Volume 4
Number 4

ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

April 2020

The Official Publication of the American Nurses Association - New York
ANA - New York Nurse will reach over 71,500 New York nurses and schools of nursing.

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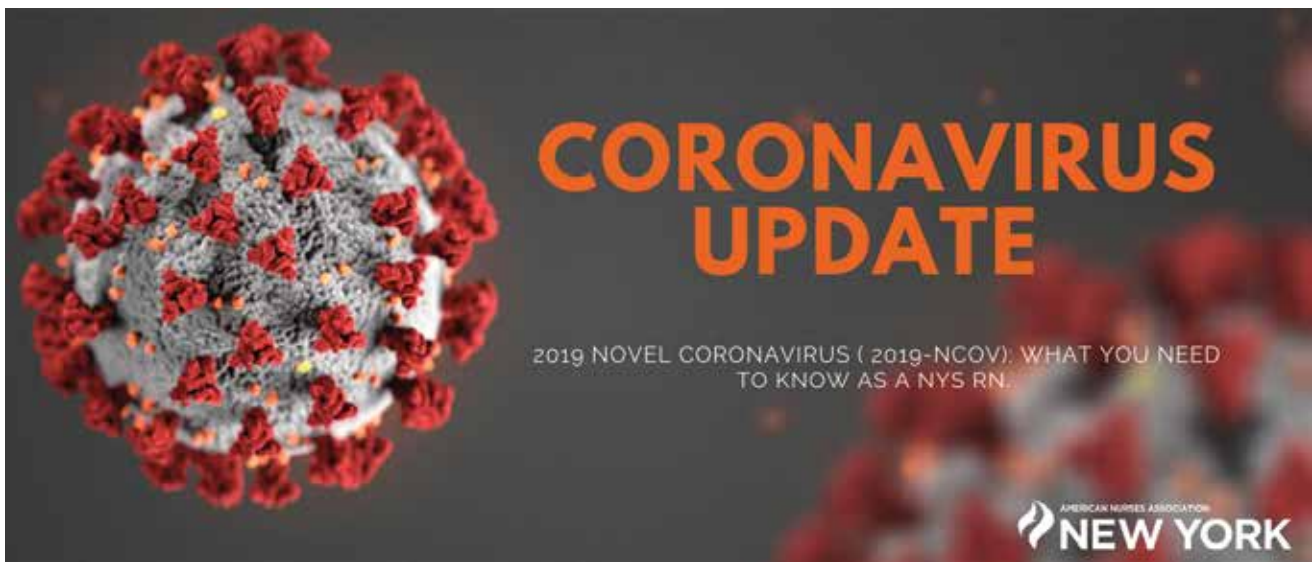
MESSAGE FROM ANA-NY'S EXECUTIVE DIRECTOR



Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN

There are nearly 250,000 registered professional nurses in New York state and we are prepared to care for coronavirus patients, just as we have been on the front line caring for patients with emerging public health challenges through history, such as tuberculosis, HIV/AIDS, SARS, Ebola, and now, COVID-19. We follow established Universal Precaution guidelines; are regularly updated by the American Nurses Association and CDC; and maintain strict handwashing protocols to protect our patients, co-workers, families, and ourselves.

Visit ANA-NY's COVID-19 resource page at http://www.ana-newyork.org. This page provides you with the following information:

- FREE Nursing Courses Focused on COVID-19
- Health Professional Survey – NYS is taking measures to create a reserve health care workforce
- Links to a variety of state and federal resources
- And much more

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PRESIDENT'S MESSAGE

Look Inside

Elisa (Lee) A. Mancuso MS, RNC-NIC, FNS, AE-C, President

2020 is The Year of the Nurse! When did you take time to truly reflect on who you are? Novices just embarking on your nursing career have you identified your personal goals? Similarly, seasoned nurses have you maintained your professional goal? Or has it been scattered by the winds of chance? "When it is obvious that the goals cannot be reached, don't adjust the goals, adjust the action steps." Confucius.

Before you can look ahead you must look back. Stop and rediscover why and how you began your nursing journey. What attributes and talents do you possess? Compassion, hard work, dedication and a passion to make a difference are nurses' core values. We have a definitive foundation composed of these basic tenets bonded with ethics and a commitment to tackle any obstacle.

Nursing is a complex and dynamic profession that inherently requires prioritization and dealing with multiple variables while working with people during their most vulnerable periods. Nurses are unique professionals who address every patient's need across the lifespan no matter how minute or all encompassing. Each nurse-patient encounter weaves a new thread into the tapestry of our profession. Individually they may not seem impressive yet woven together they create a beautiful life enriching journey that culminates in an **Awesome Nurse: You!**

Be truthful to yourself. Accept constructive comments as an opportunity for personal and professional growth and let go of the uncontrollable. Collaborate with colleagues and network with diverse interdisciplinary professionals to develop an expansive perspective. **Your vibe attracts your tribe.** Let's build positive relationships and promote inclusivity.

ANA-New York is launching a call for proposals. This will provide a venue for every member to identify any pressing professional issue. What issues are tugging at your heart strings? Are there unresolved challenges which hinder you from providing optimal patient care? This is your opportunity to articulate concerns and bring them to your professional nursing organization; collectively we can create a realistic action plan.

The 2020 Year of the Nurse is a validation of nurses' compassion, diverse expertise and critical thinking applied holistically for all patients, families and communities locally and globally. Every nurse-patient interaction is infused into our soul and molds us into our present self. Acknowledging each encounter empowers us to strive for higher ground and new levels of excellence. It behooves us to have a focused clear direction rather than just drifting along with the current. As C.S. Lewis wrote, "You can't go back and change the beginning, but you can start where you are and change the ending."

LETTERS TO EDITOR

Celebrating my 50th year in nursing this year. I weep and pray for the nurses dealing with the Covid-19 outbreak. The most trusted profession in America , it is nurses who heal the bodies and endure the emotional scars as you are the family and may be the last face or hand the patient has before dying . God keep you safe and know every nurse is praying for your courage and health . Respectfully, Eileen Howard, RN MSN

I am honored to be your colleague. Take care as you are priceless!

Sincerely,
Elisa (Lee) Mancuso, MS
ANA-New York President

Message from the ANA-NY President New York Nurses Rock

Today I want to thank my New York RN colleagues across the state for answering the call and serving on the front lines and behind the scenes during this unprecedented pandemic crisis; COVID-19.

Let's reach out virtually to one another and provide support for how to stay safe and cope with the emotional challenges of social isolation and anxieties regarding the unknown and yet to be discovered issues.

ANA-New York is here to provide the most up-to-date information on COVID-19 from the CDC, WHO and ANA. We want to ensure accurate information is quickly disseminated to our colleagues, patients and families. Nurses are the most trusted profession and it behooves us to provide relevant appropriate education and holistic care in a timely and safe manner across the lifespan.

Prophetically, 2020 is The Year of the Nurse and I am so proud to witness with America, nurses providing concrete examples of professionalism, compassion, dedication and self-sacrifice. Now the entire nation is beginning to understand and appreciate nursing is the backbone and heart of the health care system.

Thank you for your passion and I urge you to take care of yourself as you continue to care for others. Healthy Nurse = Healthy Nation. Stay safe, listen to your colleagues and your own body, rest and incorporate the 3 Hs: Hygiene, Hydrate & Healthy Coping Skills to mitigate stress and vulnerability.

Nurses are Superheroes! Be proud and take comfort in knowing you have over 6400 ANA-NY colleagues and dedicated leadership supporting you every step along this uncharted journey. Don't hesitate to reach out and share your concerns, obstacles and victories.

I am currently employed by The Execu-Search Group, assigned to a New York State Department of Health Drive-Thru testing site. Our operation was the second of its kind developed in New York State as part of our Governor's robust response to public health crisis. In this time of uncertainty and distress, nurses and nursing has mobilized and rapidly responded to the calls for help. I was fortunate to have the opportunity to join this tremendous effort in a capacity that allows me to witness nurses and our interdisciplinary teammates essentially own a small piece of history. My current responsibilities include areas that can be seen in traditional terms as being associated with nursing leadership, nursing education/professional development, and quality management.

The operation has been able to rapidly implement processes and initiatives that are extremely innovative, considering the project has existed for just over 2 weeks. We immediately had to build a culture and develop processes to address areas such as quality assurance, performance, patient/customer satisfaction, and employee engage. These are just a few of the key areas that required immediate development and refinement, and still evolve as we strive to enhance the safety of our staff and patients, while capturing opportunities to improve our processes. We have quickly achieved major goals by implementing just in time education and training, and rapid PI initiatives that must be completed in hours, as opposed to days or weeks when compared to hospitals or health systems. Our front line staff is incredible and the core leadership team that I work with have committed a tremendous amount of time and energy to ensuring we continue to improve and maintain our core objectives: the safety of our team and patients, as well as the integrity of the specimens we collect. We have applied a host of models from our respective backgrounds to create a culture, with a quality framework, service excellence initiatives and patient satisfaction program.

Letters to the Editor continued on page 6

Article Submission

- Subject to editing by the ANA-NY Executive Director & Editorial Committee
- Electronic submissions ONLY as an attachment (word document preferred)
- Email: programassociate@anany.org
- Subject Line: *ANA-New York Nurse* Submission: Name of the article
- Must include the name of the author and a title.
- ANA-NY reserves the right to pull or edit any article / news submission for space and availability and/or deadlines
- If requested, notification will be given to authors once the final draft of the *ANA - New York Nurse* has been submitted.
- ANA-NY does not accept monetary payment for articles.

Article submissions, deadline information and all other inquiries regarding the *ANA-New York Nurse* please email: programassociate@anany.org

www.ana-newyork.org/

Published by:
Arthur L. Davis Publishing Agency, Inc.

FROM THE DESK OF THE EXECUTIVE DIRECTOR

Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN,

No dependent edema here at ANA-NY! Thanks to our wonderful partners at Arthur L. Davis Publishing, our newsletter circulation has now jumped from 7,000 readers to 70,000 readers! We would like to welcome our new readers and hope that you find our newsletter informative.

A little about ANA-New York (ANA-NY). We are the professional association of New York nurses. We advocate on behalf of the roughly 260,000 Registered Professional Nurses in our state – yes, we have as many RNs in New York as all of Canada! We are a constituent member of the American Nurses Association. We currently have nine committees hard at work on behalf of our association and profession. Our committees are: Audit, Bylaws, Finance, Legislation, Nominations and Elections, Annual Meeting, Awards, Membership, and Nursing Education.

We have regional, state, and international organizational affiliates. These organizations share their programs with our members and expand our awareness activities.

If you want to find out more about us, you can:

- Continue to read our quarterly newsletter
- Visit our website http://www.ana-newyork.org
  - Check out the **News & Announcements** and **Upcoming Events**
  - Read our Mission and meet the Board of Directors in **About ANA-NY**
  - See where we stand on issues in **Policy & Advocacy**
  - Find out Member Benefits and how to join in **Membership**
  - Apply for approval of continuing education programs in **Continuing Education Approval**
  - Find courses for your professional development in **Continuing Education Offerings**
  - Search for or post job openings in **Career Center**
  - Find back issues of New York Nurse in **Publications**
- Join us at our 8th Annual Conference in October at Turning Stone Resort Casino in Verona, NY

Follow my blog at ananyexecutivedirector.wordpress.com.

BOARD BUZZ

On behalf of our members, the Board of Directors:

- Approved ANA-NY committee rosters
- Revised nomination form
- Approved a new ANA-NY award category: Nursing Practice: Early Career
- Surveyed members on interest in Success Pays program before making the commitment
- Approved stipend funding for five ANA Membership Assembly Observers to attend in addition to the six elected Membership Assembly representatives who are fully funded
- Identified two representatives from ANA-NY to New York Nursing Alliance

ANA-NY 8th Annual Conference

Turning Stone Resort Casino
October 22-24, 2020
Hotel Accommodations
1-800-771-7711 and reference the
American Nurses Association – New York room block
Conference registration opens May 2020
Queries: communications@anany.org

ANA-NY IS 6,300 MEMBERS STRONG

Like us on Facebook:
https://www.facebook.com/AmericanNursesAssociationNY/

Follow us on Twitter:
@newyork_ana

Follow us on Instagram:
@ana_ny2019

ANA COVID-19 Workplace Survey

The COVID-19 pandemic puts nurses on the front line, and preparedness is critical to preventing community spread. ANA is launching a workplace survey to gather and broadcast the perspectives and needs of nurses. The data from this survey will be aggregated and posted on ANA's website to shine a light on the needs of those providing care.

Take the survey here.
https://ana.co1.qualtrics.com/jfe/form/SV_4OpLErvMKgd6tud

FROM THE DESK OF NURSING HISTORY

Is it time to "Ring up" the Midwife? YES, it is!

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

Gertrude B. Hutchinson, DNS, RN, MA, MSIS, CCRN-R, Assistant Professor, Russell Sage College School of Nursing

As the logo announces, 2020 is the International Year of the Nurse and the Midwife. In contemplating about what to write for this issue, my mind turned to the importance of midwives throughout our history here in America. This column will be devoted to two nurse midwives – one of whom kept a diary of her life and experiences as a midwife and the other who stayed true to her geographical and genealogical roots to provide opportunities for nurses to be midwives and become midwives. If you haven't guessed by this point, I am referring to Martha Ballard and Mary Breckinridge.

MARTHA BALLARD

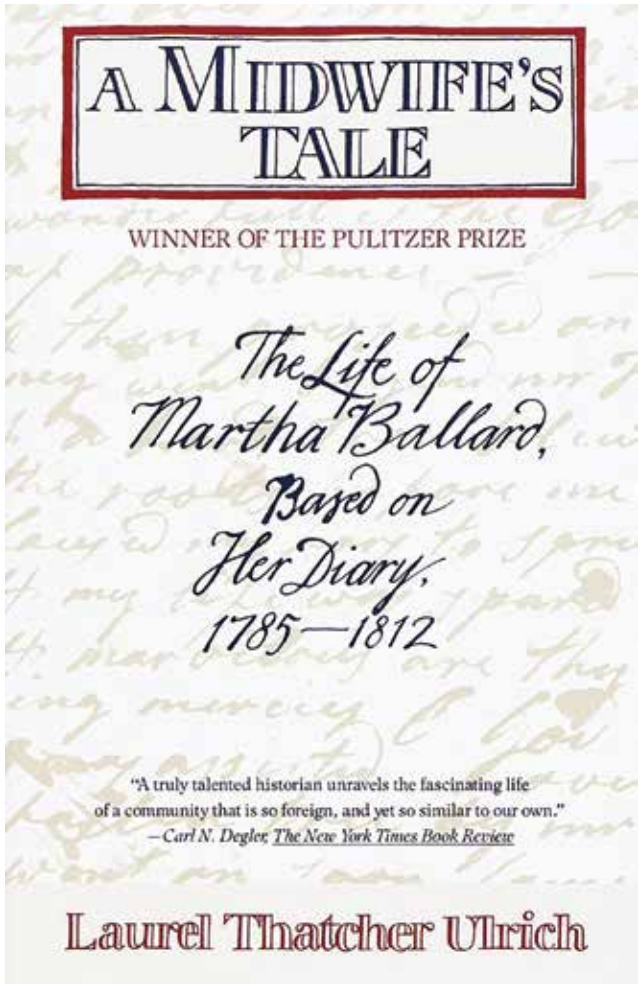
Martha Ballard lived during the colonial and revolutionary years of our country. She lived in Massachusetts and the Maine District of Massachusetts. She was a practicing midwife and fastidious documenter. From her words, we can all learn about the joys and vagaries of everyday life in the colonies under British rule and then during the Revolutionary War period, our nascent growth as a new nation, and the years leading up to the War of 1812.

She carried her diary with her to every call and would write in it when mothers were resting during their labors or after giving birth. This image obtained from dohistory.org shows how much detail Ballard included about each birth event, birth complications, neonatal deaths, antepartum and postpartum care, and observations about maternal morbidities and/or mortalities. She would periodically comment on the "gossips" who came to provide support to the laboring mother. She would travel by foot, by horse, or by canoe to her laboring mothers in all types of weather and at all times of the day or night. She would stay over at the homes of her clients for several days if needed. She would also take care of the other children in the families when they were ill. She would make "house calls" to families experiencing illness of many types.

These pages of Ballard's diary reveal that just like today, many children were born to single mothers. Just as today, many single women are reticent to name the father of their baby. By Massachusetts' law, these women had one year to name the father of the infant before that infant was recorded in the records as a child of bastardy. In her own words, she wrote about her success in getting these laboring mothers to identify the father. Her secret? She asked the mothers during the transition phase of labor. Her findings were that these mothers would – for the most part – be very truthful during that phase. Ballard wrote of effectiveness of this technique on her own future daughter-in-law when she confessed that Ballard's son was the father of her baby.

As today's nurses need to decompress for trying or difficult deliveries, so too did Martha Ballard. Her "gossips" and her family members served as sounding boards or evaluators of how to handle a situation the next time. These sessions provided exemplars to motivate others to go into the healing practices. One such young woman was a niece of Martha Ballard. This young woman, so frustrated she had been born a girl after hearing her father's stories about his service in the Revolutionary War and knowing that she could never serve, was inspired by her Aunt Martha's stories. This young girl, Clarissa Howell Barton, grew up and did indeed serve on the Civil War Battlefield. As Clara Barton, she organized the American Red Cross. One never knows the impacts that families and their stories will have on future generations.

If you are interested in Martha Ballard and midwifery, I recommend reading it for yourself. Historian Laurel Thatcher Ulrich provided interpretation and historical context in her book shown here.



Now, let's time travel to the 19th, 20th and 21st centuries with our next midwife.

MARY BRECKINRIDGE (1881-1965)

Mary Breckinridge was born into a family with deep Kentucky roots and a history of service to the nation. Her father, Clifton Rhodes Breckinridge was the son of John C. Breckinridge. The elder Breckinridge served as Vice President with James Buchanan, the 15th President of the United States.

By the time Miss Breckinridge reached the age of twenty-five (1906), she had been married for two years to Henry Ruffner Morrison and became a childless widow. The event was a major crossroads in her life. What would she do now with her life? The answer came while witnessing the illness of a child close to her. She needed to become a nurse. In 1907, she joined other women at the St. Luke's Hospital School of Nursing in New York City. At that time, young women entering nursing schools were to be unmarried. The Widow Morrison was accepted into St. Luke's as a widow under her maiden name. She fulfilled all the requirements and graduated with her nursing diploma in 1910.

The next chapter in her life took place in Eureka Springs, Arkansas. How she met her second husband is unclear, however in 1912 she once again wed. Richard Ryan Thompson was then serving as the president of Crescent College and Conservatory for Young Women. She did not utilize her nursing education and training to care for patients for several years. Instead, she became a teacher at the College and Conservatory as a French and Hygiene instructor. During the next eight years, tragedy again visited Mary Breckinridge Thompson. Once again it was death, but during these years it was the death of both her children. Whether the death of her children was the precipitating cause or other issues impacted their marriage is not known, but she could no longer continue in her marriage. She separated from him sometime before or during 1918 and finally divorced Richard Thompson in 1920.

As soldiers were returning from the Great War and bring influenza with them, Breckinridge served as a supervising nurse during the flu epidemic of 1918. After Armistice Day 1918, when many were returning home, she traveled from America to serve on foreign soil. For two years, she served with the American Committee for Devastated France and for her efforts in establishing a visiting nurse association for district nursing she received the Medaille Reconnaissance Française.

From Breckinridge's work abroad and her knowledge of life in rural southeastern Kentucky, she decided to return to the hills of her home state and provide nursing care for the families and children there. To accomplish that goal of raising health status of residents in remote areas, she raised funds using her name recognition and education in public health received at Teachers College. She knew of the birth rates and the amount of maternal, neonatal, infant, and childhood morbidities and mortalities. She knew that many midwives she was familiar with rarely called for a physician's help during a difficult labor or delivery. She also knew of the number of "home-grown" midwives who learned their trade and their superstitions from their mothers or other similarly prepared midwives in their communities. Breckinridge knew that educated, nurse-midwives were needed to turn this trend around. She led by example. Knowing the reputation of British midwives, she traveled to England to learn from the best. She left England with a certificate of midwifery from the British Hospital for Mothers and Babies, London, England.

NOW Breckinridge felt prepared to carry out her dream and goals for those impoverished families living in the Kentucky hills. The Kentucky Committee for Mothers and Babies (KCMB) – subsequently named The Frontier Nursing Service (FNS) – came into being in 1925 through the organizing efforts of Mary Breckinridge. While in England, she recruited British nurse-midwives to come to America to participate in her vision for rural maternal health care. Many did come. Many nurses from other diploma programs came to care for mothers and babies ante- and postpartum. Until the program grew sufficiently to allow the education of nurse-midwives in Kentucky, groups of nurses were sent to England and Scotland to be trained and educated in the art and science of midwifery.

Breckinridge had to consider the topography and geography of her home state. How was the best way to reach her people, their clientele? How much territory should a nurse have responsibility for? How many families could she realistically help? How will the KCMB maintain the dignity of their poor clientele (as her Kentuckians were proud and didn't like to accept charity and the stigma that went along with it)? Finally, Where to house mothers who had complications? The answers to these questions were resolved thusly: a horse, districts, staffing numbers, a paltry fee, and the establishment of a hospital. Let's look at the solutions one at a time.

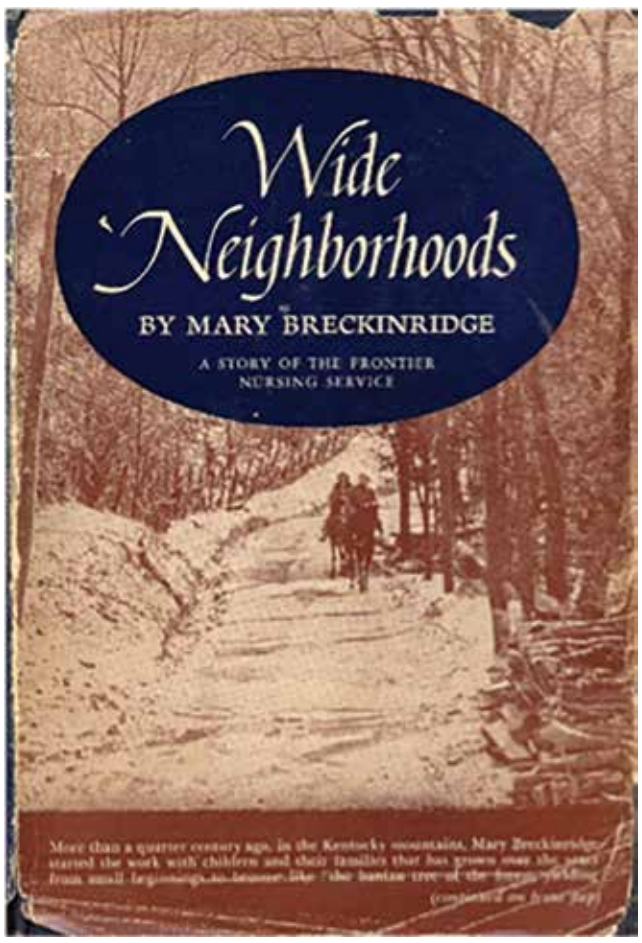
Firstly, horses could easily traverse the mountains, hillocks, and streams that would be barriers to other modes of transportation. This photograph shows Miss Breckinridge travelling on her favorite horse interacting with dogs along her way. She carried her midwifery bag and saddle bags with what would be needed to assist a mother to deliver her baby or babies.

The second and third questions were linked in Breckinridge's solution. She divided the service area in eight districts. Each of those districts were staffed by two nurse-midwives.

Fourthly, Breckinridge knew that the rural poor of Kentucky were very proud people. She knew that KCMB's clients would want to be treated as those who could afford to go to doctors for care. Therefore, a fee for services was established at $1/year + $5 for maternity care- same as non-nurse midwives. This policy was successful for both the non-nurse midwives and for the KCMB nurse-midwives.

Finally, the issue of how to care properly for mothers and their infants who sustained complications during labor and/or delivery was addressed. It would not be feasible to care for these mother-baby dyads in the home setting. Transportation was difficult. As previously discussed, nurses traveled to their clients' homes on horseback. There was not ambulance service or collapsible stretchers to facilitate movement. Whenever a stretcher was needed, construction was a community effort of ingenuity. Tree branches were readily available and so were peoples' jackets. The tree limbs were the manual carrying supports for the litter and jackets provided the bedding surface as the arms were linked through these branches. Then a team of neighbors would move the mother or mother/baby unit to a wagon for transport. But transport to where? The town of Hyden, Leslie Co., KY, opened their arms to the FNS and a twelve-bed general hospital was established to nurse these women back to health.

Part of the nursing process is evaluation of interventions and discussion of outcomes. With the implementation of Breckinridge's FNS and her district care model, she recorded a notable decrease in complications, and maternal morbidity and/or mortality. Then as now, to help advance the knowledge of nursing through evidence-based practice, nurses need to publish their research findings. So too did Breckinridge. In 1952, she published *Wide Neighborhoods* through Harper & Brothers Publishing of New York City.



If you want to learn more about Frontier Nursing University (formerly the Frontier Nursing Service) and its variety of graduate programs, you can visit https://frontier.edu/about-frontier/history-of-fnu/ for more information.

Until the next issue, have wonderful days!

Trudy

Acknowledgement of sources: International Council of Nurses; www.dohistory.org; https://frontier.edu; www.amazon.com; Bellevue Alumnae Center for Nursing History Archives; private collection of this column's author

MEMBERS ON THE MOVE

American Nurses Association (ANA) Board of Directors has selected William Rosa to receive the Public Health Service Award, which was created to recognize the exceptional leadership and outstanding professional contributions of a public health nurse in shaping the role and advancing the practice of public health nursing.

William will be recognized at a reception on the evening of Thursday, June 18 immediately preceding the 2020 ANA Membership Assembly, which is being held at the Grand Hyatt in Washington, DC.

Recipients of ANA national awards have always represented the best of the best. It is a distinct pleasure, on behalf of the board and ANA's members, for his dedication and outstanding contributions to the profession of nursing and to congratulate him on this great honor.

William Rosa, MS, APRN-BC, FCCM, FAANP, FAAN

Letters to the Editor continued from page 2

Based on the nature of the testing we perform, our actual encounter with patients is very short, and limited by design. As nurses, it became imperative that we addressed how to engage our patients and their families, within this new practice setting. As nurses we have developed and continue to explore ways to connect with our patients, while providing compassion. It is critical that we seize any opportunity, to ensure our patients feel cared for, with the hope that we can use small or simple interventions to reassure and uplift the population serve. We are one very small piece of a huge historical event, and at the end of each day, we debrief and seek feedback from all team members, to see how we can come back each day and rapidly adopt practices to enhance the patient experience.

Tim Higgins, RN

Being Prepared for the Worst

I've been in nursing for over 48 years. I've worked in a two-bed emergency department and in one of our very large emergency services department in Bellevue in Manhattan. In all those years, I've been in civilian hospitals, army facilities, and tents along with federal DMAT teams. Yet with all that experience, I'm always amazed at how ill-prepared people are in this country. I'm not being critical, just an observation. Part of the reason for me writing this article is that we as a nation need to change our attitude. I'm not saying we cannot handle the emergencies, but what I am saying is that I have observed many disasters in many years. I sometimes wonder why we don't have a better response.

A disaster can happen in a second or it can happen over days, weeks, or months. Yes, we have marvelous ways of predicting storms and developing evacuation plans. However, we don't plan well as a nation that gets struck quite frequently with wildfires to hurricanes to snowstorms. I'm aware of the need for medical teams and nurses to be prepared, yet, we usually are ill-prepared to care for ourselves and our loved ones.

If I ask you if you have a family plan in the event of an emergency, what is your honest response? Will you say I'm ready? In fact, 1 in 20 are not ready for anything coming our way.

I've been teaching disaster preparedness since 9/11/01. I can tell you that if I'm in a room with 2,000, maybe 10 people will say they are ready. Not Good.

So, let me ask you to do something this year. I want you to start preparing yourself and your family for a disaster that strikes at the heart of your community.

Let's plan for it, rather it's a snowstorm, a hurricane, a fire, or this new COVID-19 virus. Let's get ready before it comes our way. Let's, start by reviewing your need for medications. Start a list for each member of the family, add a tag for each person, especially a child should have an informational list for them on who to contact such as, emergency phone numbers, a pharmacy number, so we can refill prescriptions.

Fill a backpack with enough clothes (approximately two-days' worth), a flashlight, a can opener, a plastic gallon container for water, a small razor, soap, hand sanitizer, towels, sweatshirt, whistle, map of your area, phone numbers, small portable radio, batteries, and an extra jack for charging your phone. You will need to plan for cold and hot weather. Also, you will need to plan where to meet; will it be your home, school or another place. Make it convenient for everyone.

Finally, educate yourself about what is being recommended for each type of disaster. We never want to think about bad things happening to us. We should always think about the needs of our families and of our community. Remember if we plan ahead, we will be fine.

Laura Terriquez-Kasey DNP, MS, RN

IN MEMORIAM

Nettie Birnbach, EdD, FAAN

ANA-New York notes with sorrow the recent death of Dr. Nettie Birnbach, an ANA-NY Charter Member and a staunch supporter of this association and the nursing profession. Dr. Birnbach passed away peacefully on Wednesday, December 18, 2019.

Nettie was a proud graduate of Kings County School of Nursing in Brooklyn, New York. During World War II, she served in the United States Cadet Nurse Corps. Her cadet uniform, scholarly papers, and other memorabilia are in the collection of the Foundation of New York State Nurses in the Center for Nursing in Guilderland, NY.

Aa a practitioner, educator, and researcher Dr. Birnbach had an extraordinary vision for nursing. She spent 18 years in direct nursing practice as a community health clinical nurse specialist and 22 years as a nurse educator in baccalaureate and higher degree programs. It was in her 40s and after raising her family that Dr. Birnbach returned to school earning a Bachelor's in Nursing (cum laude) from Molloy College in Rockville Centre, NY, and a Masters in Nursing Education and a Doctorate of Education from Columbia University's Teachers College. She was Professor Emeritus at the College of Nursing, State University of New York in Brooklyn, where she was a professor and assisted in the development of a clinical Master's Degree program in Nursing.

She set and demonstrated the ultimate standard of service for her nurse colleagues. Nettie Birnbach served in many appointed and elected positions including President of the American Association for the History of Nursing (1998-2000); President of the New York State Nurses Association and the Nurses Association of the Counties of Long Island (NACLI), and Fellow in the American Academy of Nursing. Additionally, Dr. Birnbach had over 70 professional publications including her book on *Legacy of Leadership: Presidential Addresses from the Superintendents' Society and the National League of Nursing Education, 1894-1952* (1993).

A four-generation life member of Hadassah, Nettie served on its National Board in 2003. Dr. Birnbach was a leader in osteoporosis education in Florida and other states and an active volunteer with the Palm Healthcare Foundation. She was inducted into the YWCA Academy of Women Achievers in 1993.

In 2010, the recognition of Nettie's accomplishments reached a high point. She was honored with the Teachers College Nursing Education Alumni Association R. Louise McManus Award at which time she was also inducted into the Teachers College Nursing Hall of Fame. Dr. Birnbach was also inducted into the American Nurses Association's Hall of Fame. She was particularly recognized for her exceptional commitment to nursing history as demonstrated by her involvement in the American Association for the History of Nursing, serving in many leadership positions. It was stated at the ceremony that she had generated a body of historical research that illuminated the nursing profession's evolution and development. One of her most significant and lasting undertakings was her doctoral research at Columbia University's Teachers College on, "The Genesis of the Nurse Registration Movement in the United States, 1893-1903." Completed in 1982, the study concludes that "despite the immediate beneficial effects of registration, the major goal of achieving uniformity in educational preparation for professional nursing practice remains unresolved.

Nettie Birnbach, EdD, RN, FAAN was considered a renaissance woman by those who were lucky enough to know and work with her. She would be the first to urge us to not overly honor her contributions to nursing and society, but to just say that she was a dedicated wife, mother, grandmother, and a registered nurse. However, Nettie Birnbach deserves to be remembered.

New York is Committed to a Full Count in the 2020 Census

April 1, 2020 is Census Day for the next decennial census; the nation's once-per-decade, constitutionally-mandated count of every American, regardless of their citizenship status. The decennial census is one of the nation's most important programs.

New Yorkers' fair share of federal funds for programs essential to health care, education, housing, economic development and transportation, as well as our congressional representation in Washington, all depends on an accurate and fully-counted census response.

Governor Cuomo has committed resources up to $70 million to develop a comprehensive, collaborative and ongoing effort to identify hard-to-count populations and identify the most effective ways to encourage participation in the census. These efforts included the creation of the New York State Complete Count Commission. The Commission held public hearings and events to gain public input and develop a comprehensive action plan.

Additionally, the NYS Complete Census Campaign is holding conferences across the state to inform counties and community-based organizations on how to apply for available State funding as well as best practices to coordinate efforts and resources to reach at-risk and hard-to-count communities.

Source: https://www.ny.gov/programs/2020-census

The Lady With the Lamp – A Tribute to a Woman Before Her Time

Deborah Elliott, MBA, BSN, RN and Cathryne A. Welch, PhD, RN

Most nurses, if not all, know that Florence Nightingale is best known for her night rounds to aid the wounded, hence her being coined with the image "Lady with the Lamp." However, there is much more to this remarkable woman who was a trailblazer during an era when women were often marginalized. As we honor the 200th Anniversary of Nightingale's birth in 2020, let us acknowledge not only what she did to change the face of healthcare, but celebrate her courage for standing up for what she truly believed.

Nightingale, born in Italy on May 12, 1820, after receiving what she perceived to be a call from God, decided at age 16 that nursing was her divine purpose, much to the disapproval of her parents who viewed nursing as menial labor. Despite this, Nightingale enrolled in the nursing program at the Institution of Protestant Deaconesses in Germany. Returning to London in the early 1850's to work at Middlesex Hospital during an outbreak of cholera and unsanitary conditions, Nightingale made it her mission to improve hygienic practices that significantly lowered the death rate at the hospital. In 1854, Nightingale was commissioned by the Secretary of War requesting her to organize a corps of nurses to care for soldiers in the Crimean War, between England and Russia. She recruited a team of over 30 nurses from a variety of religious orders and traveled to a British based military hospital in Constantinople where most of the soldiers were dying from typhoid and cholera rather than from injuries incurred in battle. Here is where Nightingale initiated the infection control policies and procedures for which she is well-known. Upon return from the war, Nightingale received a monetary award from Queen Victoria and several private donations and established the Nightingale Training School for Nurses at St. Thomas Hospital in 1860. Her school formalized secular nursing education, promoting nursing as an honorable vocation.

Lo! in that house of misery
A lady with a lamp I see
Pass through the glimmering gloom,
And flit from room to room.
From Henry Wadsworth Longfellow's
poem Santa Filomena, 1857

In addition to improving sanitary conditions, Nightingale recognized how other factors greatly influence one's health, such as appealing food, clean linens, ventilation, light, intellectual stimulation and entertainment, etc. These were depicted in one of several publications by her known as *Notes on Nursing: What it is, and what it is not* (1860). This premise that the environment affects health outcomes is considered "social determinants of health" today. Another Nightingale publication, *Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army*, inspired the establishment of the Royal Commission for the Health of the Army. Clearly, Nightingale's use of evidence to establish practices that improved health was the predecessor of Evidence-based Practice (EBP) which continues to influence the practice of nursing and healthcare today.

Ironically, Nightingale contracted a bacterial infection, called brucellosis (Crimean Fever), resulting in a chronic condition often confining her to being homebound and bedridden. Despite this, she continued to be driving force behind health care reform and public sanitation, not only in England, but across the globe. Nightingale lived to be 90 years old and died peacefully at her home in London. She was laid to rest quietly and without fanfare, at her request, in a plot at Westminster Abbey.

In addition to Nightingale's known legacy, there are other interesting facts about this nursing icon worth noting, such as:

- She was fluent in English, French, German, Italian and Greek
- She turned down multiple marriage proposals
- Three years after attending nursing school she became the superintendent of a former London-based nursing home for women which she reorganized into a training school for nurses
- She frequently wrote letters home on behalf of dying or dead soldiers
- She helped popularize the pie chart which is still used today to represent numerical proportion
- She was admired by Queen Victoria as a "bright example to our sex"
- Her evidence and advocacy prompted British legislation that is attributed to increasing Britain's life expectancy by 20 years
- Two of her notable quotes *every nurse ought to be careful to wash her hands very frequently during the day and every nurse should be capable of being a confidential nurse* are just as pertinent today as they were 170 years ago
- During the American Civil War, she provided valuable soldier mortality statistics to Washington, D.C.
- She personally advised America's first trained nurse, Linda Richards, who attended London's Nightingale School of Nursing
- She became the first woman to be inducted into the British "Order of Merit" by King Edward VII

(Mancini, M., 2018)

Nightingale's influence on nursing in the United States is profound and enduring. In 1861, Dorothea Dix, Superintendent of the US Sanitary Commission charged with care of soldiers ill and wounded in the Civil War, requested Nightingale's review of the Commission's 1858 report. Subsequently, Nightingale's recommendations were implemented in care of Civil War soldiers.

At the end of the war Louisa Lee Schuyler, active in the Sanitary Commission, saw the deplorable conditions in Bellevue Hospital. She and friends formed the State Charities Aid Association which pledged to start a school of nursing at Bellevue patterned on the Nightingale School in London. Dr. W. Gill Wylie, a Bellevue physician, at his own expense travelled to London to meet with Nightingale and observe her theories and techniques firsthand. Too infirm to meet with him, in 1872 Nightingale wrote Dr. Wylie describing how to set up a school of nursing. That letter formed the basis of the charter of the Bellevue School of Nursing which was established in 1873 and led to development of schools of nursing based on the Nightingale principles throughout the country. Nightingale's letter to Dr. Wylie is contained in the Bellevue School of Nursing Archival Collection in the Center for Nursing's Bellevue Center for Nursing History.

Among the many accolades and honors extended to Florence Nightingale for her extraordinary contribution to humankind was the 1960 designation by the American Episcopal Church of August 12 as the Feast Day of Florence Nightingale.

A recent book titled *The Florence Prescription* by Joe Tye & Dick Schwab captures the essence of Nightingale's primary message to health care providers and the nursing profession; which is: *taking care of the sick should be a mission, not just a business, and being a nurse or any other health care professional should be a calling, not just a job*. According to Tye & Schwab, it is our responsibility as registered professional nurses to live by Nightingale's tenants of assuming ownership for the care we provide. It is more than just being accountable – ownership is comprised of characteristics including commitment, engagement, passion, initiative, stewardship, belonging, fellowship and pride.

There are many words that have been used to describe Nightingale - pioneer, rebel, leader, researcher, dedicated, compassionate, healer, heroine, teacher, statistician, consultant, humble… the list goes on and on, however, we think the best word to describe Nightingale is simply "nurse" because all nurses model these attributes at certain moments in their careers and should aspire to leave a legacy as captivating as Florence Nightingale.

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Side note: Most of Nightingale's letters, publications and personal artifacts are housed in the Florence Nightingale Museum which is located at the St. Thomas' Hospital in London. However, as noted, her letter to Dr. Wylie, donated by the Bellevue Alumnae Association, is located in the archives at the Center for Nursing History at the Foundation of NYS Nurses in Guilderland, NY.

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In the Spotlight Future Nurse Leader

Kiersten Gray

I graduated from Albany Memorial College of Nursing in May of 2019 with my Associate's Degree. During my three years of nursing school I served in the Albany Memorial Student Nurses Association for five semesters, the last two as Vice President. Being in a leadership position as a part of AMSNA I spent a lot of time volunteering within the community and mentoring other students to help guide and encourage them through the ups and downs of nursing school. I chose nursing as a career because of the diversity in specialty areas, constant learning, and having a positive impact on others. I received the ANA-NY Future Nurse Leader award at graduation and joined the ANA to continue to learn about new opportunities in the field and be a part of a positive community in helping others.

I am a Registered Nurse at St. Peter's Hospital in Albany, NY on a cardiac and telemetry floor. The majority population on this unit are patients with CHF, rule out CVA or MI, as well as post cardiac cath patients. Having a background in fertility before graduation, I really wanted to try something different to gain new skills and learn new concepts.

Currently I am taking online classes and working towards my BSN at SUNY Brockport. My five-year plan is to become a Family Nurse Practitioner. In my spare time I enjoy spending time with friends and family, trying out new recipes, and traveling.

CONTINUING EDUCATION

Building Competencies for Nursing Practice: Closing The QSEN-to-Practice Gap

Instructions

Steps to complete independent study and receive 0.75 contact hours.

- Read the article below
- Complete the post test, evaluation and registration forms. Mail to: ANA-NY, 150 State Street, 4th Floor, Albany, NY 12207
  $7.00 Fee for non-members. Members are free
  Certificates are emailed after a passing score is achieved.
- Objective/Learning Outcome: completion of this activity, the learner will be able to describe one approach to embed the QSEN competencies in the nursing curriculum.

Abstract

Background

The Quality and Safety Education for Nurses (QSEN) (Cronenwett, et al., 2007) initiative was undertaken to align nursing education with national quality and safety standards put forth by the Institute of Medicine in 2003. The challenge is to hardwire the quality and safety competencies into nursing curriculum and practice.

Method

Following the review of course evaluations, student surveys, and focus groups, an existing undergraduate nursing research course was transformed to support nursing student development of the six QSEN competencies guided by the "Seven Steps of EBP" (Melnyk, Fineout-Overholt, Stillwell, Williamson, 2010) and supported by mentored knowledge, skills, and attitude (KSA)-building learning activities.

Results

Utilizing QSEN KSAs as pillars and an evidence-based EBP competency tool, provided the needed structure to the research course in guiding instructors and students toward EBP competency.

Conclusion

Embedding QSEN competencies into a nursing research course and mentoring students through an EBP proposal helps prepare students for competent clinical practice.

Background

The focus on quality and safety in health care has never been stronger. On the throes of a strong call to bridge not only the research-to-practice gap, but also the "preparation-practice" gap (Hickerson, Taylor, & Terhaar, 2016), we as educators are compelled to embed EBP into nursing practice within a culture of quality and safety. As guided by the Institute of Medicine (IOM) (2003), six core nursing competencies were established and guided the work of the (QSEN) faculty members funded by the Robert Woods Johnson Foundation (Cronenwett, et al., 2007). QSEN defined the knowledge, skills, and attitudes (KSAs) of the competencies as: (a) patient-centered care; (b) teamwork and collaboration; (c) evidence-based practice; (d) quality improvement; (e) safety; and (f) informatics (Cronenwett, et al., 2007).

QSEN has had a great impact on building evidence-based educational strategies; however, there is less evidence of quality and safety strategies implemented in the practice setting (Burke, Johnson, Sites, & Barnsteiner, 2017). EBP provides a framework to bring quality evidence and clinical expertise to the bedside using a patient-centered approach (Melnyk & Fineout-Overholt, 2005). Organizational and individual characteristics have long been recognized as barriers to EBP adoption (Fiset, Graham, & Davies, 2017; Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012). Both novice and experienced nurses have reported they do not feel prepared for EBP. Furthermore, novice nurses report that although their educational program prepared them for licensing, it had not prepared them for clinical practice (Hickerson, Taylor, & Tehaar, 2016). A plethora of research has demonstrated that the lack of KSAs is a barrier to adopting an evidence-based practice (Fiset, et al, 2017; Melnyk, et al., 2004; Melnyk, Fineout-Overholt, Stetler, & Allen, 2005). More specifically, the lack of a mentor and the knowledge and skill to access and use the evidence to apply in practice, has been cited (Melnyk, et al., 2004; Melnyk, Fineout-Overholt, Giggleman, & Cruz, 2010). Although EBP competencies involve understanding and applying research evidence in practice, at our graduation, the nursing department outcome surveys demonstrate students have less interest in research courses because they focus on courses that develop their clinical knowledge and skills, a finding supported by Ryan (2016). It is worth noting that a scoping report by Fiset, et al. (2017) identified that "taking a course or participating in education related to EBP" (p. 536) was a facilitator of EBP for nursing students.

It is essential to integrate the KSAs for QSEN into the curriculum (Bryer & Peterson-Graziosi, 2014). The traditional undergraduate research course teaches students about different research traditions and the research process, and also provides instruction in critiquing the research evidence, but there continues to be a demonstrated "lack of QSEN content" (Altmiller & Armstrong, 2018, p.128) in many nursing research courses. While our research course introduced the key elements of EBP it did not support EBP competency development as described in the literature. This article will present the way in which a traditional undergraduate nursing research course has been transformed to support the development of QSEN competencies with a focus on EBP. The same framework could support practicing nurses as well.

Method

The nursing department student surveys administered to both pre-licensure and RN-BS Completion students at graduation from 2016 to 2018 demonstrated students' lack of perceived value for, and satisfaction with, the existing undergraduate research course entitled *Modes of Inquiry*. As this face-to-face research course was about to be launched in our new asynchronous RN-BS Completion online program, it was critical to clearly align the course objectives and exemplars with learning activities and learning outcomes.

The concepts identified for this course are: (a) professionalism; (b) leadership; (c) assessment; (d) caring; (e) intervention; (f) EBP; (g) health, wellness, and illness; (h) clinical judgment; (i) advocacy; (j) ethic and (j) teamwork and collaboration. After mapping the course concepts through the course outline, not only was a gap across the course objectives with learning activities and learning outcomes identified, but also a tremendous lost opportunity for students to translate new knowledge into skills. It was posited based on the literature that building QSEN and EBP KSAs into a tangible learning experience would enhance the value of the research course and increase student satisfaction while also building their QSEN competencies in preparation for practice (Melnyk, et al., 2010).

Information from graduate outcome survey data, course evaluations during the past five years, as well as information obtained through student focus groups from 2016-2018, was examined to inform course revisions that were integrated progressively throughout four semesters. Revisions were finalized for the Fall, 2019 semester. Utilizing the QSEN competencies as pillars and Melnyk, et al's (2010) Seven Sequential Steps of EBP as a framework for EBP, a traditional undergraduate nursing research course was transformed to promote EBP competency.

Intervention

This course was organized in the Blackboard Learning Management System, Blackboard, Inc®. The "Seven Steps of EBP" as described by Melnyk, et al. (2010), were embedded in the course and taught in alignment with course content. Much of the KSAs from the QSEN competencies were integrated throughout with the remaining two QSEN competencies (quality improvement and safety) continuing to be a focus in the following semester.

Students were introduced to the course concepts the first day of class as the learning objectives were introduced. Teams of three to four students were formed and a specifically created *Team Toolkit* was introduced in week two to develop *teamwork and collaboration* KSAs (Cronenwett, et al., 2007). The *Team Toolkit* contained documents for *Team Rules of Engagement, Team Roles and Responsibilities*, and a *Team EBP Task List*, much of which team members develop together with a selected "Team Leader." We found the *Team Toolkit* to be essential in the online environment.

Step 0: Spirit of inquiry. Following a preliminary discussion about the development of a PICOT (problem, intervention, comparison, outcome, timing) question (Polit & Beck, 2018) for their *Team EBP Presentations,* students were asked to select a research article that reported an *EBP nursing intervention.* Students were asked to begin thinking about a structured research question around this topic. A short paper was assigned that reported the evidence for and against a selected intervention. To set the stage for this assignment, students read *Routine Supplemental Oxygen for AMI: Modern-day Myth* (Chen & Lim, 2018). Students expressed their thoughts about the intervention they selected based on knowledge or clinical expertise and then compared that with the evidence they discovered about their selected intervention in a guided discussion. This class is taught both at the undergraduate and post-licensure level, so the discussion was stimulated by different probes. Registered nurse students talked about how it related to their clinical practice, usually reporting why it did or did not work. Pre-licensure students ignited their "spirit of inquiry" earlier expressing the many possibilities that can come from or around the reported intervention. At the end of the first two classes, the instructor facilitated a discussion about the power of research knowledge to influence healthcare outcomes. Students were empowered with the idea that they can and must "change the world." The *Team EBP Intervention Proposal* template following the "Seven Steps of EBP" (Melnyk, et al., 2010) was sequentially introduced over the semester.

Step 1: Ask the clinical questions in format. Guided by a PICOT formatting template found in Polit & Beck (2018), students were asked to discuss their individually created PICOT questions with their teammates before selection of a team EBP question that guided the development of their *Team EBP Intervention Proposal* following the "Seven Steps of EBP" (Melnyk, et al., 2010) over the semester. Close mentoring was needed here to guide students from crossing from EBP to research methods although theoretical frameworks were added.

Step 2: Search for the best evidence. Students were presented with a library workshop developed specifically for this class. Students were mentored in searching databases for relevant evidence and further development of their PICOT question. Mentoring has been shown to be a facilitator of EBP (Melnyk, Fineout-Overholt, Feinstein, et al., 2004) and it was continued at different intervals as the course progressed. The online class is mentored through synchronous recorded collaborate meetings.

Step 3: Critically appraise the evidence. Following the instructors lecture, students learned how to apply their knowledge related to the quality of the evidence through their *CQ* homework assignments adapted from the "Guide to a Focused Critique of the Evidence Quality in a Quantitative Research Report" (Polit & Beck, 2018). We currently assign the article, *Promoting Evidence-Based Practice Through a Research Training Program for Point-of-Care Clinicians* (Black, Balneaves, Garossino, Puyat, & Qian, 2015) as this mixed method research report focused on improving EBP in clinical practice with opportunities for scholarly discussion around the critique. In preparation, students were probed to determine the quality of the evidence of various research articles in class. Open discussion stimulated critical thinking as they evaluated and challenged the comments made by peers. Critiquing research is challenging; therefore, students were introduced to each sub-section of the Black, et al. (2015) article sequentially, using the *CQ* homework questions. The first critique (*CQ1*) directed students to evaluate the title, abstract and, introduction. In our online program, the *CQ* questions were tied into discussion boards. Simultaneously, each student applied their critiquing and appraisal skills to their selected research articles.

Step 4: Integrate the evidence with clinical expertise and patient preferences and values. Integrating patient preferences relevant to evidence was difficult for students to conceptualize. *Based on the Principles of Patient Engagement* (Sofaer & Schumann, 2013), students were directed to think through what it means to be engaged and patient-centered focusing on a deeper understanding of the patient's perspective. Students were provided with templates reflecting the seven steps and mentored in the development of their *Team EBP Intervention Proposal* for their final presentation assignment.

Step 5: Evaluate the outcomes of the practice decisions or changes based on the evidence. As these students would not actually implement their proposed interventions during the semester, they had to identify how and what outcomes they would measure and when they would do this. Instructors ensured interventions were feasible and in alignment with the original PICOT question.

Step 6: Disseminate EBP results. In the last two weeks of the semester, students presented their comprehensive *Team EBP Intervention Proposals*. Allotted 30-40 minutes, each team was peer-scored on a rubric developed to ensure they had included the "Seven Steps of EBP" (Melnyk, et al., 2010). Students were asked to report how they intended to disseminate EBP outcomes to their interprofessional colleagues both locally and beyond.

Outcome

At the completion of the semester, students had acquired QSEN KSAs and a basic EBP competency as described by Melnyk, Gallagher-Ford, & Fineout-Overholt (2017). Learning objectives that had been met were demonstrated by the: (a) formation of an effective team in developing an EBP proposal; (b) identification and assessment of client/population need or condition; (c) research and discovery of current nursing practice in the delivery of care to this client/population; (d) interpretation of research results; (e) examination and appraisal of relevant literature related to patient/population need or condition; (f) rating of relevant research found in review of literature to support/justify nursing practice change in addressing client/population need or condition; (g) determination of which research reports are most relevant to current topic under investigation; (h) outlining an EBP proposal for development, and (i) the provision of a plan for dissemination of research results (Polit & Beck, 2018).

Although the course revisions are too new to assess, students' anecdotal comments are positive expressing they can already identify things that aren't going right in healthcare and they are "going to change the world". Students presented posters at the college research day and we are assessing EBP competency outcomes.

Conclusions

Quality and safety education are paramount to quality and safety in clinical practice. Novice nurses are at great risk for producing, or being a part of, medical errors (Kim, M.Y., Kim, & Kang, 2016; Smith & Crawford,

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2003) emphasizing the need to close the preparation-to-practice gap. Furthermore, QSEN KSAs are the vehicle in closing the quality/safety-practice gap. Clinical and academic educators should look for every opportunity to convert learning activities into QSEN KSA competencies in preparation for clinical practice. Exemplars of QSEN strategies in practice can be viewed at https://qsen.org/teaching-strategies/. While we may never catapult all nurses and nursing students into a flurry of inquiry, those we do capture have the potential to have a great impact on the future of quality and safety in health care.

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Registration Form

Name: _____

E-mail address: _____

Address _____

_____

_____

Phone number _____

Continuing Education Post-Activity Questions

1. The QSEN Competencies were guided by
   a. The ANA Scope and Standards of Nursing Practice
   b. The ANA Ethics Statement
   c. The IOM Future of Nursing Report
   d. The ANCC Competencies of Baccalaureate Nursing

2. The QSEN Competencies are important for
   a. Nursing Practice
   b. Evidence-Based Education
   c. Patient-Centered Care
   d. All of the above

3. _____ nurses report that they do not feel prepared for EBP.
   a. Novice
   b. Experienced
   c. Both novice and experienced
   d. Neither novice nor experienced

4. During the Spirit of inquiry step, students were empowered to
   a. Change the world
   b. Change their major
   c. Become a primary investigator
   d. Create a research proposal

5. EBP intervention is the same as research methods.
   a. True
   b. False

6. PICOT stands for

_____

_____

7. Students not only proposed, but also implemented their EBP interventions during this study.
   a. True
   b. False

8. This study required students to work
   a. Independently
   b. As a team

9. QSEN Competencies are important practices to reduce the risk of errors in health care.
   a. True
   b. False

10. _____ educators are encouraged to look for opportunities to implement QSEN Competencies.
    a. Academic
    b. Pre-licensure
    c. Post-licensure
    d. Clinical
    e. All of the above

EVALUATION FORM

1. The learning outcome(s) for this activity was met?

_____ Yes

_____ No

2. I found this activity worthwhile for my professional practice. (If you select "Disagree" or "Strongly Disagree," please provide a comment below.)

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

_____

_____

3. This activity will enhance my knowledge/skill/practice as a health care provider. (If you select "Disagree" or "Strongly Disagree," please provide a comment below.)

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

_____

_____

4. The authors were knowledgeable about the topic:

Strongly Agree - Agree - Neutral - Disagree - Strongly Disagree

_____

_____

5. As a result of this activity, please share at least one action you will take to change your professional practice/performance.

_____

_____

6. Was this independent study an effective method of learning?

_____

_____

7. What other topics would you like to see addressed in an independent study?

_____

_____

CONTINUING EDUCATION STATEMENT:

The continuing education program is approved for 0.75 contact hours. The Northeast Multistate Division is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

COMMITTEE CHAIRS

ANNUAL CONFERENCE & MEETING COMMITTEE

Gorete Crowe

I am Gorete Crowe, RN, ADN. I am a Staff / Charge Nurse at Westchester Medical Center Oncology/Bone Marrow transplant unit. I have 34 years of nursing experience, starting in the Medical Surgical, Pediatrics, and Preoperative (OR) units. I've been in the Oncology Unit for the last 24 years.

I have ACLS, Oncology and Bone Marrow, and First Responder certifications.

I am a member of the Sleepy Hollow Ambulance Corp, Oncology Nursing Society of the Hudson Valley, Tarrytown Fire Department Hope Hose, Boy Scouts of America Venture Crew 2279 board member, Village of Sleepy Hollow Zoning board member, Democratic District Leader for District 5 of the Town of Mt Pleasant, and ITAV 10591 (It Takes a Village 10591).

I have presented and lectured on Diabetes and ANA-NY for the Sleepy Hollow Senior Citizen Community, the Road to Eagle Scout for the Boy Scouts of America Westchester Division, and the American Red Cross CPR and First Aid Instructor.

I have received many awards during my tenure as a nurse. I received the American Cancer Society for Relay for Life award in 2000, the American Red Cross award in 2002 (service After 9/11- working at ground Zero), the District Award of Merit from the Boys Scout of America (first female to win the award in Westchester County) in 2004, Sleepy Hollow Proclamation Gorete Crowe Day for Service to the Village in 2011, and the NYSNA Legislative Award in 2011.

I am still very involved with my church, Old Dutch Church, as a Deacon and in the community, especially the ITAV 10591 (It Takes a Village 10592). We help seniors and people in need and provide rides to their doctor appointments, grocery shopping, and so much more.

AUDIT COMMITTEE

Claire Murray, MS, RN

Retired CNO, adjunct faculty for graduate nursing programs and Chair, Public Policy Committee NYONEL, ED Emeritus of the NYONEL and former Executive Director

AWARDS COMMITTEE

Jennifer Nahum, DNP, RN, PPCNP-BC, CPNP-AC

Dr. Nahum is a clinical assistant professor at NYU Rory Meyers College of Nursing. She is a pediatric nurse practitioner with an interest in neonatology and experience as an emergency department nurse practitioner. After spending her early nursing years as a bedside nurse in a Level-III intensive care nursery in Philadelphia, she currently practices in a busy emergency department in the Bronx. Dr. Nahum earned her DNP at New York University and MSN and BSN at the University of Pennsylvania.

Dr. Nahum has served on the ANA-NY Awards committee as a member since 2015 and excited to continue as chair for the second year.

BYLAWS COMMITTEE

Catherine S. Finlayson, PhD, RN, OCN

Catherine S. Finlayson, PhD, RN, OCN has been a clinical nurse at Memorial Sloan Kettering Cancer Center for over 12 years. She recently earned her PhD from New York University's Rory Meyers College of Nursing. Dr. Finlayson received the Doctoral Degree Scholarship in Cancer Nursing from the American Cancer Society which supported her dissertation. She was the recipient of the 2018 Oncology Nursing Society Trish Greene Memorial Lectureship.

Dr. Finlayson holds a Bachelor of Arts in Political Science from New York University. A Master of Science in Urban Policy Analysis and Management from the New School for Social Research and a BSN from SUNY Downstate Medical Center.

FINANCE COMMITTEE

Sue Penque, PhD, RN, NE-BC, ANP-BC

LEGISLATION COMMITTEE

Beverly Karas-Irwin, DNP, RN, NP-C, HNB-BC, NEA-BC

Beverly Karas-Irwin, DNP, RN, NP-C, HNB-BC, NEA-BC is the Director of Nursing Excellence, Magnet Recognition at NewYork-Presbyterian in New York, NY assisting 11 campuses on their Magnet initial and redesignation journeys. Dr. Karas-Irwin is a nurse leader with over 35 years' experience in professional nursing practice and nursing education. She is a Magnet Appraiser for the American Nurses Credentialing Center. She has authored publications and has presented locally and nationally. Dr. Karas-Irwin is an adjunct professor at Ramapo College of New Jersey and Case Western Reserve, Cleveland, Ohio. She was previously a member of the Organization of Nurse Executives-NJ Advocacy Committee and was appointed to the ANA-NY Legislative Committee in 2017 and Chair of the committee in 2019.

Dr. Karas-Irwin obtained her Doctor of Nursing Practice in Nursing Administration from University of Pittsburgh, Pennsylvania; Master of Science in Nursing – Adult Nurse Practitioner from St Peter's College, NJ; Master of Science in Health Service Management from New School for Social Research, NYC; and Bachelor of Science in Nursing from University of Pittsburgh. She is nationally board certified as an adult nurse practitioner, holistic nurse-baccalaureate, nurse executive-advanced and is a fellow in The New York Academy of Medicine.

MEMBERSHIP COMMITTEE

Amy Caramore, RN

NOMINATIONS AND ELECTIONS

Gertrude B. Hutchinson, DNS, RN, MA, MSIS, CCRN-R, The Sage Colleges, Russell Sage College School of Nursing

Gertrude B. (Trudy) Hutchinson, DNS, RN, MA, MSIS, CCRN-R is currently an Assistant Professor of Nursing, Russell Sage College (Troy, NY) and an Adjunct faculty in the graduate program at SUNY Empire State College. She previously worked as the Director of History and Education and Archivist at the Center for Nursing at the Foundation of New York State Nurses in Guilderland, NY. Dr. Hutchinson holds membership in numerous professional organizations such as: Sigma Theta Tau International Honor Society, and Phi Kappa Phi (life member); International Nurses Association; NLN and NYLN; ANA and– ANA-NY. She contributes to ANA-NY at annual conferences and through committee work such as chairing the Nominations and Elections Committee. Dr. Hutchinson earned her Doctor of Nursing Science in Leadership and Education from The Sage Colleges School of Health Sciences, a MA in History and MS in Information Systems (MSIS) both from SUNY Albany, a BA in History from California State University, San Bernardino, and her Diploma in Nursing from United Hospital SON. She has an extensive background in critical care, neonatal, emergency department, and air & ground CCT. She held national certifications - CCRN and CEN - until her departure from the acute care setting to pursue graduate education. She received recognition by P.O.W.E.R. for her contributions to nursing and received the NYONEL Northeast Region's Leadership Award (2015). Dr. Hutchinson will be the keynote speaker at the 2nd Annual Eva Allerton History Lecture (Rochester, NY) in April. Her areas of research focus on: nursing, women's, and oral history; military nursing; and nursing education. She has presented widely in the Capital District of NYS and at national and international conferences on her research. She has written numerous articles and papers including her dissertation, *Unsung Heroines' Roles in Establishing Nursing Training Schools in the Upper Hudson Valley of New York State, 1872-1930,* and the Foreword for William Patrick's book, *The Call of Nursing: Stories from the Front Lines of Health Care.*

NURSING EDUCATION COMMITTEE

Susan Birkhead

Dr. Susan Birkhead graduated from Boston University in 1974. She worked in various staff nurse positions in Boston. In 1984, she worked for eight months in a refugee camp in Thailand. When she returned to the US, she attended Johns Hopkins University, where she earned a master's degree in public health. Subsequently, she worked in public health, including a year as a nurse epidemiologist at the Centers for Disease Control. She spent the majority of her career in nursing education at the Samaritan Hospital School of Nursing, first teaching and then as the director of the program. During that time, she earned a doctorate in nursing science at the Sage Colleges in 2015, concentrating on assessment of learning using written exams. Dr. Birkhead is a certified nurse educator. She recently retired and is working as an adjunct professor at Empire State College. She serves as an auxiliary member of the NYS Board for Nursing. She has published several articles in the peer reviewed literature.

COMMITTEE SPOTLIGHT

Awards Committee

Jennifer Nahum, DNP, RN, PPCNP-BC, CPNP-AC

Dr. Nahum is a clinical assistant professor at NYU Rory Meyers College of Nursing. She is a pediatric nurse practitioner with an interest in neonatology and experience as an emergency department nurse practitioner. After spending her early nursing years as a bedside nurse in a Level-III intensive care nursery in Philadelphia, she currently practices in a busy emergency department in the Bronx. Dr. Nahum earned her DNP at New York University and MSN and BSN at the University of Pennsylvania.

Dr. Nahum has served on the ANA-NY Awards committee as a member since 2015 and excited to continue as chair for the second year.

Liz Catherine S. Cory, MSN, APN, FNP- BC

Nurse Practitioner serving adults and geriatrics. Currently practicing at Center of Aging with NYP Weill Cornell Medical Center.

DNP student at University of Massachusetts- Amherst, and a proud alumni of Rutgers Knights. I am also active member in ANA's mentorship program.

I love to travel, experience different cultures, spend time with my family, and read. I believe nurses should always be recognized not just this year, but for the countless days that they serve and help others heal.

Not pictured
Linda Millenbach, RN
Lynn James, RN
Priscilla Worral, RN

Jake Wilkins, RN

I began my nursing career in 1997 as an LPN in a small hospital in Middle Georgia. In 2000, I moved to Western New York to work in a diagnostic clinic and long-term care, and while I'd enjoyed these opportunities, I found there was something missing from my professional career. My passion for nursing was renewed when I began service to my community as a Hospice nurse in rural Chautauqua County. In 2009, I completed my studies and became an RN focusing my career in traditional Certified Home Health. The clinical skills I learned in school were honed in varying capacities from Field nurse, to Manager, Director, and currently as an Associate VP of Home Health. Service to my community in support of those with special needs has become my niche area and has extended my impact to support other clinicians in the field through education, guidance and leadership.

Verlia M. Brown, MA, RN, BC

Retired Critical Nursing Care Coordinator, Kings County Hospital Center, Brooklyn, NY.

Serving second year term on the Board of Directors ANA-NY. Member of Bylaws Committee and board liaison to the Awards Committee. ANA-NY representative to the ANA membership assembly to be held in June 2020 in Washington, DC.

Member of American Association of Critical Care Nurses and Sigma Theta Tau International Honor Society of Nursing. Served ten years as an auxiliary member to the New York State Education Office of the Profession.

How We Pay for Health Care is Changing - What Does It Mean for Nursing?

Jason Helgerson, Founder / Chief Solutions Officer
Helgerson Solutions Group LLC, www.helgersonsolutions.com

The way we pay for health care in the United States is rapidly changing. The old method known as "fee for service" reimbursement which pays providers for units of service is quickly being replaced by a new system that ties payments to patient outcomes. This new system - value-based payment - is designed to reward providers when patients get better or when the services provided are effective. The goal with the new system is to reward better outcomes and to encourage great collaboration amongst providers.

What does this change mean for nursing? The hope is that it will drive even greater appreciation for the role played by nurses and possibly lead to expanded roles and responsibilities. Demand for nurses in community settings will likely grow as providers work together to keep patients out of the hospital.

The future of nursing is bright and the move to value-based payment only makes that future brighter. The ultimate goals is to get to a system where unnecessary paperwork is replaced by more direct care and the role of nurses expands so that patients and communities can be better served.

GVNA
VISION VOICE ACTION
Genesee Valley Nurses Association GVNA

Annual Legislator Reception

The Genesee Valley Nurses Association GVNA is hosting the 36th Annual Legislator Reception in February 2020. This region has a committed group of members on the GVNA Legislative Committee who have been active participants in advocacy and lobbying for decades and have established close working relationships with the elected members who represent this area in Albany and Washington.

Recent attendance for this event has topped 200 members and guests. The goal in sharing the format and details is to encourage other groups around the state to host similar events that give nurses and nursing students the opportunity to interact with their representatives in government.

- The GVNA Legislative Committee invites all regional professional nursing organizations to co-sponsor and encourage their members to attend
  - o Sponsorship levels are whatever the organization can support and the money is used to pay for refreshments
  - o Acknowledgment is given to all sponsors at the event
- The event is scheduled for a Thursday evening early in the session, usually February, when the NYS Legislative Calendar indicates that the Assembly and Senate are not in session that day (the Presidents' day week is often a good time to boost attendance from legislators)
- The event is held at a local college that has meeting space, free parking and easy access area expressways
- All professional nursing organizations and area nursing schools/programs are sent "save the date" flyers and registration information in late fall and early January.
  - o Students turn out in large numbers (both undergraduate and graduate)
  - o Often faculty include attendance at the event with a related writing assignment as a project option in the professional issues or leadership courses
  - o Students sign in so faculty have a record of attendance
- All elected representatives in the GVNA multi-county area are sent email invitations using the League of Women Voters directory
  - o Follow-up emails are sent to confirm attendance by members of the Legislative Committee and elected representative or their staff are logged in at the sign-in table so they can be introduced at the event
- Each reception includes a short (15-20 minute) presentation about a local/regional topic related to health care or advocacy by an individual or member of a community-based organization and short legislative update reflecting ANA-NY priorities from a member of the Legislative Committee
- After the program, all legislators or staff representatives are introduced and have an opportunity for brief comments
- A "Q & A" follows which gives all attendees an opportunity to ask the legislators questions or comment on current legislative or regulatory issues
  - o 1 CE is granted for this event
- The event is free and all attendees are encouraged to register in advance (for planning purposes) using the online registration process on the flyer

Dr. Marilyn L. Dollinger Professor, Executive Associate Dean, Wegmans School of Nursing at St John Fisher College; ANA-NY Legislation Committee Consultant and Past-Chair.

Call for Nominations for the 2020 ANA-NY Awards

Honor your colleagues. ANA-NY members are doing great work, please take the time to recognize them and submit those nominations!

ANA-NY is excited to announce the **Call for Nominations for the 2020 ANA-NY Awards.**

The four award categories for 2020 are:

Friend of Nursing:

The ANA-NY Friend of Nursing Award recognizes non-nurse individuals or organizations (excluding professional nursing organizations) who have had a significant positive impact on ANA-NY, the health care community, and/or the health of people.

Criteria:

- Demonstrated commitment to the purposes and goals of ANA-NY.
- Demonstrated superior achievement and leadership in their field of work.
- Sustained contribution(s) of lasting significance to ANA-NY, the nursing profession, and/or the health of people in New York State.
- Examples of contributions to the nursing profession include, but are not limited to:
  - Leadership in strategic efforts to promote legislation and/or regulation supportive of Registered Nurses and their patients
  - Implementation of critical research which supports the nursing profession
  - Provision of exemplary service to a professional nursing organization
  - Participated in or lead collaborative efforts to improve health care
  - Demonstrated leadership in the promotion of Registered Professional Nurses as equal partners in the health care system

Mentorship:

The ANA-NY Mentorship Award recognizes a nurse who has been an exemplary mentor to less experienced nurses (novices) in any domain of nursing – education, research, practice improvement, clinical practice, and/or health policy. The recipient of this award will have provided professional guidance and support to the mentees over a protracted time period during the evolution of their careers in an effort to help the mentees reach their professional, mutually agreed upon goals.

Criteria:

- Demonstrated activity as a mentor through:
  - Documentation by at least two (2) mentees of the role played by the mentor in helping them to achieve their professional goals
  - Collaborative publications and/or presentations with mentee as first author; and
  - Acknowledgement of mentor in published works (mentor not author) or awards supported by mentor (mentor not part of award).
- Protracted relationship between mentor and mentee (i.e., going beyond a work relationship). Examples: If a faculty member, working with a student beyond graduation from a program. If in a clinical role, meeting and working with mentee beyond work hours.

Nursing Practice- Early Career:

The ANA-NY Nursing Practice Award recognizes and celebrates excellence in the provision of direct care to patients, families, communities, and/or populations. The recipient of this award exemplifies a high level of compassion and expertise in the provision of such health care.

Criteria:

- Within five (5) years of initial licensure
- At least a Bachelor's degree in nursing
- Demonstrated evidence of significant contribution to improved quality of patient care
- Demonstrated evidence of recognition for excellence in practice
- Modeled a holistic approach for care of both family and patient, cultural sensitivity, and excellent patient/family education

Policy and Service:

The ANA-NY Policy and Service Award recognizes a nurse who has made significant contributions in the policy, legislative, and/or nursing service sectors of the profession and has contributed in these realms beyond their own practice to advocate within the policy and/or service arenas to bring change to nursing and the healthcare system.

Criteria:

- Demonstrated activity in policy and/or service through a minimum of two (2):
  - Political activity (i.e., development and support of legislation, campaign work, fund raising, or lobbying), which promotes the nursing profession in political and health care arenas
  - Advancement of the knowledge of nurses, politicians, and policy makers concerning the contributions of nursing in the health care field
  - Development of mechanisms to promote the effectiveness of nursing's role in the provision of health care services through political and/or legislative activities
  - Promotion of the role of nursing as a scholarly discipline by using research findings as a foundation for legislative and regulatory initiatives that promote the role of nursing and the safety and quality of care of our patients
- Demonstrated activity in ANA-NYs policy, leadership, scholarship and/or educational agenda

To nominate someone for an ANA-NY award please complete the online form at: https://form.jotform.com/80644963230153 by April 17, 2020.

DONATE LIFE NEW YORK STATE

April is National Donate Life Month!

Celebrated in April each year, National Donate Life Month features an entire month of local, regional and national activities to help encourage Americans to register as organ, eye and tissue donors and to celebrate those that have saved lives through the gift of donation. This year, Donate Life New York State (NYS) is calling on all ANA-NY members to partake in National Donate Life Month activities by championing the cause of organ and tissue donation in your workplace.

The springtime scene of a garden inspired the theme for 2020. A garden and the insects within in it serve as symbols of hope, courage and transformed life — themes repeatedly found within the donation and transplantation journey. The Donate Life garden depicts an ecosystem of plants, insects, and other components working together to form an interconnected living system.

The artwork also includes butterflies, signifying resurrection, endurance, change, hope and life; dragonflies, which symbolize adaptability, courage, strength and joy; and ladybugs, a symbol of luck and leading a vibrant life.

We each have the potential to nurture and enrich our communities through organ, eye and tissue donation. Nurses in particular, however, are in a unique position to champion the Donate Life cause.

"Nurses need to take charge and be the leader in all activities," says Donna Ferris, RN, MSICU Manager at St. Joseph's Hospital. "I give my staff much autonomy and authority to make decisions and lead in various events with my support. When we facilitate peer to peer initiatives, they support each other with greater intensity and believe in what they are doing."

Hospitals and healthcare settings can participate in this celebration of life in many ways. Information can be included in newsletters, staff-wide emails and on the organization's website. Events to honor donors and donor families may include a flag raising or tree planting ceremony. Lunch and learns and donor drives are effective ways to engage with staff and visitors.

Invite your colleagues to celebrate "Blue and Green Day" on Friday, April 17, 2020 by wearing the Donate Life colors and decorating break rooms, cafeterias or waiting areas. Take a team photo to submit to the Donate Life NYS Facebook photo contest. The more creative the better!

The staff at Donate Life NYS and our member organizations are available to help you plan your Donate Life Month activities and are happy to provide sample material and speakers. Please contact communications@dlnys.org for guidance, information and speaker requests.

Be sure to also follow DonateLifeNYS on social media, including Facebook, Twitter, Instagram and LinkedIn!

Donate Life NYS wishes you a happy National Donate Life Month. On behalf of the 9,600 New Yorkers waiting for a lifesaving organ transplant, we thank you for your efforts to promote organ, eye and tissue donation and the importance of registering the decision to be a donor.

RESEARCH YOU CAN USE

Negotiating Emotional Order: A Grounded Theory of Breast Cancer Survivors

Reprint permission from author:
Jennifer A. Klimek Yingling, Utica College

Abstract

In this article, classic grounded theory captures the processes of 12 women who had completed initial treatment for breast cancer. The qualitative data analysis reveals the basic social process of negotiating emotional order that describe how breast cancer survivors perceive their illness and decide to take action. From the data, five stages of the process of negotiating emotional order emerge: 1) Losing Life Order, 2) Assisted Life Order, 3) Transforming 4) Accepting, and 5) Creating Emotional Order. This study may help healthcare providers who care for breast cancer survivors understand the depth of perpetual emotional impact that breast cancer survivors endure. This study will potentially serve as a path for future research and aid in the understanding of the psychological impact that breast cancer has upon survivors.

Keywords: breast cancer, survivor, chemotherapy, emotional order

What Sparked This Research

I cared for a patient who I had gotten to know as her child often visited the emergency department due to hemophilia. She was a pleasure to work with, strong, level headed, and upbeat. On this particular day she was the patient. Her complaint was simple: a cough and she clearly wasn't herself emotionally. I was surprised to discover, when I took her past medical history, that she was a breast cancer survivor. After I discussed her chest x-ray results I sensed she was still upset and filled with uncertainty. Then the lightbulb went on. I asked her directly if she was concerned if the cancer was recurring. She said yes and her tears flowed. I do believe if I had not dug a little deeper into her emotional state she would have left the emergency department with much of the same emotional duress that she initially had. This interaction sparked my research as it was clear that breast cancer survivors endure a process after treatment ends. For these survivors the treatment is over but the emotional aspect of breast cancer is not. It also became evident to me that health care providers need to know more about this process in order to be able to treat patients holistically.

Negotiating Emotional Order: A Grounded Theory of Breast Cancer Survivors

Breast cancer is the most prevalent cancer found in women worldwide (American Cancer Society [ACS], 2016; Ferlay et al., 2104). In the United States, it is estimated that 3.5 million women have been diagnosed with breast cancer; 245,000 will be newly diagnosed; and, approximately 40,000 women will succumb to breast cancer annually (ACS, 2016; Breastcancer.org, 2016). Early detection and improved treatment is credited to the rising population of women who are breast cancer survivors (Howlader et al., 2015; McCloskey, Lee, & Steinburg, 2011). Concerns about the psychosocial ramifications of chronic illness have a long history. The Institute of Medicine (2009), American Cancer Society (2015), and the American Society of Clinical Oncology (2015) resonate concern about psychosocial hindrances regarding cancer patients, citing them as a critical area needing improvement within the nation's health care system.

The literature suggests breast cancer survivors endure psychological stressors after the completion of treatment including the following: loneliness (Marroquin, Czamanski-Cohen, Weihs, & Stanton, 2016; Rosedale, 2009), anxiety and depression (Walker, Szanton, & Wenzel, 2015), uncertainty (Dawson, Madsen, & Dains, 2016; Mishel et al., 2005), and fear of recurrence (McGinty, Small, Laronga, & Jacobsen, 2016). The phenomenon of breast cancer survivorship has been identified with qualitative methods, yet is lacking explanatory theory (Allen, Savadatti & Levy, 2009; Pelusi, 1997). Qualitative analysis uses inductive rather than deductive investigation of a clinical phenomenon for capturing themes and patterns within subjective perceptions to generate an interpretive account to inform clinical understanding. Inductive methods are used by the researchers to discover and generate theory (Artinian, Giske, & Cone, 2009; Glaser, 2008). Therefore, grounded theory was chosen to study the process of survivorship in women who have completed treatment for breast cancer.

Method

A Glaserian grounded theory design was chosen to explore the process of transition survivorship in women who have completed treatment for breast cancer. Grounded theory allows the researcher to explore a phenomenon and build theory from concepts going through processes and transitions (Glaser & Strauss, 1967; Glaser, 2008). The ACS defines *cancer survivor* as "anyone with a history of cancer, from the time of diagnosis through the remainder of their life" (ACS, 2016, p. 3). This definition was used for inclusion criteria for this project. Prior to commencement of the research, approval from the university's institutional review board was secured. A purposive sample was sought and participants were self-identified breast cancer survivors in a suburban community in Northeast United States. A presentation was made at a local breast cancer survivorship group. Flyers were posted in community centers, libraries, and public places including areas that reach numerous individuals. Based on these recruitment efforts, 12 women were interviewed during a four-month period.

Data Collection

All participants received written and verbal information about the study and gave informed consent. Data were collected by completing the following: a demographic data form, approximately one-hour individual in-depth interviews, observational notes, and field notes. All of the data was handled in a confidential manner. Each interview session lasted approximately one hour in length. Broad open-ended questions were used to stimulate discussion of thoughts and feelings about extended survivorship. Focused questions and prompts were used to elicit more specific information from participants about their actions to attain and maintain psychosocial health after the completion of breast cancer treatment. The focus questions also elicited information about processes used to modify and maneuver through adversities after completion of treatment. Each participant was asked to describe situations when she knew something had changed in her health and psychosocial status after the completion of treatment for breast cancer. Participants were asked to answer the questions until they felt they had no information to add to the topic.

Data Analysis

Data analysis took a Glaserian approach in which data collection, analysis, and memoing were ongoing and concurrent throughout the research. Each interview was digitally taped and transcribed. Atlas ti software was used as a depository to code, store, and memo during analysis. Data was coded line by line to fracture the data into nouns formed from a verb or gerund. The interviews were re-coded on three different occasions. After the initial interview was coded, the second interview was coded in a similar fashion and the data were examined for common constructs that were clustered. Subsequent interviews were open-coded and compared with ideas and relationships described in the researcher's memos. As the categories unfolded, some categories were re-coded or combined with other categories. At the conclusion of the last interview, all codes were sorted to certify fit. Once a core variable or category was identified, coding became selective. The researcher continued the interviews and coding until saturation of the core variable was achieved. On saturation, theoretical coding was used to intersect categories within the data. Exploration of the literature for substantive codes that were significant was conducted each day. Extensive memo taking was used via manual notes and also as freehand drawn visuals created by the researcher to capture the researcher's mind set.

Trustworthiness

For the purpose of this paper, a conglomerate of trustworthiness criteria grounded from the recommendations of Glaser (1978, 1998, 2001) was employed. The researcher who conducted this study had scant exposure to extended breast cancer survivors in her personal and professional realm. Techniques to establish credibility included prolonged engagement and peer debriefing. Theoretical sampling and constant comparison took place when data, analytic categories, interpretations, and conclusions were discussed and tested with study participants throughout the interview process. Prolonged engagement developed rapport and participant trust. To address transferability, the following groups of data was included in an audit trail: 1) raw data, 2) data reduction and analysis notes, data reconstruction and synthesis products, 3) process notes, 4) materials related to intentions and dispositions, and 5) preliminary development information. The researcher kept a reflexive journal to record methodological decisions and the rationale for the decisions, the planning and management of the study, and reflection upon the researcher's own principles, feelings, and interests. Lastly, external audits were conducted by several researchers not involved with the research process on several occasions.

The Theory of Negotiating Emotional Order

The main concern of the women is the struggle for emotional order. The meaning inherent in the basic social process of Negotiating Emotional Order is that women who have been diagnosed with breast cancer strive for emotional order by negotiating control of the negative feeling of threats to their mortality and to live their daily lives. The process described in the theory of Negotiating Emotional Order changes as the situation of the breast cancer survivors' changes. As time passes, the women move from discovering an abnormality to a time after treatment ends. This process is dynamic and perpetual in nature because the threat of cancer recurrence remains until the end of the breast cancer survivor's life. For some women, negotiating emotional order is achieved even when the cancer recurs or metastasizes.

The participants' actions and decisions illuminate the perpetual struggle to negotiate emotional order. For some, order is compartmentalizing negative thoughts and emotions that they could not control. For others, they accept the fact that they cannot control cancer but project order onto other aspects of their lives. The struggle for emotional order is present from the time the survivor found the abnormality into long-term survivorship and at times is cyclic. Five stages of the process of negotiating emotional order emerges from the data: 1) Losing Life Order, 2) Assisted Life Order, 3) Transforming, 4) Accepting, and 5) Creating Emotional Order.

Losing Life Order

During this time period, the realization of the threat of breast cancer disrupts emotional order with intense fear and uncertainty of the future. The breast cancer survivor often makes decisions and acts on her instincts to placate the immediacy that she feels prior to starting treatment, often seeks information from the Internet, popular literature, media and from others who have experienced breast cancer. Unfortunately, their need for immediacy is often not met by the health care community, so they take matters into their own hands and act.

Many of the participants voice that this time period is difficult, as they have multifaceted family roles as wives, mothers, and children of parents of their own causing additional emotional turmoil. The participants continue or attempt to continue with their family roles by working, caring for children, and maintaining their households. The breast cancer survivors voice that they don't have time to let cancer get in the way emotionally as they are too busy with family and work responsibilities. The participants speak of emotional duress when they see their families react to their illness and chose to protect their families by concealing their emotions. One participant talked about why she concealed her emotions: "The emotional impact it had on my family was horrible…I felt like I had to be strong for them…I would not show any emotions about being sick."

Losing order encompasses two properties of disorder: losing emotional order and losing physical order. Upon discovering an abnormality, and then confirming breast cancer, the breast cancer survivors report loss of control of their bodies, which causes emotional duress. This stage

marked the survivors' first sense that cancer cannot be controlled. Loss of emotional order is represented by feelings of sadness, anger, immediacy, loneliness, fear, and uncertainty. This stage is hallmarked by emotional chaos and decision making. Approaches the women use in this stage are: taking matters into own hands and concealing to maintain family order.

Assisted Life Order

Surprisingly, although treatment is a physically draining endeavor, the breast cancer survivors voice that it is a time of respite when they focus on physical well-being rather than the emotional disruption that is occurring. During this phase, the women are often consumed with treatments of surgery, chemotherapy, and/or radiation. The participants state they feel proactive and protected while under the frequent care of health care providers. This participant's narrative exemplifies the feeling of being assisted emotionally and physically by health care providers: "While you're getting chemotherapy, you think you're doing something to kill off any additional cancer that the surgery didn't get. You have certain protection."

The breast cancer survivors verbalize feeling lonely, despite having much social and family support, and purposely seek out other women who endured breast cancer for emotional support. Breast cancer survivors seek emotional support from formal and informal support persons. The participants also discuss a phenomenon where other breast cancer survivors would approach them after hearing about their diagnosis and come to their assistance to provide support. The importance of this camaraderie is evident in this narrative: "I didn't know people that have been through this…people came out of the woodwork. People that I had known that I didn't know that had cancer who shared their stories with me." Some of the breast cancer survivors express the need to have a connection with someone who has experienced breast cancer. Some women seek formal support groups for this need and continue to use them after treatment is completed.

The second stage of negotiating emotional order is assisted life order that occurs when the breast cancer survivor enters treatment and focuses all of her energy into physical well-being. At the same time, survivors entrust their life order into the hands of health care providers and rely on social support to carry them through the time that they are in treatment. During this time, the breast cancer survivor keeps physically and emotionally occupied with the routine of appointments and treatment. During this time, the women feel treatment is a sanctuary and they express that during this time they feel lonely in their current experience. During the second period, they engage with others with formal training or personal experience with breast cancer to establish emotional order.

Transforming

At this stage of the process, the breast cancer survivors report a cutting point or a crossroads and make a change in thought process. They are autonomously responsible for their physical and emotional well-being. This autonomy is a sharp contrast to their behavior while in treatment, where they live day to day and do not think about the future. Once treatments end, survivors must take the wheel and navigate into their life and the future. It does appear that this cutting point is an emotionally charged timeframe: the temporary sanctuary of treatment ends and many survivors feel the need to take subjective responsibility of their emotional order. The survivors speak about the need to reach inward to claim emotional order to live their lives beyond breast cancer.

During this stage, the threat changes from the fear of the diagnosis of cancer to the fear of cancer. The fear of cancer can be recurrence of breast cancer, occurrence of a new cancer, and/or cancer metastasis. The process of beginning to move on from the emotional effects of the diagnosis of breast cancer begins shortly after the end of treatment. Fear is initially intense then becomes manageable over time for many. Several women note the recurrent fear abates somewhat after the first year and even more after five years. The fear of recurrence also can return many years after the completion of treatment. This dread is especially true if the breast cancer survivor discovers new symptoms or abnormalities that lead her to believe the cancer has returned. Often waiting for the results of diagnostics causes extreme anxiety and fear of recurrence.

The interviewed participants ranged from three months to twenty-four years post treatment. Despite the variation of time since the ending of treatment, all of the participants discussed levels of fear of recurrence. Often, the fear of recurrence affects their daily lives initially until they set cancer apart from living their present life. Several of the participants state it is not so much an inherent process rather an active decision to take control of their feelings of fear and move onward. In this stage, the turning point is the active decision to leave breast cancer in the past and focus on the present and future. Another participant, who is thirteen years post treatment, discussed this decision: "I told myself, I have to make a move here. You can curl up in a ball and die or I can move on. I started moving on."

When the breast cancer survivors leave treatment, they are at a crossroad in which feelings of loss and confusion are produced. After adjuvant treatment ends, the breast cancer survivors must remap their lives and begin to strive for a new normalcy in their lives. The threat at this stage changes from the diagnosis of cancer and is replaced with the fear of recurrence. The breast cancer survivors often revisit their own mortality during this time and these feelings can cause loss of emotional order. During this time the breast cancer survivor transforms, remapping their life course and also moving on from fear.

Accepting

Uncertainty of the future also causes emotional distress for breast cancer survivors. The reality that none can control their own mortality or cancer, is an aspect of the emotional trajectory that the breast cancer survivors struggle with initially. Once breast cancer survivors make this realization, they can then subjectively gain order of their emotions. This action is autonomous as no one else but the breast cancer survivor can complete this task. One participant spoke about this decision: "There are things that I can change and there are things that I am powerless over. It's distinguishing and I do have control over what I'm thinking."

Although the breast cancer survivor attempts to control her emotions, she often will come to the realization that she can keep her emotions in order rather than control them so that she can move on in her life and get serenity with the past diagnosis of breast cancer. Several of the participants state the turning point occurs when they realize they cannot control cancer or their feelings, and thus accept order versus control. As the threat of recurrence is no longer an issue, they accept their mortality and are living in the present day. A participant reflection on this concept: "We'll all go some day. It's just my time might come sooner than expected. A part of life."

Feelings of emotional loss of control can be triggered by reminders after treatment ends. Reminders include physical reminders, body image reminders, diagnostics, and society cancer awareness. Although gaining realization of their own mortality, living with reminders forces the breast cancer survivors to cope on a daily basis with the fear of recurrence as they are reminded by physical and cognitive aftermath of breast cancer. Additionally, diagnostics and health care visits can elicit feelings of fear. Breast cancer survivors also voice that breast cancer or cancer awareness activities in the community and media also trigger feelings of fear. The impact of reminders is showcased by one participant's remarks: "I worry about it all the time. Every ache and pain I have. When my bones hurt I wonder if it is bone cancer. Every time I have to have a mammogram, I pray it's not there."

Creating Emotional Order

Inherently, human beings have emotions. One of these emotions is fear in response to a threat. As the threat of cancer recurrence has a perpetual quality in women who have been diagnosed with breast cancer, the emotional aspect of cancer recurrence is long-standing. Since she cannot fully control her emotions, the breast cancer survivor will compartmentalize negative feelings of uncertainty and fear to achieve emotional order. To protect themselves emotionally, several of the participants speak about triaging these emotions to the back of their heads and putting these feelings away. One participant illustrates this behavior: "It's probably because I pushed it to the back of my head because I don't want to deal with those emotions."

Once the breast cancer survivor accepts the fact that there are aspects of her life she can control and there are aspects over which she has no power, she will begin to create emotional order. Having control over actions and or parts of her life allows the breast cancer survivor to have emotional order. During times of emotional distress, they also increase their attempts to distract themselves from their emotions. This increase in activity temporarily increase with times of stress. Often, after the breast cancer survivor feels well, she redefines the actions in which she participates. Survivors express themselves by participating in activities that they enjoy or want to experience but did not have the courage to do so prior to diagnosis. Breast cancer survivors also talk about controlling their family roles and home environment. The breast cancer survivor might demonstrate control by creating a household routine or enumerating familial activities. Distracting self with other aspects of life also is a way that breast cancer survivors create emotional order. By immersing themselves back into their daily routines of work, marital, household, and family roles, survivors limit the amount of time they have available to think about the fear of recurrence, which is similar to using activity to occupy time during the assisted life order stage.

Social comparison through self-evaluations is another way that these participants achieve emotional order. Breast cancer survivors use social comparison as a method to create emotional order by viewing their experience as better than others who experienced poor outcomes. As a defense mechanism, if the breast cancer survivor views her experience as positive then she reaffirms she is a survivor. Social comparison is evident almost unanimously in the data. Participants speak often of reflecting on the experience they endured and feel lucky. While exploring this code the researcher asked the participants what they meant by luck or being lucky. Consistently the participants talk about luck as comparing outcomes as better or worse. For example, when asked what she meant by having better luck, a participant replied: "Well I was thinking someone maybe had the same surgery as me, did better than me." Here is an example of a breast cancer survivor socially comparing her experience as worse than another person's experience.

In addition to evaluating the actual treatment outcomes and evaluating the way that they physically dealt with treatment, the breast cancer survivors also evaluate the entire experience of breast cancer by reflection. The ability to reflect onto the past experience to find benefits and assign positive outcomes related to the cancer allow the survivor to make sense of the experience and create emotional order. In many ways, the survivors feel everything that they endured was worth what they became. Many reflect back and feel they gained knowledge of self-meaning knowing their bodies and emotions and realized they have abilities to endure adversity that they did not know before the experience of breast cancer. The breast cancer survivors reflect back in awe of the emotional stamina that they had during adversity and were proud of their accomplishments. One participant states: "It is amazing. Yeah if someone had told me I could write a book, become a massage therapist and learn the body the way I have. I would have said no way."

"I feel like I know these people. You have been through what they have been through." This participant's narrative sums up the transparent common bond the participants feel with other cancer survivors. To create emotional order, the breast cancer survivors help others as a way to help themselves emotionally. Planned helpfulness allows the breast cancer survivor to create emotional order by gaining satisfaction through assisting others. Often breast cancer survivors employ ambiguousness until they are ready to disclose their survivorship status. This opacity allows them to experience empowerment and also allows them life choices-a common theme throughout the interviews. Breast cancer survivors plan and decide how they would help others; many are grateful for the acquaintance disclosure and guidance they receive early in their disease trajectory and want to pay forward some type of comfort to others who are enduring cancer.

Once survivors accept the fact that they cannot control their mortality and cancer, the breast cancer survivor creates social order to protect herself emotionally. Breast cancer survivors are acutely aware that their actions do not guarantee that cancer will not return, but in this stage they want to maintain a status of being physically and emotionally healthy. One participant communicates: "What work do I need to do. I am a survivor and want to be a survivor for a long time." Although reminders often trigger fear, the survivors often use methods to create emotional order, to find balance and not allow feelings of fear to overcome them.

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Negotiating Emotional Order continued from page 15

Breast cancer survivors protect themselves by controlling their actions, compartmentalizing negative feelings, using social comparison and/or engaging in planned helpfulness.

Creating Emotional Order allows breast cancer survivors to transcend the fear of recurrence by controlling their actions, compartmentalizing negative feelings, and using social comparison and planned helpfulness. Although they cannot control their emotions or control cancer, they can control the way they react to emotions and take control of their life actions. Many of the participants shelve their negative emotions in order not to let the psychological aspect of breast cancer interfere in their daily lives. The participants show evidence that the survivors can regress between stages of this theory, but after their initial passage through the stages progress forward quickly and resiliently.

Limitations

There are several limitations in this research. First, the researcher attempted to recruit a variety of participants from diverse social and demographic backgrounds through flyers posted in public places. Despite this attempt to obtain a diverse population, all the participants are White and hold high school education or equivalency and most of the sample had three or more years of college education. Most of the participants are married or partnered. Economic and insurance status information is not included in the demographic data. Expanding the demographic sample might have allowed modifiability of the theory to explore additional relationships between these variables and the process of survivorship.

Finally, grounded theory analyses are population specific. This research represents the primary step in theory development. The aim of grounded theory construction is to hone and develop a theory in the attempt to produce formal theory. Testing the applicability of this theory may be appropriate in other populations who face severe illnesses, for example individuals as they face the aging process, individuals who are facing a terminal illness, veterans returning from war diagnosed with post-traumatic stress disorder, men facing prostate cancer, and/or women facing infertility.

Discussion

The aim of this study is to contribute to the knowledge of breast cancer survivorship. This research contributes to the literature as a lack of holistic research exists on the process of extended survivorship that involve the fragments of the process of survivorship. Breast cancer is a significant and prominent healthcare challenge for many women in the United States. Negotiating emotional order is identified as the core category allowing women to survive emotionally after completing treatment for breast cancer. Five stages were identified including the following: Losing Life Order, Assisted Life Order, Transforming, Accepting, and Creating Emotional Order. The grounded theory of negotiating order integrates and highlights the importance of recognizing emotional health in breast cancer survivors.

This research challenges a staple in cancer survivorship literature that is reported by Mullan (1985) in several ways. First, in the current study, breast cancer survivors described the process of survivorship beginning before diagnosis with the discovery of an abnormality. This variation in the genesis of process of survivorship is different from Mullan's (1985) model in which the process of survivorship is said to begin with diagnosis. Second, a new stage that represented transitional survivorship or Stage III: Transforming is described in the current study as the period immediately following the completion of treatment. Third, Mullan (1985) described extended survivorship as ending once the survivor enters remission. Although most breast cancer survivors interviewed for this study entered remission, several experienced recurrences or metastatic breast cancer so Mullan's model excluded the process that these individuals endured.

Lastly, in this study extended survivorship appeared to be a continuous state rather than a conduit to permanent survivorship as Mullan (1985) described in his model. Mullan (1985) stated permanent cancer survivorship begins once the person is considered cancer free and can successfully return to their normal physical and emotional abilities prior to the cancer diagnosis. The survivors in this study describe extended survivorship to have a perpetual nature rather than being permanently cured physically or emotionally. They also challenge the fact they would return to "normal." One of the participants states, "It was a rough road. Trying to figure out who I was, where I belong. Because they say your life goes back to normal, there is no normalcy. I don't feel I am normal today." This idea is significant as many breast cancer survivors may feel the need to feel "normal" due to the extensive publication of Mullan's (1985) model. The use of Mullan's (1985) model by many credible cancer authorities may prove to be confusing and frustrating to breast cancer survivors who lack the feeling of normalcy after treatment is completed and into extended survivorship.

The theory of Negotiating Emotional Order supports several existing theories that describe how individuals handle severe illnesses beyond cancer. This work complements several authors who described survivorship beyond the biomedical model that psychosocial and environmental factors influence (Collins, 1995; Festinger, 1954; Folkman & Greer, 2000; Taylor, 1983; Walker, Jackson, & Littlejohn, 2004).

The construct of control can be found in the literature in multiple patient populations including breast cancer (Warren, 2010), cardiac disease (Svansdotti et al., 2012), patients with obsessive compulsive disorder (Kang, Namkoong, Yoo, Jhung, & Kim, 2012), diabetes (Hughes, Berg, & Wiebe, 2012), and sexual assault (Frazier, Morlensen, & Steward, 2005). In this study, loss of emotional control is important, as it serves as a catalyst shaping the decisions and actions of the participants. Additionally, controlling actions were used later by the participants as a means to cope, thus creating emotional order. This theme is analogous with Folkman's (1984) description of control as dynamic coping mechanism with shifting appraisal as result of a stressful encounter or environment.

Benefit finding and planned helpfulness that are reported are consistent with Taylor's (1983) proposed theory of cognitive adaptation in response to threatening events as both are displays of a search for meaning in the experience and attempts of mastery to restore self-esteem. It may also be noted that Taylor (1983) linked an individual's sense of control to positive cognitive adaptation. Lastly, social comparison is evident in this group. This observation echoes Festinger's (1954) work hypothesizing that social comparison is done to promote self-normalcy. Social comparison in this population is a mechanism to negotiate emotional order by improving the survivors' positive perception of their situation and is consistent with the work Collins (1995) reported.

Implications for Practice

This research affords a glimpse into the experience of survivorship from the perspective of women who have completed treatment for breast cancer and how they survived emotionally from the detection of an abnormality into extended survivorship. This work aids in the development of a broad understanding of the processes that individuals endure when faced with a serious health status alteration. This information might aid health care providers to understand the immediacy that breast cancer survivors experience during the disease trajectory and the concept that the fear of recurrence can last perpetually and be an issue that is important to survivors until the end of their lives.

A lesson that can be taken away from this work is that women are continuously attempting to create emotional order and this clearly indicates they need support to continue well after treatment ends. In terms of theory, the identification of the process used by breast cancer survivors to negotiate emotional order may be helpful for health care providers who care for, educate, and design nursing interventions for this population. This study of survivorship after breast cancer establishes the beginning process of generating a formal grounded theory on survivorship that could, through further theoretical sampling, be extended beyond this patient population. Building on existing theory, this qualitative data analysis may help explain the mechanisms used by populations who have experienced a life-threatening illness personally or while supporting a loved one.

Acknowledgements

I would like to thank the breast cancer survivors who shared their personal survivorship journey for this research. I also thank Dr. Elise Lev, Dr. Karen D'Alonzo, Dr. Claudia Beckman, Dr. Louise Dean Kelly and Naomi Tobes for their encouragement and invaluable contributions to this work.

Declaration of Conflicting Interests

The author declares no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

This research is supported the Rita C. Koph Memorial Research Award generously given by the Foundation of New York State Nurses, Cathryne A. Welch Center for Nursing Research

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Source:
http://groundedtheoryreview.com/2018/12/27/negotiating-emotional-order-a-grounded-theory-of-breast-cancer-survivors/

ORGANIZATIONAL SPOTLIGHT

Sigma
Chi Gamma Chapter

Chi Gamma chapter of Sigma (STTI) is proud to become an ANA affiliate this fall! Our chapter was established in 2013 in Farmingdale State College. In following the mission and vision of Sigma we are committed to change lives and advance health care by collaborating, connecting, and catalyzing. Our chapter has some very exciting news to share! This fall our chapter received the Showcase of Regional Excellence Certificates recognizing outstanding achievement for Presidential Call to Action for Collaborate and Connect! We also celebrated Founder's Day and had our annual induction. Both events were very successful! Some other events that we hosted this fall were Narcan Training, Human trafficking, Zumba night, Self-Care for Nurses.

As part of our commitment to service, Chi Gamma has been very active in developing and promoting the **Henny Care Bag** project. The Henny Care Bag is a gift of items that patients can use after a mastectomy at home. The idea for this project was initiated by Harriet (Henny) Goldenberg, a dental hygiene professor, who is a breast cancer survivor. This gift is given to patients who are unable to obtain the necessary items that they need for recovery. The Chi Gamma Chapter of Sigma conducts fundraising and partners with various organizations to obtain these items. We are proud to announce that we have received a grant of one thousand dollars annually for four years from Henry Schein Cares, to support our project! Henry Schein is committed to "helping health happened" through their global social responsibility program, *Henry Schein Cares.*

In the recent SIGMA Biennial Convention in Washington DC, on November 16-20, 2019 some of our members presented their research projects.

Drs. Maria Nikolaidou, Jennifer Bryer, Virginia Peterson-Graziose, and Janet Raman presented their research titled: *"Variables that Influence Retention in RN-BS Students: A Multisite Longitudinal Study."*

Dr. Lynn Johnson presented her dissertation research titled: *"Personal Attributes Contributing to EBP Adoption by Nurses: Commitment, Empathy, and Reflection."*

We are looking forward to connecting and collaborating with other ANA members and affiliates!

Founders' Day Celebration. From left to right: Harriet Goldenberg (Henny), Dr. Maria Nikolaidou, Dr. Christine Glaser, Professor Donna Marie Flumignan, Dr. Joanne Lapidus Graham, and Dr. Bonnie Ewing.

Chapter members presenting at the Sigma Biennial Convention. From left to right: Dr. Virginia Peterson-Graziose, Dr. Jennifer Bryer, Dr. Maria Nikolaidou, Dr. Janet Raman.

Chapter members during the Narcan training event. From left to right: Front: Dr. Sherry Manansingh, Student Kelly Rodriguez, Dr. Maria Nikolaidou, Dr. David Neubert, Lila Hageman-Sheehan, RN. Back: Professor Suzan Ellie, Dr. Joanne Lapidus Graham

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If you know of someone in need of this bag contact Henny at 1-516-428-0240 or Dr. Maria Nikolaidou, Chi Gamma President nikolam@farmingdale.edu

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This project was made possible with the generous support of Henry Schein Cares

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An Essay on Faculty Roles and Productivity

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Sara Hawkins PhD, RN, CPPS
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The rich culture and tradition of higher education in the United States (U.S.) is showing signs of deterioration and decay as academic institutions deal with changing societal values, increasing global technologies, and declining professorates (Honan & Teferra, 2001; & Slaughter & Leslie, 1997). As stakeholders debate educational reforms, the discussion tends to concentrate upon the role of faculty as central to issues of quality, fiscally sound education. Inevitably, resultant campaigns for reform call for adjustments to the workload and role of faculty as policy makers and financial stakeholders call into question "what is it that… faculty members really do?" (American Association of University Professors [AAUP], 1993, para.1).

Added to the misperception and misrepresentation of faculty workload, is a growing shortage of doctoral prepared educators. For example, the discipline of nursing is facing a projected loss of almost 30% of nurse faculty to retirement by the year 2026 without an adequate reserve of younger educators to fill these positions (Keefe, WIN Conference 2013). A lack of understanding of these dynamics may further aggravate the infrastructure of higher education and actually stifle involvement, innovation, and autonomy of existing educators (Doughty, May, Butell, & Tong, 2002).

Here, I will compare and comment on the influence of an institution's mission and type on faculty workload. I use the term workload to mean the three faculty roles of research, teaching and service (AAUP, 1993; Bartels, 2007; & Wolf, 2010). Then, after a more detailed examination of the teaching role, I will reflect on my personal vision for teaching in an ideal academic environment.

Control of the Institution and Mission Determine Faculty Workload

There are three categories used to describe colleges and universities: public versus private, research intensive versus teaching intensive, and religious versus secular. Differences in these types hinge primarily upon control of the institution, that is, revenue sources. For instance, the major source of funding for public universities and colleges are local and state governments, while private institutions generate revenue through higher tuition costs and private sources (Honan & Teferra, 2001). Religious universities are connected to a religious faith and cater to special student populations, benefiting from tax-exempt status and subsidies from the parent organization. However, in today's turbid economic climate, all colleges and universities are feeling the pinch and calling for more efficient use of assets while increasing student capacity. The call for frugality directly impacts faculty workload as workloads were originally designed to shape the actual budget (Honan & Teferra, 2001).

Public versus Private Workload Allocation

Historically, public institutions faced more stringent workload standards and accounting procedures given the governmental oversight. Workload or productivity was defined by the hours per week of formal class meetings; the credit hour (AAUP, 1993; Ehrlich, 2003; & Wolf, 2010). Ehrlich (2003) points out that this measure of credit hour meant that faculty were expected to teach for a given number of credit hours per semester. The workload focus was teaching with no expectation for research.

In contrast, workload standards for private institutions were not made public and were regulated directly by department chairs and deans (Ehrlich, 2003). While the workload focus remained with teaching, it was calculated not with credit hours but rather based on the number of courses taught each semester.

Research Intensive versus Teaching Intensive Workload Design

Beginning in the 1950's, research began to be favored over instruction. Consequently, faculty work and accomplishment in research linked directly to rewards such as hiring, promotion, tenure, and compensation (Bartels, 2007; & Ehrlich, 2003). Professors sought out more release time and could "buy out" of class with grant monies, leaving the direct instruction to teaching assistants and non-tenured faculty (June, 2011).

Workload Linked to Mission

Workload models may vary widely from institution to institution and may be best reflected in the mission statement of the facility. Mission statements directly guide the curriculum and overall program and student learning outcomes. Mission statements relate the expectations of what is required to do on the part of those with stewardship over program and course development (June, 2011). Hence, the value on instruction versus research or even service becomes clear.

What also becomes clear is that the standard metrics of credit hours or number of courses does not accurately, nor equitably demonstrate the true elements of faculty productivity. The defining features of research, teaching, and service are much more complex.

Research, Teaching, and Service

Long held productivity models apply to teaching effort only, making them inefficient and unwise (Wolf, 2011, p. 247). The AAUP (1990) issued a statement on faculty workload addressing inequities caused by such a narrow scope of practice. The statement outlines a more representative description of faculty roles and productivity.

Research and Scholarship

In the traditional sense, research includes discovery and publication, including creative work activities. This traditional view does not take into account serving on dissertation committees, supporting colleagues in their scholarly work, applying new knowledge in course work or even the pursuit of doctoral education.

Teaching

Teaching is the most basic activity of the faculty and encompasses laboratory and classroom instruction, advising, mentoring graduate students (AAUP, 1993). Teaching effectively requires huge investments in preparation, innovative pedagogy and strategies in the classroom. The teaching role extends far beyond the classroom in advising students, answering emails and maintaining office hours, grading, attending meetings, and covering others during times of illness.

Service

Faculty work includes examples of both internal/institutional service and external/community service. Internal service may include participation in shared governance and other committee memberships, peer mentorships and reviews, participation in faculty conferences and exchanges. External service may involve active participation in professional organizations and the community partnerships. According to Bartels (2007) service also encompasses continued competency and expertise in practice.

Expanding on the Role of Teacher

June (2011) describes how there is public perception and criticism that teaching is not a priority for university faculty and that students consequently suffer because of it. Through a variety of anecdotal stories from professors, June drives home the perspective that the public and lawmakers miss; that of "there are many more than three hours involved in teaching three hours" (para. 45). The realities of the modern-day educator appear to prove that it is not a lack of productivity that may hinder student learning, but rather it is the high levels of workplace pressures, considerably lower salaries than in industry practice, and the thinning faculty workforce that present the problems (Durham, Merritt, & Sorrell, 2007; & June, 2011).

Imagining the Ideal

In a study by Doughty, May, Butell, and Tong (2002), the perception of nurse faculty found that the pressure they experienced, exceeded their expectations. In an ideal world, there would be transparency in new faculty assignments, orientation to the roles and responsibilities, collegiality and collaboration, and a clear process for accountability (Durham et al., 2007). Faculty rewards such as tenure would foster accountability and innovation instead of squelching it.

Faculty need to be the best in teaching and best for the profession in terms of scholarship (Bartels, 2007). In an ideal environment, faculty members would embrace technology and innovation and formal mechanisms for faculty development and role consolidation would exist (Bartels, 2007).

Conclusion

The role of educator is fundamental for advancing practice, scholarship, and policy. Despite the "silver tsunami" phenomenon described as occurring in nursing, I am confident that the pool of novice educators will develop and facilitate the transformation of nursing education into the future (Keefe, WIN Conference 2013). In this paper, educator roles have been explored, the role of the faculty as teacher explicated, and an ideal for the future identified.

I suggest that efforts to eliminate workplace pressures, foster collegiality and collaboration, and value accountability are imperative.

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FLAVORS HOOK KIDS NY

ANA-NY and many other organizations across the state are in support of banning flavored vaping products targeted toward children. During the press conference on March 3, 2020, it was reported that almost half of high school seniors are vaping. Children in kindergarten and first grade are using these nicotine products. Several articulate young people spoke to this growing issue. One high school senior, who had been addicted for a few years, remarked on how adults have products, such as nicotine gum and patches, available to help them break their addiction to nicotine. Kids have to go cold turkey! Not only do we need to stop youth access to these products, we also need to support them as they are coming off of this terrible addiction. #parentsvsv #NoVapeNY

ANA President Proud of Nurses for Maintaining #1 Spot in Gallup's 2019 Most Honest and Ethical Professions Poll

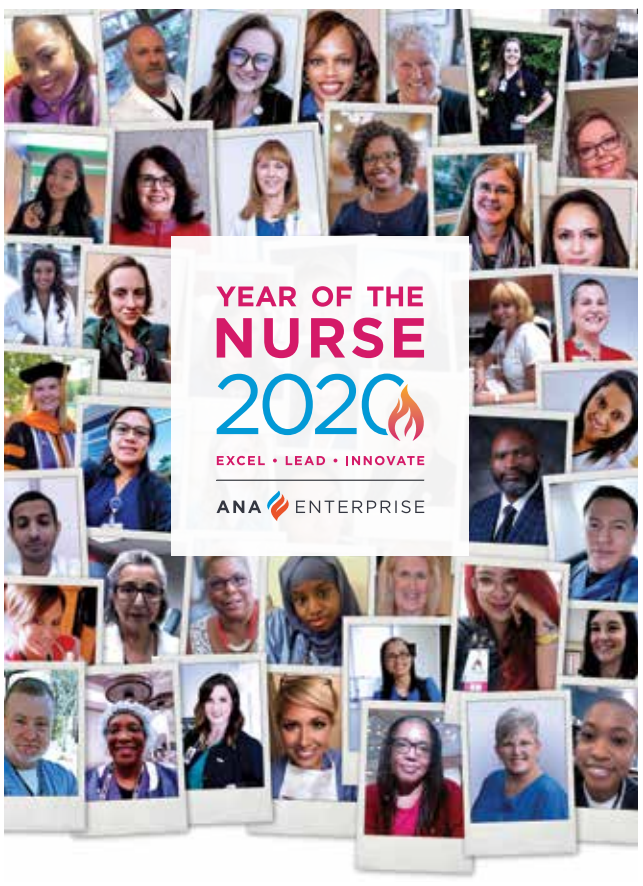
The American Nurses Association (ANA), which represents the interests of the nation's four million registered nurses, congratulates nurses for maintaining the #1 spot in Gallup's annual Most Honest and Ethical Professions Poll for the 18th consecutive year. The American public rated nurses the highest among a host of professionals, including medical doctors, dentists and pharmacists. Nurses taking the top spot in Gallup's most recent poll comes as ANA celebrates the "Year of the Nurse" in 2020, which was designated by the World Health Organization (WHO) in honor of the 200th birth anniversary of Florence Nightingale.

"I am extremely proud that nurses everywhere have been bestowed this wonderful accolade by the people whose lives they touch every day. The fact that nurses have been consistently voted the most honest and ethical professionals is a testament to the public's trust. We'll work hard to keep their good faith throughout 2020 and beyond. I couldn't think of a better way to enter into the "Year of the Nurse," said ANA President Ernest Grant, PHD, RN, FAAN.

According to the poll, 85% of Americans rated nurses' honesty and ethical standards as "very high" or "high." The second highest-rated professionals, engineers, were rated 19 percentage points behind nursing.

"Gallup announcing nurses as the most trusted profession is not only another reason to celebrate nurses during the "Year of the Nurse," but also an opportunity to shine a light on this noble profession. This milestone celebration offers a platform to raise the visibility of nurses and increase the capacity of the nursing workforce. Nurses occupy many roles in our society and are on the front lines when it comes to immunizations, natural disaster preparedness, shaping health policy, and advocacy," said Grant. "For this reason, nurses are critical in improving the landscape of health and health care because an effective health care system is one that values all nurses."

"ANA will promote inclusivity and wide engagement of all nurses throughout "Year of the Nurse." This includes expanding National Nurses Week to a month-long celebration to elevate and celebrate the profession with all nurses and the public. Here's to the "Year of the Nurse."



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Nurse Executive	✓	✓	NE-BC
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Nursing Professional Development	✓	✓	RN-BC
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Pediatric Nursing	✓	✓	RN-BC
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