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WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

April 2021

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ANA - New York Nurse will reach over 72,600 New York nurses and schools of nursing.

INDEX

MEMBER HIGHLIGHT

Annual Conference Keynote Speaker Shantay Carter, BSN, RN

When it comes to Shantay Carter, helping others is more than just a job—it's her passion and her purpose. From her daily work as a dedicated nurse to her ambitions as founder of Women of Integrity Inc., the New York area native has an extensive history of letting her caring nature guide her path.

Influenced strongly by the superwoman role models in her family, Shantay decided to dive headfirst into the nursing field. After spending years selflessly volunteering as a candy striper while in high school, she headed to Binghamton University where she received a Bachelor of Science degree in Nursing. In 2000, she began working at Binghamton General Hospital as a registered nurse and in 2002, Shantay continued her career at North Shore-LIJ Health Systems, where she currently works as an Orthopedic/Trauma nurse on a medical/surgical floor.

After noticing the lack of guidance for young girls in the Long Island area, Shantay decided to create

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Hotel Accommodations
Hilton Long Island
598 Broad Hollow Road
Melville, NY 11747
Hotel Reservations
URL: https://www.hilton.com/en/hotels/isphhhf-hilton-long-island-huntington/
Number: 1-631-845-1000
Mention code: ANA for discount rate

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MEMBERSHIP APPLICATION ON PAGE 18

FROM THE DESK OF THE EXECUTIVE DIRECTOR

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

Are you missing out on vital ANA-NY and ANA information? ANA-NY uses your *My ANA* information to contact you. Check your *My ANA* account to make sure that we have accurate contact information for you. You don't want to miss out on all of the activity and information that will be coming soon: call for poster abstracts, annual conference registration, call for awards nominations, call for Nightingale remembrance names, call for nominations for ANA-NY leadership positions, call for ANAI fellowships, and call for JANANY Summer Issue submissions (the Winter Issue is available on our website). Also, please follow us on social media for updates and issues.

Watch our platforms for our 10 x 10 campaign, starting soon!

ANA-NY Request Names for the Nightingale Tribute

The Nightingale Tribute was first designed and developed in 2003 by the Kansas State Nurses Association to honor deceased nurses.

Please help us to honor our deceased colleagues in this year's ANA's Nightingale Tribute by sending names and year lost by filling out this online form at https://form.jotform.com/90654770919165 by **May 17, 2021**.

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- Email: programassociate@anany.org
- Subject Line: *ANA-New York Nurse* Submission: Name of the article
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- If requested, notification will be given to authors once the final draft of the *ANA - New York Nurse* has been submitted.
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PRESIDENT'S MESSAGE

Marilyn L. Dollinger, DNS, FNP, RN

As the largest general purpose professional nursing organization in New York State, ANA-NY has strategically increased its influence on policy issues related to healthcare and nursing with elected New York State officials over the last two years through our focus on increased engagement in the legislative process at the state level. It is time to take the next step for ANA-NY by adding another tool to our advocacy efforts by creating a political action committee (PAC).

I am pleased to announce that the ANA-NY Board of Directors approved the formation of the ANA-NY PAC at the January board meeting and approved the maximum organization donation of $5000 from ANA-NY to fund the beginning PAC work and fundraising.

I am also excited to announce that at the ANA-NY February Board meeting, the Board approved the first ANA-NY PAC Board: Mel Callan, Linda O'Brien and Beverly Karas-Irwin. The general criteria considered in naming the PAC Board included geographic, role and experience diversity; specific criteria included:

- Treasurer:
  - Extensive policy and political advocacy experience
  - Leadership experience
  - Ability to work effectively with ANA-NY Lobbyists
  - Willingness and ability to mentor PAC Board members

- PAC Board Members:
  - Interest in serving on the PAC and experience in policy, politics and leadership

To support continuity, mentoring and succession planning, I proposed an initial 3-year term for the treasurer, one 2 year term and one 1 year term for the two Board members. After the designated terms are completed, all appointments going forward are for staggered three-year terms. An individual can serve only two consecutive terms on the PAC and cannot hold any other ANA-NY leadership positions during their time on the PAC Board (ANA-NY Board or Committee Chair).

The PAC Board will provide regular updates to the ANA-NY Board but it is completely independent in its activities. Members of the PAC Board will work closely with the ANA-NY lobbyist Amy Kellogg and her team to make sure that the PAC Board follows the New York State Board of Elections rules that govern all political action committees.

I know that the new PAC Board members will be familiar to many of you but let me share their qualifications that make them well suited to provide leadership for the first ANA-NY PAC.

Treasurer: Mel Callan FNP RN; Rochester, Monroe County; initial 3-year term

- PAC experience in professional nursing associations; past-president of state wide nursing organization; current leadership experience with national nursing professional associations; experience in the New York State Senate as a Chief of Staff; extensive professional, policy, political and community advocacy experience.

Board member: Linda O'Brien RN Long Island; initial 1 year term

- PAC and Legislative Committee experience in professional nursing associations; past-president of state wide nursing organization; extensive leadership and in regional professional associations and policy advocacy

Board member: Beverly Karas-Irwin DNP ANP-C RN; NewYork-Presbyterian; lives in Orange County; initial 2-year term

- Director level leadership experience in practice; experience as Magnet Recognition Program® Appraiser and immediate past ANA-NY Legislation Committee Chair and experience with policy advocacy

The Challenge

I am challenging all ANA-NY members: GOAL—to achieve 100% participation from our over 8000 members in ANA-NY PAC donations the first year.

As a Founding Member of ANA-NY, I am pledging a PAC donation of $1000. I am challenging all of my 38 colleagues who are also Founding Members to match my donation.

I am asking all other members to make a donation of $10 for every year you have been a RN. If all members do this—we can work together and put our PAC on "the map" in New York State.

You will be receiving information about how to make your donation from the PAC Board shortly. As a reminder, PAC contributions are not tax deductible, must be made in your own name and cannot be reimbursed by anyone else such as an employer.

In my statement when I ran for ANA-NY President I called for nurses to move from "most trusted" to "most influential"-- This is one strategy that we can use to help make that happen.

BOARD BUZZ

On behalf of our members, the Board of Directors:

- Created an ANA-NY Political Action Committee (PAC).
- Accepted the 2021 Annual Budget as proposed by the Finance Committee.
- Finalized 2021 committee leadership and rosters, and appointed BOD liaisons.
- Congratulated ED J. Santelli upon having information from her Clinical Simulation White Paper incorporated into the Governor's State of the State Address.
- Endorsed a letter by the NYS Council of Deans to Governor Cuomo requesting that nursing students be included in the state's COVID 19 vaccination administration workforce.
- Proposed to Governor Cuomo that ANA-NY be represented on the task force examining a proposal for new SED regulations for flexibility in the use of high-fidelity clinical simulations in place of clinical placement hours for all nursing programs in New York State.
- Initiated implementation of a digital marketing plan designed by Communications Coordinator S. Hernandez to more effectively promote ANA-NY membership benefits.
- Approved the recommendation of the Program Committee to collaborate with the Bassett Medical Center to establish a confidential peer support network for NYS nurses.
- Sponsored the Nurses House Dolphin Award ceremony.
- Accepted the Nigerian Nurses Association USA, INC as an organizational affiliate.
- Joined WHO, AARP and HANYS in endorsing the NY Age-Friendly Health Systems Action Community.
- Established two 'Nurse Hero/Nurse Heroes' Awards as proposed by the Awards Committee to recognize practitioners involved in the care of COVID 19 patients.
- Extended kudos to the office team for their success in exceeding 2020 membership goals.
- Exhibited at the NSANYS Annual Convention and sponsored the keynote speaker.
- Continued to participate in virtual leadership activities with ANA and other professional organizations.

Details on these and other Board activities may be accessed in the Approved BOD Minutes on the Members Only website.

Member Highlight continued from page 1

her non-profit, Women of Integrity Inc. The ten-year-old organization has already made huge strides in its mission to "empower and educate women of all ages and ethnicities" and its signature event is its prom dress drive, dress giveaway, and makeover project that is executed each year.

"I believe that what you put out in life, you get back," explains Shantay. "So, if you put out positivity, then you will get back positivity— it's our job to give back in any way we can."

Shantay modestly holds a number of accomplishments and honors for her work including being a Wholeness of Life Award winner at North Shore University Hospital in 2012 and a NSLIJ Health System. 2013 President's Award nominee. In 2014, Shantay was honored as a Making A Difference Award honoree and a semi-finalist in P&G's My Black is Beautiful Ambassador Search. More recently, in 2015, she received the Darby Foundation's Community Service Award and a Community Service Award from the Hempstead Chamber of Commerce. In 2017, she was a 2017 Woman Of Power Honoree from the Caribbean Business Connections Organization. In 2018 she received the Caribbean American Healthcare Award, from Caribbean Life Magazine. She also was the Keynote Speaker for the Excellence in Success Nursing Awards. In 2019, she was a Long Island Diversity In Business Award Honoree. She is also the Best-Selling Author of Destined for Greatness. She is also The Founder of Men of Integrity Inc., and Co-Founder of Nurses Of Integrity.

Shantay currently lives in Hempstead, NY and when she's not helping patients or out making teen girls feel amazing, you can find her enjoying music, art, baking…or flashing her award-winning smile. She is a proud member of Alpha Kappa Alpha Sorority, Incorporated, The NAACP, The American Nurses Association, The Greater NYC Black Nurses Association Chapter, and the Nassau County Medical Reserve Corp.

No Kidding!

Connie J. Perkins, Ph.D., RN, CNE

What's scarier than a dinosaur? A bedsore.

Now that I have your attention with a water cooler (or opening to your next zoom meeting) worthy medical joke, I'd like to talk about the epic pain in the "*you know what*"- pressure ulcers also known as bedsores. Not only are these painful for our patients, they are painful for our healthcare agencies. According to the Agency for Healthcare Research and Quality (AHRQ) (2014), "Pressure ulcers cost $9.1-$11.6 billion per year in the U.S…affect 2.5 million patients per year [and]…added $43,180 in costs to a hospital stay." Furthermore, "the average settlement of a pressure ulcer lawsuit is $250,000, with some awards topping $312 million" (Petrone & Mathis, 2017). Some forms of ulcers, like Marjolin's ulcers, can even develop into squamous cell carcinoma leading to more pain and treatments for our patients (Mayo Clinic, 2020). While the nursing world's backs are thankful for equipment that lift and reposition patients, what have we learned from history and what else can we do to prevent the financial burden from continuing to rise?

Evidence of bedsores have been around for over 5,000 years first being treated with moldy bread or honey by the Egyptians (Agrawal & Chauhan, 2012). For them, moldy bread served as an easy ingredient found around the house (or pyramid) that packed, absorbed, and thanks to the mold thwarted further infection. While we aren't using moldy bread as wound packing these days thanks to sterile sponges, its' fungal principle, chitosan- a natural polymer and antibacterial agent, is making a promising come-back. Today, chitosan is sterilely created in a lab and found in wound dressings such as Opticell®, Axiostat®, and HemoPore® (Matica, et al., 2019). Honey on the other hand, hasn't been lost in the medical translation shuffle and still owns the credit as a holistic treatment. More commonly used for burns over ulcers, its anti-inflammatory and antimicrobial properties have shown positive treatment outcomes (Samarghandian, et al., 2017). Plus, its viscosity works similar to an ointment to create a protective barrier.

When it comes to what more the nursing profession can do in the fight against bedsores, competence ownership could go a long way. Bedsores are not "*the flavor of the month*" or isolated to one nursing specialty, so all nurses should consider their own knowledge and skills on the topic. Since wound staging and treatment is part of entry-level nursing education, the push should be for evaluating our own competence throughout our careers. If staging and treatment isn't something you do daily, challenge yourself to seek out the appropriate evidence from reliable sources for the populations you do encounter in your practice. One available free online resource is *Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care* from the AHRQ, which provides tools and best practices on the topic. Don't look at this as adding something more to your already full nursing plate, but instead view it a way to refine your competence rather than relying solely on your organization to do it. Competency checklists and skills days commonly used by healthcare agencies should be viewed as a starting point and part of administrative documentation, not the only education received annually. Competence is in the eye of those who practice it. Spend as much or as little time on it as you need personally; and be honest if you don't know something. Share your research and the concept of competence ownership with your peers as well. What you don't know could be something a peer does. If you find a good resource that you believe should be policy, send it to the powers to be in your organization. With this new knowledge power, we can all look forward to bedsores being less scary and who knows maybe even one day having the same fate as our dinosaur friends.

Agency for Healthcare Research and Quality. (2014, October). *Are we ready for this change?* https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/pu1.html

Matica, M. A., Aachmann, F. L., Tondervik, A., Sletta, H., & Ostafe, V. (2019, November 24). Chitosan as a wound dressing starting material: antimicrobial properties and mode of action. *International Journal of Molecular Sciences, 20*(5889). http://dx.doi.org/10.3390/ijms20235889

Mayo Clinic. (2020, February 29). *Bedsores (pressure ulcers).* https://www.mayoclinic.org/diseases-conditions/bedsores/symptoms-causes/syc-20355893

Petrone, K. & Mathis, L. (2017, September). *Pressure ulcer litigation: what is the wound center's liability?* Today's Wound Clinic. https://www.todayswoundclinic.com/articles/pressure-ulcer-litigation-what-wound-centers-liability#:~:text=Estimates%20on%20the%20prevalence%20of,and%2015%25%20in%20acute%20care.&text=The%20average%20settlement%20of%20a,to%2087%25%20of%20these%20cases.

Samarghandian, Farkhondeh, & Samini (2017, Apr-June). *Pharmacognosy Research, 9*(2), 121-127. Doi: 10.4103/0974-8490.204647

COMMITTEE SPOTLIGHT

Program Committee

Program Committee is to design and implement programming/member engagement activities through the year and around the state. Collaborate with Organizational Affiliates for innovative activities.

Elisa (Lee) Mancuso RNC-NIC, MS, FNS, AE-C - Committee Chair

My nursing career has evolved over the past 35 years as an NNP & Professor of Nursing @ SCCC specializing in Neonatal ICU, Pediatrics, Oncology, Mental Health and Leadership. I was the President of the American Nurses Association (ANA) - New York (2016-2020) and now am the chair for the Program Committee. I am honored to utilize my expertise in curriculum development and advanced communication skills as we embark on our new Peer Support Program. I am President-elect for the Professional Nurses Association of Suffolk County (PNASC) 2020-2022.

I have been actively engaged with Suffolk County Medical Reserve Corps (MRC) since 2009 and currently am performing rapid COVID-19 testing and administering vaccines 10–12-hour shifts. Retirement from my faculty position allows me to spread my wings in new directions! My clinical expertise across the lifespan and counseling skills have been invaluable during numerous deployments.

Volunteering is an opportunity to "Pay It Forward". I embrace this by shaving my head annually for St. Baldrick's (9 years raised > $50,000), Asthma Coalition of LI, (faith-based asthma in-services), Health Welfare Council Long Island (HWCLI) - Census 2020, and Patriot Guard Riders (PGR) honoring veterans with flag lines during funeral ceremonies. Additionally, I honor my spirituality by serving as Deacon for Christ Community Church of East Islip with community outreach projects.

James Connolly MSN, RN – Board Liaison

James Connolly is a master's prepared ER nurse. He is a Director-at-Large for ANA-NY, Board Liaison to the Program Committee, and membership assembly representative. He has been driven to create a more active and engaged membership organization that can drive the profession of nursing forward.

Michele Caliva, RN, MA, CSPI

Ms. Caliva is the Administrative Director of the Upstate New York Poison Center at SUNY Upstate Medical University, a position she has held since 2003. Currently she is the Co-Director of Upstate's COVID Hotline and Vaccine Hotline Ms. Caliva is a frequent invited guest lecturer on topics related to toxicology and drugs of abuse. She provides over 50 professional education presentations annually. Ms. Caliva was the past president of the New York State Public Health Association, and she is currently on their board. She is also on the ANA- NY Program Committee, a member of the American Public Health Association, American Nurses Association, American Academy of Clinical Toxicology and the Emergency Nurses Association. Ms. Caliva has a nursing degree from SUNY Empire, a Bachelor of Science degree from SUNY Empire in Health Care Administration and a master's degree in Homeland Security from the Naval Post Graduate School.

Paula Donaldson

Perioperative Nursing is Paula's passion. Paula Donaldson has been a Perioperative Nurse for over 30 years and a Perioperative Nurse Executive for 10 years providing expertise and support to nurses caring for patients in the perioperative setting, driving practice changes throughout the perioperative setting and ensuring the use of best practices and evidence-based care to achieve the best possible patient outcomes. Paula is an Advanced Practice Nurse, Clinical Nurse Specialist, and a Certified Nurse in the Operating Room. Paula assisted in the coordination of the several Perioperative Expos as a planner and a presenter. She served Adjunct Clinical Nursing Professor for Long Island University-Brooklyn campus. Paula received a BSN from Adelphi University and a master's from Long Island University at CW Post Campus in Brookville New York. Paula is a member of Association of periOperative Registered Nurses (AORN), New York Organization of Nurse Executives and Leaders (NYONEL), National Nurses in Busines Association (NNBA) and American Nurses Association- NY -Program Committee. Paula has given numerous lectures on surgical site verification empowering audiences on patient advocacy.

Nadia Joseph, MSN, RN-BC

Nadia Joseph is currently employed at Mount Sinai South Nassau Hospital as a Nursing Professional Development Specialist/Orientation Coordinator and Faculty Student Placement Coordinator. She received her Bachelor of Science in Nursing from SUNY at Downstate and her Master of Science with education track from Molloy College. She is board certified from ANCC. She has over 25 years' experience in nursing ranging from critical care level 1 trauma from Stony Brook University Hospital, Assistant Nurse Manager at Winthrop University Hospital, Faculty at Nassau Community College and adjunct faculty at Adelphi University. For the past decade, Nadia has been an educator/faculty and is committed to promoting advanced education for all nurses. Nadia served as a member of Nurses Association of the Counties of Long Island (NACLI) and ANA-NY, education committee and an active member for ANA Mentorship Program.

Andrea A. Kabacinski, MS, RN, NEA-B C, Associate Director of Nursing, Neurosciences and Inpatient Oncology, Stony Brook University Hospital

Andrea Kabacinski is the Associate Director of Nursing for Neurosciences and Inpatient Oncology at Stony Brook University Hospital, Stony Brook, NY. She holds a bachelor's degree in nursing from the University of Scranton, PA and a master's degree in nursing as an Adult Health Nurse Practitioner from SUNY Stony Brook. Ms. Kabacinski has over 25 years of nursing experience in neuro trauma critical care nursing, emergency department nursing education and nursing administration. She has held roles as nurse educator and nurse manager and most recently as a nursing director. She is board certified since 2007 as Nurse Executive, advanced from the American Nurses' Credentialing Center. Ms. Kabacinski joined Stony Brook University Hospital in 1997.

Marilyn Klainberg, Ed.D.,RN

Dr. klainberg is full professor at Adelphi University College of Nursing and Public Health. Her specialty is Community Health. Dr. Klainberg's research is mostly related to student success and her most research is on the impact of sleep on student nurses during a pandemic.

Seon Lewis-Holman, DNP, MSN, RN, NEA-BC, NPD-BC, ACNS-BC

Seon Lewis-Holman is the Senior Director, Clinical Professional Development at Northwell Health-Lenox Hill Hospital, part of a twenty-three hospital healthcare system in New York. Dr. Lewis-Holman has 30 years of progressive healthcare experience covering a broad range of settings. Dr. Lewis-Holman holds a BSN and MSN from Hunter-Bellevue School of Nursing, a Post Master's Certificate in Distance Education from Thomas Edison State College and a Post Mater's Certificate in Nursing Education from Hunter College. She obtained a Doctor of Nursing Practice degree from Chatham University in 2014. Dr. Lewis-Holman's experience includes the development of clinical and population disease management programs for hospital and community health settings. Additionally, her experience also includes private, federal and state funded grant writing and management. She has co-authored peer-reviewed manuscripts, and book chapters and presented podium and poster presentations both nationally and internationally. She is currently responsible for the development, planning, coordination, and implementation of educational and staff development programs for three sites.

Ebele Maduekwe, RN, BSN

I have been a Registered nurse since 2002. I currently work on a cardiac unit at Stonybrook hospital. Member of American Nurses Association, Nigerian Nurses Association, and American Association of Critical Care Nurses.

Jennifer Rosen RN, MSN, IP

RN, Pace University 1998, MSN Nursing Administration from Adelphi University 2016, Infection Prevention 2016

Director of Nursing Education and Infection Prevention at Northwell Health System, Orzac Center for Rehabilitation

Nursing experience for 20+years. Surgical, recovery room nurse at NYU Medical Center 9yrs, Community nurse 10+ years with Visiting Nurse Service and currently Director of Nursing Education and Infection Prevention at Northwell Health System. Focus in healthcare improvement, Health Equity and Patient Experience. New committee member with ANA-NY and looking forward to making positive change in nursing and supporting our nurses across the continuum.

Jen Zuber-Bozek MBA, RN-BC, CPHIMS

Jen is a Clinical Consultant with Cerner Corporation. In this role she works with clients to optimize their electronic health record by making best practice recommendations and advising on complex clinical workflows. She has been a Registered Nurse for over 20 years. In addition to her informatics experience, her direct patient care experience includes Emergency Room, Perioperative and Long-Term Care nursing.

Jen holds a Master of Business Administration Degree with a focus in Health Services Management from the SUNY Institute of Technology at Utica/Rome, a Bachelor of Science Degree in Education from SUNY Oswego and an Associate's Degree in Nursing from St. Joseph's Hospital School of Nursing. She is Board Certified in Nursing Informatics by the American Nurses Credentialing Center and a Certified Professional in Healthcare Information and Management Systems by the Health Information Management Systems Society.

LEGISLATIVE UPDATE

Amy Kellogg

The 2021 legislative session began on Wednesday, January 6, 2021 with the Senate and Assembly convening their session remotely. At this point, we are anticipating that the entire 2021 legislative session, which is scheduled to conclude on June 10, will be fully remote. While we are adjusting to the new remote version of session, we are in the full swing of session here in Albany.

A new legislative session always begins with the State of the State address from the Governor, where he outlines his legislative priorities for the year. The Governor's 2021 State of the State address was remote and delivered over four days. The Governor outlined an action plan that focused on seven key priorities: defeat COVID; vaccinate New York; address the budget deficit; invest in the future; transition to a green economy; understand the long-term effects of COVID; and address systemic injustices. Many of these priorities were outlined with more detail in the Governor's proposed budget.

The Governor unveiled his proposed budget the third week of January. He focused on how this would be a different type of budget because of the effects of COVID-19, in particular a $15 billion budget deficit. He emphasized that assistance from the federal government would be necessary to overcome this deficit. The Governor stated that his budget proposal had been developed while contemplating that New York would only receive $6 billion in federal assistance. Under this scenario, New York would have to implement $9 billion in revenue raisers and across the board funding cuts, including cuts to education and healthcare. If New York receives more than $6 billion in federal assistance, all cuts could be avoided. In addition, the State would be able to pursue initiatives to fund rental assistance, fully fund higher education and provide funding for childcare in New York.

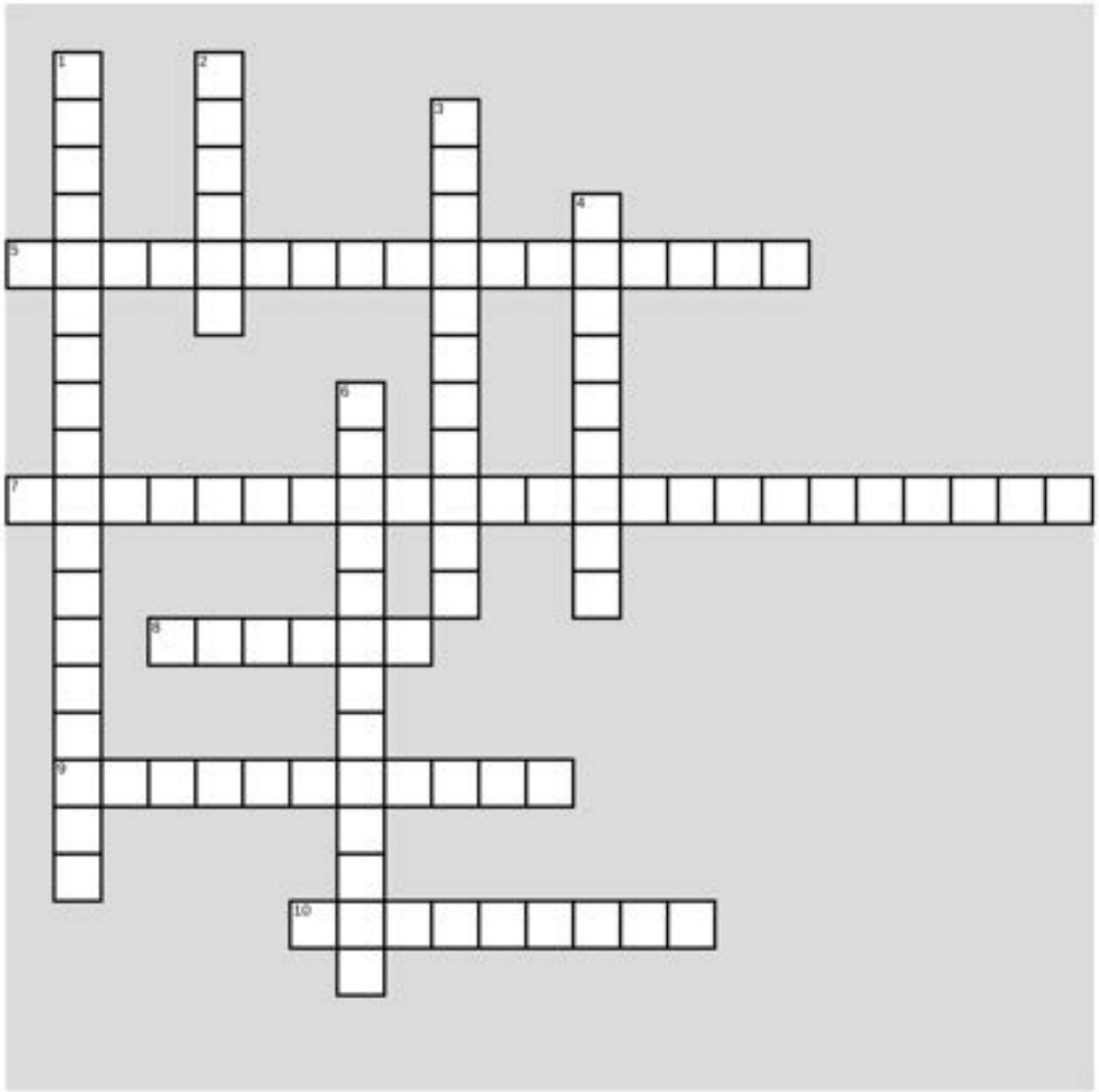
As of the drafting of this newsletter, the federal legislation has passed, and New York received $12.5 billion in direct funding. This means that all cuts have been avoided and full funding will be restored to key areas. After the Governor released his proposed budget, the Senate and Assembly convened joint budget hearings where they heard testimony from individuals and groups regarding the proposals. Once the hearings were completed, each house released their own individual budget proposals. The Assembly budget proposal contemplated a total spending level of $208.3 billion, and the Senate budget contemplated a total spending level of $209.98 billion. Both the Senate and Assembly budget proposals included a tax increase on the wealthiest New Yorkers. In addition, both houses had proposals to increase taxes on certain corporate entities and a proposed increase in the estate tax on larger estates. Both budgets also include small business tax relief, residential rent relief programs and the phase in of income tax reductions for middle class taxpayers.

For the past two weeks, the Governor, Senate and Assembly have been negotiating in an attempt to reach a final budget deal by April 1, which is the start of New York's new fiscal year. As of this writing, we have passed April 1, and we don't yet have a final deal in place. All parties are continuing to negotiate, and it is anticipated that a final deal will come together over the next several days.

After the budget is completed, there will be a break and then the final weeks of session will focus exclusively on non-budget legislative items. During the beginning of a new session, most of the focus is on the budget, but there has been attention on non-budget legislation as well. The safe staffing bill has begun the process of moving through the New York State Assembly. We have begun to have conversations on the bill and have asked for a few amendments that we think will strengthen the bill and ensure that nurses can spend their time focused on patient care. We also continue to work on other key issues including exploring a continuing education bill and supporting legislation to recognize those who were essential workers during the pandemic. We will also continue our coalition work on key issues related to a smoke free New York and vaccinations.

If you have any questions about the legislative process or the priorities of ANA-NY, please contact a member of the Legislative Committee. As always, we welcome your questions, thoughts, ideas or comments on legislation or the bill track.

April 2021 Newsletter



Across

5 ANA-NY CONFERENCE THEME 2021
7 PAC
8 APRIL 15
9 E-LEARNING COMPETENCY
10 FRONT LINE NURSES

Down

1 CoI
2 DUE APRIL 1
3 CERTIFICATION SAVINGS
4 NEWEST ANA-NY
6 ANA-NY Keynote speaker 2021

WORD LIST:

BUDGET
COMMUNITYOFINQUIRY
DEDICATED
INFORMATICS
NOKIDDING
NURSEAVOICETOLEAD
POLITICALACTIONCOMMITTE
SHANTAYCARTER
SUCCESSPAYS
TAXDAY

CONTINUING EDUCATION

E-Learning: An Overview

Continuing Education Instructions

Steps to complete independent study and receive 0.75 contact hours

- Read the article.
- Complete the post-test, evaluation, and registration forms online at https://form.jotform.com/210685808123051.
- Fee of $7.00 for non-members, ANA-NY members are free.
- Certificates will be emailed after a passing score of 75% or higher is achieved.
- There is no conflict of interest or commercial support for this offering.
- This enduring continuing education offering expires on 12/31/2021.
- Learning outcome: It is the intended learning outcome that participating nurses will be able to expand their understanding of the current issues influencing the profession of nursing and be prepared to perform at their highest professional level in a rapidly changing practice environment.

Continuing Education Statement: This nursing continuing professional development activity was approved by American Nurses Association Massachusetts, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

E-Learning: An Overview

by Maria A. Mendoza, EdD, RN, ANP, CNE
Assistant Clinical Professor, Director, Nursing Education Master's & Advanced Certificate Programs, New York University Rory Meyers College of Nursing

"The secret of change is to focus all of your energy, not on fighting the old, but on building the new."
Socrates

Introduction

2020 was a year to remember. Many lives were changed and affected by the pandemic. The United Nations (2020) reported that this pandemic affected 1.6 billion learners from 190 countries in all the five continents. Historically, this disruption is of epic proportion and is expected to have substantial long-lasting effects on education and beyond. It has exacerbated disparities across economic and social strata by reducing access to quality education. Class differences have become more pronounced as school districts scramble for financial resources to have access to technology-assisted learning. It has led to drastic immediate changes in the way we conduct our classes in the educational environment.

Like millions of Americans, I was greatly affected by the pandemic. As a university teacher my lifestyle and academic routine changed overnight, literally. In early March 2020, the school announced immediate cessation of traditional classes and we were informed that we were to switch to online teaching using Zoom the following day. A short Zoom tutorial was set-up, the information technology staff was mobilized, and overnight the faculty was converted to online teachers and students to distance learners. We were expected to be quick adopters to the new technology, if the goal was survival. I decided to move head on, learn fast, keep an open mind, and be optimistic. Albert Einstein's quote "In the midst of every crisis lies great opportunity" gave new meaning on how I would conduct myself for the rest of the pandemic.

E-learning is a catch-all-word to imply learning enabled electronically. It is designed to create an online communication between the teacher and the student and a way to learn using electronic technologies and media. It may be used to complement classroom. Typically, it is conducted on the Internet, where students can access their learning materials online at any place and time. E-learning utilizes digital tools for teaching and learning, and the technology facilitates the learning process. Online learning, distance learning and remote learning may come under the umbrella of e-learning. This article will cover an overview of e-learning. I will focus on two things: (1) the theoretical framework and (2) the approaches to promote student engagement in a virtual environment. The readers should note that I will use the term "online learning" (which is a form of e-learning) to refer to my experiences.

Theories behind E-learning

What is a theory? The dictionary defines a theory as a set of carefully thought-out ideas or organized principles that guide the practice of an activity or course of action. In science, a theory represents a statement that has withstood the rigors of experimentation and control. In education, a theory is a system of explanations from observations and experiments that collectively provides a framework to explain how people learn (Picciano, 2017). Theories provide a basis of reasoning for a course of action.

Why do we need a theory of learning? Learning theories are important components of the pedagogy. Theories are the framework that guide my teaching-learning strategies and educational assessment. Theories of education are derived from many disciplines like psychology, sociology, philosophy, anthropology and more recently neuroscience. They explain how people learn. Having a guiding theory of learning provides a broader perspective of our practice of teaching. Many educators do not just have one theory that they adopt as a framework for practice. Although some lean towards a specific theory, many have eclectic approach. This eclectic approach is transferable from one experience to another.

There is not one integrated theory of E-learning. The field pulls out relevant assumptions from a variety of major learning theories such as andragogy (adult learning), constructivism, behaviorism, and social cognitivism. My intent here is not to review all these classic theories and how they apply to e-learning but rather to bring to light two major theories proposed by experts. These theories include cognitive load theory and community of inquiry model.

Cognitive Load Theory

Cognitive Load Theory (CLT) was first described by John Sweller (1988). This theory derived its major assertions from the theory of cognitivism and neuroscience. CLT is based on the model of human information processing research showing that short term memory is limited in the number of elements it can contain simultaneously. Information from the sensory memory passes into the working memory, where it is either processed or discarded. Working memory can generally hold between three and five items (or chunks) of information at any one time. Therefore, only a small amount of information is processed and moved into long-term memory, where it is stored in knowledge structures called "schemas." Sweller posits that schemas are the cognitive structures used by the individual to organize knowledge and guide cognitive processes and behavior and interpret information. Schemas allow us to organize and interpret a large amount of information.

CLT is mostly applied in designing instructions in e-learning. Training designs that reduce the demands on learners' working memory to learn more effectively is key to CLT. There are two major techniques in CLT. One is *chunking*, a cognitive process that recodes information by breaking large amount into "chunks" to increase working memory capacity and improve retention. Another process to decrease competing effects of sensory input on the working memory is called the *modality effect.* The modality effect principle states that items presented using one sensory stimulus would likely be an inefficient way to learn compared to using multiple sensory stimuli, e.g., auditory and visual. Therefore, it is recommended that a multimodal approach in instructional design be employed because that strategy would be less taxing on the working memory load.

Community of Inquiry

The Community of Inquiry (CoI) is a theoretical framework used in instructional design of online learning that supports critical thinking, analytical inquiry and dialogue among students and teachers. Although popularized at the turn of the 21st century, it was first described by educational philosophers like John Dewey and C. S. Pierce (Shields, 1999). The underlying principles of the CoI model are based on constructivism, a belief that learning occurs through active engagement of the learner to construct new knowledge from previous experiences. Dewey was a firm proponent of collaborative and experiential learning. He believed that students assimilate and accommodate new knowledge and assume responsibility for their own learning (Stanford Encyclopedia of Philosophy, 2018).

The concept of "community" was applied to a group of individuals with shared commitment to address a common interest. CoI was a major part of the seminal work of Garrison, Anderson and Archer (1999, 2010). Their work centered on the discovery of knowledge and methodology to study effective computer conferencing. CoI is a model for online learning based on three phenomena of "presences," namely cognitive, social, and teaching (see Figure 1). In CoI, learning is dependent on a design that promotes active interaction between three components: the learner, the teacher, and the content. In applying the CoI concept to instructional design, three presences are in play:

1. Social presence is the ability of the learner to exercise one's belief, feelings, personality to establish relationship, trust, and open communication.
2. Cognitive presence is the ability to make meaning of one's learning experiences through reflection and interaction with others.
3. Teaching presence is the freedom of the teacher to create learning experiences, design instructions, facilitate social and cognitive presence to achieve the highest quality outcomes for students.

Critics of CoI proposed adding more "presences" to the equation, such as student presence. However, reading the work of the creators of the model would suggest that social presence includes the students. I think a valid addition to the model is the emotional component of learning. It was Dewey who proposed holistic education (Stanford Encyclopedia of Philosophy, 2018) that includes, cognitive, biological, psychosocial and emotional components. Hence renaming the social presence to socio-emotional or psychosocial presence might be more appropriate.

Figure 1: A depiction of Anderson & Garrison's Community of Inquiry Model for Online Learning

Engagement in E-Learning

Student engagement is defined as the time and energy expended by the student to interact with peers, with teachers and the content (Hu & Li, 2017). Engagement activities may be classified as behavioral and cognitive. There are numerous approaches to promote student engagement in E-learning. I will use the Anderson's (2017) model of Education Interactions as a framework in presenting these approaches. Many of the approaches or strategies I will cite here are those that I learned and applied in my online classes; some were from my readings, others were learned from attending classes on e-learning, and a few are from interactions with my peers, my own community of inquiry.

Based on the CoI model, Anderson described the interactions among the three major components of online learning: the student, the content, and the teacher. He believed that the interaction is not only occurring between the component, but also within the components as depicted in Figure 2.

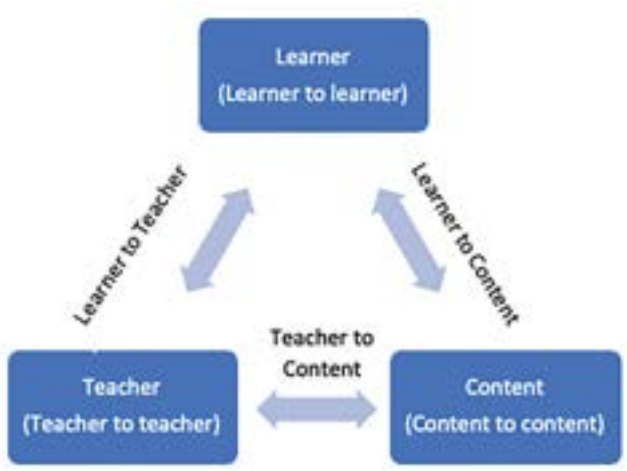


Fig 2: Depiction of Anderson's Interaction in Online Learning

Below are a variety of approaches or strategies classified under each type of interaction.

Learner to Teacher and Teacher to Learner

These approaches for student engagement based on learner to teacher interactions are written from the perspective of the teacher.

- **Be present in your course.** One of the difficulties of online instruction is the perception that the absence of physical presence leads to feelings of isolation by the student. I use the word perception because this is not necessarily true if the teacher is able to devise ways to decrease that feeling of isolation. Here are some approaches I used in my practice.
  - **Create a safe learning atmosphere.** This starts from the beginning of the semester by allowing students to have a welcoming introduction. I have a small class, so the introductions were done at the beginning of the class. In large classes, you can be creative and use many free apps out there and have the student prepare a short personal introduction in video such as Flipgrid or Animoto. Setting all the expectations of the course, including the assurance of privacy and that everyone can speak up respectfully without fear of recrimination, creates a safe environment.
  - Offer **virtual office** hours weekly which simulate my walk-in office hour. Students can come into the Zoom virtual office meeting. To ensure privacy, I set up the waiting room where students wait for their meeting with me. Students also know they can set up individual meetings outside of the virtual office time.
  - Provide **regular timely feedback** in the form of emails, LMS announcements, forums, discussion boards or zoom meetings. Respond to emails promptly, within limits you have set. Just be cautious about sending too many emails which can be disruptive and overwhelming.
  - **Poll students** during and between class sessions. This gives you a chance to identify issues early and address them. I use *Survey Monkey, Poll Everywhere, Zoom internal polls*, etc. I send out anonymous polls to get a sense of students' satisfaction with the course throughout the semester.
- **Use active teaching-learning strategies.** There are numerous to mention but the major ones include problem-based, project-based, and inquiry-based and collaborative learning. These strategies ensure that students participate actively in their learning process. I use vignettes with a problem situation, break up the class into small group to brainstorm, then allow them to share their discussion with the whole class. In asynchronous class sessions, I use collaborative group assignments or projects. This strategy serves two purposes: it increases student accountability in completing the session and gives them an experience in working with peers. One of the approaches I use frequently, especially because I teach in the nursing education program is allowing the students to teach small parts of the content. This serves two purposes; students learn how to teach and they actively participate in learning the content.
- **Pace the time and load of learning.** One of the dangers of online teaching is that we may underestimate the amount of cognitive load we require of students on a weekly basis. When we design a self-instructional module that includes required readings and videos, it is good practice to include the estimated time of completion. An asynchronized class session should be equivalent to the time spent in synchronous class session. Another approach to pace the academic load is to stagger the submission of assignments and projects. Do not use holidays or breaks to assign projects. Remember, our students need to maintain physical, emotional, and mental health; holidays and breaks are designed to support this.
- **Conduct formative assessments to ensure students are learning.** There are many formative assessment strategies. Angelo and Cross (1993) listed hundreds in their classic book *Classroom Assessment Techniques: A Handbook for College Teachers*. I found a *pdf* online that itemized 50 of their classroom assessment techniques into categories (see link in References below). I have a few that I use regularly, such as think-pair-share, group reflection on take-aways, parking lot, quizzes, and poll questions. Small assignments and short quizzes are good ways to assess students' learning. Another tool to assess students' engagement in the learning process is learning analytics which are data that monitor and track the sites visited by students in the LMS and the amount of time they spend on the site. These data provide quantitative information about engagement.
- **Provide incentives for individual and group activity.** I was in meeting where one of the participants asked how he can make students do what he asked them to do. I blurted out the idea of using grades to motivate the students. My response was a surprise to few who did not think of grades as a motivator. In my online classes, I grade the students' participation on discussion. I created a rubric for grading discussion which is shared with the students. I find that by doing this, the students do their readings to actively participate in their learning. I include self-assessment quizzes (usually 5-10 questions) in self-instructional modules and give extra credit for submission. I have not known a student to skip this opportunity to get extra credit.
- **Allow students to do mini-presentations or mini-teaching.** Experts believe that being able to teach content is the highest level of learning. This type of teaching approach forces the student to master the subject matter to effectively teach it. It is an appropriate learning activity for my students since they are in the nursing education program and will be future educators.

Learner and Teacher to Content

- **Chunk complex topics.** I discussed chunking when describing cognitive load theory. When we try to teach everything to our students, they end up learning nothing. Teach what is important and relevant; in other words, "must" learn, not "nice" to learn topics.

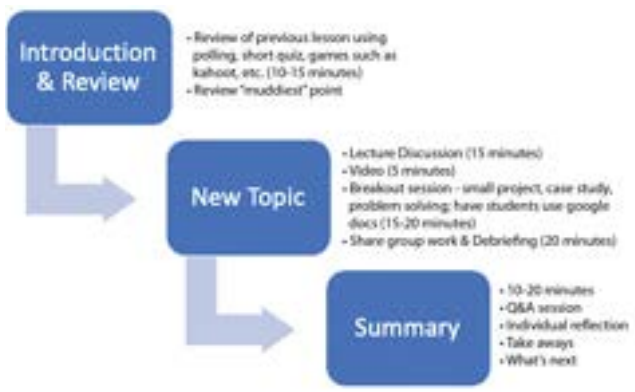


Fig 3. Example of a class format to increase student engagement.

- **Use multimodal approach** to decrease cognitive overload. This was also discussed in the cognitive overload theory. The attention span of learners has been decreasing over time. Changing the learning activity every 10-15 minutes would be reasonable to keep students engaged. See Figure 3 for a schematic diagram of a multimodal approach to breaking down a class.
- **Use technology to enhance instructions.** Technology does not replace the teacher and the instructional design, but many tools and apps are available (many are free) to use as adjunct to teaching content. I used apps on infographics and mind maps to teach my students critical thinking. The students were assigned a complex topic and presented it as an infographic or concept map. This exercise allowed the students to learn how to analyze the complex topic by breaking it down into multiple parts and demonstrating how the parts are interrelated with each other.
- Use synchronized and asynchronized sessions to deliver content. Some courses are designed to be purely online where students interact with content directly and the teacher indirectly. I believe a combination of synchronized and asynchronized session is far better for effective online instruction.

Learner to Learner

For this section, I itemize below numerous approaches that I find effective in enhancing learner to learner interactions.

- Student sharing to explore information together
- Collaborative group projects
- Use breakout rooms
- Small group reflection on learning – "take-aways" from the lesson
- Group discussion in a forum for problem solving or discussing controversial issues
- Students mentoring students
- Promote social interaction among students
- Facilitate student-to-student communication by using forums, blogs, google docs, etc.
- Peer-based learning

Conclusion

One of the unexpected educational outcomes of the COVID-19 pandemic is the exposure of a large number of faculty to e-learning. Many faculty members learned from their experience and established creative and effective teaching strategies to enhance student engagement. This article discussed two theoretical frameworks on online teaching and proposed numerous strategies for effective student engagement. The Anderson's Model of Education Interaction was used to categorize the strategies. There are loads of information about e-learning. More research for stronger evidence-based practice that enhance student engagement are needed.

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Last year at this time, Donate Life New York State (NYS) was happily making plans to promote organ, eye and tissue donation through outreach activities. April is National Donate Life and in a typical year, some of our most enthusiastic participants are staff at hospitals and healthcare centers who host donor drives, flag raisings and other events to increase awareness of our lifesaving mission.

Obviously, it was not 'celebrations as usual' in 2020 when the pandemic hit and New York went into a 'pause.' With restrictions still in place, Donate Life Month won't be observed as usual in 2021 either, but that doesn't mean we can't move forward! Like virtually every business in the world, we have adapted to the times. In fact, we have an exceptionally powerful **no-cost** way to increase enrollment in the New York State Donate Life Registry (Registry) and we hope you can help!

In 2019, Donate Life NYS rolled out the introduction of "Registry Partner Portals," making it possible for healthcare organizations and other businesses to place the Registry enrollment form directly on your website. Gone are the days of handing out brochures! You can drive your patients and customers to your website to sign up as organ and tissue donors. We also created custom and trackable URL's for organizations to use in donation related promotional campaigns. The first step of the application process can be done right online at donatelife.ny.gov/partners.

As a Registry partner, your organization can promote organ and tissue donation and enroll new donors by utilizing these custom Registry promotion tools. What's more, the community outreach effort can be tracked during any campaign or timeframe so we can acknowledge your successes.

These partnerships are wonderful and Donate Life NYS is deeply grateful for every organization that joins in our mission. This effort has also revealed **an incredibly powerful way to enroll more people with** minimal staff effort by having the link 'live' on patient portals, like Epic's MyChart patient portal.

For example, the University of Rochester Medical Center (URMC) added a link to the Registry as one of four scrolling messages across the banner of their login page. It is also available under the Quick Links and appears in automatically generated emails. In total, 665 new organ and tissue donors enrolled through those links in 2020 alone. It was a simple task for the URMC team to execute that yielded fantastic results.

We invite your hospital to do the same. Donate Life NYS is here to help! Our staff would be happy to work with your hospital's marketing/communication departments or business offices. For more information, talking points, and other ideas, please reach out to Donate Life NYS at communications@dlnys.org or call (518) 326-3237.

This is a simple way to increase the number of registered organ, eye and tissue donors in New York and will truly have a lifesaving impact. Donate Life NYS would love to chat with you today to see what we can do together!

As always, thank you for all that you do every day

ANA-NY ORGANIZATIONAL AFFILIATE SPOTLIGHT

ANA-NY welcomes newest organizational affiliate. Nigerian Nurses Association of USA Inc.

"Nurses Dedicated to promoting health in their communities"

Nigerian Nurses Association of USA (NNAUSA), is a non-profit organization, registered as 501(c) (3) tax-exempt organization. The organization was started on April 27, 2002 out of the need of our community. It was observed that many Nigerians were neglectful of their health and as a result, developing preventable chronic diseases and dying from them. The **mission** of NNAUSA is to improve the health of the communities that NNAUSA serve by: (a). Promoting health, increasing health literacy and providing free health screening to Nigerian Community and other Communities in the United States of America, the Federal Republic of Nigeria and other African countries. (b). Encouraging and assisting members to attain the highest professional standard and seek greatest height through education and mentoring.

The **purpose** of NNAUSA is to serve as an organization that meets the health needs of Nigerian communities in the United States & Africa, and to uphold the image and foster the welfare of Nigerian Nurses as a professional group.

NNAUSA objectives are to:

(i) Assist Nigerian community in making healthy lifestyle changes necessary by providing information needed to make informed decisions.

(ii) Promote health maintenance and wellbeing among Nigerians and other communities in the United States and in Nigeria

(iii) Secure funding through fund raising, donations and grants to support NNAUSA Programs.

(iv) Foster educational and professional growth among Nigerian nurses living in USA and in Nigeria through networking and mentoring.

(v) Assist newly migrated Nigerian nurses and Nigerian nursing students to adapt to nursing profession in the United States.

(vi) Unite all Nigerian Nurses in the United States towards promoting the highest standard of professional practice, educational, cultural advancement and socio-economic stability.

(vii) Provide forum or avenue where Nigerian Nurses in United States speak with one voice, uphold the international code of nursing ethics, promote and support the laws or reforms on matters affecting nursing.

(viii) Collaborate with other organizations in addressing current issues of health care in Nigeria such as, but not limited to HIV/AIDS, Genital Mutilation, Communicable Diseases, Mental Health, Women's and Children's Health, Gerontological Health and Rural Health.

MEMBERSHIP:

Membership of NNAUSA shall be open to any Nigerian Professional Registered Nurse (RN), living in the United States.

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By joining NNAUSA, you made an authoritative statement about your commitment to Nursing and the health of the Nigerian community in United States and Nigeria.

Professionally, your membership opens you to many opportunities including mentorship, networking, discount on NNAUSA Educational Seminars, free NNAUSA Newsletter, and advancing your higher education at a discount rate, through the national education agreement and coalition of NNAUSA national body, with some universities in the United States. Improving your leadership skills by working with, and learning from local and national leadership members.

Socially, your membership opens you to NNAUSA social support system through "Sunshine Benefits" including member presence at your social events, member or spouse's death benefit and opportunity to participate in the national group term life insurance initiative. Furthermore, as a member, you are a member of the National Association Nigerian Nurses in North America (NANNNA), a strong voice that upholds the mission of improving the health and wellbeing of Nigerians at home and abroad. You can also connect with the Nurses and Midwifery Council of Nigeria (NMCN) through NNAUSA.

Your membership qualify you to network with fellow Nigerian nurses by signing up with one or more of our Standing Committees: Community Outreach, Medical Mission, Education, Finance, Membership and Domestic Violence Committee.

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COVID-19 and mental health: Self-care for nursing staff

Gráinne Ráinne Clancy, BN, MIACP; D'Arcy D. Gaisser, DNP, MS, RN, ANP-BC; and Grace Wlasowicz, PhD, RN, PMHNP-BC, ANCC NP

This article has been adapted for space and originally appeared in the September 2020 issue of Nursing © 2020 Wolters Kluwer Health, Inc.

Along with incalculable loss, the coronavirus (COVID-19) outbreak has had devastating effects on the mental health of people with COVID-19, their families, and the community at large. Healthcare workers face tremendous stress, both emotionally and physically, from the grueling work hours and the threat of contracting the virus at work.

This article addresses the potential mental health issues for healthcare workers that may emerge from this pandemic as well as treatment options and self-care activities that promote recovery.

COVID-19 and mental health

Nurses working on the front lines of the COVID-19 pandemic may experience various mental health problems. Here are a few examples:

- Chronic stress. Nurses are continuously fearful of contracting COVID-19, infecting others, encountering prejudice from the public due to working as a nurse, and dealing with inadequate supplies of PPE.[1] Stress becomes chronic when it is overwhelming and cannot be resolved, resulting in relationship, health, and sleep problems.[2-5] People with chronic stress experience intense emotions that can feel overwhelming and result in thinking negatively.[6] Nurses on the front lines in COVID-19 hotspots report feeling like a graduate nurse again, filled with uncertainty and worry.[7]
- Acute stress disorder. Nurses with acute stress disorder may have trouble sleeping, worry constantly, and experience persistent negative thoughts about their role in the traumatic event, such as thinking "I should have done more to help."[8] When we experience trauma, we detach from the memory. We ignore our emotions to protect against the pain, but these emotions reappear over time and impact our lives.[9] The nurse may respond to a minor irritation as if it were a life-threatening event.[10] Nurses may feel they are in a dreamlike state that impacts their ability to think, process their emotions, and respond appropriately to situations.[11] If signs and symptoms of acute stress disorder persist for more than a month, posttraumatic stress disorder (PTSD) may be diagnosed.[12]
- PTSD. Nurses are not strangers to caring for critically ill patients who die.[8] However, the number of patients dying amid a surge in COVID-19 cases is causing healthcare workers to feel powerless, which can lead to PTSD. PTSD can develop after direct or indirect exposure to a traumatic event, such as hearing about a traumatic event involving a family member, friend, or colleagues. Those with PTSD experience recurrent intense and disturbing thoughts and feelings stemming from one or more traumatic events.[10,13,14] Nurses with PTSD may relive an event through flashbacks or nightmares, and they may feel sadness, fear, anger, guilt, shame and detachment or estrangement from other people.[14] Many traumatized individuals have a robust and unconscious inclination to go inward, often to re-experience their distressing thoughts, painful memories, and uncomfortable sensations.[15] They may have an exaggerated, startled response to certain situations and develop problems with concentration and sleep.[5]

The nursing team's role

When nurses struggle personally, we tend to be critical of our colleagues or management and withdraw from others. Such a change in personality is often an indicator of struggle. It is often a team member who will notice that you are not your usual self and may be struggling with anxiety and stress. Asking yourself or a colleague three simple questions can raise awareness about a possible problem:

- Am I ok? Are you ok?
- Do you feel you cannot give anymore?
- Do you feel your work is ineffective?[16]

If you are struggling, speak with your colleagues, acknowledging those feelings and thoughts in the first instant. If you feel you are not performing effectively in your workplace, talk with your manager and state your opinions on being ineffective. Everyone has limits, and sometimes just taking a week off might be sufficient.

Nurses who continue to feel this way should discuss it with their primary healthcare provider and their employer and review the options available. A range of supports may be available from your employer or your professional organization.[17,18] Some nurses may want the support of a counselor. It is a strength to realize that you are struggling with your mental health and need help.

Early psychological intervention does make a difference.[19] Each of us has a limit to stress, and it is important not to compare your stress levels to those of another person. There is strength in being vulnerable and showing our thoughts and emotions. Brené Brown defines vulnerability as uncertainty, risk, and emotional exposure.[20]

Topping off emotional reserves

Nurses on the COVID-19 front lines are plagued by drained emotions loneliness, and fear. These are normal reactions to an unfamiliar, uncertain environment. Transitioning away from work at the end of the day is essential for nurses to top off their emotional reserves.

If you have had a particularly stressful day, acknowledging and discarding any negative thoughts or feelings can help improve sleep quality. Having a ritual to signal the end of work is essential. Here are some suggestions:

- Take a shower. Visualize all the worries of the day disappearing down the drain.
- Write down any thoughts or feelings in a notepad.
- Watch a favorite TV program.
- Read a book.
- Listen to your favorite music.
- Contact a friend.
- Write down three things you were grateful for today.

Final thoughts

The COVID-19 pandemic is an unprecedented event in our lifetimes that will have untold mental health implications for nurses and other healthcare professionals on the front lines, both in the short and long term. Although scientists and healthcare professionals know more about the disease and how to treat it now, nurses in current COVID-19 hotspots will still be treating patients with a serious and rapidly spreading disease while possibly contending with shortages of PPE, equipment, and treatments.[21]

Nurses will need to receive support from their team, practice optimal self-care strategies, take measures to replenish their emotional reserves, and learn how to transition mentally from work to home after their shift. Recognizing stress and learning how to cope will help nurses protect their mental health as we move forward during this pandemic.

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Failure to report changes in a patient's condition

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A nurse's ability to recognize and respond to changes in a patient's condition is a crucial element of professional nursing practice. Failure to respond appropriately to clinical changes can lead to complications and even death.[1] In a study that investigated the impact of communication in malpractice lawsuits, communication failure was a factor in 32% of cases involving nurses, with most involving poor communication with other healthcare professionals about the patient's status. These cases often result in huge financial consequences in cost of care and legal damages.[2]

Communication

Communication of a patient's status has been the focus of much attention and research, and various communication frameworks have been generated to facilitate clinical communication among healthcare professionals about patient status.[3,4] Widely used examples include SBAR (situation, background, assessment, and recommendation) and ISBARR (introduction, situation, background, assessment, recommendation, and read back).

In some cases, however, it is not about the nurses' ability to communicate with primary care providers. Rather, they are about the competence and decision-making skills needed that enables a nurse to assess a patient's condition and determine the appropriate intervention, including when to escalate care and seek the expertise of appropriate personnel.

Barriers to Communication

Many factors can play into why nurses may not communicate a patient's status promptly or at all. These include a busy schedule, a reluctance to "bother" the primary care provider, or a failure to recognize the circumstances under which a primary care provider should be notified due to a lack of clinical competence.[2] Nurses need to recognize the severity and emergent nature of a patient's condition.

A nurse's failure to recognize an emergency indicates a lack of competence in nursing fundamentals and a lack of knowledge about the possible physiologic consequences. This gap in knowledge can contribute to a catastrophic deterioration in the patient's condition.

Critical thinking extends beyond mere information, attentiveness, and assessment. How do nurses acquire the decision-making and critical-thinking skills necessary for their practice? The clinical competence needed to make decisions, especially in acute situations, develops over time as the nurse advances from novice to expert.[5]

Implications for practice

To determine appropriate interventions and recognize when it is necessary to escalate care, nurses must:

- accept only patients that they are capable of caring for.[6]
- develop the education and skills necessary to recognize when the interventions they initiate are not effective.[1]
- escalate the patient's care to a more experienced nurse or the healthcare provider when they find that a patient's status change is beyond their capability.[7]
- follow the facility's chain of command. A nurse's vigilance, recognition of an urgent situation, evaluation of changes in the patient's condition, and steps taken to escalate appropriately should be evident in the medical record.[8] Documentation should include the persons consulted and the actions that resulted from the consultation.[9]
- be aware that nurses can be held legally liable for actions they omit as well as actions they fail to take in a timely manner.[7]

Guidelines for practice

Keep these general guidelines in mind:

- When documenting adverse events, follow your facility's policies and procedures. The record should be objective, including only clinical facts without any guesses, assumptions, speculations about the cause of the event, or personal opinions.[10]
- Listen to family members' concerns. They are often at the bedside much longer than the clinical staff. They know the patient and are likely already engaging in the care of the patient at home. They are a valuable source of information and their concerns should be taken seriously.[11]
- Nurses should consider carrying their own liability insurance, both for the purposes of legal liability and for any disciplinary actions taken by the board of nursing.[12]

The failure to report changes in a patient's condition can have serious health consequences for the patient as well as legal and financial implications for all involved in the care of the patient. But by meeting the standards of professional nursing care, nurses can and should avoid these costly consequences.

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Simple Actions Make a Difference: Interview with a New York RN on the Front Lines

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Media outlets and journalists continue to share compelling stories from nurses working on the front lines during the pandemic. A recent video, Death, Through a Nurse's Eyes posted in the New York Times (https://www.nytimes.com/video/opinion/100000007578176/COVID-19-icu-nurses-arizona.htm) provides a real time, heart wrenching account of ICU nurses dealing with death on a daily basis. Often portrayed as heroes and saviors, most nurses will tell you they are just doing what they do best – taking care of their patients.

Nurses not working on the front lines during the pandemic often feel a sense of intense pride, as well as intermittent remorse, when hearing of the exhausting shifts, tremendous loss, and innovative challenges their colleagues are experiencing. For as many stories told through sweat and tears, there are continued accounts of remarkable recoveries and successes.

Julie, a mother of three sons, 14, 11 and 7, and wife to an essential worker, says the most fulling part of being a nurse is "making a difference in someone's life." She claims that "even the simplest actions impact a patient." After graduating college with bachelor's degree in biology, Julie got a job as a PCT in a hospital. She saw the rewards of interacting with the patients and seeing them get well. Filled with admiration for the nurses and amazed at watching what they did while working alongside them, Julie realized that nursing was something she needed to pursue.

Upon graduating from nursing school in 2002, Julie began her nursing career at Westchester Medical Center in Valhalla, NY in a program designed for new graduates with a desire to work in the ICU. Transitioning from the ICU and relocating to upstate NY, Julie found her niche in the Cardiac Cath Lab where she continued to work for more than 10 years. At the onset of the COVID-19 pandemic in early 2020, Julie was working Monday-Friday in an outpatient procedural setting but was quickly detailed to work 12-hour shifts in the ICU, rotating weekends and working holidays.

WORK ENVIRONMENT

Deb: How has your daily work routine changed with the introduction of COVID-19?

Julie: In September I went back to Endoscopy but was detailed back to ICU with the onset of the second surge after Thanksgiving. The biggest change since COVID was with my schedule. I went from Mon-Fri with weekends off to working 12 hour shifts in ICU with rotating weekends.

Deb: Did your hospital/workplace have a shortage of PPE? How was this problem dealt with?

Julie: Fortunately, my hospital did not have a PPE shortage. Initially, we were taking the precautions with the use of our PPE by beginning to recycle and sterilize used N95 masks, but once we realized we would not be short, this process stopped and fortunately we never had to reuse a used N95 mask. In fact, our hospital had sufficient PPE on hand and never once was a staff member unsafe in a COVID-19 situation. Currently, most staff are using PAPRs (Power Air-Purifying Respirator) for protection. This minimizes the usage of N95 masks.

Deb: Was your hospital prepared for this pandemic?

Julie: I do not think any hospital was prepared for the pandemic with how fast it came on, but as soon as there was notification that we would be dealing with COVID-19, our hospital was able to ensure PPE for their employees. They also immediately began cross training staff from clinic/outpatient areas to assist with inpatient volume.

Deb: Do you feel at risk while working?

Julie: Never! I am confident in the PPE I wear each day. I also think the process our hospital does with testing EVERY patient who is admitted to the hospital for COVID-19 helps alleviate fears, because as a nurse, I know who is infected or not and am more prepared to enter their room.

Deb: Has the pandemic affected your personal relationships with co-workers?

Julie: If anything, it has brought us closer. I have had the opportunity to work with people and to meet people that I would not have if not for these circumstances. We are a true team, who are there to help one another. I am fortunate to work with very supportive people.

Deb: Were you reassigned to a COVID-19 Unit? If so, did you receive any orientation?

Julie: I was assigned to the ICU at my hospital. I did receive a brief orientation to the unit and the charting system. I had a preceptor available for questions when needed.

PATIENT CARE

Deb: Has the way you interact with patients changed? How?

Julie: Yes, I am not so rushed when I am with patients now. It is so hard for patients to have no family or visitors while in the hospital and I recognize that these patients are very lonely. I try to find the time in my shift to sit and chat with the patients, so they know they are more than just a patient in the hospital.

Deb: Regarding patient care during this pandemic, what are you most proud of?

Julie: I was most proud when I was able to see a patient who was so sick from COVID-19, on a vent for a month plus, walk out of the hospital. This was awesome to see and to be a part of. Especially knowing that I had something to do with their recovery.

Deb: What was the nature of your involvement in caring for patients with COVID-19?

Julie: I am a nurse caring for COVID-19 patients in the ICU. Most patients I cared for were intubated and sedated.

Deb: What was the nature of your involvement with patients' families and loved ones?

Julie: Due to a no visitor policy, I had to give updates to families via telephone. The families of my patients would call once a shift to get updates. We also had iPads available to families that we would bring into the patient's room and allow the family to speak to and see their loved ones.

Deb: Did you participate in helping family members say goodbye to their family member?

Julie: This was always the hardest part. To have to hold an iPad as loved ones said their final goodbyes.

Deb: What were the most stressful aspects in these situations?

Julie: That we were unable to be there to support the family physically. It was a difficult situation to be in.

Deb: What were the most satisfying?

Julie: Calling a family on an iPad to have them see their family member extubated after a month-long battle with COVID-19. This made it all worth it.

PERSONAL CARE AND FAMILY

Deb: What was the impact of your involvement with COVID-19 patients on your family?

Julie: My family was very cautious initially. We all were. They were interested in what we were seeing as the news reported such overwhelming circumstances in hospitals. I kept them informed about what I was learning about the disease and explained that the patients I was dealing with were very sick.

Deb: Were you apprehensive that you would contract COVID-19 and bring it home?

Julie: Initially, Yes! We knew so little about the disease and the CDC was changing daily on how it spread. I would not wear the clothes I wore to work to my home. I would strip down and run to the shower and scrub before seeing my family. I had an action plan in place if I felt I was exposed without PPE. I would stay in our family camper to keep distance from my family. After many months, I truly trusted that the PPE worked and worked well. I knew if I wore it correctly, I would be protected, I was vigilant in making sure I had it on correctly before entering a patient's room.

Deb: Were you ever quarantined and if so, for how long?

Julie: Thankfully, no

Deb: What is the hardest thing you had to deal with in your personal life during this pandemic?

Julie: The hardest thing was having my three kids do virtual learning when my husband and I who are both essential employees, had to be at work. Even when my husband was able to work from home, it was difficult helping the kids log on and stay involved in their classwork. After long days working, we were exhausted coming home and having to prepare the kids for their next day of class.

Deb: How has your involvement in caring for COVID-19 patients affected you physically and mentally?

Julie: It has been exhausting, but so rewarding. It has been difficult to see how fast this virus progresses and how it does not discriminate.

Deb: Have you been able to discuss your experience and feelings with your family or friends?

Julie: Yes, they have been very interested in hearing things from someone who is front line.

Deb: How did you cope with the loss of so many patients?

Julie: It was devastating, but each day there are more patients to care for. You must be there for your patients. With no visitation, they rely on seeing you so much.

Deb: Did you seek any help from mental health practitioners, counselors, or pastoral care?

Julie: Yes, I found speaking to a counselor during this time has been helpful. Whether it be work, family, or social, this pandemic has been stressful in all aspects of life.

FUTURE CAREER & HEALTH CARE

Deb: Will you remain in the profession and the clinical are you worked in before COVID-19?

Julie: Absolutely, I love nursing. I did love my time in ICU, but due to family obligations I will be returning to my previous schedule in Endoscopy.

Deb: What changes do you think will occur in the practice of nursing in the future due to the pandemic?

Julie: There will be more precautionary measures in place, permanently. For example, in Endoscopy, all procedures are considered aerosolizing procedures and all staff present in the room wear PPE.

Deb: What do you find most challenging in your profession as an RN?

Julie: The most challenging part of being a nurse is the politics in hospital administrations. It is difficult to make changes in practice.

Deb: Are there any messages about your experience that you would like to share with other nurses?

Julie: I have seen the strength in our profession. Of course, we were scared, but we did what we knew we had to do. We were cautious, but got the job done. We were tired and burnt out, but still went to work, to care for OUR patients. Our patients were grateful and appreciative for all that we do. We were a team, and as a team cared for so many patients. With families not present, it was so hard. But the families will remember us and all we did for their loved ones.

Julie shared that the hospital she currently works for is a small hospital and did not have the volume of COVID-19 patients that other hospitals did. And even though at times she and her co-workers felt overwhelmed, she cannot imagine what many nurses felt with the number of COVID-19 patients they cared for. She said, "so many hospitals were pushed to capacity. The nursing profession is made up of caring, hard-working individuals and it was nice to see the appreciation for nurses by our country."

Julie is passionate about cooking and reading, and most of all spending time with family and friends.

For information about resources for nurses visit the ANA COVID-19 Resource Center

https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/

https://ananewyork.nursingnetwork.com/page/94058-covid-19-resource-center

2021 ANA-NY Elections – Call for Nominations

The ANA-New York Nominations and Elections Committee is seeking nominees from the membership for a slate of candidates to be elected by secret electronic ballot during the third quarter of 2021. Call for nominations April 6-May 15, 2021.

Election polls open July 27, 2021 and close on September 4, 2021.

SLATE OF OPEN POSITIONS

Officer Positions

- Vice President and ANA Membership Assembly Alternate to President (two- year term, 2021-2023)
- Secretary (two- year term, 2021-2023)

Director-at-Large Positions

- Three (3) Directors-at-Large (two- year term, 2021-2023)

Nominations Committee

- Two (2) Positions (two- year term, 2021-2023) - the candidate with the most votes will be chair-elect

ANA Membership Assembly Representative and Alternate

- Five (5) Representatives and Alternates (two- year term, 2021-2023)

Eligibility Requirements

The ANA-NY Bylaws state under Qualifications:

To be eligible to serve on the Board of Directors, a person shall:

1. hold current membership.
   b. not concurrently serve as an officer or director of another organization if such participation might result in a conflict of interest with ANA-New York.
   ANA-New York places a high priority on diversity and seeks to encourage and foster increased involvement of minorities and nurses from a variety of settings, specialties, and positions at the state level.

Board of Directors Responsibilities and Duties of Officers. The information can be find in ANA-NY Bylaws Article V Section 5 and Section 9 on our website.

Section 5. Responsibilities

The Board of Directors shall:

a. exercise the corporate and fiduciary duties of the association consistent with applicable provisions of law and these Bylaws.
b. provide for implementation of association policies and positions approved by the ANA-NY Governing Assembly.
c. establish policies and procedures for the transaction of business, coordination of association activities, and operation and maintenance of a state headquarters.
d. establish financial policies and procedures, adopt the budget, and submit all books annually to a certified public accountant for review, and present an annual financial statement and financial review or audit results to the membership and the Governing Assembly.
e. establish policies and procedures for approving publications and other printed materials prior to their distribution.
f. establish policies and procedures for the collection, analysis and dissemination of information.
g. establish policies and procedures for nominations and elections in accordance with these Bylaws.
h. establish committees of the board as deemed necessary for the performance of its duties, and define the purpose and authority of such committees in accordance with these Bylaws.
i. define qualifications for appointive positions, make appointments and fill vacancies unless otherwise specified in these Bylaws.
j. appoint, define the authority and responsibilities of, and annually review the performance of the Executive Director as the chief executive officer.
k. accept organizational affiliation of associations meeting qualifications established in these Bylaws and deemed appropriate by the Board of Directors.
l. establish fees for all meetings, specified activities, and services.
m. control the use of the official ANA-NY logo and insignia and the procurement and sale of replicas thereof.
n. provide for organizational affiliate liaisons or representation at meetings of voluntary organizations and of public or governmental agencies.
o. establish relationships and collaboration with the Nursing Students Association of New York State (NSANYS).
p. establish relationships with other constituent/ state nurses associations of the ANA, including participation in a Multistate Division, if deemed appropriate.
q. assume other duties as may be provided for elsewhere in these bylaws and by the ANA-NY Governing Assembly.

Section 9. Duties of Officers

a. The President of ANA-NY shall serve as the official representative of the association and as its spokesperson on matters of association policy and positions; as the chair of the Governing Assembly, the Board of Directors, and the Executive Committee; as an ex officio member of all committees except the Nominating Committee; and as a representative to the Membership Assembly, as well as the voting representative of ANA-NY to the Leadership Council of the ANA.
b. The Vice-president shall assume the duties of the President in the President's absence or at the discretion of the President and serve as an alternate to the President at the ANA Membership Assembly.
c. The Secretary shall be responsible for ensuring that records are maintained of meetings of the Governing Assembly, the Board of Directors, and the Executive Committee of the Board of Directors, and shall notify members of meetings of the Governing Assembly.
d. The Treasurer shall be responsible for monitoring the fiscal affairs of the association and shall provide reports and interpretation of the ANA-NY financial condition to the Governing Assembly, the Board of Directors, and the membership. The Treasurer shall serve as a member and chair of the Finance Committee.
e. Officers and Directors-at-Large shall fulfill the responsibilities of the Board of Directors as defined in these Bylaws.

The Nominations and Elections Committee shall:

1. be composed of five (5) members elected in accordance with the Nominations provisions in these Bylaws
2. solicit the names of members qualified and willing to serve if elected
3. prepare a slate of qualified candidates for each office to be filled
4. assure geographic and occupational group representation on the ballot
5. implement the policies and procedures for nominations and elections as established by the Board of Directors or as provided for in these bylaws.
6. ensure implementation of the Nominations and Elections provisions of these Bylaws

ANA Membership Assembly

1. ANA-NY is entitled to representation at regular and special meetings of the ANA Membership Assembly in accordance with ANA Bylaws and policy.
2. The President of ANA-NY shall serve as a representative to ANA's Membership Assembly.
3. Other representatives and alternates to the Membership Assembly shall be elected by secret ballot to serve a two-year term or until a successor is elected. A mail ballot or appropriate electronic ballot is permissible.
4. Except for the president, the vice-president as alternate to the president, ANA representative(s) and alternate representative(s) shall be elected and shall serve based on those who received the highest number of votes.

Nomination form is available at https://form.jotform.com/90785787972177.

Questions about this process, please contact ANA-NY at: info@anany.org or (888) 587-4818.

ANA-NY Membership Activation Form

AMERICAN NURSES ASSOCIATION NEW YORK ANA AMERICAN NURSES ASSOCIATION

Essential Information

First Name/MI/Last Name

Mailing Address Line 1

Mailing Address Line 2

City/State/Zip

County

Professional Information

Employer

Type of Work Setting: (eg: hospital)

Practice Area: (eg: pediatrics)

Ways to Pay

Monthly Payment $15.00 — ***Signature below is required**

☐ Checking Account *Attach check for first month's payment.*

Checking: I authorize monthly recurring electronic payments to the American Nurses Association ("ANA") from my checking account, which will be drafted on or after the 15th day of each month according to the terms and conditions below. Please enclose a check for the first month's payment. The account designated by the enclosed check will be used for the recurring payments.

☐ Credit Card

Credit Card: I authorize monthly recurring electronic payments to the American Nurses Association ("ANA") be charged to my credit or debit card on or after the first of each month according to the terms and conditions below.

*Monthly Electronic Deduction | Payment Authorization Signature

I understand that I may cancel this authorization by providing ANA written notice seven (7) days prior to deduction. I understand that ANA will provide thirty (30) days written notice of any dues rate changes. I understand that my dues deductions will continue and my membership will auto-renew annually unless I cancel.

Annual Payment $174.00

☐ Check ☐ Credit Card

Please note: $49 of your membership dues is for a subscription to *American Nurse Today*. American Nurses Association (ANA) membership dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the ANA is not deductible as a business expense and changes each year. Please check with your State Nurses Association for the correct amount.

Date of Birth

Gender: Male/Female

Credentials

Phone Number *Check preference:* ☐ Home ☐ Work

Email address

Current Employment Status: (eg: full-time nurse)

Current Position Title: (eg: staff nurse)

Required: What is your primary role in nursing (position description)?

☐ Clinical Nurse/Staff Nurse
☐ Nurse Manager/Nurse Executive (including Director/CNO)
☐ Nurse Educator or Professor
☐ Not currently working in nursing
☐ Advanced Practice Registered Nurse (NP, CNS, CRNA)
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Loretta C. Ford, Co-founder of Nurse Practitioner (NP) Profession, Receives U.S. Surgeon General's Medallion for Contributions to Nation's Health

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https://www.aanp.org/news-feed/loretta-c-ford-co-founder-of-nurse-practitioner-np-profession-receives-u-s-surgeon-generals-medallion-for-contributions-to-nations-health

December 27, 2020

AUSTIN, TEXAS — The American Association of Nurse Practitioners® (AANP) applauds the U.S. Surgeon General's selection of Loretta C. Ford, EdD, RN, PNP, NP-C, CRNP, FAAN, FAANP, as the recipient of the Surgeon General's Medallion. The Medallion, the highest honor granted to a civilian by the Public Health Service and the U.S. Public Health Service Commissioned Corps, is awarded by the Surgeon General for actions of exceptional achievement to the cause of public health and medicine. Dr. Ford, who will celebrate her 100th birthday on December 28, 2020, co-founded the first NP program at the University of Colorado and created a profession that is integral to our nation's health care infrastructure.

"Dr. Ford has received this recognition for her vision and commitment to the health of our nation," said AANP President, Sophia L. Thomas, DNP, APRN, FNP-BC, PPCNP-BC, FNAP, FAANP. "Thanks to her trailblazing efforts, millions of patients have access to high-quality health care from NPs, the provider of their choice, and the profession has grown to more than 290,000 strong."

"As we celebrate Dr. Ford's 100th birthday, I can't think of a more fitting tribute to this titan of American health care. From co-creating the NP profession to advocating for patient access to NP care, she has played a profound role in strengthening health care access and choice for America's patients," said David Hebert, JD, Chief Executive Officer of AANP.

For more than half a century, Dr. Ford has been an active champion for the NP community in areas of practice, education and research. At the University of Colorado in 1965, Drs. Ford and Henry Silver started the nation's first NP program. This pediatric nurse practitioner (PNP) program expanded the role of public health nurses to focus on illness prevention and health promotion. Ford then became the founding dean of the University of Rochester School of Nursing in 1972 and continued to positively influence graduate-level nursing education, developing a model that melded practice, education and research.

Dr. Ford is an inaugural member of the Fellows of the AANP (FAANP), the author of more than 100 publications and has served as a consultant and lecturer to multiple organizations and universities. She holds several honorary doctorate degrees and is the recipient of numerous awards, including the Living Legend Award from the American Academy of Nursing (AAN) and the Gustav O. Lienhard Award from the National Academy of Medicine. She has also been inducted into both the National Women's Hall of Fame and the Colorado Women's Hall of Fame.

The American Association of Nurse Practitioners® (AANP) is the largest professional membership organization for nurse practitioners (NPs) of all specialties. It represents the interests of the more than 290,000 licensed NPs in the U.S. AANP provides legislative leadership at the local, state and national levels, advancing health policy; promoting excellence in practice, education and research; and establishing standards that best serve NPs' patients and other health care consumers. As *The Voice of the Nurse Practitioner®*, AANP represents the interests of NPs as providers of high-quality, cost-effective, comprehensive, patient-centered health care. To locate an NP in your community, visit npfinder.org. For more information about NPs, visit aanp.org. For COVID-19 information from AANP, visit aanp.org/COVID19.

https://www.aanp.org/news-feed/loretta-c-ford-co-founder-of-nurse-practitioner-np-profession-receives-u-s-surgeon-generals-medallion-for-contributions-to-nations-health

MEMBERS ON THE MOVE

ANA-NY Member Establishes New Research Endowment Fund in Health Informatics & Innovations through the NLN Foundation for Nursing Education

Edmund J. Y. Pajarillo, PhD, RN BC, CPHQ, NEA BC, ANEF, the inaugural Editor-in-Chief of the newly launched Journal of the American Nurses Association – New York (JANANY), is the benefactor of this Health Informatics & Innovation Collaborative Endowment Fund. Dr. Pajarillo is a staunch informatics scholar whose research focus on the intersection of informatics, leadership and mentoring in nursing education, practice, research and administration. He is an Associate Professor and Chair of the Graduate Studies in Nursing at Adelphi University in Garden City, New York, and a founding member of the ANA-NY.

The Edmund J.Y. Pajarillo Health Informatics & Innovation Collaborative Endowment Fund will seek applications for 2022 grants, with guidelines and the call for grant applications coming out this fall 2021. With the grant's focus on informatics and innovation in the use of data, data outcomes, and health information technology, the Pajarillo fund opens a new avenue of scholarship to support the League and its members. Grant applicants will be nurses pursuing advanced degrees (master's and doctorates) who will serve as principal investigators to transition to full-time nurse educators with an interest in theoretical and applied informatics in nursing education. Nurse-applicants may have collaborators in their teams coming from nursing and other disciplines but the grantee is the primary investigator. Applications to the Pajarillo fund for grants in the 2022 funding cycle fall under three broad categories:

- Projects that conceptualize and translate nursing informatics concepts and theories into new applications and systems to facilitate nursing education, practice, and science.
- Projects that establish, pilot, expand, and influence future nurses' roles to further optimize and magnify their marketability and professional demand.
- Projects that create nursing educational technology to foster and enhance high impact practice (HIP) learning.

In partnership with the NLN Foundation to set up the fund, Dr. Pajarillo said, "Informatics has a strong impact on nursing, whether in practice, education, research or administration. We have seen how nursing and nurses' roles have evolved with the introduction of new technologies. It is up to us, practitioners in nursing, to change the course and direction of nursing. We need to rethink how these technologies and informatics concepts can help us transform our roles, rather than technologies forcing us into roles and responsibilities that we do not like, or those that go against the values and tenets of nursing as our profession. It is the aim of this scholarship that I encourage nurses to lead collaborative teams to think of innovations that are informatics-mediated and to re-envision what our future as nurses will be like."

Applicants are students in accredited graduate level programs, having completed at least one year of study towards their degree. Nurses of color and members of other underserved populations interested in transitioning from practice to full-time teaching will be given special consideration by the Selection Committee of the NLN Foundation. For more information and some examples of each of the three categories of the Edmund J.Y. Pajarillo Health Informatics & Innovation Collaborative Endowment Fund, click here.

http://www.nln.org/professional-development-programs/grants-and-scholarships/nursing-education-research-grants/edmund-j-y-pajarillo-health-informatics-and-innovation-collaborative-endowment-fund

Peer Support Network Program

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

Nurses are consistently submerged in a highly stressful environment where repeated daily exposure to excessive workloads, ethical challenges and multiple losses especially this past year has predisposed them to depression and burnout. The COVID-19 pandemic has magnified work related stressors resulting in anxiety, PTSD, self-doubt, feelings of incompetency, frustration and the ultimate negative mental health outcome = nurse suicide.

The primary focus of this article is to introduce the Peer Support program and offer this support to our colleagues.

Confidential peer support is one intervention to defuse high stress situations by decreasing isolation and providing compassion for our colleagues and ourselves. Health care provider suicide rates have decreased where peer support programs are implemented. ANA-New York is developing a peer support program for NYS nurses, ***Nurses Supporting Nurses***, by collaborating with Bassett Multi-institutional Clinician Peer Support Program (CPSP-CNY) directed by Dr. Caroline Gomez Di Cesare. This program will enhance ANA-NY's dedication to provide a safe space for our members' emotional concerns, promote excellence in nursing practice, improve the quality of health care services and promote professional and leadership development of RNs.

The main peer support network principle is to provide a loving presence to your colleague. Listen attentively, validate their concerns, review effective coping strategies, reframe their positive impact as nurses, acknowledge grief and embrace gratitude for what is going well and promote self-compassion.

Colleagues trained as peer supporters will be matched with other NYS nurses who are experiencing distress and requested this service. **This is not therapy.** It is support from a peer trained with effective listening and communication skills, who understands the pressures of navigating challenging circumstances.

The goal of the peer support program is to assist inpatient and outpatient nurses emotionally at times when they are most vulnerable, to decrease isolation and minimize the risks of burnout and its sequela. The anticipated outcomes for this peer support program include:

- Improved nurse well-being, satisfaction and engagement
- Improved nurse retention
- Decreased barriers and stigma to nurses seeking help
- Improved patient care

There will be more information coming your way about how to participate in this exciting program either as a peer supporter or as a peer participant.

CLIFTON PARK RESIDENT HONORED FOR ALZHEIMER'S ADVOCACY WORK

Statewide Advocate Jennifer Pettis Named the Recipient of 2021 Frank Carlino Award

ALBANY, N.Y., March 8, 2021 – Today, the Alzheimer's Association announced that longtime Alzheimer's advocate Jennifer Pettis of Clifton Park, Saratoga County, is the recipient of the Frank Carlino Award in recognition of her outstanding advocacy on behalf of individuals and families living with Alzheimer's and all other dementias. Pettis will be presented the award digitally at this year's New York State Alzheimer's Virtual Advocacy Day on March 10.

Pettis is the Alzheimer's Ambassador for Senate Majority Leader Charles E. Schumer and a Chapter Board member and community educator for the Alzheimer's Association Northeastern New York Chapter. Alzheimer's Ambassadors are grassroots volunteers for the Alzheimer's Impact Movement—the advocacy arm of the Alzheimer's Association—working to develop and advance policies to overcome Alzheimer's disease through increased investment in research, enhanced care, and improved support. As the main point of contact for Senator Schumer on issues related to dementia and Alzheimer's, Jennifer has visited several of his regional offices throughout the State (pre-COVID-19) and has worked to mentor other Ambassadors and advocates across New York State. She has taken a unique approach through her own network to engage Senator Schumer and has developed a trusted relationship with his congressional offices to ensure her voices is heard by policymakers.

In one of her many roles, Pettis is the acting director of programs for Nurses Improving Care for Healthsystem Elders (NICHE) at the NYU Rory Meyers College of Nursing. Established in 1992, NICHE is the leading nurse-driven program designed to help hospitals and healthcare organizations improve the care of older adults. Pettis has more than 25 years of healthcare experience as a nurse, nurse researcher, educator and consultant working to improve healthcare for older adults.

"There are 6.2 million older adults age 65+ living with Alzheimer's, and that number is expected to double to 12.7 million by 2050. In short, Alzheimer's disease is a public health crisis, and the time to act is now," said Pettis. "I humbly accept this award, but my work is far from over. I will continue to advocate for those living with this disease and their caregivers, as well as push to ensure that health systems are prepared to provide person-centered, quality care to individuals living with Alzheimer's and other dementias."

In the early 2000s, Frank Carlino of Cornwall, Orange County, became the face of Alzheimer's at a time when people with the disease did not speak out about it. Carlino shared his experience living with Alzheimer's in a variety of public settings – including testimony before Congress in 2000. His work led to the establishment of the Alzheimer's Association's Early Stage Task Force, and he started the Alzheimer's Coalition to Inform Others Now Coalition with Dr. Larry Force from Mount Saint Mary College. Diagnosed when he was in late 50s, Carlino lived with Alzheimer's for several years before his death from lung cancer at age 67.

The Frank Carlino Award celebrates his visionary spirit and is given yearly to recognize an advocate who exemplifies the qualities of dedicated perseverance and creativity that help people with Alzheimer's and their families.

"It gives me great pleasure to present this year's award to a Northeastern New York advocate," said Alzheimer's Association, Northeastern New York Executive Director Beth Smith-Boivin. "I have been fortunate enough to work alongside Jen for a number of years and she holds us all to a high standard. Her compassion and steadfast determination make her a remarkable advocate."

In New York State alone, there are more than 410,000 people who live with Alzheimer's disease and 586,000 caregivers who provide 7.74 million hours of unpaid care to their loved ones with dementia valued at nearly 15 million dollars.

Alzheimer's Association®

The Alzheimer's Association is a worldwide voluntary health organization dedicated to Alzheimer's care, support and research. Its mission is to lead the way to end Alzheimer's and all other dementia—by accelerating global research, driving risk reduction and early detection, and maximizing quality care and support. Visit alz.org or call 800.272.3900.

NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

Nurses Improving Care for Healthsystem Elders – Driving Nurse-Led, Quality Care for Older Adults

By Jennifer L. Pettis, MS, RN, CNE,
Acting Director of Programs
Nurses Improving Care for Healthsystem Elders (NICHE), NYU Rory Meyers College of Nursing

Welcome to the first NICHE Age-Friendly Nursing Practice Pearls, a new recurring column in the ANA-New York Nurse newsletter. In this month's newsletter, I am delighted to tell you a little about Nurses Improving Care for Healthsystem Elders (NICHE) and what to expect from this column in the future. Additionally, it is my pleasure to share some articles previously published in The Director, the official journal of the National Association of Directors of Nursing Administration in Long-Term Care (NADONA/LTC).

NICHE, a program of the NYU Rory Meyers College of Nursing, is a nurse-led intervention aimed at improving care for older adults. Developed in 1992 and initially designed for hospital settings, NICHE is also successfully implemented in long-term and post-acute settings. The principles of NICHE include evidence-based care at the bedside; patient- and family-centered care environments; healthy, productive nursing practice environments; and multidimensional quality metrics (Berman et al., 2020; NICHE, n.d.). The NICHE program enables nurses and interdisciplinary teams to develop age-friendly practice and improve the overall quality and experience of care for older adults, reduce costs associated with low value care, and influence nurses' job satisfaction and work engagement (Squires et al., 2019).

In upcoming NICHE Age-Friendly Nursing Practice Pearls columns, you can expect to read useful information about caring for older adults and their caregivers. I will be sure to share evidence-based practice and quality improvement information, and, from time to time, I will invite my colleagues to join me for an interview to share their great work to advance age-friendly care in the column. I would love to hear from you about what quality improvement priorities related to older adults you and your colleagues are working on. Please reach out to me at jenpettis@nyu.edu to share your work. Perhaps your quality improvement focus can be my area of focus in the next NICHE Age-Friendly Nursing Practice Pearls column!

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Fostering a Kind and Civil Culture in Long-Term Care

Jennifer Pettis, MS, RN, CNE, WCC,
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Provision 1.5 of the American Nurses Association's (ANA; 2015a) *Code of Ethics for Nurses,* Relationships with Colleagues and Others, describes a nurse's responsibility to interact respectfully with all individuals, including their colleagues. This *NICHE Evidence-Based Corner* highlights the ethical imperative of creating healthy work environments based on high quality relationships and offers insights into how nurse leaders can foster a kind and civil culture among all staff, including those in front-line leadership positions. Nurse leaders in long-term and post-acute care settings face unique challenges in implementing and maintaining such a culture yet doing so is a must to ensure healthy work environments in which staff provide safe, quality care (Nickitas, 2014; Oppel, Mohr, & Benzer, 2019).

In the *Code for Ethics for Nurses,* the ANA (2015a) calls on nurses to "maintain professional, respectful, and caring relationships with colleagues" and create "an ethical environment and culture of civility and kindness, treating colleagues…with dignity and respect" (p. 4). Further, in their *Position Statement on Incivility, Bullying, and Workplace,* the ANA (2015b) calls on nurses and "employers to create and sustain a culture of respect, which is free of incivility, bullying, and workplace violence" (p. 1). Despite these tenets of nursing practice, incivility and bullying are commonplace in healthcare environments, including nursing homes, with all-too-often negative impacts on residents, staff, and organizations (ANA, 2015b; Clark, 2019; Lynette, Echevarria, Sun, & Greene Ryan, 2016).

In their work on incivility in clinical and academic settings, Lynette and colleagues (2016) suggest that Bandura's Social Learning Theory is a useful framework to understand and address incivility in the workplace. This constructivist theory explains one's behavior is driven by what they have observed and learned. As such, when nursing staff observe negative behaviors, particularly those left unchecked by leadership, they imitate them. The opposite is also true; when kindness and civility are the norm, they are imitated (Clark, 2019; Lynette et al., 2016; Kurt, 2019). Bandura's theory emphasizes that observation can lead to imitation without learning, however. It also stresses the need for attention, retention, reproduction, and motivation for learning to occur (Kurt, 2019). The final two of these are especially pertinent in promoting a kind and civil culture in long-term care. It is important for nurse leaders to repeatedly practice (or reproduce) positive behaviors and require that their front-line leaders to do the same. Additionally, it is critical that leaders motivate staff to act with civility and kindness by rewarding such behaviors. All too often, nurse leaders focus their energy and attention at addressing problematic behaviors while not taking the time to reward those exhibiting collegial, positive behavior.

Based on their literature review on incivility, Lynette and colleagues (2016) suggest a three-prong approach to create a civil and kind clinical environment. First, acknowledge that incivility and unkindness exist. Openly identify unacceptable behaviors, including verbal and nonverbal behaviors, and address them. Next educate staff, including on how incivility negatively impacts the residents, fellow staff members, and the organization. Consider using case studies as a neutral method to teach acceptable behavior as well as how to confront colleagues who are displaying unacceptable behaviors. Finally, "create an environment of integrity" (Lynette et al., 2016, p. 266). Doing so includes setting and communicating expectations for behavior during orientation to the organization and on an ongoing basis. Nurse leaders should ensure that their behavior is congruent with the *Code of Ethics for Nurses*, and they should not accept less from their colleagues on the nurse leadership team or the staff.

Despite the ethical tenets of nursing supporting civility and kindness among colleagues, incivility continues to pervade healthcare across the continuum. Nurse leaders in long-term and post-acute care are uniquely positioned to address this issue through modeling, teaching, and only accepting kind and civil behavior in the workplace. By ensuring a kind and civil workplace, nurse leaders support positive resident outcomes, staff satisfaction, and overall organizational health (Nickitas, 2014; Oppel et al., 2019). The steps to address incivility are not complex; however, successfully implementing takes true leadership and perseverance. Nurse leaders in long-term and post-acute care are surely up for the task.

Nurses Improving Care for Healthsystem Elders (NICHE) is a nursing education and consultation program designed to improve geriatric care in healthcare organizations. Find out more about NICHE at nicheprogram.org.

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NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

Preventing Geriatric Syndromes During Crisis Situations

Jennifer Pettis, MS, RN, CNE, WCC, Associate Director Long-Term Care Nurses Improving Care for Healthsystem Elders (NICHE), NYU Rory Meyers College of Nursing

Geriatric syndromes are often preventable iatrogenic events (Fulmer, 2007; Mitty, 2010). The geriatric syndromes include pressure injuries, urinary incontinence, falls, decline in physical function, and delirium, among others. Nurses play a key role in preventing, identifying, and managing geriatric syndromes (Aronow et al., 2014; Brown-O'Hara, 2013; Fulmer, 2007). This is especially true during crisis situations such as infectious disease outbreaks like the 2020 COVID-19 pandemic or natural disasters. In this NICHE Evidence-Based Corner, I describe how to use the SPICES screening tool to identify the risk for or presence of six common geriatric syndromes. I link the SPICES domains with evidence-based assessment tools for nurses to gather additional data to investigate the flagged conditions. Finally, I present a framework to integrate comprehensive nursing assessments to guide care planning for older adults.

Developed by Dr. Terry Fulmer, SPICES is an acronym to focus assessments and guide both nursing and interdisciplinary care management of six common geriatric syndromes: sleep problems, problems with eating or feeding, incontinence, confusion, evidence of falls, and skin breakdown (Fulmer, 1991). Long-term care nurses can use the SPICES framework during routine rounds each shift to evaluate resident's health and wellbeing. Moreover, the SPICES model offers nurses a framework to discuss clinical changes with providers and focus nursing care activities carried out by the direct care staff. In the event changes in status related to any of the six areas are identified, additional assessments using validated tools such as those identified in Table 1 are required. Learn more about SPICES and many of the assessment instruments in Table 1, including how to administer them, at the Hartford Institute for Geriatric Nursing's *Consult Geri* resource page (https://hign.org/consultgeri/try-this-series).

Table 1: Assessment Instruments Aligned with SPICES Domains

SPICES Domain	Assessment Instruments
Sleep problems	• Epworth Sleepiness Scale • Pittsburgh Sleep Quality Index • Insomnia Severity Index
Problems with eating or feeding	• Mini Nutritional Assessment-Short Form • Kayser-Jones Brief Oral Health Status Examination • Katz Index of Independence in Activities of Daily Living • Edinburgh Feeding Evaluation in Dementia Scale
Incontinence	• Urinary Distress Inventory • Incontinence Impact Questionnaire-7
Confusion	• Mini-CogTM • Confusion Assessment Method • Brief Interview for Mental Status
Evidence of falls	• Falls Efficacy Scale-International • Hendrich II Fall Risk Model
Skin breakdown	• Braden Scale for Predicting Pressure Sore Risk© • International Skin Tear Advisory Panel (ISTAP) Skin Tear Framework

Sources: Boltz, Capezuti, Fulmer, & Zwicker, 2020; Hartford Institute for Geriatric Nursing, 2020

After thorough assessment, nurses lead person-centered, interdisciplinary care planning. The "4Ms" – What Matters, Medication, Mentation, and Mobility – of the Age-Friendly Health Systems initiative provide a useful framework to focus care planning to meet the unique health needs of older adults (Institute for Healthcare Improvement [IHI], 2019). Taken together, the 4Ms are intended to guide care that is evidence-based, safe, and congruent with the resident's and family's wishes (IHI, 2019).

- To address "What Matters," interdisciplinary teams must identify and implement care that is consistent with the resident's goals and preferences. This includes, but should not be limited to, end-of-life care.
- "Medications" for older adults, when needed, should cause no harm. Medications should align with goals of care and not effect mentation and mobility.
- To address "Mentation," care planning should focus on preventing, identifying, treating, and managing delirium, dementia, and depression.
- Care planning for "Mobility" should center on promoting safe movement to improve or preserve function while allowing the older adult to do what matters.

Learn more about Age-Friendly Health Systems at http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx.

Nurses who are well versed in identifying the geriatric syndromes can promote wellness for the older adults in their care, including during emergencies. Using validated screening tools, such as SPICES, as a framework for routine resident rounds and team huddles can help long-term care teams prevent as well as rapidly detect and treat geriatric syndromes (Aronow et al., 2014; Brown-O'Hara, 2013; Fulmer, 2007). Preventing, detecting, and addressing these iatrogenic events is an important first step in ensuring high-quality, safe care that promotes resident function and quality of life.

Nurses Improving Care for Healthsystem Elders (NICHE) is a nursing education and consultation program designed to improve geriatric care in healthcare organizations. Find out more about NICHE at nicheprogram.org.

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NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

Shared Governance: What It Is and Why Long-Term Care Needs It

Jennifer Pettis, MS, RN, CNE, WCC, Associate Director Long-Term Care Nurses Improving Care for Healthsystem Elders (NICHE), NYU Rory Meyers College of Nursing

Shared governance is a model in which managers and nursing staff are mutually accountable for the quality and safety of clinical care, peer relationships, and professional development. For more than thirty years, the nursing profession has advocated that all nurses practice under shared governance structures, yet, they are rarely seen in long-term care (LTC), despite their well-documented benefits (Lyons, Specht, Karlman, & Maas, 2008; Bieber & Joachim, 2016; Guanci, 2018). This *NICHE Evidence-Based Corner* provides an overview of the shared governance model and discusses the benefits of adopting shared governance in LTC settings.

Shared governance, also referred to as professional governance, engages licensed nurses and nursing assistants in making decisions that directly impact their work (Bieber & Joachim, 2016; Porter-O'Grady, 2019). Shared governance positions front-line staff as partners with their managers, and it bestows on them the responsibility, ownership, authority, and accountability for decisions guiding patient care (Bieber & Joachim, 2016; Guanci, 2018; Hess, 2004; Porter-O'Grady, 2019). Shared governance should not be misinterpreted as a replacement for effective leaders, a chain of command, or individual accountability for practice (Guanci, 2018). Rather, it is a model in which staff have a voice in making decisions that impact them.

For example, nursing staff and managers come together to discuss the quarterly fall rates in their nursing home that are above the national average. After reviewing practice protocols and policies, the staff noticed that falls increase during mealtime as residents walk to the dining room unassisted. Based on a review of evidence-based interventions, the staff and managers agree to implement a new hourly-rounding program with the goal of reducing preventable falls.

There are three overarching models of shared governance:

- Councilor model. The councilor model is the most common form of shared governance. In this structure, subcommittees are responsible for different areas of practice such as quality assurance, professional development, or professional relationships. The subcommittees report to a larger coordinating council.
- Administrative model. In the administrative model, two groups of smaller committees report to clinical and management forums who in turn report to the executive committee and director of nursing.
- Congressional model. In the congressional model, staff serve as the congress, and committees' work is ultimately submitted to an executive cabinet for staff vote on practice issues and actions to address them (Hess, 2004).

Regardless of the model chosen, it is vital that front-line staff understand the goals of shared governance and the opportunities that are available to them to participate. Similarly, despite all staff having the opportunity to participate, managers must understand that all staff may not wish to participate. Additionally, all involved need to acknowledge that moving to a shared governance model doesn't happen overnight. Rather, "it is a journey, not a destination" requiring ongoing reexamination, at times rejuvenation, and continually inviting others to join the trip (Hess, 2004, p. 4).

Research on shared governance suggest that the most successful bodies are those that have at least six structural elements:

- A charter, including outlining the boundaries of decision-making;
- Collaboration between staff co-chairs and the area manager;
- Regular meetings with a formal means of communication to all staff;
- Mutually planned agendas (co-chairs and manager) distributed before the meetings;
- Ground rules of how to work together, be it in-person meetings or online meetings;
- Striving for consensus decisions, meaning that everyone agrees to support them after having discussed the options (Hess, 2004; Porter O'Grady, 2019).

To get started on the journey toward shared governance, nurse leaders will need to prepare their team, including educating all nursing staff in the principles of shared governance. Those who will participate in governance activities will need additional training to support their success. For example, many front-line nursing staff members have strong clinical skills but have not received training and mentoring in management skills such as those required of effective meeting participants or leaders (Hess, 2004).

Shared governance is a vehicle for nurses to take control over their practice and contribute their expertise and professional wisdom to improve the quality and experience of care. Changes occurring within the LTC offer nursing staff an opportunity to lead and make important changes so that older adults consistently receive high-quality, evidence-based care. If you are interested in learning more about shared governance, its benefits, and how to get started on your organization's journey, many nursing journals are a useful source of information, including many case studies on how to begin. The Forum for Shared Governance, available at https://sharedgovernance.org/, offers a number of resources and organizational assessment tools. These resources are helpful for nurse leaders in LTC to determine that shared governance is, in fact, one way to help their staff, residents, and organizations thrive.

Nurses Improving Care for Healthsystem Elders (NICHE) is a nursing education and consultation program designed to improve geriatric care in healthcare organizations. Find out more about NICHE at nicheprogram.org.

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Nurses House to Host Annual "Dolphins for Nurses Campaign" – A Nurses Week Fundraiser to Help RNs in Need

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For Immediate Release:

(March 16, 2021) - Nurses House, Inc. is pleased to announce plans to launch its fifteenth annual "Dolphins for Nurses Campaign" to raise funds for nurses in need throughout the United States. The campaign, sponsored by Stat Staff Professionals and Davin Workforce Solutions, soon to be Davin Healthcare, will run from April 12-May 12, culminating in National Nurses Week. The campaign involves nursing groups and hospitals nationwide hosting Nurses Week fundraisers by offering white, gold and blue dolphins in exchange for $1, $5 or $10 donations. All proceeds from the campaign will be put towards the Nurses House Service Program to benefit nurses facing health issues and other dire circumstances.

Nurses House, Inc. is the only national 501(c)3 organization offering financial assistance to registered nurses in need. The organization's main goal is to provide short-term aid to nurses who are unable to support themselves financially as a result of illness, injury, disability, or catastrophic event. Last year, Nurses House collaborated with the American Nurses Foundation to establish a fund for nurses affected with COVID-19. The fund provided almost $3 million in aid to nurses affected and Nurses House continues to assist those having long term complications from the virus as well as nurses facing other serious illness.

Nurses House is run by an Executive Director and a volunteer Board of Directors. Funds come from donations by nurses, nursing organizations, friends of nurses and through various annual fundraising activities. Since its inception, Nurses House has helped thousands of nurses in all fifty states regain health and productivity. Last year alone, Nurses House provided support to over 2,500 nurses in need. An application for assistance and guidelines can be found on the Nurses House website at www.nurseshouse.org.

This year's campaign is sponsored by Stat Staff Professionals, a healthcare staffing and managed services organization, and its sister company, Davin Workforce Solutions, a software development firm focused on simplifying the clinical placement process. The organizations are undergoing a re-branding and integration of service lines which they hope will offer more consistent messaging, but their respective missions will remain the same. By Nurses Week 2021 Stat Staff Professionals will become Davin Healthcare Workforce Solutions and Davin Workforce Solutions will be become Davin Healthcare Education Solutions. David Theobald MS, RN, CSP, CEO and President was asked why supporting this campaign is so important to him. "In 1924, Emily Bourne made a bequest to establish Nurses House because she wanted to help nurses who became ill to receive the rest and support they deserved. It is inspirational to witness Emily's philanthropy continue to flourish well into the future. We are honored to collaborate with Nurses House and join the national effort. The monies raised will be used to help nurses from all over the United States with much-needed financial assistance, emotional support, and other relief during the deadliest public health crisis in modern history. We are grateful to be a part of this wonderful campaign and to help fellow nurses in need."

To learn how your group can participate in the Dolphins for Nurses fundraiser, or to get started by ordering a fundraising packet, please contact Stephanie Dague at sdague@nurseshouse.org or (518) 456-7858 x127. To make a donation online, visit the Nurses House website at www.nurseshouse.org.

A Women's History Month Tribute to a Mostly Forgotten Group of Women: The Spanish American War Nurses

By Carole Cryer, MS, RN, NE-BC

During my one year Covid lock down I have been finding things to keep me busy. At first figuring out how, where, and when to order food was a priority. But I finally was able to navigate Shipt, Instacart, Doordash and Peapod with ease. Then I did some cleaning out of drawers and closets. I got bored with that much quicker than I hoped plus organizations weren't coming to pick up donations, so that went by the wayside. I've done some 1000 piece puzzles but that activity also ran its course. I paint and even did a painting project for frontline nurses and while that was good I needed some new inspiration.

Then I decided to follow up on some research into our family history. I started this project years ago and didn't get very far but now with time on my hands and resources like ancestry.com and DNA I could deeply and diligently delve into this project.

Just recently on my ancestry search I found that my husband's grandmother (she died long before he was born) was one of the first ever female nurses contracted by the US Army. This led me to further research and I found some information that I thought would be interesting, not only for Women's History Month, but also for nurses. The Spanish American War was fought in Cuba and the Phillipines from April 1898 to August 1898 when Spain signed a peace agreement.

My husband's grandmother was Ruby Yates Cryer (1872-1917) she served as a nurse in the Spanish American War in 1898. I know she was a graduate nurse but I don't know where she was educated or where she served during the war. I do know that an early US Census report lists her occupation as Nurse. She did work at the National Homeopathic Childrens Hospital in Washington, D.C. in 1897. She was present at the dedication and unveiling of the Spanish American War Nurses Memorial at Arlington Cemetery in 1905. Ruby was elected as a Vice President of the Spanish American War Nurses branch in Washington. D.C. She died young at 44 years old. Old family members have reported that her death was related to a disease she contracted during her war service, and probably malaria. She could have been buried at Arlington but instead was buried at Congressional Cemetery with a son that had died in infancy.

This information drew me to researching these brave women who served in the Spanish American War in 1898. I learned that since the Civil war ended and until the Spanish American all nurses in the military were men. These were usually infantrymen who were reluctantly assigned to do this work and were poorly trained as corpsman. It is thought that they were not using good sanitary practices and were often the actual cause of the spread of diseases in the camps. The Surgeon General at the time initially believed that women were "out of place"[1] in the military. It was acceptable to him however that 250 Sisters of Charity and other religious orders volunteered their services, but it was a totally insufficient number to assist the thousands of men suffering from the diseases of typhoid fever, yellow fever, dysentery, measles, and malaria. It is a fact that seven times the number of deaths in this war were caused by disease rather than battle wounds. It is known that most of the army was decimated by disease before the fighting actually began.

In April, 1989 the Surgeon General made a request to the US congress to employ nurses under a contract and make an agreement for their payment. Dr. Anita Newcomb McGee, the Vice President of the Daughters of the American Revolution was appointed to select nurses for service in the Army. They were to receive either $30 dollars a month in the US and $50 if out of the US, plus room and board.[2] Most served in hospitals in the US but some were sent to Cuba, the Phillipines and aboard ships. The now famous Army nurse Clara Maass served in a special Hospital in Cuba for Yellow fever victims. She volunteered to participate in an experiment to be bitten by a mosquito that had fed on a victim with a mild case of Yellow Fever thinking that this would give immunity. She received seven such bites and she actually died of the disease.[3] Clara Maass Medical Center in East Orange, NJ named in her honor is still in existence today.

Eventually more than 1500 female, all graduate nurses,[4] served in the Army during this war. The living and sanitary conditions for the women nurses were deplorable in this patriarchal military society. You can read actual accounts by googling Spanish American War nurses. It was proven that these female graduate nurses made a tremendous impact on the health and well being of the Army. This led to one of the great outcomes of the Spanish American War, the formation of the US Army Nurse Corps (female) becoming permanent in 1901. It took five years to raise the funds and get approval for the Spanish American War Nurses Memorial in Arlington Cemetery. It took another 20-30 years to get official recognition for their service.

Some of these brave women who sacrificed so much, in some cases their lives, did not receive pensions. Many like my husbands grandmother died before she even had the right to vote.

We must thank, honor, admire and remember these strong courageous and caring women from so many years ago.

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Telehealth and Social Media Usage Since COVID-19: How the Pandemic Has Forced Healthcare Change in 2020

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Telehealth and Telemedicine

Eight years ago, I was introduced to the concept of telehealth, and the potential use of technology as a means of delivering medical and behavioral healthcare at a distance to rural areas and large agricultural communities. According to The National Organization of Nurse Practitioner Faculties (NONPF), telehealth is defined as "the use of technology to provide healthcare services at a distance including direct patient care, remote monitoring, and education" (Rutledge et al., 2018, p. 1). Telehealth includes both clinical and nonclinical aspects of healthcare, such as administration and financial services, while telemedicine is a narrower term limited to the provision of clinical services. Although the concept of telemedicine seemed logical and within our nation's technological capabilities, there have always been stringent conditions and regulations regarding its use. For example, reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other health insurance companies has been complicated and inadequate. These conditions clearly discouraged providers from utilizing telehealth technology in practice.

Regulations and reimbursement practices quickly changed due to the circumstances of the COVID-19 pandemic. Recently, the U.S. Congress passed the Emergency COVID Telehealth Response Act, which allowed all providers the ability to furnish telemedicine services eligible for Medicare reimbursement (U.S. Congress, May 1, 2020). This act improved access to health care during the pandemic by providing compensation of medical services without face-to-face interaction. Jerich (2020) noted, "The relaxation of telehealth regulations in response to the COVID-19 pandemic has triggered a wave of interest and support, with patients noting the convenience, discretion, and safety of virtual care as a major selling point" (p. 1).

Increased Use of Telehealth

Even prior to the pandemic, there has been an increase of telemedicine-related services across all sectors of healthcare. Advancements in technology, electronics, computers, and the internet have made healthcare delivery possible through telemedicine (Claypool, 2019). A few years ago, NONPF suggested that telehealth be incorporated into the core curriculum of nurse practitioner (NP) education, so students could become knowledgeable and proficient at delivering healthcare in this manner (Rutledge et al., 2018). Presently, the COVID-19 pandemic has forced us into a situation that warrants the use of telemedicine in order to safely deliver healthcare. According to Webel et al. (2020), the response to COVID-19 has included an astonishing increase in telemedicine usage and applications. For example, since the outbreak of COVID-19, my stepfather, a psychiatrist, has conducted the majority of his patient visits through the application doxy.me. This provides him a safe, reliable, and fairly easy way to deliver healthcare while maintaining social distancing. Prior to the pandemic, my stepfather only used telemedicine to deliver care to patients in rural areas. Puro and Feyereisen (2020) reported that prior to COVID-19, rural areas were already utilizing telemedicine as a means to deliver healthcare. They concluded that urban areas hard-hit by the pandemic have the potential to improve outcomes by exploiting this same capability. The COVID-19 pandemic has opened up a sort of "Pandora's Box" of developments in technology use that leads to the question: How can providers best use technology during this pandemic to improve both business practices and benefit patient outcomes?

Social Media in Healthcare: Implications for Practice

Increased Use of Social Media

Social media has become ubiquitous in our culture, with more and more users being added daily. According to Ventola (2014), the term "social media" has a "constantly evolving" definition but can be loosely defined as "internet-based tools that allow individuals and communities to gather and communicate; to share information, ideas, personal messages, images, and other content; and, in some cases, to collaborate with other users in real time" (p. 491). Ventola (2014) identified categories of social media tools as:

Social networking (Facebook, MySpace, Google Plus, Twitter),
Professional networking (LinkedIn),
Media sharing (YouTube, Flickr),
Content production (blogs [Tumblr, Blogger] and microblogs [Twitter]),
Knowledge/information aggregation (Wikipedia), and
Virtual reality and gaming environments (Second Life).

Ventola reported that over 70% of healthcare organizations, systems, and companies use social media to their benefit, with the most popular being Facebook, Twitter, and YouTube.

Benefits of Social Media in Healthcare

The benefits of social media are multiple. It can be used locally, regionally, nationally, and even world-wide. For example, a healthcare provider (HCP) working as an infectious disease specialist out of London, England, can utilize a social media application to connect with another HCP in a third-world country like Somalia. Another example is how certain medical and surgical procedures can now be streamed via YouTube. Social media signals a new era of communication and networking, where HCPs can exchange information and knowledge at an unparalleled rate (Ventola, 2014). I recently performed a Google search (www.google.com) and found that Facebook alone has over a billion users. With such a large audience, social media has the potential for a tremendous impact on patient empowerment and outcomes. It can facilitate dialogue between sizable groups of providers and patients, as it offers quick and widespread communication (American Hospital Association, 2018). In a systematic review of social media in healthcare, Smailhodzic et al. (2016) reported that patients found social media to be a helpful tool for social, emotional, and informational support in healthcare.

Social Media Obstacles

The negative aspects of social media include potential loss of privacy, being targeted for promotions and labeling, and addiction to social media itself. These disadvantages are complicated by numerous factors. First, there are no encompassing social media standards to guide its appropriate use in healthcare. The American Nurses Association's (ANA) social media guidelines and tips specify that nurses must use the same professional standards online as in other circumstances and also need to develop organizational policies and ensure privacy settings are in place when using technology (ANA Enterprise, n.d.). The American Medical Association's (AMA) Journal of Ethics recommends that online behavior should reflect "offline professional conduct found in-person" as a starting point (Kind, 2015, p. 442). They also suggest that social media guidelines should help users address opportunities and challenges that arise in new platforms.

Although many HCPs would never deliberately commit a violation of patient privacy, many end up doing so by simply posting online about their day at work (Sewell, 2019). Patient privacy is also under the constant threat of unauthorized users trying to illegally access sensitive information. Malicious security breaches include: social media intrusions, identity thefts, phishing scams, malware, misinformation, and misuse of sensitive medical information. While most providers do maintain high ethical standards when using social media, this does not guarantee that the platform will exist without issues and non-professional behavior (Claypool, 2019).

Facilitating Patient Use of Social Media in the Pandemic

At the hospital where I work as a critical care nurse, mandatory physical distancing requirements are in place and have resulted in restrictions to visitation rights for patients/families and limitations on staff meetings. These policy changes have led to greater use of technology applications such as secure work chats and use of Facetime and Zoom to help our patients communicate with loved ones. On my current unit, the staff often connect family/friends on a tablet at a scheduled time. Once all participants are accounted for, we place the tablet on a secure stand next to the bedside, and the family can interact with their loved one while we assume care of other patients. The process is not perfect but overall has been well received.

Patients throughout the U.S. are not limited to a single avenue of social media for encounters with their providers. The variety in online communication methods is rapidly increasing, and patients can often choose the platform they prefer. Although the opportunities for social media seem promising, there are still many obstacles and challenges to overcome. Examples include limited access to the internet or devices (computers and smartphones) and limited user knowledge regarding such technology. These barriers are typically more prevalent in the poorer/rural communities (Koonin et al., 2020).

From my experience working in an ICU during this pandemic, families have been able to communicate with their loved ones infected with COVID-19 through social media, the most popular choice being Facetime. My co-workers and I welcome the use of such communication options, as we witness firsthand the feeling of isolation and helplessness our patients are experiencing. In the past, many clinicians were wary about using social media as a method of communicating with patients and their families (Ventola, 2014). However, it is now considered commonplace amongst hospitals/clinics, colleges, businesses, and many other organizations. Users are finding that it provides a sense of community and sharing that was unimaginable years ago (Sewell, 2019).

I predict that social media and telehealth will continue to see favorable acceptance by providers; the public's response and acceptance during the pandemic suggests that its use will continue to grow. However, as we gain access to more technology and scientific evidence, there is also a growing need to govern and legislate the appropriate use of the information available (Kind, 2015). Evaluating the safety, privacy, and quality of information being delivered remains a cause for concern.

Conclusion

With the rapid advancement of telehealth and the use of social media, it seems clear that a high percentage of patients and providers will continue to use this technology after the COVID-19 pandemic comes to an end. Koonin et al. (2020) found that consumers use social media as a complement rather than a replacement to healthcare services. Whether a provider is treating the patient face-to-face or online, the standards of professional behavior should remain the same: Providers should maintain their integrity, respect, and compassion for others. If committed to these principles, HCPs will be able to use social media for educational purposes, networking, quality improvement initiatives, satisfaction surveys, and measuring outcomes (Kind, 2015). As long as social media and telehealth are consistent with current models of ethics, such as the ANA Code of Ethics for Nurses with Interpretive Statements (ANA, 2015), these technological advancements will augment what providers are capable of offering (Sulmasy et al., 2017). The COVID-19 pandemic has been a tragedy and struggle for so many people worldwide. However, one silver lining is the opportunity to evaluate the success of telemedicine and the ways that it has helped us provide better medical services during this challenging time.

The author reports he has no conflicts of interest with this content.

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Will Your Next Prescription be for the Pharmacy or the Farmacy?

Joanne Evans, MEd, RN, PMHCNS-BC, ISNA Member

Reprinted with permission from Indiana The Bulletin, February 2021

Almost 2500 years ago Hippocrates said "Let food be your medicine and medicine be your food." These words are still relevant today. Some diseases are acute while others are chronic. Those that are chronic may include heart disease, hypertension, diabetes, asthma, arthritis, COPD, kidney disease and some cancers.

The leading causes of death in the US from disease are heart disease, followed by cancer, chronic lung disease, stroke, Alzheimer's, diabetes and chronic kidney disease. Diabetes is actually the fastest growing chronic disease in the US. In 2017, Indiana was ranked 6th in the country with diabetes being the leading cause of death and 13th in the country with heart disease as the leading cause of death.

In 2014, they counted over 6600 medication prescriptions plus over the counter medications. We can only imagine what the number is today. According to the data from the National Health and Nutrition Examination Survey in 2015–2016, 45.8% of the U.S. population used prescription drugs. Nearly 40% of older adults take five or more prescription drugs. All these medications have side effects including nausea, fever, chills, headaches, itching, wheezing, tightness in chest, vomiting, red and irritated eyes and the list goes on and on. Pharmaceuticals are actually the ones that benefit the most from people being sick.

Is it possible that some of these chronic diseases could be prevented or reversed by nutrition? There has been extensive research for well over 40 years showing how food can be used to treat and sometimes reverse many chronic diseases. There is continual research showing that plant-based nutrition:

- Prevents and reverses heart disease, diabetes and some cancers
- Decreases cholesterol and reduce blood sugar levels
- Decreases obesity and complications from being overweight
- Improves mood, sleep, energy, depression, anxiety
- Reverses many chronic diseases
- Increases work productivity

In a research study in five corporate locations in the US, those practicing plant-based nutrition (PBN) showed improvement in body weight, blood sugar levels, and emotional state including depression and anxiety. In another study, diets that were higher in plant foods and lower in animal foods were associated with a lower risk of cardiovascular morbidity and mortality in a general population. The more people adhered to a healthy plant-based diet, the lower their risk of cardiovascular disease. In regards to obesity, research shows that those who followed a plant-based diet had more weight loss compared to those who followed a vegetarian and non-vegetarian diet that included diary, eggs, fish, or meat at two-month and six-month intervals.

What specifically is plant- based nutrition (PBN)? What does it include?

- Vegetables – dark greens, dark yellows and orange, sweet potato etc.
- Whole Grains – pasta, rice, corn, whole grain bread, tortilla etc
- Fruit – whole fruit which is better than juice due to fiber
- Legumes – beans, peas, lentils, tofu, soymilk, chick peas etc.
- Nuts and seeds
- limited processed foods
- avoiding oil, flour and sugar

With over three million nurses, it seems we could make a dramatic change in health care for people in the US, including Indiana, if we shared information about plant-based nutrition. We all work in a wide variety of settings including hospitals, (state, local and private), ambulatory clinics, outpatient offices, home healthcare, regulatory agencies, organizations, schools, residential care and etc.

I have volunteered to conduct several 21-day plant-based programs utilizing the Physicians Committee for Responsible Medicine (PCRM) which is a free on-line Kickstart program. The results were published in the American Journal of Nursing and the Holistic Nursing Association Journal. I collected lab work on two occasions which supported the research already published. Some people dropped up to 59 points in cholesterol in 21 days while others also lost weight, improved their energy and were sleeping better.

In talking with nurses around the country, there seem to be many reasons nurses do not share information about plant-based nutrition. They reported the following:

- Feel they do not know enough and were worried they could not answer patient's questions
- Think it was too difficult
- Did not know who to refer patients to
- Thought it may be too expensive
- Thought patients may not be interested

When I spoke with nurses around the US, they shared that this form of nutritional information was not given to them in nursing schools. All the nurses interviewed for my book, Cultivating Seeds of Health With Plant Based Nutrition, Nurses Share Educational Approaches to Prevent and Reverse Chronic Disease (available on Amazon) learned about PBN after graduation from their nursing programs. Some learned about it after their own illness and others when a family member became ill. Several nurses saw their patients taking the recommended medications and they were still not getting well. Others recognized that "everything in moderation" was not working. Another group of nurses read the China Study by Dr. Colin Campbell or saw the movie Forks Over Knives, both of which convinced them that PBN was the way to treat many chronic diseases.

Once nurses become knowledgeable about plant-based nutrition, they have many options to share this information including:

- Talking with colleagues about plant-based nutrition (PBN)
- Having plant-based food at all meetings and conferences
- Hosting monthly pot lucks with colleagues and community groups (post Covid)
- Show movies on PBN and discuss the information provided
- Ask more detailed questions about nutrition on intakes with patients including
  - How many fruits did you eat in past 24-48 hours
  - How may vegetables did you eat in past 24-48 hours
  - How many portions of dairy food did you eat I past 24-48 hours
  - How many portions of meat did you eat in past 24-48 hours
  - Have them complete a nutritional assessment - http://4leafsurvey.com
- Have care plans include PBN
- Have discharge summaries include PBN
- Request PBN guest speakers in educational settings for undergraduate and graduate level nursing programs
- Incorporate PBN into all discussions about chronic diseases
- Join a community PBN group or start one
- Collaborate with other health care providers interested in PBN
- Encourage hospitals to have plant-based foods at all meals
- Monthly lunches with discussions on various PBN topics (post Covid)
- Host a free online 10-day (McDougall) plant-based program https://www.drmcdougall.com/health/education/free-mcdougall-program/ or host a free 21-day (PCRM) online plant-based program – including menus, recipes, cooking classes, and additional Information - https://kickstart.pcrm.org/en

There are several groups available specifically for nurses interested in learning more about plant- based nutrition. PCRM hosts the Nurses Nutrition Network which provides educational programs for nurses. https://www.pcrm.org/good-nutrition/nutrition-for-clinicians/nurses-nutrition-network. The American College of Lifestyle Medicine has a nurses' support group and has presentations open to all nurses. https://lifestylemedicine.org/What-is-Lifestyle-Medicine. There is also a new health care professionals group forming in Indiana focusing on PBN and lifestyle to prevent and reverse chronic diseases.

There are about 110,00 nurses in Indiana. Our patients need to have a choice on how they will resolve their chronic health issues and nurses can educate patients so they hear for the first time that there is a nutritional option to prevent and reverse many chronic diseases. Patients should be given all the options to make educated decisions about their health. Sometimes it starts with medication while they are making nutrition and lifestyle changes. Eventually it may be the nutritional changes alone that reverse the chronic disease process. Nurses have an opportunity to educate people to be healthier in Indiana. Let 2021 be the time that it happens!

Resources

Some examples of breakfast might be the following:

- Cold cereal – with soymilk or rice milk with peaches, berries or another fruit
- Whole grain toast with jam and fruit
- Oatmeal with non-dairy milk with cinnamon and raisins
- Blueberry buckwheat pancakes and meat-free bacon

For lunch, you might consider:

- Veggie burger with whole grain bun and salad
- Bean burrito, fruit
- Soy yogurt, fruit, vegetable soup, whole wheat bread
- Hummus wrap with whole wheat pita, shredded carrots, cucumber, tomato

Some options for dinner might include:

- Black bean chili with cornbread, salad, greens
- Whole grain pasta marinara with mixed vegetables, salad
- Fajitas with peppers, onions, tomatoes, beans, broccoli
- Beans and rice with salsa, corn, salad

Resources for learning about plant-based nutrition are the following:

- *Becoming Vegan, Express Edition: The Everyday Guide to Plant-based Nutrition,* Brenda Davis, RD and Melina Vesanto, MS, RD
- *The China Study. Startling Implications For Diet, Weight Loss and Long-Term Health.* T. Colin Campbell, PhD and with Thomas M. Campbell II, MD
- *How Not to Die: Discover the Foods Scientifically Proven to Prevent and Reverse Disease,* Michael Greger MD. FACLM and Gene Stone
- *How Not To Diet*, Michael Greger MD
- *The Starch Solution,* John McDougall MD
- *The Vegan Starter Kit: Everything You Need to Know About Plant-Based Eating,* Neal Barnard MD
- *Prevent and Reverse Heart Disease,* Dr Caldwell Esselstyn

Some good cookbooks are:

- *Dr. Neal Barnard's Cookbook for Reversing Diabetes: 150 Recipes Scientifically Proven to Reverse Diabetes Without Drugs,* by Neal Barnard MD and Dreena Burton
- *The China Study Cookbook* by Leanne Campbell, PhD
- *Engine 2 Cookbook* by Rip Esselstyn and Jane Esselstyn
- *Forks Over Knives–The Cookbook: Over 300 Recipes for Plant-Based Eating All Through the Year,* by Del Sroufe, Isa Chandra Moskowitz, Julieane Hever MS, RD, CPT, Darshana Thacker, Judy Micklewright
- *The Get Healthy, Go Vegan Cookbook: 125 Easy and Delicious Recipes to Jump-Start Weight Loss and Help You Feel Great,* Neal Barnard, MD
- *How Not to Die Cookbook,* Michael Greger, MD
- *The McDougall Quick and Easy Cookbook: Over 300 Delicious Low-Fat Recipes You Can Prepare in Fifteen Minutes or Less,* John McDougall, MD and Mary McDougall
- *Prevent and Reverse Heart Disease Cookbook,* Ann Crile Esselstyn and Jane Esselstyn

Nurses interested in websites might consider:

- Dr. Greger - https://nutritionfacts.org - updated research on nutrition and disease – many short videos
- American College of Lifestyle - https://www.lifestylemedicine.org
- Dr. McDougall - www.drmcdougall.com – free newsletters, testimonials, current research, Starch Based Solution Certificate Program, 10-day residential programs
- Physicians Committee for Responsible Medicine - www.pcrm.org – free monthly Kickstart programs, newsletters, current research, multiple languages, handouts for offices

- Forks Over Knives - https://www.forksoverknives.com/ - recipes, plant-based news, meal plans, success stories, cooking course
- Plantrician Project - https://plantricianproject.org/vision - list of plant-based doctors, peer review journal, conferences, cooking class, research and more

Nurses looking for apps may be interested in:

- 21-DayVegan Kickstart – PCRM
- Dr. McDougall Mobile Cookbook
- Forks Over Knives
- Michael Greger - Dr. Gregers' Daily Dozen

Some good plant-based movies are:

- *Forks Over Knives – especially for diabetes, heart disease and chronic health issues*
- *Code Blue – focusing on medical training and health care system*
- *Game Changers- focus on vegan athletes*
- *Cowspiracy – focus on the environment*
- *Food Inc – food supply and industry*
- *Eating You Alive – food connected to chronic disease*
- *Meat the Truth – livestock farming and the environment*

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Developing a Peer Support Program to Mitigate Compassion Fatigue in Health Care: A Quality Improvement Project

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Nurses are tasked with providing exceptional care for patients and families above all other priorities. However, we may encounter roadblocks when nurses themselves need care. It does not matter what discipline, role or unit; we all have the potential to be negatively affected by the work we do. Caregivers are at risk for compassion fatigue, defined as emotional exhaustion, depersonalization, inability to work effectively and provide empathetic care (Crewe, 2017). Compassion fatigue can be related to exposure to a patient's trauma or simply being a witness to another's despair (Sinclair et al, 2017). As compassion fatigue takes hold, nurses can quickly lose their empathy for patients, families and colleagues and quality of care can suffer (Swensen, 2018). The Compassion Fatigue Awareness Project (2017) notes that this can also lead to conflict amongst staff, increased absences, turnover, lateral violence and inability to honor commitments. The Compassion Fatigue Awareness Project is a great resource which seeks to educate professionals about compassion fatigue, risk factors, signs and symptoms as well as recommendations for wellness.

Organizational resources may not be as available or sufficiently robust to address the needs of employees suffering from compassion fatigue. At our institution, we decided to utilize our most valuable resource, our own staff, to fill this gap by developing our Care for Caregivers program. Through this program, we had high hopes of developing a more empathetic culture. We began by developing a steering team of five individuals who each expressed a particular interest in preventing compassion fatigue, some due to a personal experience of their own. The team included physician and nursing leadership as well as front-line staff members. The bulk of the efforts came from one front-line staff member and a single nurse manager. Over a period of one year (2013-2014), this steering team trained over 90 peer supporters to cover the needs of employees at our 195-bed academic pediatric hospital. Our hospital employs approximately 1,500 individuals, so this was a small, but mighty group of peer supporters.

Training consisted of peer support techniques such as active listening, normalizing emotions, reframing the situation, sharing stories and offering ideas for coping mechanisms and self-care. Referrals to the peer support program began on a paper form but quickly transitioned to an online submission format to allow for a timelier response. Referrals are routed to two members of the steering team who then assign referrals to trained peer supporters. Peer supporters are asked to contact the individual who was referred within 48-72 hours. Referrals are assigned to supporters in like roles or units, to provide a frame of reference and hopefully, benefit from an existing relationship. Supporters are encouraged to identify themselves as members of the Care for Caregivers team to ensure that their knowledge of the event was through secure channels. Confidentiality and respect are emphasized at every step of the process; we want staff to feel comfortable confiding in their peer supporter without fear of gossip or judgment. We maintain program utilization data including number of referrals made, vague reason for referral, role of individual referred and role of individual who submitted referral. We intentionally do not keep any identifying information related to persons or events. The majority of referrals result from traumas and patient deaths, though we have seen a steady increase in workplace violence, possibly associated with higher levels of stress in our community. Most referrals are placed by peers or direct managers, 50% and 31% respectively. Anonymous referrals and self-referrals are permitted though these referrals comprise less than 10% of overall referrals.

Since the program's inception, 1,035 team members have been referred for support; our largest group of recipients are nurses, encompassing 71.4% of referrals. Care has also been offered to physicians, support staff such as respiratory therapists and pharmacists as well as ancillary teams-environmental services and security. We do not ask peer supporters to report back on the content of any discussions they have though we do encourage them to reach out to the steering team if they feel the employee needs more support that they can provide safely. Additional resources available include the employee assistance program, professional debriefings and pastoral care.

While the bulk of the work is conducted by the peer support team, everyone in the organization plays a role. All staff are offered an awareness of the program through new employee orientation and staff meetings. Peer supporters are given monthly information about the program to help encourage referrals as well as proactive ways to support their teams. Leaders are invited to participate by identifying team members who may be interested in becoming a peer supporter, making referrals as needed and attending program events.

The organization was surveyed by the Agency for Health Care Research & Quality in 2014 and again in 2016. In 2014, 56% respondents shared that they experienced a patient safety event that caused anxiety, depression or concern about their ability to perform their job-only 16% of those respondents felt adequately supported by the hospital. In 2016, 15% of respondents experienced such an event while 83% felt adequately supported by the hospital.

We have been able to maintain a core group of 75-90 peer supporters and have been able to encompass a more diverse group - including physicians and ancillary team members. For the first few years of the program, we offered four training sessions per year - now we are able to maintain a sufficient amount of peer supporters with one or two sessions per year. Peer supporters are provided monthly communication about the program. Our daily leadership huddle provides a reminder for leaders to submit referrals for events within the last 24 hours.

As our program matures, we have been able to offer a more proactive approach in addition to our referral response. Monthly sessions are provided on self-care, techniques for mindfulness and resilience. Popular activities include yoga and meditation. Participation in our monthly programs averages from 20-60 employees and we are exploring methods to bring these activities to the bedside to reach more staff in their own work environments.

Our program incurs very little cost. Initially, we spent about $250 per year, funded by our own bake sales. In 2019, our Care for Caregivers program became part of our employee appeal and now garners donations from our own employees. Most of our funds are spent on supplies for self-care activities (journaling, art therapy, etc.) and candy offered for program publicity. Several staff members donate their talents in yoga and guided meditation. The generous gift of a private donor this past year has allowed us to hire a program manager with professional counseling experience. In the future, we plan to provide a quiet space for employees to decompress after challenging events or have a forum to learn self-care techniques whenever it is convenient. We will continue to follow employee engagement data related to support of the organization during traumatic events as well as program utilization, first year turnover and employee retention. Culture change is a slow process. However, dedicated efforts from the front-line coupled with leadership support can make a tremendous difference.

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