patient provides consent for their affirmed name and pronoun to be used across settings, and regardless of who is in the room, the correct name and pronoun should be used at all times. If the patient does not provide consent for their affirmed name and pronoun to be used across settings, be sure to ask which name and pronoun to use in their medical file. It is important to remind patients and families that a patient's legal name and assigned sex will still appear on some documents for insurance or medical reasons. It can help to warn patients and apologize about this in advance.

For younger patients, you might say something like, "Do you want others to use words like 'she' when describing you? Or words like 'he'? Or 'they'? Or something else?" If a youth's pronouns are different from what would be "expected" based on their assigned sex or appearance, it is very important to ask if you have their permission to use their affirmed pronouns in front of others (e.g., parents or guardians). For safety reasons, a youth may ask providers to switch between pronouns, depending on who is in the room; for example, using 'they' pronouns when other providers are in the room, but using 'she' pronouns when their parent or guardian is in the room. This is very important to respect; using the affirmed pronouns when a parent or guardian has not been previously informed can put a youth at risk for negative reactions or even rejection.

Common pronouns

You may see this list and think to yourself "'They' cannot be used as a singular pronoun!" In fact, 'they' *can* be used as a singular pronoun (www.merriam-webster.com/words-at-play/singular-nonbinary-they) and it's already a common part of the English language (go back to the second paragraph for a great example). Still, you may

feel that this requires some reorganizing of your grammatical neuropathways… and that's OK! Mistakes are understandable. If you make a mistake with your patient's affirmed pronouns, apologize briefly, correct yourself, and move on. Committing to learning "new" grammar is much easier and much less damaging than the alternative of someone being misgendered (using incorrect name or pronouns)! Being cisgender comes with privilege, and part of being an effective ally is learning new things and advocating along with our transgender and gender diverse patients and colleagues.

Finally, what can you do in your workplace to promote a welcoming environment for LGBTQ+ patients? First, provide a gender neutral restroom! Update your clinical forms to be inclusive and respectful. Don't make assumptions about someone's gender identity, pronouns, or sexual orientation. And don't assume patients will share information without being asked. Greet patients in a gender neutral way, especially in public spaces; for example, using a person's first name rather than saying "Mr." or "Mrs." Mirror language used by your patients (e.g., if a patient identifies as genderqueer, document "patient identifies as genderqueer"). If your office has brochures with health information, be sure to include materials showcasing diverse sexual orientations and gender identities, as well as different types of families (e.g., same-sex parents). Showcasing rainbow imagery – a pin on a lanyard, a sticker on an ID badge, a sign on your office door – may help LGBTQ+ patients and families identify that you are an ally. Adding your pronouns to your email signature, badge, or business cards can also signal that you are someone who recognizes the importance of using affirmed pronouns. Putting your pronouns in these places is a step toward making it part of everyday practice.

Clinician's Guide vocabulary

Sex assigned at birth (noun) is the determination of an infant's sex at birth. Typically, anatomical characteristics are used to classify an infant as female or male or intersex. Often referred to as simply "sex" and should not be confused with gender. Often "biological sex" is seen as a binary but there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics. It is more accurate to view sex as a spectrum, which is more inclusive of intersex people and trans-identified people.

Intersex (noun) is a person whose combination of chromosomes, gonads, hormones, internal sex organs or genitals differs from the two "expected" patterns of male or female. Differences/disorders/diversity of sex development, or "DSD," is also often used. Formerly known as hermaphrodite or hermaphroditic, these terms are now considered outdated and derogatory.

In the past, intersex was considered an emergency that doctors moved to "fix" right away in a newborn child by assigning a male or female sex. There has been increasing advocacy and awareness brought to this issue. Many individuals advocate that intersex individuals should be allowed to remain intersex past infancy and should not automatically be treated as a medical emergency.

Gender identity (noun) is the internal perception of one's gender, and how a person labels themselves based on how much they align or don't align with what they understand their options for gender to be. Common identity labels include man, woman, genderqueer, trans and other diverse gender identities. Gender is not to be confused with sex assigned at birth or "biological sex."

Gender expression (noun) is the external display of one's gender through a combination of dress, demeanor, social behavior and other factors, generally measured on culturally-sanctioned scales of masculinity and femininity.

Cisgender (adj.; pronounced "siss-jendur") is a person whose gender identity corresponds with their biological sex assigned at birth (for example, assigned male at birth and identifies as a man). This term can be shortened to "cis," which is a Latin prefix that means "on the same side [as]" or "on this side [of]."

Trans (adj.) is sometimes considered to be an umbrella term for people whose gender identity differs from the sex they were assigned at birth. Trans people may identify with a particular descriptive term (transgender, genderqueer, FTM/Female to Male, etc.) or identify simply as "trans." Though some non-binary individuals do not consider themselves under the "trans" umbrella and consider the term to be an abbreviation for transgender only. Always follow an individual's self-identified terms.

Transgender (adj.) typically indicates a person who is living or transitioning into living as a member of a gender other than what would be "expected" based on their sex assigned at birth. What this means can vary from person to person. For example, a

person may or may not choose to have any medical interventions (e.g., surgery, hormones) and/or a person may or may not change their name and/or pronouns to affirm their gender. Transsexual is a relatively outdated clinical term that you may encounter in medical literature used to refer to transgender people who are choosing to pursue medical interventions, but many people in the transgender community find this term offensive.

Because sexuality labels (e.g., gay, straight, bi) are generally based on the relationship between the person's gender and the genders of individuals they are attracted to, a trans person's sexuality can be defined in a variety of ways. Take the person's lead on their own labels and definitions.

Heteronormativity/cisnormativity (noun) is the assumption, in individuals or in institutions, that everyone is heterosexual and cisgender, and these identities are more "normal" or superior compared with other sexualities and gender identities. This leads to invisibility and stigmatization.

Gender diverse or gender non-binary (adj.) are catch-all terms for gender identities outside of the gender binary and cisnormativity. People who identify as gender diverse or non-binary may think of themselves as one or more of the following, and may also define these terms differently:

- aspects of both man and woman (bigender, pangender)
- neither man nor woman (genderless, agender)
- moving between genders (genderfluid)
- additional terms including but not limited to genderqueer, third gender, other-gender, gender expansive and gender creative

Microaggressions (noun) are the everyday verbal, nonverbal, and systemic insults and slights, whether intentional or unintentional, that communicate hostile, derogatory or negative messages targeting individuals based solely on their marginalized group membership.

Queer (adj.) is generally used as an umbrella term to describe individuals who identify as non-straight or gender non-binary, and is sometimes used interchangeably with LGBTQ – "the queer community." Queer was historically a derogatory term, and some may still find this term offensive. Always respect an individual's own identity labels and definitions, and only use this term if the person/group has indicated the term first. Many individuals identify as "queer" and do not to use other labels such as "gay" or "bi." If appropriate, you might ask someone what it means for them so you don't make any assumptions.

Katharine Thomson, PhD (she/her/hers) is a clinical psychologist on the Psychiatry Consultation Service at Boston Children's Hospital, co-chair of Boston Children's Rainbow Consortium on Sexual and Gender Diversity, a Boston Children's Safe Zone lead facilitator and Instructor in Psychiatry at Harvard Medical School.

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Healthy Nurse, Healthy Nation

On May 1, 2017, ANA Enterprise launched a bold initiative — Healthy Nurse, Healthy Nation™ (HNHN) Grand Challenge— to transform the health of our nation by first improving the health of its 4 million RNs. In just over a year, more than 25,000 individuals and 350 partner organizations have joined this exciting movement.

What is HNHN Grand Challenge?

Grand challenges embrace beneficial goals addressing systemic and embedded social problems through collaboration and joint leadership. Past examples include campaigns to stop littering and to encourage seatbelt use. This grand challenge focuses on improving the health, safety, and wellness of nurses and nursing students, leading them to be more effective role models, advocates, and educators.

HNHN:

- Connects and engages individuals and organizations to take action within five domains: physical activity, sleep, nutrition, quality of life, and safety.
- Provides a web platform to inspire action, cultivate friendly competition, provide content and resources, gather data, and connect nurses, employers, and organizations.

When participants join, they create a profile page, make a health commitment, join challenges, engage in discussion, access resources and blogs, and take a health-risk appraisal (HealthyNurse® Survey)—all available on the interactive HNHN Connect platform. A private Facebook community and text-to-join option are available. Nurses and nursing students are chosen for a biweekly #healthynurse spotlight showcasing their wellness journey in blog, social media, and newsletter content. Contests for health and wellness prizes are offered. Our first year's most popular challenge, Curb Your Sweet Tooth, urged participants to decrease sugar in their diet.

Join the movement! Nurses and nursing students face unique hazards in the work place and multiple health, safety, and wellness risks in their personal lives. The ongoing data from the Healthy Nurse® Survey show there is room for improvement in nurses' health, particularly with physical activity, nutrition, rest, safety, and quality of life. Effective workplace programs are still needed for wellness, safe patient handling and mobility, needle-stick prevention, workplace violence, stress reduction, and other issues. Nurses need to be involved in the planning and implementation of these programs as well as in the selection of safety devices. Since 64% of nurses surveyed reported putting the health, safety, and wellness of their patients before their own, now is the time to educate nurses and employers on the importance of nurse self-care and safety, and encourage nurses to put themselves first. Nurses give the best care to patients when they're operating at their own peak wellness. HNHN is here to fill that gap. Join the movement at hnhn.org and text healthynurse to 52-886 to get challenge tips.

HEALTH/SAFETY/WELLNESS

HEALTH

- 89% responded affirmatively to "Do you feel well today?"
- About three-quarters received routine checkups and dental care within the past year
- 91% received the seasonal flu vaccine in the past 12 months
- 43% of those that qualified for the pneumococcal vaccine received it
- The average body mass index (BMI) for respondents was 27.6, which was in the "overweight" category
- Allergies (44%) and lower back pain (31%) were the most commonly diagnosed medical conditions among respondents

SAFETY

- 88% used sunscreen with SPF 15 or higher
- About 11% had used an artificial UV light to tan in the past year
- Talking on the phone was the most frequently identified distracted driving behavior

WELLNESS

- Only 16% ate five or more servings of fruits or vegetables per day, and 35% ate 3 or more whole grain servings
- 48% of respondents did muscle strengthening activities two or more days per week
- 58% went out to eat two or fewer times a week
- 85% drank 35 ounces or less of sugar-sweetened beverages weekly
- 94% did not smoke cigarettes at all, and of those who did smoke, 56% were actively trying to quit
- On average, respondents slept seven hours in a 24-hour period

Source: *American Nurses Association & Insight Consulting Group (2016). Health risk appraisal exploratory data analysis. November 30, 2016. (PowerPoint slides).*

bulletin board

Friday, March 29, 2019,

Royal Sonesta Boston/Cambridge, MA

Join us at the 18th **Anniversary Spring Conference** as we share knowledge and celebrate nurses at the Annual Awards Dinner.

8:30 AM Conference: Responding to Rising Challenges in Nursing and Healthcare This year's conference discusses responses to rising challenges in nursing and health care including violence against nurses, nursing resiliency during the opioid crisis, concussion management and weight stigma.

4:30 PM Annual Business Meeting

6PM Annual Awards Dinner ANA Massachusetts Awards honor the remarkable, but often unrecognized work of members. You probably work with or know nurse colleagues whose commitment to nursing and to patient care is exemplary. Yet in the rush of today's world, there is often little time to acknowledge them and their professional contributions. ANA Massachusetts has established several awards to recognize those nurses who have made a difference.

March 27, 2019

The Future of Health Reform: What Happens Next? Regis College Educational Offerings for Spring, 2019, Co-Sponsored with Harvard Pilgrim Health Care

As some work to undermine the Affordable Care Act (ACA), health care stakeholders, such as consumers, providers, insurers, policy-makers, and some politicians struggle to maintain the recent gains made under the ACA in expanding health insurance coverage. Don't miss this opportunity to hear experts discuss today's challenging politics and the future prospect for policies designed to reduce the number of uninsured Americans, and improve quality and access to care.

Contact Hours: 2

Location: Regis College, Casey Theater, Fine Arts Center, 235 Wellesley Street, Weston, MA 02493

Time: 6:15 – 8:30 pm

Fee: None

Registration: 781-768-8080 or email: presidents.lectureseries@regiscollege.edu or Online Registration: http://www.regiscollege.edu/reform

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April 24, 2019

The Challenge of Climate Change: Its Impact on Population Health

Given the current changes in policy and industry regulations, is bridging climate change and health a seemingly insurmountable mountain? Not even a possibility. Come get a better sense of the current challenges we face and how Massachusetts, as well as the country continues to push forward. Hear from experts in public health, meteorology, and health care. For certain, you will walk away enlightened!

Contact Hours: 2

Location: Regis College, Casey Theater, Fine Arts Center, 235 Wellesley Street, Weston, MA 02493

Time: 6:15 – 8:30 pm

Fee: None

Registration: 781-768-8080, Email: presidents.lectureseries@regiscollege.edu Online Registration: http://regiscollege.edu/climate

Save these dates for our fall series, to include Health Care by Zip Code: Health Disparity or Equity?

October 16, 2019, November 13, 2019

Thursday, April 4, 2019

from 7:30 am to 12 noon

6th Massachusetts Regional Caring Science Consortium Conference

The Healing Power of Caring Communication and Relationships with Self and Others in Nursing Practice and Educational Settings

Inviting nurses to attend the 6th Massachusetts Regional Caring Science Consortium (MRCSC) half-day conference on Thursday, April 4, 2019 at Regis College, Weston, MA from 7:30 am to 12 noon.

The conference will focus on The Healing Power of Caring Communication and Relationships with Self and Others in Nursing Practice and Educational Settings. The MRCSC is a forum for nurses to share and explore caring nursing practices that foster and sustain personal and professional well-being, healing relationships, healthy environments and best outcomes in patient care.

The keynote conference speaker will be Sheila Davis, DNP, ANP-BC, FAAN, Chief of Clinical Operations and the Chief Nursing Officer for Partners In Health (PIH), an international health organization deeply committed to improving global health of the poor and marginalized, particularly in underdeveloped countries. Dr. Davis has served as the Chief of the Ebola Response from September 2014 to May 2016 where she led emergency response for and transition to health system strengthening in Sierra Leone and Liberia. A nursing leader in the field of HIV/AIDS since its emergence in the mid-1980s, she served on the National Board of the Association of Nurses AIDS Care (ANAC). In 1999 she entered the global health arena working in a number of countries during the HIV pandemic. She was the co-founder of a small NGO that worked in South Africa and Boston from 2004-2010 on health projects, including a rural village nurse clinic. Dr. Davis brings a rich and global perspective of Caring Communication with world-wide communities and health care partnerships. Please see the MSCRC website (https://MSCRC.org) for more about Dr. Davis' career and work.

The conference will also feature 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 discuss practical caring practice projects they have launched at their workplaces, including topics that address moral distress, difficult end-of-life conversations, and creating healing staff and patient environments in ambulatory, primary, and outpatient care settings. There will be time for questions, discussion and some take-home handouts.

Come and join the presentations and conversation to renew your caring practices and heart of nursing. Continental breakfast, parking, and nursing contact hours provided. There is no fee to attend, but registration is required by April 1, 2019. You can register on the MRCSC website at www.mrcsc.org or by contacting Lynne Wagner at alynnewagner@outlook.com. All registrations will be confirmed. Registrants will receive further conference details before the conference.

Saturday, March 16th

9AM-1:30PM, First Baptist Church, 1500 Andover Street, Tewksbury, MA 01876.

Medical and Biblical Perspectives on Chronic Pain

Chronic pain is real and affects many people both physically and spiritually. Join us to learn what the Bible tells Christians about suffering, the science of chronic pain and strategies to help.

Host: Simeon Damas, M. Div., Th.M., Pastor First Baptist Tewksbury. Light breakfast and lunch. Wheelchair accessible building and bathrooms. There is no fee to attend, but registration is appreciated. For questions or to RSVP call (978) 851-6575 or fbc.tewks@verizon.net.

Friday, June 7, 2019

ANA MASS Approver Unit Spring Symposium, Milton, MA

Join us for the Annual ANA Mass Approver Unit Spring Symposium.

bulletin board

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- 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
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- 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

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

ANA Massachusetts Mission

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

Vision

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

Health Policy Committee Updates

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

Greetings from the Health Policy Committee! We have been busy reviewing our priorities for the coming year and would like to share two bills that are on the docket to be filed by ANA Massachusetts in 2019.

AN ACT RELATIVE TO THE CREATION OF A COMMISSION ON QUALITY PATIENT OUTCOMES AND PROFESSIONAL NURSING PRACTICE

ANA Mass is proposing the creation of a commission that will review and make recommendations regarding best nurse staffing practices designed to improve the patient care environment, quality outcomes, and nurse satisfaction. The commission will include representatives from organizations including ANA Mass, Organization of Nurse Leaders, Massachusetts Nursing Association and others who are committed to the provision of high quality, safe care for all individuals in our Commonwealth. On the heels of the outcome of Ballot Question One, this is the opportune time to have our nurses engage in thoughtful inquiry, dialogue and recommendations on best nurse staffing practices with outcomes that all can be proud of.

AN ACT RELATIVE TO THE GOVERNANCE OF THE HEALTH POLICY COMMISSION

ANA Massachusetts filed this bill in 2017 & 2018. On average, over 8,000 bills are filed each legislative session. With the due diligence required in the legislative process, it can be expected to take many years to pass a bill into law. We are committed to this process and will work diligently to advocate for this important legislation in the upcoming session. We are refiling in 2019 as nursing expertise is critical in guiding key decisions in this rapidly changing health care environment.

The Health Policy Commission is charged with making important decisions about the course of health care delivery in Massachusetts and has been dealing with critical issues that affect the practice of nursing, like mandatory overtime legislation, ICU staffing acuity and mental health/substance misuse management. Because there is not a nurse on the Health Policy Commission, representatives of the Commission have had to reach out to ANA Massachusetts for clarification and advice on many issues requiring our expertise. We believe that a nurse on the Health Policy Commission will assure that the voice of the nursing profession are included when important decisions about the delivery of health care are made.

In addition, the Health Policy Committee will be planning a Health Policy Forum for the fall of 2019, monitoring the status of other legislative priorities in the Commonwealth and providing testimony on key issues. Our meetings are held monthly on the 1st Tuesday. If you are interested in participating, please contact us.

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