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

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

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

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

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March 2018

Do you know this nurse? See page 5

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

Nurses and the Centennial of the Halifax Explosion
Page 10

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

Congratulations to the 2018 LIVING LEGENDS
Jeanette Ives Erickson, DNP, RN, NEA-BC, FAAN
Marilyn Lewis Lanza, DNS, RN, FAAN

SAY THE DATES

See page 3 for information on upcoming events!
hindered by dramatically increased emergency premiums, deductibles and taxes. Care will be costs will be passed on to them through higher vulnerable hospitals to completely close. community hospitals, likely forcing financially workforce, and endanger the viability of smaller to support the required additional nursing burden will severely limit hospitals' ability to allow nurses at the bedside to decide how they provide care after thoughtful consideration of the acuity of the patient, the experience level of the unit, and the available resources on the unit. In stark contrast, MNA's petition works against these objectives. It requires that hospitals across the state, no matter their size or specific patient needs, adhere to rigid nurse staffing ratios within all patient care areas. The petition would create an unfunded mandate that requires our state's acute care hospitals to meet these ratios "without diminishing the staffing levels of [their] healthcare workforce." The measure will cost more than $800 million each year to implement, costs that will be felt across our healthcare system. This financial burden will severely limit hospitals' ability to support the required additional nursing workforce, and endanger the viability of smaller community hospitals, likely forcing financially vulnerable hospitals to completely close. Our patients will also suffer. The additional costs will be passed on to them through higher premiums, deductibles and taxes. Care will be hindered by dramatically increased emergency

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SAVE THE DATES
To register for events go to www.anamass.org.

Tuesday, March 20, 2018
ANA Massachusetts Lobby Day
State House, Boston, MA

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

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

Conference
(7:30 a.m. - 4:00 p.m.)
Running a Clinical Marathon: Keeping Up with the Rapid Changes in Clinical Practice
Join us as we hear from Nursing experts concerning the assessment, diagnosis, treatment, current evidence, and practice implications for patient care in Stroke, Diabetes, Heart Failure, Psychiatric Response in the Medically Ill Patient and Oncologic Implications in Acute and Chronic Illness.

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

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

ANA Massachusetts Annual Business Meeting
(4:30 p.m.)
ANA Massachusetts Annual Awards Dinner (cocktail reception begins at 6:00 p.m.)
Celebrate the Past, Present and Future of Nursing in Massachusetts!
Check website for list of award recipients.

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

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

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

Friday, June 1, 2018
ANA Massachusetts Approver Unit Provider Symposium
Curry College, Milton, MA
Registration Open - Early Bird through March 30th
ANA Massachusetts Accredited Approver Unit Annual Spring Symposium: The Necessity of Evaluation Join ANCC Program Director Jennifer Guzhe, MSN, RN, NEA-BC & ANA MA Nurse Peer Review Leader Judy Sheehan, MSN, RN-BC
Understanding a multi-level evaluative approach to planning nursing continuing education and meeting ANCC criteria.

October 19, 2018
ANA Massachusetts Fall Conference
Sturbridge Host Hotel, Sturbridge, MA
Check out www.ANAMASS.org for up to date event information

EDITORIAL

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

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

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

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

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

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

Just culture “seeks to create an environment that encourages individuals to report mistakes so that the precursors to errors can be better understood in order to fix the system issues” (ANA Position Statement on Just Culture, http://nursingworld.org/justculture). Rather than the “blame and blame” culture that penalizes people for reporting their errors, just culture recognizes that systems problems often contribute to errors. In a just culture, the emphasis changes from errors and outcomes to system design. Near misses are analyzed to determine what went wrong, as well as events that actually caused harm. A just culture does not give a pass to negligent or reckless behavior or conscious disregard of clear risks to patients. Ignoring policy, such as skipping the required patient identification for medication administration, is still unacceptable and can result in blame and punishment. What just culture does do is seek to identify “what went wrong” rather than “who is to blame.” A just culture looks to find a balance between a blame-free environment and a punitive environment.

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

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

References available on request from slarocco0603@curry.edu.

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

And then fire broke out in the Melody Lounge. Within two to four minutes it had raced up stairs that acted like a chimney drawing the fire and its toxic gases into the street level foyer. From there it continued through the stairwell into the rear, by a ventilating fan into the dining room and then into the new Broadway Lounge. The Fire Commissioner estimated only twelve minutes had elapsed from the start of the fire in the Melody Lounge at the lower level to its arrival at the Broadway Lounge. Patrons fell as if by instinct towards the revolving door through which they had entered the club. The onrush of people intent on escape quickly jammed the slow revolving door. Other exits were locked to prevent patrons from leaving the club before they had paid their bills. Tables, chairs and decor blocked still other exits that were hidden behind decorative walls. Even if unlocked, according to post fire thinking, the intense heat of the fire would have made these exits impassable. Waiters and entertainers who knew the layout of the building led the lucky few—about 220—through safer. Illuminated exit signs visibly point the way to transport most of the victims to Boston City Hospital, the usual destination for emergency cases. During one seventy-five minute period, victims arrived there at the rate of one every eleven seconds. One hundred and eighty died in transit and ten to fifteen died within a few minutes of arrival. One hundred and thirty-four were admitted to wards that had been reserved for war victims. Seventy-five of the one hundred and fourteen victims that arrived at Massachusetts General Hospital died on arrival. The thirty-nine still alive were admitted to the White unit. Eventually ambulances were directed to other hospitals and military hospitals in the area.

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

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

Two of the dwindling number of survivors attended the 75th Anniversary Memorial. Joyce Specter Melkoul and Marshall Cole, both nonagenarians, recounted their escape from the Grove as well as spoke of the psychological scars they still bear. Nurses who cared for the Grove victims are also declining in number. Barbara Poremba, EdD, RN, Professor Emeritus of Salem State University, presented excerpts from her ongoing study of these nurses. Anne Montgomery, for one, was a nineteen-year-old nursing student at BCH when Margaret Bushe, the Director of Nursing, exclaimed “This is it!” It was not the enemy; the hospital had been preparing for but victims from the fire at the Grove. Montgomery left the dance in
the nurses home for duty in the accident room where she said the dead “were flowing in faster than they could bring them over to the morgue across the street…. They sent me to guard the bodies,” and was directed, “Make sure no one robs them of their valuables.” Montgomery added, “I was only a kid, I was scared…. Seeing all of these dead bodies.”

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

Fifty years later, Dr. Stanley Levenson credited nurses “And most of all,” he added, “We had wonderful doctors, interns and medical students. The nursing care at the MGH was no less exemplary as Mary Larkin, the President of the MGHSN Alumni Association has discovered in the MGH Alumnae Association Oral History Project. Among nurses she has interviewed was Marion Bates, a 1934 graduate of the MGH School of Nursing who in 1942 was night supervisor when the fire’s victims arrived. The nonagenarian who has since died said that the sight of so many bodies of those who were dead on arrival lined up in the corridor was “a sight [she] would never forget.” Indeed as Donna White, the President of BCH School of Nursing Alumni Association told attendees at the 75th Anniversary Memorial, the lessons nurses learned as they cared for the Coconut Grove victims, became the lessons they taught to the next generation of nursing students.


2 The Boston Globe, November 28, 2013, 1, 12.


Mary Creagh

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

Photo Credit: Ken Marshall

SEEKING INFORMATION

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

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

Contact her at bporemba@salemstate.edu.
Patients Safe: Transforming report entitled: Keeping work environment – was to safe, quality health care about factors that contribute of Nurses nurse practice models and work environments. As opportunities exist for innovation of current transformation across the health care industry, injuries, adverse patient events, missed care, and factors such as nurses’ surveillance capacity, errors, and organizational cultures. In the years since that committee recommended that significant changes were structured, including: management and leadership; workforce development; work processes; and organizational cultures. In the since that IOM report, numerous other studies have followed that have consistently reaffirmed the importance of nurses’ work environment relative to the provision of safe, quality care and its impact on related factors such as nurses’ surveillance capacity, errors, injuries, adverse patient events, missed care, and role satisfaction and engagement. Given the almost constant state of reform and transformation across the health care industry, opportunities exist for innovation of current nurse practice models and work environments. As providers who understand the unique knowledge and competencies they bring to patient care safety and quality, nursing needs to lead this aspect of health care reform. Imagine you have the freedom to determine how your time as a nurse caring for patients is best spent and to redesign the care environment in which you practice. What would have to be the ones to lead that change.

Think about how you currently spend your time on an average shift and ask yourself a few important questions: Is your time being expended engaging in activities that best utilize your unique nursing knowledge and competencies? What would those activities include? Do you often find yourself leaving your shift mindful of missed care with the potential to cause avoidable harm to your patients because you didn’t have enough time? What are you currently spending your time doing that could be safely delegated – with proper training and supervision – to another member of the health care team? Given your knowledge and clinical competencies, how would your time be best spent to the benefit of your patients? In addition, you might consider: Is your time used getting to know your patients and their families and developing an understanding of their care and quality of life preferences? Do you have the time to adequately monitor your patients, conduct ongoing assessments, critically think and reflect, and conduct discharge teaching? Do you have the time and resource capacity to adequately monitor your patients, conduct ongoing assessments, critically think and reflect, and conduct discharge teaching? Do you have the time to engage with your patients and their family members in conversations directed towards helping them maintain their health, manage chronic disease and prevent future complications and illness? As their direct care provider, are you part of the team helping to coordinate their care? What factors within your current practice environment seem to impede safe, timely and efficient care delivery?

Finally, ask yourself: Do you ever challenge the day-to-day status quo when you know your work environment might be made more efficient and safe? Do you use your voice and engage with others to identify system issues that pose barriers to quality care? Is your practice environment collegial and supportive - one in which you experience open, respectful and transparent communications? As professionals, we have the knowledge and capacity to contribute to improvement and innovation of care delivery and our work environments. Nurses need to be the ones to lead that change.


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NURSES are at greater risk of workplace violence than police officers or prison guards.

BSN in 10: The New York Experience Continues
Barbara Zittel, RN, PhD

WE HAVE A SIGNED BILL! WE HAVE A SIGNED BILL! WE HAVE A SIGNED BILL! That is the message that was sent to the nursing profession in New York State and to our colleagues and friends across the nation and throughout the world. On December 18, 2017, New York Governor Andrew Cuomo signed the BSN in 10 bill (S6768/A18442) sponsored by Senate Majority Leader John Flanagan and Assembly Majority Leader Joseph Morelle. This legislation establishes an evidence-based educational mandate to meet increasingly complex health care needs of the residents of New York State. At the same time, the legislation continues to permit RN licensure after completion of a diploma or associate degree nursing program. The legislation recognizes that the diploma and associate degree in nursing are appropriate entry points into the nursing profession with academically demanding and clinically challenging courses of study. The newly enacted legislation also recognizes that additional education makes a difference in the skill and competence of RNs, just as it does for other licensed health professionals.

Given the enhancements to articulation between associate and baccalaureate degree nursing programs and the ever-increasing options for advanced placement and distance learning, we believe that the legislation can be implemented without disadvantaging future newly-licensed RNs. The law specifies that future graduates of diploma or associate degree nursing programs have up to ten years to obtain their baccalaureate degree, with the possibility of extensions for extenuating circumstances. RNs not meeting the requirement will have their licenses placed on “HOLD” a policy currently used by the State Education Department for licensees not meeting the continuing education requirement in many other licensed professions.

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

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

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

The resolution calls upon all nurses to recognize nursing civility and take steps to systematically eliminate all acts of incivility in their professional practice, workplace environments, and in our communities.” The Tri-Council urges that nursing civility be practiced throughout the US “to establish communities.” Tri-Council urges that nursing civility be practiced throughout the US “to establish communities.”

“Civility forms the foundation of a culture of respect for one another and is non-negotiable for team-based care,” said Juliann Sebastian, PhD, RN, FAAN, and chair of the American Association of Colleges of Nursing. “As the most trusted healthcare provider, registered nurses understand the connection between treating patients with respect, establishing open lines of communication, and realizing positive care outcomes.”

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

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

“Civility forms the foundation of a culture of respect for one another and is non-negotiable for a healthy, safe and ethical work environment,” commented. “The ANA has zero-tolerance for intolerance, and disregard for emotional health: difficulty in nurse recruitment and retention, high rates of burnout, fatigue, depression and other psychological problems facing nurses in front of the Texas and Rhode Island Boards of Nursing since 2001. Lilly worked as a nurse in acute and chronic care settings before joining the Division of the American Nurses Association.

The Cruise takes place in conjunction with National Nurses Week (May 4-11) and offers a fun way to earn Continuing Education credits. Nurses from across New England and New York are invited to attend.

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GUEST SPEAKERS
Keynote Speaker: Karen Doley, PhD, RN, FAAN. Doley served from 2010 to 2014 as the president of the American Nurses Association, the nation’s largest nursing organization representing the interests of the nation’s 3.6 million registered nurses. She has spent more than 25 years in clinical practice. Doley was listed among Modern Healthcare’s “100 Most Influential People in Health Care” and, in 2013, was selected by Modern Healthcare as one of the “Top 25 Women in Healthcare”.

Speaker: Joyce Stamp Lilly, RN, JD. Lilly is a Registered Nurse and lawyer who has served on the Rhode Island Boards of Nursing since 2001. Lilly worked as a nurse in acute and community settings including: medical, surgical, and psychiatric settings. She is familiar with the culture of nursing and understands many of the problems facing nurses today. For more information about Lilly, see her website nursingcomplaint.com.

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ANA Massachusetts Approver Unit News

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

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

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

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- STD Update for Clinicians
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Continuing Education

ANA Massachusetts Approver Unit Frequently Asked Questions

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

SUMMARY REPORTS

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

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

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

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


MULTIFOCUS ORGANIZATIONS

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

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

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

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

At Atrius Health, we serve our community with quality care in an environment where everyone fits in. We are proud of the diverse population we serve and workforce we employ. Diversity and inclusion make us a better organization. If you would like to be a part of our compassionate nursing team, please visit www.atriushealth.org/careers for a complete list of nursing opportunities available.

Care to Give Your Best.

We have much to offer and want you on our team!
My name is Myra F. Cacace and I have been a nurse practitioner since 1994. I am also the Past President and present Co-chair of the Health Policy Committee of the American Nurses Association Committee of the American Nurses Association Massachusetts. ANA Massachusetts is the constituent organization of the American Nurses Association (ANA). We are the largest voluntary professional organization representing professional nurses, including Advanced Practice Nurses in Massachusetts. On behalf of our nurse members, I would like to thank you for giving me the opportunity to submit testimony regarding H2451 and S1257.

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

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

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

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

Sincerely,

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

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

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Co-Chair, Health Policy Committee, Past President
Nurses and the Centennial of the Halifax Explosion

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

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

Twelve hours after receiving the news that Thursday morning, Massachusetts’ Committee on Public Safety’s Abraham C. Ratkesky, a prominent banker and civic leader, was sending two Pullman cars, one baggage car and a buffet car to Halifax filled with nurses, doctors, workers and medical supplies. The relief train left Boston that night at 10:00 pm, plowed its way through a blizzard and arrived Saturday morning at 6:30 am. Although somewhat delayed, the relief train was ready for their response from outside the Halifax area providing a respite to the local nurses and doctors who had been working tirelessly since the explosion.

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

The people of Halifax have never stopped saying thank you to the people of Boston for their wholehearted response. MGH nurses, mindful of their past, know the full significance of the tree that arrives every November from Halifax to grace Boston Common for Christmas. They know that at a time when MGH nurses were in Halifax doing their best efforts to creating that proper welcome.

Beth Thomson (MGHSON 1953), the last nurse from Halifax arrived on the Common that would mark the centennial of the Halifax Explosion. The Committee was more than receptive to Fisher’s report of her meeting with Day and considered whether the upcoming Centennial was an opportunity for a closer connection with the nurses from Halifax. “If they’re coming for the tree lighting,” Georgia Peirce, the Committee’s chair added, “I think we’ll want to do some planning to welcome them properly.” For the next eighteen months the Committee bent its best efforts to creating that proper welcome. A town crier alerted Boston as the tree arrived on Boston Common early in November. Several weeks later, on November 29th the commemoration began with state and municipal dignitaries welcoming their counterparts from Halifax at the State House. Beth Thomson (MGHSON 1953), the last person on the opening program, spoke of her mother and father, both of whom were Halifax natives, only 12 and 11 at the time of the explosion. The little girl was late for class and anxious as she grasped the doorknob to her classroom. At that moment the Mont Blanc exploded. She thought that her being late had been to her advantage and her being late had been to her advantage and the standing ovation that swept over Beth as the program concluded.

Tragedy, and Extraordinary Heroism.

Then Deborah Ann Sampson, PhD, APRN presented an excerpt from her on going research on nurses’ involvement in the relief efforts during the Halifax Disaster. After the formal part of the program, Haligonians and Bostonians relaxed for a while as they mingled over lunch. The festivities continued later at the Canadian Consulate Reception at the Omni Parker House and once again, Beth was part of the formal part of the program. By this time nurses from Halifax and Boston were well advanced in forming bonds with one another. Then with traffic stopped and guided by mounted police the celebrants left the Omni Parker House and crossed Tremont Street for Boston Common for the tree lighting ceremony. At 8:00 pm Boston’s Mayor Martin Walsh and Halifax Premier Stephen McNeil flipped the switch. The Centennial tree exploded in a blaze of color amid a cacophony of cheers commemorating the relationships created one hundred years before.

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

The little boy was at another school in the United States, they taught the lesson they had learned – take care of others. As petite as Beth is, she became a giant as she paid homage to her parents and Halifax roots. Nurses from Halifax led the standing ovation that swept over Beth as the program concluded.

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http://www.cbc.ca/beta/news/thenational/halifax-explosion-100-years-later-1.4436885

March 2018 Massachusetts Report on Nursing • Page 11

Diversity and False Comfort

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

I recently met a close friend for brunch. Lisa is not a woman of color. We typically talk about various topics over good food. Of course, a conversation about diversity always cropped up. We disagreed that facing the lack of diversity in nursing faculty, leadership and workforce requires great patience and skill, especially if there is doubt or questions about diversity agenda but instead remain in neutral. It part, we neither advance nor fall back from our engagement and attention to the issues. For the most diversity is set apart as a special project within the profession are a legacy of those times. Today sincere based social barriers that were once the dictates of the larger society. The demographics of our workforce require great patience and skill, especially if there is doubt or questions about diversity agenda but instead remain in neutral. It part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our diversity agenda but instead remain in neutral. It part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our engagement and attention to the issues. For the most part, we neither advance nor fall back from our eng...
Upon awakening – probably more of not being totally unconscious rather than really awake – I had no idea where I was or why. I am sure that many people told me that I was in the ICU, but it was not what was expected and therefore, at the time, these words meant nothing to me. My family was there, but that did not register either. As things started to fall into place, I remembered that I had gone to surgery for a possible small malignancy in my lung, and yes it would be painful, but the hospital stay would probably be 3 to 4 days. If ICU had been mentioned, it was as a remote possibility. I do remember someone saying yes it was malignant. 

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

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

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

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

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

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

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

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

Carol Bradley, RN

HELP!

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

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

The Survey Contractor

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

Did you Know?

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

The Survey Results

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

Endorsements

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

HELP!
Imagine yourself being so sick that you are sedated, intubated and admitted to the Intensive Care Unit (ICU). While you are sedated, doctors, nurses, and other staff members are in and out of your room taking care of you. Your family and friends are sitting by your bedside, talking to you and perhaps praying for a speedy recovery. You experience periods of wakefulness during repositioning. You may travel off the unit for diagnostic testing and procedures. You can hear alarms and voices but aren’t quite aware of where you are, what day it is, what time of day it is, or what is happening. Titration of sedating medications for spontaneous awakening trials may produce anxiety. Then the big moment comes and you are extubated. Now you are left to wonder what one is, and eventually the patient. Champions journals was required for our staff, the patients’ and their families. We implemented journals could be beneficial in reducing PICS with how a simple intervention can make such a significant impact in patient care. Moving forward, we anticipate that the journals will help our unit decrease the incidence of PICS in our patients.

Many intubated patients develop a Post-Intensive Care Syndrome (PICS), which refers to the “new or worsening mental health, physical, and cognitive outcomes that linger past the ICU stay” (Davidson & Harvey, 2016, p. 183). According to Locke et al (2016), “The prevalence of this syndrome is variable but can be high, occurring in 15% to more than 50% of ICU survivors” (p. 213). As you can imagine this can be a scary time for patients and their families. Patients are often left with few and distorted memories from this time.

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

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

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

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

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

Consistently and very clear in your responses. Your lovely sons were in to visit you today and left a beautiful blue crystal rosary that we/you keep in your hand. I hope you can feel it and that Our Blessed Mother and Jesus bring you much comfort during this challenging time.

Your nurse,
Katy

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

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

References

See “Delirium in the ICU: A Patient’s Perspective” on page 12

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

Victoria Greymont, RN; Kathryn Harper, BSN, RN; Sara Landry, BSN, RN; Amanda Watkins, BSN, RN; CCRN; Adam Castagno, BSN, RN
Pharmacological Treatment of Binge Eating Disorder

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

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

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

Individuals with BED are at a higher risk for concurrent psychiatric disorders including: (a) mood and anxiety disorders (Becker & Grilo, 2015; Cossrow et al., 2016; Swanson et al., 2011), (b) attention deficit and hyperactivity disorder (ADHD) (Cossrow et al.,) and (c) post-traumatic stress disorder (PTSD) (Kessler et al., 2013; Olguin et al., 2016). Selective serotonin reuptake inhibitors (SSRI) have also been used to treat BED. Fluoxetine and sertraline, in particular, have been found to be effective in reducing episodes of binge eating and weight (Reas & Grilo, 2015). An extended release formula combining topiramate and the appetite suppressant phentermine is approved as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management of obesity in adults. This drug has been found to be effective in the cessation of binge eating behaviors and weight loss (Guerdjikova, Fitch, & McElroy, 2015).

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

References


6. Resurgence in the role of public health nursing to provide care of a loved one or oneself in a holistic manner. Nurses will care, treat, and refer as needed in the community and in acute care settings. “Caring” remains at the center. – Janet Monagle, PhD, RN

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

– Don Anderson, EdD, RN

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

– Susan R. James PhD, RN

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

– JBK
ensuring access to high quality care.

The Board of Registration in Nursing (Board) must comply with the law that requires training for health care providers on the issue of domestic and sexual violence as a condition of licensure (M.G.L. c. 112, § 264). DPH’s Division of Sexual and Domestic Violence Prevention and Services continues its work developing an e-Learning tool that will be housed on its DPH’s Domestic and Sexual Violence Integration Initiatives web page. Once the e-learning tool is available. After the training information is posted on the Board’s website, nurses (who have not renewed yet in 2018) will have an additional six months to complete the training. Nurses who have renewed prior to the posting must complete the training prior to their next renewal.

A nurse participating in a currently approved in-person training program will not be required to complete the training prior to the required renewal date, as long as the nurse registers for and attends the approved in-person training and submits documentation of attendance to the Board.

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

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It is unusual to hear nursing students say their passion is mental health nursing. More often, I hear pediatric or maternity nursing. Forty years ago, I was not very different from most of my current students. I knew well before entering nursing school that my passion would be pediatric nursing.

After years of personal and professional experience I have come to realize that physical problems are often more comforting for nurses to address than mental health problems, particularly in children.

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

According to the National Alliance on Mental Illness (NAMI), 1 in 5 children between the ages of 13 to 18 have, or will have, a serious mental illness (2017). The prevalence of mental health disorders among children ages 8 to 15 is 13%. Mental health conditions such as attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder before (ODD), post traumatic stress disorder (PTSD), anxiety disorders, mood disorders and repeated suicide attempts are at the top of the list (NAMI, 2017). Most of us know a family that is affected by these conditions. Yet, as professionals we have taken the time to understand the stress and trauma these families experience daily?

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

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

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

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

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

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

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

Regardless of the practice setting, nurses should become familiar with current mental health issues for children and adolescents. Nurses can help child and family advocates navigate the system and assist in getting necessary services. Advocacy is the most important role for nurses working in any setting. Begin by supporting the Substance Abuse and Mental Health Services Administration (SAMHSA) (2017) promotion of children’s mental health awareness day on May 10, 2018. Do what you can as a professional to advocate for children’s mental health services and support families!

References


Pain assessment in children is challenging. Pain is a multidimensional experience. For those who can communicate the pain experience to someone who can help, pain management is a crucial component of compassionate care. The first step in pain management is communicating (verbally or nonverbally) his or her pain experience. For example, for self-report, behavioral pain assessment tools can be used. For example, for infants and children up to age 7 years old, the FLACC (Face, Legs, Activity, Cry and Consolability) scale is a commonly used behavioral pain assessment tool. For children 7 years and older, the FACES tool is comprised of six black and white cartoon faces that portray increasing levels of pain. The scale consists of faces that score 0 (smiling face), 2, 4, 6, 8 and 10 (crying face). The NRS scale is scored from 0 (no pain) to 10 (worst pain imaginable) and is typically reported verbally. The NRS is used for children 7 years and older.

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

For children unable to self-report, behavioral pain assessment tools can be used. For example, for infants and children up to age 7 years old, the FLACC (Face, Legs, Activity, Cry and Consolability) is a commonly used behavioral pain assessment tool. The FLACC scale is comprised of 5 items, face, legs, activity, cry and consolability. Each item is scored from 0 to 2. Items are added together to result in a total score from 0 to 10 (Merkel et al., 1997). Pain assessment is comprised of a thorough assessment of a child’s facial expression of pain, pain behaviors, emotional response to pain, physical function and physiological measures of pain. When assessing pain using self-report, observe the child to ensure that other aspects of pain are consistent with the self-reported pain intensity. For example, a child may report a score of 0/10 if he believes that it will get him discharged from the hospital.

Certainly, there is a need for health care professionals to reeducate the public on the use of opioids to manage pain. Not all pain requires an opioid for treatment. In order for the pain treatment plan to be safe, effective and appropriate, the treatment plan must be based on the source and intensity of pain and how the pain affects the patient. Pain assessment and development of a safe and effective pain treatment plan can be challenging for any population. There is no ideal pediatric pain assessment tool but rather many components that go into the development of a complete pain assessment. In doing these assessments routinely, conceivably the healthcare provider’s assessment may be more sensitive to each specific child. Furthermore, pain treatment plans may be optimized, as not all pain responds to opioid management.

References:

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