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ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

April 2022

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

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PRESIDENT'S MESSAGE

Marilyn L. Dollinger, DNS, FNP, RN

I hope that this message finds all of you taking a quick pause from the Omicron surge that impacted so many across the country over the holiday season and into the winter. The devastating increase of illness, hospital admissions and ICU patients was an unwelcome addition to everyone's holiday plans.

The cumulative strain on the current nursing workforce from the pandemic is unprecedented. To be clear, a significant nursing shortage was evident before the pandemic, but the frustration and burnout that nurses and all front line providers in the healthcare workforce in New York State and across the country are experiencing, is at a crisis level.

Professional nursing associations, your "professional home," have never been more important. **At all levels of government, money is being funneled to nursing and healthcare workforce initiatives. The funding for proposed grants and programs MUST have the input of nursing leaders who are listening to what frontline nurses need.**

We must have programs that have an impact on retention: staffing levels in all settings; pay that reflects the challenges of surviving frontline conditions; and, safe workplace environments. Capacity in nursing education programs is also important but until workplace conditions are addressed effectively—the "leaky bucket" of nurses entering the workplace and leaving again will continue in this vicious cycle.

I know many of you live this every day. I want to make sure that each of you know about the advocacy that is going on at the state and national levels.

Our ANA-NY lobbyist, after discussions with the Legislation Committee and Board, is working closely with Governor Hochul and legislators in both the Assembly and Senate to make sure that 2022 budget funds are directed strategically to address priorities that will have a positive and specific impact on nurses in New York State.

On February 2, I was interviewed by the editor of the *Journal of Health Care Finance* about nursing workforce issues. This was an opportunity to amplify the voices of nurses across New York State and share their concerns about staffing levels, pay, and workplace violence, among other issues. ANA-NY will share the link for this audio interview when it is available.

At the national level, Dr. Ernest Grant, ANA President, convened a nurse staffing "think tank" January 11, 2022 (https://www.nursingworld.org/practice-policy/nurse-staffing/nurse-staffing-think-tank/) to meet six times between January and March to identify strategic priorities for the National Staffing Task Force that launches in late March. Members of the Task Force include the American Association of Colleges of Nursing (AACN), American Organization for Nursing Leadership (AONL), Healthcare Financial Management Association (HFMA) and Institute for Healthcare Improvement (IHI). **This coordinated and informed "voice" from nursing and healthcare stakeholders is essential.**

ANA-NY also has initiated several programs to support nurses in New York State while legislative and regulatory solutions are being considered. If you need support or are considering a change in your nursing career, please access the member benefit services below:

- All ANA-NY members will now have access to a professional coach as one of their member benefits. Phyllis Quinlan PhD, RN, NPD-BC will provide a free 90 minute coaching session for up to five ANA-NY members per month. Visit Dr. Quinlan's website (https://mfwconsultants.com/) to learn more about her and watch for more information on the ANA-NY website and in the quarterly ANA-NY newsletters.
- *Nurses Supporting Nurses* is a peer support program that pairs trained ANA-NY members to other members in distress for free, confidential, and empathetic peer support. See more about

President's Message continued on page 2

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FROM THE DESK OF THE EXECUTIVE DIRECTOR

Spring has sprung!

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

We have a jam-packed issue for you this quarter. Be sure to look for:

- An introduction to our newest member of the office team, Ana Quian, Member Engagement Associate
- Scholarship and grant opportunities
- An article on Black History and Women's History
- Legislative news from our lobbyist
- Accomplishments of our members in Members on the Move
- An article on geriatric care education
- Upcoming events
- An informative, and funny article on bedpans
- Highlights of the ANA-NY Board activities in Board Buzz
- An article and other important information from the Center for Nursing Research
- Member benefits
- An article comparing the pandemics of 1918 and 2020
- A statement from the ICN on the invasion of Ukraine

Don't forget to visit our website to view the latest issue of JANANY, our peer reviewed scholarly journal.

President's Message continued from page 1

this program on the ANA-NY website (https://ananewyork.nursingnetwork.com/page/96232-requesting-supp)

- *Terra Firma for Nurses*, an app that provides six months of online coaching and resources after completion of the Stress Release Program (15 CNE from ANCC) for $69.95. Watch for updates about this member benefit on the website and in future newsletters.

Let us know how you are doing and what you need to stay healthy and feel supported on the frontlines. Please make plans to join us for the annual meeting October 27-29, 2022 in Niagara Falls. I look forward to meeting you and celebrating the incredible dedication and contributions of all members.

ANA-NY IS 8,300 MEMBERS STRONG

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- Email: programassociate@anany.org
- Subject Line: *ANA-New York Nurse* Submission: Name of the article
- Must include the name of the author and a title.
- ANA-NY reserves the right to pull or edit any article / news submission for space and availability and/or deadlines
- If requested, notification will be given to authors once the final draft of the *ANA - New York Nurse* has been submitted.
- ANA-NY does not accept monetary payment for articles.

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FROM THE DESK OF THE HISTORIAN

A PROUD LEGACY

Gertrude B. Hutchinson, DNS, RN, MA, MSIS, RN,
Assistant Professor Nursing, Russell Sage College

As you read this month's issue, spring is here, and hopefully, the crocuses and hyacinths are starting to emerge from their winter hibernation. This column's creation started on the cusp of two important months – the terminus of Black History Month and the beginning of Women's History Month – so my thoughts revolved around a way to include both. What historical event in nursing linked with spring? The eureka moment came as I saw Dr. Janice Gray's book *The Alumnae Association of the Lincoln School for Nurses, Inc. 1902-2002: 100 Years of Service to the Nursing Profession and Society (2002)* on my bookshelf—talk about the formation of the Lincoln School for Nurses and its impact on our profession. Her text is the foundational source for this column, and unless otherwise noted, all quotations come directly from Gray's text.

"In May of 1898," Gray wrote, "an unheralded but ultimately significant event [took] place in The Bronx, New York." A newly opened school, the "School for Colored Females in Nursing Arts at the Colored Home and Hospital" began accepting its first students to train as nurses – with the caveat that this care will be for "colored women." Two years later, the AJN Vol. 1, 1900, listed the location of the school and named its first six graduates: "Misses Grace G. Newman, Nettie F. Jarrett, Annie L. Marin, Gertrude Johnson, Margaret M. Garner, and Mrs. M. E. Harris." In 1902, the name of the school was officially changed. Young women of color came from all over the United States and many foreign countries to attend the Lincoln School of Nursing (LSON). Following its final graduation in 1961, 1,864 young Black women proudly held the titles of Lincoln School of Nursing alumnae and registered nurses. While time and space precludes discussing all of these women's accomplishments, let me highlight just a few.

Mrs. Adah Belle Samuel Thoms, Class of 1905, became a leader in nursing at Lincoln and a champion for desegregation of the profession. Mrs. Thoms organized a group meeting of Black nurses to discuss issues facing them in the early 20th century. August 28, 1908 marked the first meeting of the National Association of Colored Graduate Nurses (NACGN). Several peers of Mrs. Thoms were charter members. NACGN representatives joined the International Congress of Nurses (ICN) at the invitation of Miss Lavinia L. Dock. From there, Thoms set her sights on the issues of public health.

In 1917, in her position as Acting Director of LSON, Thoms added public health nursing courses into the curriculum of study. She pushed on to break the defacto Jim Crow laws by urging Black nurses to join the American Red Cross and the Army Nurse Corps. At first, the doors were closed to them, but letters between Mrs. Thoms and Miss Jane Delano had the desired effect: eighteen Black nurses entered the Army Nurse Corps. Three of the 18, Pearle Helen Billings, Francis Alberta Stewart, and Anna Elizabeth Olive Ramos – all LSON graduates Class of 1918 – served during the Flu Epidemic of 1918 stateside at Camp Grant, Illinois. Mrs. Thoms helped win the day.

Dr. Mary Elizabeth Lancaster Carnegie, Class of 1937, was a soft-spoken, powerful nurse who left a meaningful legacy. She was an educator, a civil rights groundbreaker, an historian, a mentor, and a prolific author. As a regional officer of NACGN, and a representative to the Florida State Nurses Association (FSNA), she won election for the FSNA thereby achieving desegregation of that organization. Dr. Carnegie was the chief editor of Nursing Research. She was teaching and mentoring students up to a week before her death. As a point of personal privilege, meeting Dr. Carnegie and having one-on-one time with her was a highlight of my life.

No article about LSON would be complete without discussing Mrs. Ivy Nathan Tinkler, Class of 1931. Mrs. Tinkler made history in 1954 as she assumed leadership of the LSON as its Director while simultaneously becoming the Director of Nurses at the Lincoln Hospital and Home. She was the first alumna and woman of color to hold these positions and shape the lives of generations of Black nurses. She served on the NYS Board of Nursing for many years and she helped promote health and wellness in her nursing and faith community of St. John's Episcopal Church and received numerous awards as a result.

Thanks for reading this column and learning, or re-learning about these nurses who paved the way for so many others in so many ways. Until the next issue,

Trudy

BOARD BUZZ

On behalf of our members, the Board of Directors:

- Approved the transition to a new, more customizable website over the coming year
- Endorsed 10th Annual Conference theme: Sowing the Seeds of Nursing's Future
- Endorsed exploration of 40 under 40 member recognition program
- Approved Personal Coaching member benefit
- Decided to rework our former Future Nurse Leader Award program. Awards will be suspended for 2022 with goal to launch new program in 2023.
- Modified Awards policy to allow previous nominators and nominees to be contacted to refresh their packets for resubmission for future award
- Endorsed procedure for NSANYS engagement during our annual conference
- Endorsed 10 by 10 membership growth initiative
- Welcomed Ana Quian, Member Engagement Associate to the ANA-NY office team
- Endorsed Program Committee programs
  - o Resilience Building Blocks webinar on 3/30/22 @ 4p
  - o Books & Brunch reading group on 4/9/22 @ 11a
  - o Jones Beach State Park Field 10 Clean-up on 4/30/22 @ noon
- Endorsed exploration of creating an ANA-NY podcast in 2024
- Welcomed guest, Dr. Susan Birkhead, RN, who reported on the Capital Region Charter School
- Received monthly reports from our lobbyist, Amy Kellogg, JD, Esq., on the budget proposals and negotiations. These updates are particularly relevant as there are numerous nursing and healthcare proposals being put forward in NYS.

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

Call for Scholarship Applications!

The Center for Nursing at the Foundation of New York State Nurses, Inc. is pleased to announce the St. Luke's Hospital School of Nursing Alumnae Association

2022 Nurse Educator Scholarship Program

A $3,000 scholarship will be awarded to a qualified registered nurse advancing his/her education to complete academic credentials for a nurse educator position.

Eligibility criteria, application and reference forms are attached or can be obtained from Deborah Elliott, Center for Nursing at 518-456-7858 or delliott@cfnny.org

Application deadline is June 17, 2022

Scholarships will be awarded by August 2022

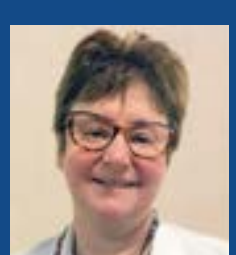
“We don’t count the days. We make the days count. We’re Calvary Nurses.”


Latisha Russell, RN, CCC
Bronx Campus Nurse


Shawn Boyd, RN
Bronx Campus Nurse


Kevin Nyack, RN
Hospice Nurse


Kelly Saulnier, RN
Hospice Nurse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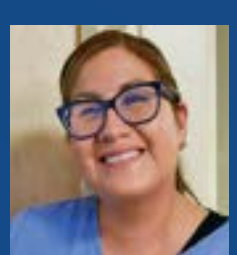
Brooklyn Campus
Nurse Administrator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Lisa Irwin, RN
Hospice Nurse

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LEGISLATIVE UPDATE

By Amy Kellogg and Caiti Anderson

The 2022 legislative session began on January 5, 2022, when Governor Kathy Hochul delivered her first State of the State address. A few short weeks later, she unveiled her proposed $216 billion state budget. This budget proposal is starkly different from the 2021-2022 budget. Last year, New York was facing a multi-billion-dollar deficit. Now, the state has a surplus of nearly $13 billion, thanks to federal COVID-19 recovery funds, increased income taxes on high-earners, and better-than-anticipated sales tax collection. Looking to the future, the Governor is hoping to increase the state's reserves to 15% of the state's operating budget by FY 2025 so that the state is better prepared for the next crisis.

The budget was all-consuming until the budget deadline on April 1. Included in Governor Hochul's proposed budget were several proposals that would directly impact the nursing profession in New York. The first proposal that we reviewed and discussed was a proposal to add New York to the Nurse Compact License. The Nurse Compact proposal allows nurses from other Compact-Member States to practice nursing in New York. There was also a proposal for certain healthcare workers to receive a one-time bonus. As it was initially drafted, the proposal would allow for healthcare workers making $125,000 or less annually to receive one-time bonus of up to $3,000. A separate proposal would expand the Nurse Loan Forgiveness Program. This program would repay the loans of nurses who work in areas determined by the Department of Health to be "underserved communities" for three consecutive years.

Another proposal would create a community paramedicine model in New York. This proposal would broaden the definition of emergency medical service to include, among other things, the ability to provide preventative care in a non-emergent situation. The Governor's budget also contained a proposal to make the Nurse Practitioner Modernization Act permanent. Finally, there was a proposal that would move the oversight and licensure of all healthcare professionals, including the nursing profession, from the State Education Department to the Department of Health. This proposal has been met with resistance from the State Education Department and a number of legislators.

As of the writing of this article, we are awaiting the release of the Assembly and Senate one-house budget proposals, which are their response to the Governor's proposed budget. Once we have those budget proposals, the negotiations toward a final budget by the April 1, 2022 deadline happened. It's not until those final negotiations are completed that we will have a clear picture of which of the above proposals will be included and which will be eliminated and/or modified accordingly. We will be sure to include an update on the outcomes in our next update.

Once the budget is complete, we will exclusively focus on non-budget issues until the conclusion of the legislative session on June 2, 2022. We will continue to work with the Legislative Committee and the Board to weigh in on issues impacting the profession throughout the course of this legislative session. The legislature is still fully remote at this point, but we are watching carefully to see if there will be an opportunity for an in-person lobby day. Even if we are able to do an in-person lobby day, we will still have a virtual component for those that won't be able to make it to Albany, so stay tuned for those details. We are targeting National Nurses week for these activities.

In addition to our legislative work, we are assisting in the preparation of comments to submit to the State Department of Health on their proposed safe staffing regulations. The draft regulations were released in mid-February, and comments on the proposed regulations are due by April 18, 2022. The Department of Health must assess all comments that it receives, which may or may not lead to the proposed regulation being revised. If the proposal does not undergo a substantial alteration, it will be adopted by the Department soon after the comment period closes.

While we are dealing with a very active legislative session, we are also dealing with the fact that 2022 is an election year, and many of those races are taking up a lot of the air in the room. All 213 members of the New York State Assembly and Senate are up for reelection, as well as all four statewide offices (Governor, Lieutenant Governor, Attorney General and Comptroller). At the federal level, all House seats are up for reelection, as well as Senate Majority Leader Charles Schumer. These races are all set against the backdrop of redistricting, with New York losing a seat in the House of Representatives. New York's independent redistricting commission failed to come to a consensus in drawing the legislative maps, leading the State Legislature to adopt their own maps. The maps are being challenged in courts by a group of New York voters who are arguing that the maps are gerrymandered.

In terms of who is running for office, there have been some significant shakeups. In December 2021, Attorney General Letitia James suspended her gubernatorial campaign and announced that she would instead seek reelection to her current post. She is now the only Democrat running for Attorney General. Governor Kathy Hochul is the clear frontrunner for the Governor's office, but is facing primary challenges from Jumaane Williams, the current New York City Public Advocate, and Tom Suozzi, a Long Island Congressman. On the Republican side, the frontrunner to be their Gubernatorial candidate is Lee Zeldin, a current Congressman from Long Island. He is facing a primary challenge from Rob Astorino, the former Westchester County Executive, Andrew Giuliani, the son of Rudy Giuliani and Harry Wilson, a businessman who had previously run as the Republican candidate for Comptroller. For Attorney General on the Republican side, there are three announced candidates, Michael Henry, Joseph Holland and John Sarcone.

In the State Assembly and Senate, we are anticipating that we will see a lot of new faces in Albany next year. To date, a number of veteran Assembly and Senate members have announced that they will not be seeking reelection to their current posts. In addition, there has been an increased number of primary challenges announced in both houses. Of note, Assemblymember Dick Gottfried, the chair of the Assembly Health Committee has announced that he will be retiring at the end of this term. He is the longest serving member of the legislature and has been a champion of healthcare issues for years. His retirement means that we will see a new Assembly chair of the Health Committee for the next legislative session.

While we mention these legislative races so that you are familiar with what you will see at the ballot during the primaries in June and the general election in November, we also mention these races to remind you that ANA-NY now has a Political Action Committee (PAC). The ANA-NY PAC will be supporting candidates that support the profession and issues of importance to our members. We urge you to visit the ANA-NY PAC web site and make a donation.

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.

Cathryne A. Welch
Center for Nursing Research

CALL FOR AUTHORS

Evidence You Can Use
Regular column in the ANA-NY newsletter

1. **Purpose**: to highlight an Evidence Based Practice (EBP) project, quality improvement project, comprehensive narrative literature review, or other scholarly project presented in a manner that will encourage readers to look further at the evidence about this topic and how it might inform their practice, be replicated, and/or be implemented.
2. **Target audience**: all nurses, especially administrators, managers, and direct care providers.
3. **Format**: Word file, 12 pt font, single spaced, approximately 1500 – 2000 words.
4. **Guidelines**: Tone should be conversational. References should be included in APA format. The take home message(s) should be explicit. Include names and affiliations of all authors.
5. Submissions from students will be accepted; they must be reviewed and submitted by their faculty advisor.
6. Submissions and questions should be sent to Deb Elliott at delliott@cfnny.org

Mary J. Finnin Grant for Nursing Innovation in Oncology

Award Intent: To assist a qualified registered professional nurse who are currently or interested in pursuing nursing innovation in the field of **oncology**.

Amount of Award: This is a one-time award totaling **$5,000**. This amount may be split between multiple grants depending upon the need and at the discretion of the grant selection committee. Preference is given to projects which will be completed within 24 months of the receipt of the grant.

Eligibility and Use of Funds

To be eligible to apply for the Mary J. Finnin Grant, the applicant must:

1. Hold licensure as a registered professional nurse in New York State;
2. Have a baccalaureate or higher degree in nursing from a nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE); and
3. Reside in and/or practice professional nursing in New York State.

Preference will be given to professional nurses who have a clinical mentor or advisor available to assist with the project.

Appropriate Use of Grant Funds

Grant funds may be used to support:

- Salaries for assistants (e.g., tape transcription)
- Travel expenses incurred while collecting data
- Photocopying
- Postage
- Equipment to support the data collection process (e.g., tapes, tape recorder)
- Participant reimbursement
- Poster development

For more information and to download the grant application packet visit the Center for Nursing website at www.cfnny.org and click on the Awards, Scholarships and Grants link on the Home page.

EVIDENCE YOU CAN USE

Heparin Versus Normal Saline for Occlusion Prevention in Central Venous Catheters

Kristen Kelly BA, BSN, RN, Upstate Medical University in Syracuse, NY, FNP graduate student, Le Moyne College, Syracuse, NY
Gina Myers PhD, RN, Adjunct Professor, Le Moyne College Nursing Department, Syracuse, NY, Research Consultant, St. Joseph's Health, Syracuse, NY.

Vascular access devices (VADs) are a means of delivering lifesaving treatments to those who cannot receive them in the conventional way and can be inserted peripherally or centrally. Peripherally inserted venous catheters (PIVC) extend a few inches into a peripheral vein and allow for the delivery of intravenous medications with minimal complications. Central venous catheters (CVC) are inserted either peripherally or centrally and end in larger veins such as the proximal third of the superior or inferior vena cava. CVC types include tunneled, non-tunneled, peripherally inserted central catheters (PICC), and implantable ports (López-Briz et al., 2018).

Approximately three million CVCs are placed in patients yearly in the United States (Edgeworth, 2009) to deliver vesicant medication classes since peripheral delivery can lead to tissue necrosis (Bradford, Edwards & Chan, 2015). However, after prolonged use, CVCs can either partially or completely occlude.

If a catheter is functioning properly, infusions flow freely and there is an obtainable blood aspirate (Bolton, 2013). Partial occlusions occur when the clinician can flush the catheter but not aspirate blood. Complete occlusions result in the inability to freely flush the catheter or aspirate blood. If the clinician is unable to verify CVC placement with flushing and blood aspirate it is considered occluded (Zhong et al., 2017). CVC occlusions can be further subcategorized by type of occlusion such as mechanical, chemical (precipitate by drugs/mineral deposits) or thrombus or fibrin sheath formation (Zhong et al., 2017). Interventions for resolving catheter occlusions depend on the partial or complete nature, as well as the subtype of occlusion.

Mechanical occlusions can be resolved by visually looking for an external occlusion source such as a suture being too tight. Chemical occlusions depend on the blockage inside of the catheter. If the chemical occlusion is from a lipid source such as total parenteral nutrition (TPN), then sodium bicarbonate 0.1% or hydrochloric acid can be instilled and withdrawn to dissolve the lipids. Occlusions related to a thrombus are typically resolved using anti-coagulation such as Alteplase or tPA (Bolton, 2013).

Heparin cannot be used to restore patency of an occluded CVC but can be used to prevent an occlusion. Anti-coagulation methods to dissolve a thrombus include Urokinase or Alteplase (rtPA). If these do not resolve the occlusion, replacement of the central line becomes necessary (Bolton, 2013). The formation of a clot can be a breeding ground for bacteria leading to an infection of the central line (López-Briz et al., 2018). The occlusion and subsequent replacement of a central line can halt the treatment process, increase morbidity, mortality, and lead to greater spending of healthcare dollars (Zhong et al., 2017).

Heparin and 0.9% Sodium Chloride are both used to prevent the formation of a CVC obstruction related to a thrombus or fibrin sheath. It is common practice to flush with heparin or normal saline to maintain the patency of the CVC (Bolton, 2013). Heparin is used for its anti-coagulant properties to prevent blood clot formation in the central venous catheter. However, Heparin has its own potential risks including coagulation disorders, Heparin-induced thrombocytopenia (HIT) and other adverse reactions (Zhong et al., 2017).

Due to these potential risk or complications, researchers have sought safer alternatives for preventing CVC occlusions (Zhong et al., 2017) such as the use of normal saline with a push-pause technique and a positive pressure lock. This method may be just as effective at decreasing fibrin sheath formation as Heparin (Bradford et al., 2015).

Another common practice to avoid catheter occlusions, thrombus formation or catheter bloodstream related infections are proper flushing and locking techniques. These primary interventions prevent blood from back flowing into the lumens of the central catheter and therefore decrease occlusion risk (Zhong et al., 2017). However, a standardized guideline for flushing methods or solutions is lacking and flushing procedures lack consistency across healthcare institution. To this point, a survey conducted in ICUs across the United States found 31% of clinicians flushed with Heparin while 64.4% flushed with 0.9% Sodium Chloride (López-Briz et al., 2018).

Purpose

The most common cause of occlusions is related to thrombus formation such as a fibrin sheath which encases the outside tip and inner cannula of the CVC within one to 14 days after insertion (Zhong et al., 2017). This leads to a lack of blood aspirate or resistance with flushing (Bolton, 2013). Using the correct flushing solution could reduce the cost that results from central line complications such

as the need for rtPA and central line exchanges, as well as further decrease the risk of morbidity or mortality of patients due to central line complications. This led to the formation of the PICO question "In patients with central venous catheters, is flushing with Heparin or Heparin Sodium in comparison to 0.9 % Sodium Chloride better at decreasing the risk of fibrin sheath development?"

Search Strategy and Selection Criteria

To answer this question, a search of the electronic databases included Cochrane, PubMed, Biomedical Central, and Google Scholar. Search terms included flushing central lines, central venous catheter, heparin, saline, 0.9 % Sodium Chloride, occlusion, and systematic review. Studies were excluded based on non-relevance, pediatric studies, non-systematic reviews, and those not written in English. For this review three systematic reviews with meta-analysis and one clinical practice guideline were included.

Synthesis of Current Knowledge

Zhong et al. (2017) concluded with their systematic review and meta-analysis that Heparin wasn't superior compared to NS for maintaining the patency of CVCs. However, there also was not enough evidence to support the effectiveness of NS in comparison to Heparin in keeping CVCs patent.

Conversely, a systematic review by López-Briz et al. (2018) found evidence to suggest Heparin resulted in fewer occlusions in CVCs when compared to NS and determined that varying concentrations of Heparin did not make a difference with line patency. They also found no evidence to suggest any safety differences with either Heparin or NS in relation to sepsis, hemorrhage, mortality, and not enough evidence to detect rare adverse events like HIT (López-Briz et al., 2018). While these findings seem to favor Heparin, they are based on low quality evidence.

Key implications of Sharma et al.'s (2019) systematic review and meta-analysis concluded that Heparin was no more effective than NS in maintaining the patency CVCs and that evidence on the secondary outcomes such as infections related to CVC, bleeding from a body site, CVC related thrombus formation, and mortality between groups was not clear except for HIT. HIT as a secondary outcome in two studies showed a contradictory effect with Heparin in which case there were fewer cases of HIT with the Heparin group compared to the NS group. The researchers determined that Heparin tended to be associated with fewer occlusion rates than 0.9% Sodium chloride in CVCs but this was not statistically significant and is based on low quality evidence. Both Sharma et al. (2019) and López-Briz et al. (2018) concluded that low quality evidence prevents them from identifying which solution is better for maintaining CVC patency.

Last, Gorski et al. (2016) constructed a clinical practice guideline that concluded that using either Heparin or 0.9% Sodium Chloride as a flushing solution is acceptable, but recommended Heparin with caution due to previous sentinel events with varying heparin concentrations in the neonatal and pediatric populations. They noted 0.9% Sodium Chloride was less expensive than Heparin. The guideline recommends using occlusion prevention tactics (push-pause technique, valve change) and infection prevention practices when flushing CVCs.

Practice Recommendations and Intervention

As of February 2022, the U.S. food and drug administration announced a national heparin shortage (U.S. FDA, 2022). Currently, there is no standardized guideline that recommends flushing with one specific solution over the other to prevent central venous catheter occlusions or the development of fibrin sheaths.

Based on the body of evidence from all systematic reviews and the clinical practice guideline by Gorski et al. (2016), it is recommended that CVCs are flushed routinely with ten ml of preservative-free 0.9% Sodium Chloride to prevent occlusions. The use of a pulsating positive pressure technique (push-pause technique) is recommended by administering 10 one ml boluses that are interrupted by short pauses to minimize blood reflux back in the CVC lumen. The pauses may be considered more effective at removing fibrin sheaths in comparison to a low flow rate technique (flushing all at once), and locking the clip on the catheter lumens immediately before and after each use is essential. Preservative-free 0.9% Sodium Chloride was also associated with less potential for adverse reactions and less expensive (Gorski et al., 2016, López-Briz et al. 2018, Zhong et al., 2017, Sharma et al. 2019).

For occluded CVCs, vigorous flushing with the push-pause technique, changing of the outer anti-reflux valve, chest x-ray to confirm placement of central lines as well as tPA for restoring catheter patency is recommended. If there is a lack of blood aspirate after all the above interventions have been performed or infection of the line occurs, then removing the CVC is recommended with replacement of a new one only if indicated (Gorski et al., 2016, López-Briz et al. 2018, Sharma et al. 2019; Zhong et al., 2017).

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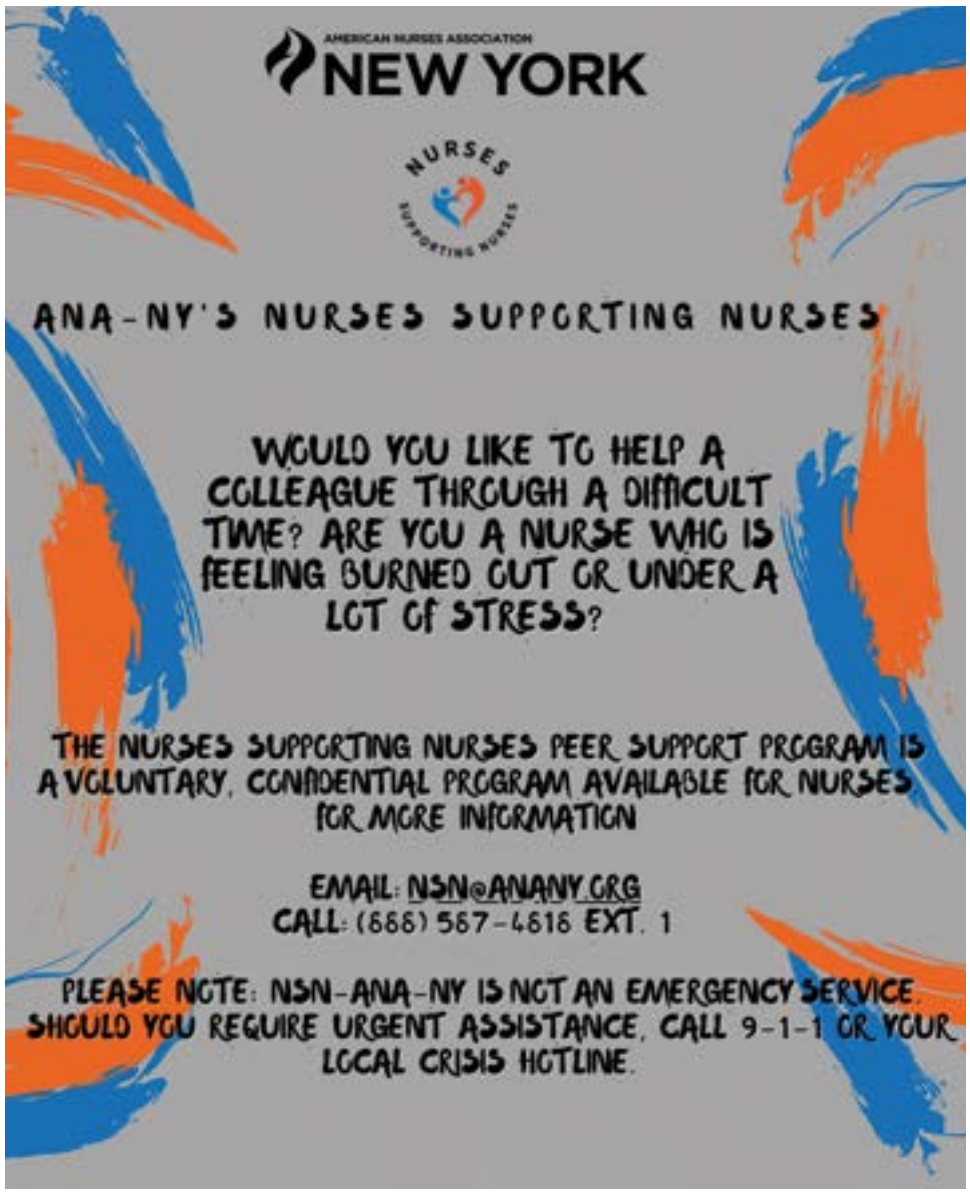


ANA-New York is proud to announce that **Wayne Health Care** has achieved the prestigious Pathway to Excellence® designation.

Pathway to Excellence recognizes excellence in positive practice environments and ensures that nurses are empowered, engaged, and have a strong voice in their practice.

Join us in congratulating **Wayne Health Care** for making this commitment to their nurses!

ANCC
AMERICAN NURSES CREDENTIALING CENTER
PATHWAY TO EXCELLENCE

AMERICAN NURSES ASSOCIATION
NEW YORK

ANA-NY Looks Toward the Future of the Nursing Field

ANA-NY is working closely with SPEAKHIRE for a partnership that will instill an understanding of the nursing field in young adults across the country.

SPEAKHIRE is a nonprofit organization whose mission is to develop the social and cultural capital of individuals from immigrant families to become leaders in the workforce. Their award winning approach of delivering multigenerational virtual career and culture mentoring and coaching to young people from immigrant backgrounds ages 13 to 23 by exposing them to multiple career professionals, called Career Pathways Champions, to learn about different industry specific skills, career ecosystems, civic engagement, and how to develop their resume and search for opportunities has been called innovative and brilliant. They are positioned to truly strengthen the school to career pipeline for all young people.

Last year, November to June, 25.1% of SPEAKHIRE students were interested in a career in Health Sciences. SPEAKHIRE is seeing similar numbers this year. Additionally, many of the incoming SPEAKHIRE students speak Spanish, Pashto, Mandarin, Arabic, and French. They are recruiting now for professionals to meet this year's impact. With this in mind, we may be asking ANA-NY Members to volunteer time as a Career Pathways Champion, to speak with these young adults about the nursing field. For information on how to apply, visit https://speakhire.org/champions

Continuing Education Opportunity

comMIt (comprehensive motivational interviewing training) for health care professionals is an e-learning program accredited for eight hours of approved continuing education credit for nurses, pharmacists, physicians and social workers. The learner has three months to complete this highly interactive program and receive CE credit. Learners may stop at any point in the program and then return to it where they left off. Learners may also review each module completed as often as they would like during the three-month time frame. This unique program uses a sense making approach to motivational interviewing by Drs. Bruce A. Berger and William A. Villaume. The modules use numerous real examples of patient encounters and self-assessment questions to help learners internalize skills. The price of this training is typically $125, however please use the Discount code 'ANANY2021' at checkout to receive the training for $80. See https://tinyurl.com/PurdueCE-MI-HCP for more information.

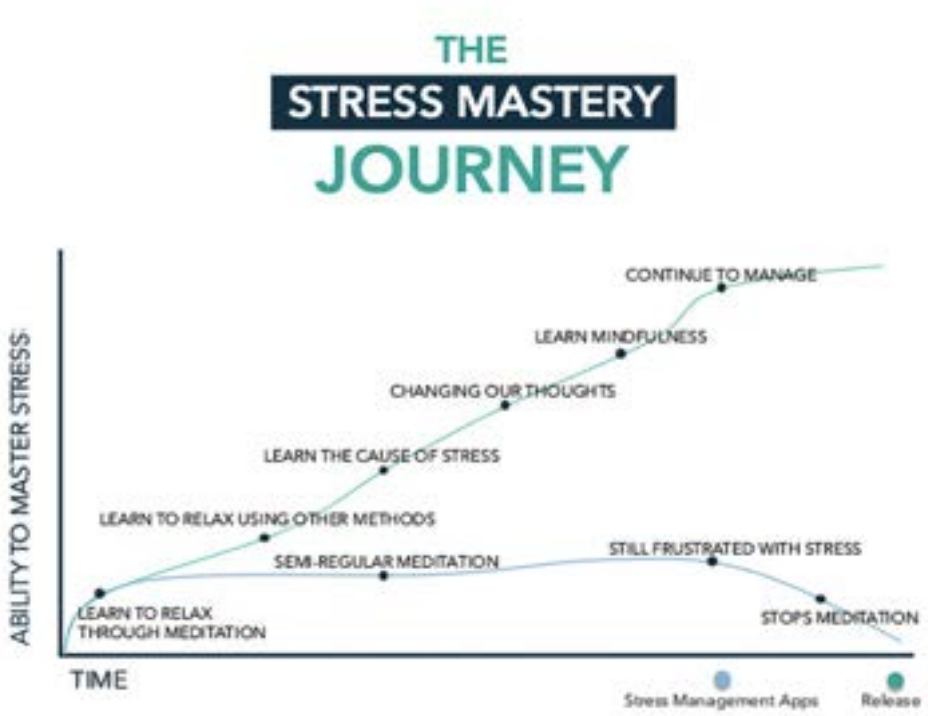
ANA-NY Works to Reduce Stress for All New York Nurses

ANA-NY is working closely with Dr. Michael Olpin and Dr. Greg Waddoups of the **Terra Firma App** and Stress Release Course, to make these available to all New York Nurses. The **Terra Firma App** and **Stress Release** Course can be used to assist in reduction and management of stress, as presented by Dr. Michael Olpin. According to Dr. Olpin, *"Terra Firma is a multidimensional, research-based approach that help you turn off your stress to feel better, be healthier, and to build a strong foundation from which you can thrive." His work is "… guaranteed to relieve your stress and improve your well-being and happiness."*

We here at ANA-NY are excited to team up with Dr. Olpin to support our Nurses during these stressful times. Dr. Liz Close of the Utah Nurses Association states *"The Terra Firma App (TFA) goal is to decrease the unnecessary emotional and physical impacts of stress on the nurse, patient and organization. Stress can negatively affect nurses' physical and mental health precipitating sleep disorder, depression, anxiety, elevated blood pressure, lack of energy, diminished cognitive ability and challenging interpersonal relationships in and outside the work environment. These effects can translate to poor patient outcomes, mediocre retention rates, and unnecessary increased organizational costs. Nursing students have the additional burden of stress related to the overwhelming nature of nursing education requirements which traditional campus mental health services may not be well prepared to address."* With this in mind, we truly hope this offering will help all of the Nurses in New York State.

Some unique features of the **Terra Firma App** and **Stress Release** Course are:

- "TFA is not like other apps that give quick tips or tricks to temporarily "relieve" stress. It is a multi-dimensional and research-based tool designed to continuously and seamlessly support nurses' stress mastery development.
- It offers education on stress prevention and mastery, focuses on challenges faced in the health care delivery environment, contains a library of meditations for sleep and anxiety, has social community online availability and offers personal access to an expert coach.
- It is tailored for nurses to fully understand the actual causes of stress, how to change thinking about stress-producing circumstances, strategies for establishing more positive reaction to stress and ultimately achieve the upper trajectory depicted below.



- AND… unlike other apps, it is designed to be interactive, supplying an expert human interface (coach) to support all aspects of the stress management journey. Subscribers may also elect to join all-nurse synchronous and asynchronous discussion groups."

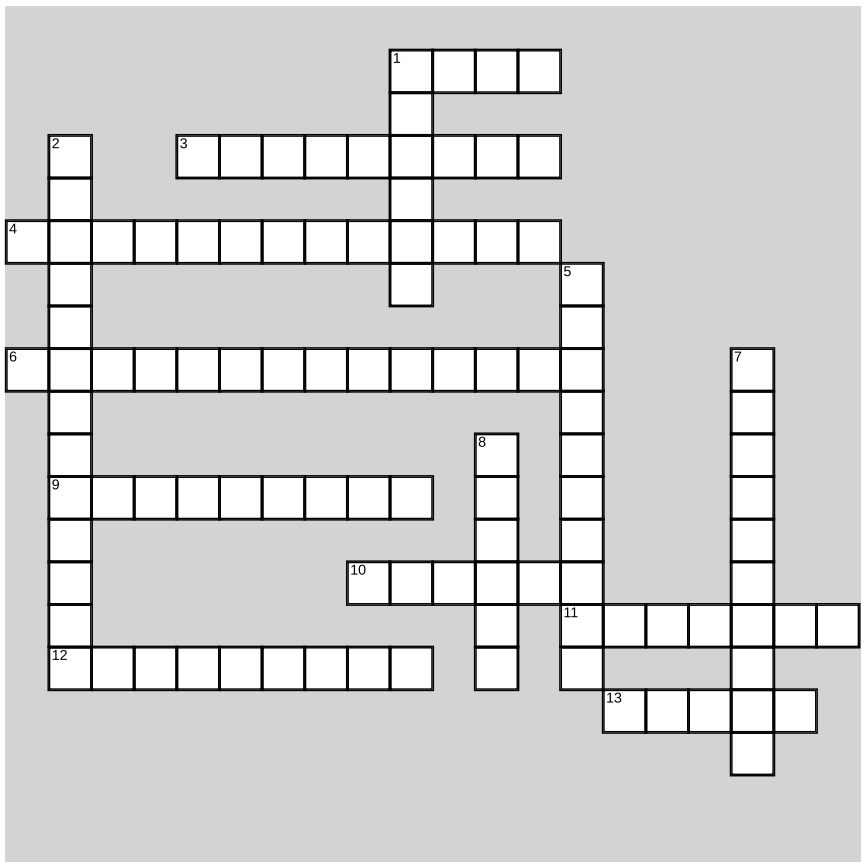
For more information, please visit https://terrafirmaapp.com/

Other ways in which ANA-NY hopes to help our members to combat stress are through our Wellness Wednesday posts on all our social media platforms, as well as our Nurses Supporting Nurses Program. Please follow all our socials to stay up to date.

For more information on becoming a volunteer for Nurses Supporting Nurses, visit our website at https://ananewyork.nursingnetwork.com/page/96231-volunteer-to-be-a-peer-supporter .

For more information on requesting peer support, visit our website at https://ananewyork.nursingnetwork.com/page/96232-requesting-support

ANA-New York April 2022 Monthly Crossword



Across

1 Save the date! Also known as Pride Month, the 22nd of this month is the day on which our next ANA-NY mixer will take place.

3 The Doctor of Nursing Science to whom this surname belongs is your ANA-NY President!

4 With this resource on the ANA-NY website, nurses can find their next perfect job and health provider can find their next perfect nurse!

6 This PhD is your national ANA President and this year's keynote speaker at the 10th annual conference.

9 In the spotlight this month, we have our Bylaws Committee. Their Committee Chair is...

10 This committee is responsible for reviewing and helping to manage the ANA-NY bylaws. Our April Committee Spotlight is...

11 Be there with bells on! On the last weekend of this month, ANA-NY's annual conference will take place only half a mile away from the roaring falls.

12 This ANA-NY opportunity gives members an opportunity to mentor the future leaders of nursing.

13 This Member on the Move is also your ANA-NY Treasurer. Her surname is...

Down

1 With the goal of promoting high standards of nursing, ANA-NY's scholarly journal goes by this acronym.

2 At last! This Western NY city will be our location for the 10th Annual Conference.

5 A proud legacy indeed, this BOD Secretary is also the author of the article "A Proud Legacy" in this month's newsletter.

7 This newsletter feature keeps you up to date on your Board's activities.

8 This city in New York state is home to the ANA-NY office and your ANA-NY staff.

ORGANIZATIONAL AFFILIATES

ANA-NY is proud and honored to be associated with our Organizational Affiliates

American Psychiatric Nurses Association - New York Chapter

Central New York Nurses Association, Inc. (CNYNA) -

Chi Gamma Chapter Sigma

Genesee Valley Nurses Association (GVNA) -

Mohawk Valley Nurses Association (MVNA)

New York State Association of Nurse Anesthetists

New York State Association of Occupational Health Nurses

Nigerian Nurses Association of USA Inc

Northeast New York Professional Nurses Organization, Inc. (NNYPNO)

Nurses Association of the Counties of Long Island, Inc. (NACLI)

Professional Nurses Association of Dutchess/Putnam Counties https://pnadp.nursingnetwork.com/

Professional Nurses Association of Rockland County (PNARC)

Professional Nurses Association of Suffolk County (PNASC)

Professional Nurses Association of South Central New York

Professional Nurses Association of Western New York, Inc. (PNAWNY)

Are You A Member of a Nursing Group that Should Become an organizational Affiliate?

Here are some benefits: 1. A discount on exhibiting at ANA-New York annual meeting; 2. Attendance at ANA-New York's annual meeting at a member registration rate for the organizational affiliate's representative; 3. Right of organization affiliate's RN liaison to attend and speak at ANA-NYs governing assembly, without vote; 4. A link with your logo on ANA-NY's Website with recognition of Organizational Affiliate Status; 5. Access to professional development opportunities for affiliates members and staff; 6. Access to experts in a variety of nursing specialties; 7. Opportunities to network with ANA-NY members across New York state; 8. Access to speakers from the membership on a variety of nursing topics; 9. Preferred sponsorship opportunities at special events and other programs; 10. A complimentary subscription to ANA-NY's quarterly Newsletter for your members.

Register online:
https://form.jotform.com/73165345530150

Queries: contact programassociate@anany.org for more information.

Bylaws Committee

The Bylaws Committee shall:

1. be composed of a minimum of five (5) members and a maximum of seven (7) members appointed by the ANA-NY Board of Directors.
2. review the bylaws of ANA-NY and recommend corrections or amendments to the Board of Directors.
3. collaborate with ANA's Committee on Bylaws to ensure congruency with ANA's Bylaws.
4. draft the proposed text of all amendments to the ANA-NY Bylaws and, upon review by the Board of Directors, and review by the ANA Committee on Bylaws for harmony with the ANA Bylaws, then submit and explain them to the Governing Assembly in accordance with the Amendment provisions of these Bylaws.

Verlia M. Brown, MA, RN, BC (Retired)

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

Served as director for ANA-NY board of directors from 2018 to 2021. Board liaison to the Awards Committee from 2020 to 2021. Current member of the Bylaws Committee. Delegate representative to the American Nurses Association Membership Assembly.

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

Tiana Arroyo

My name is Tiana Arroyo. I graduated from City College New York with a Bachelor of Science in Nursing. My career as a nurse has been diverse and fulfilling. I have been privileged to work in many healthcare setting in the public and private sectors as a clinical nurse until the present time. In 2018, I completed a Master of Jurisprudence in Health Law with a concentration in Healthcare Compliance. I have always had an interest in policies, regulations, and Standards of Care and Practice and how they could influence patient care and safety. I look forward to serve in the ANA-NY Bylaws Committee for another year.

Meghan Scanlon

Hello! My name is Meghan Scanlon, and I am a member of the ANA-New York Bylaws Committee. I attended Villanova University in Villanova, PA for my undergraduate BSN degree. After school, I moved back home to Long Island, New York, where I started my career as a Surgical ICU RN at Long Island Jewish Medical Center in New Hyde Park, NY. After some time working as a clinical RN, I transitioned into a role in hospital administration at North Shore University Hospital in Manhasset, NY. My current role is in Finance and Operations Management for Hospital Administration. I am also a student in the MSN Healthcare Organizational Leadership/MBA track at Johns Hopkins University. In my free time, I enjoy running (particularly marathons), spending time with family and friends, reading, and going to the beach. I very much look forward to continuing my role in the ANA-New York Bylaws Committee this year, connecting with other ANA members to ensure that our bylaws continue to reflect their priorities and values and position the nursing profession well for the future.

Catherine S. Finlayson

Catherine S. Finlayson, PhD, RN, OCN has recently joined the faculty of Pace University's Lienhard School of Nursing as a tenure-track Associate Professor. She earned her PhD from New York University's Rory Meyers College of Nursing in 2018. Dr. Finlayson received the Doctoral Degree Scholarship in Cancer Nursing from the American Cancer Society to support her dissertation research, which subsequently won the outstanding dissertation award that year. She was the recipient of the 2018 Oncology Nursing Society Trish Greene Memorial Lectureship. She has been a clinical nurse at Memorial Sloan Kettering Cancer Center for the past 15 years and has taught as an Adjunct Professor at Pace for the last two years. She is also the past President and current Director-At-Large for ONS NYC and is the Bylaws Committee Chair for ANA-NY. Dr. Finlayson holds a Bachelor of Arts in Political Science from New York University. A Master of Science in Urban Policy Analysis and Management from the New School for Social Research and a BSN from SUNY Downstate Medical Center.

Bios and Photos are not available:

Tanya Finch, RN, FNP

Ann Tahaney, RN

New Membership Engagement Associate

Ana Quian

Hello! My name is Ana Quian and I'm excited to introduce myself as your new Membership Engagement Associate. I am a recent graduate of the University at Albany where I earned my Bachelors of Arts in Communication with a minor in English Literature. My position with ANA-NY is my first following my undergraduate career. Prior to my place in this role, I worked at the University at Albany as an Office Assistant and a Student Leader in several on-campus initiatives. In my spare time, I enjoy cooking, writing, talking with loved ones, and bothering my two mackerel tabby cats, Saffron and Jamie. I'm deeply looking forward to working with you all to continue to make ANA-NY an incredible support system for nurses in our state. I am sending you all well wishes and a beautiful Spring.

AMERICAN NURSES ASSOCIATION
NEW YORK

"We've Come a Long Way Baby"... or Have We?

A Brief Review of Recent Nursing Literature Comparing the Lessons Learned from the 1918 Pandemic and the COVID-19 Pandemic

Kennedee Blanchard, BA, Communications Manager, Center for Nursing at the Foundation of NYS Nurses, Inc.
Susan Birkhead, DNS, MPH, RN, CNE, Nursing Education Consultant
Martin Dornbaum, MS, FAAN, Director Health Professions Education Center, Hunter-Bellevue School of Nursing
Deborah Elliott, MBA, BSN, Executive Director, Center for Nursing at the Foundation of NYS Nurses, Inc.
Joan Madden Wilson, MS, BS, RN, President, Center for Nursing at the Foundation of NYS Nurses, Inc. and President, Bellevue School of Nursing Alumnae Association

Nurses often look to the past to inform our present and future. We learn from our history and from those who went before us. We value nurse theorists, research, and evidence to guide our practice. Many of the original principles of the American Nurses Association (ANA), back when it was first founded as the Nurses Associated Alumnae of the United States and Canada in 1896, still hold true today. However, when it comes to preparing for and providing care during a pandemic, how much have we learned and how much has improved?

A few nurse leaders and researchers have pondered this question in light of the challenges and issues revealed during the current COVID-19 pandemic. The authors of this article reviewed recent articles that highlight some of the similarities and differences between the 1918 influenza pandemic and the ongoing COVID-19 pandemic.

Pandemic Preparation and Taking Precautions

In attempt to minimize fear and panic among the public, as well as to maintain a positive morale during wartime, little acknowledgement of the severity of the disease behind the 1918 pandemic or details about its impact were openly shared. This led to misunderstandings and delayed responses when attempting to prevent the spread of infection (Gordon et al., 2020). Robinson (2021) noted that little has changed since then; despite the known results of the devastating 1918 pandemic and outbreaks of various other pathogens, nurses today are still not being provided the necessary preparation and resources to protect themselves and their patients during a pandemic. Reports from nurses indicate of lack of information, or inaccurate information, during the recent pandemic—just as it was in the early 1900's.

"Effective preparation and planning must occur with public health, healthcare, and emergency management partners working together to develop new approaches to provide protection, both nationally and globally against the next influenza pandemic." (Robinson, 2021, p.354)

Nursing Care

Most patients during the 1918 pandemic received care in their homes, whereas most patients during the earliest phase of the COVID-19 pandemic were hospitalized. However, despite the difference in settings, nurses demonstrated their power in both pandemics to provide excellent care despite challenges (Robinson, 2021). According to Gordon et al. (2020), priority nursing care of infected patients in both 1918 and 2020 required constant attention to "breathing, positioning, nutritional and hydrational status, and mental and emotional morale" (p. 29), even though today's nurses are aided by advanced technologies.

In both pandemics, those with preexisting conditions have been more vulnerable. In 1918, nothing beyond expert nursing care could be offered to the sick, and this was generally true at the onset of the current pandemic. In the absence of curative treatments, quality care has remained crucial to the survival and recovery of acutely ill patients. In the case of the COVID-19 pandemic, nurses are administering novel treatments to patients in need, even as "nursing care has become increasingly more complex and significantly more technical in nature" (Talbot et al., p. 29).

Supplies and equipment

Johnson (2021) shares the accounts of her grandmother, Kathryn (Katie) Ann Darmody, RN, who worked at St. Lawrence Hospital in Ogdensburg, New York during the 1918 pandemic. Katie recounted how "fellow nurses were overwhelmed by the influx of patients and experienced a severe shortage of protective equipment. As the pandemic progressed, supplies such as gauze, sheets, and towels were repurposed and turned into masks, protective coverings for nurses, and compresses for patients" (p. 63). Similarly, during COVID-19, a nationwide survey of nurses reported that the lack of personal protective equipment (PPE) was a concern of nine out of ten frontline nurses, and many admitted they created their own masks at times (Robinson, 2021). While there were reports of limited supply of masks and other protective equipment during the early phases of the COVID-19 pandemic, it didn't deter nurses from providing care. In troubling times, they found ways to improvise or reuse items as safely as possible. This is indicative of the spirit of the nursing profession, which remains as true today as it was a century ago.

Nursing shortages , staffing, and training

Talbot et al. (2021) comment on the similarities in circumstances of the two pandemics: a shortage of nurses; overcrowded hospitals; a new and lethal respiratory virus; few treatment options; and limited approaches to infection prevention and control. They also point out one significant difference in the two pandemics: in the 1918 pandemic, a high number of severe cases occurred in healthy, younger adults. These patients faced a crisis when presented with a pressing nursing shortage, as not enough nurses were available to treat them. During the 1918 pandemic, many nurses were deployed overseas supporting the armed forces in World War I, resulting in a shortage in the United States. While that was not the case in 2020, communities nationwide were impacted due to nurses traveling to the cities to treat patients living in COVID-19 epicenters, such as New York City. The fact that many nurses fell ill and had to quarantine themselves also contributed to shortages; many have died as a result of frontline exposure. However, in both pandemics 100 years apart, nurses came out of retirement, or delayed retirement, to answer the call (Robinson, 2021). Others learned new skills in order to work temporarily in different areas of specialization, such as critical care areas. In both pandemics, student nurses were put to work. While there are limited reports of on-the-job training of nurses during WWI, the use of just-in-time training for military nurses in war or pandemic situations has been described. Throughout the current pandemic, many civilian nurses have also received just-in-time training, assuming their responsibilities after getting redeployed to unfamiliar work settings.

"While the number of [nurses] available was altogether inadequate to meet the needs of this unprecedented situation, the response of the rank and file of the great nursing body was so splendid that we now have an enlarged vision of the courage [and] the self-sacrificing spirit…of nurses." (Palmer, 1919, p. 83-84)

Nurse Wellbeing

In both pandemics, nurses endured working long, arduous hours with significant physical and emotional stress. This results from the nature of the work, uncertainty, fear of becoming ill or carrying the illness to loved ones, unremitting exposure to death, and lingering grief in those who survive. Isolation is also a stress factor impacting nurses' health. The use of PPE in and of itself can be an isolating experience. Gordon et al. (2020) state that donning PPE "can be traumatising [sic]. It is an act that preludes the day's hard work and its attendant emotional and physical stresses. PPE highlights risk and is symbolically akin to battledress of a soldier or a medic" (p. 30). Isolation also occurs when nurses who work in a COVID unit are separated from colleagues and may be shunned by them. Nurses may continue isolation even outside of work hours, in order to protect their family and friends from infection through self-imposed separation.

Talbot et al. point out that "crises … remove barriers [and generate] rapid innovation to meet the nation's needs" (p. 27). This has always been a hallmark of military nursing. They state that the military nurses in WWI "advanced nursing science and practice in practical ways through the management of the ill and the wounded" (p. 29). They suggest that the current pandemic has revealed areas where additional research is needed: exploring the effects of the psychological and physical distress experienced by nurses who care for COVID patients. They further postulate that enough staffing, access to adequate PPE, and education on the spread of disease could help mitigate nurses' suffering.

"My grandmother was one nurse among thousands who responded to the 1918 pandemic. But her story helps connect the nurses of a century ago to those of today, displaying the continuous courage and self-sacrificing spirit of nurses throughout time." (Johnson, 2021, p. 65)

How the Past Informs the Future

The lessons of the 1918 influenza pandemic are particularly pertinent today, as the COVID-19 pandemic rages on and nursing care is forever altered in response. Examining both pandemics in tandem provides an opportunity to examine current crises from a different perspective, allowing us to draw conclusions to better inform clinical care and provide a solid foundation for nurses today. Through studying the history of pandemics and incorporating necessary changes, front line nurses can become better prepared to deal with similar situations in the future.

"Now, as we move forward, it is worth noting that by documenting and preserving nurses' experiences in the COVID-19 pandemic, we can provide valuable lessons for future nurses dealing with future pandemics." (Keeling, 2021, p.5)

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Post note: The Center for Nursing History at the Foundation of NYS Nurses is interested in collecting oral histories from nurses on the front lines, in management, or academia during the COVID-19 pandemic in order to document and preserve nurse experiences to inform future generations. If interested, please contact Kennedee Blanchard at kblanchard@cfnny.org

Cathryne A. Welch
Center for Nursing Research

The Noah Tubbs Family Trust Nursing Research Grant

Award Intent: To assist qualified registered professional nurses to pursue nursing research. Special consideration will be given to nurses pursuing research in the field of **geriatrics**.

Amount of Award: Total amount awarded on an annual basis is $5,000. This amount may be split between multiple grants depending upon the need and at the discretion of the grant selection committee. Preference is given to research projects which will be completed within 24 months of the receipt of the award.

Eligibility and Use of Funds

To be eligible to apply for The Noah Tubbs Family Trust Nursing Research Grant, the applicant must:

1. Hold licensure as a registered professional nurse in New York State;
2. Have a baccalaureate or higher degree in nursing from a nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE);
3. Reside in and/or practice professional nursing in New York State;
4. Approved awardees may apply for one subsequent grant. Applicants who are denied are eligible to reapply.

Preference will be given to professional nurses who 1) show they have a research mentor available to assist with the project (e.g., nursing research faculty or a nursing research consultant), or 2) have prior nursing research experience.

Appropriate Use of Grant Funds

Funds from The Noah Tubbs Family Trust Nursing Research Grant may be used to support:

- Salaries for research assistants (e.g., tape transcription)
- Travel expenses incurred while collecting data
- Photocopying
- Postage
- Equipment to support the data collection process (e.g., tapes, tape recorder)
- Participant reimbursement
- Poster development

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Speakers Bureau

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If you would like to be included, send your information, including content area(s) of expertise, to executivedirector@anany.org

The Speakers Bureau is an internal listing. It is not a public database. Should an inquiry for speakers come in related to your region and topic, ANA-NY staff would reach out to you to determine your interest and availability. Should you be interested in that specific speaking opportunity, we would then connect you with the host group.

International Council of Nurses and European Nursing Organizations Condemn Invasion of Ukraine

The International Council of Nurses (ICN), the European Federation of Nurses Associations (EFN) and the European Forum of National Nursing and Midwifery Associations (EFNNMA), speaking on behalf of the world's 28 million nurses, utterly condemn the illegal invasion of Ukraine and the military attacks on its people. We call for an immediate ceasefire, an end to all hostilities and for the commencement of intensified diplomatic negotiations to secure peace.

Nurses and other healthcare workers deliver care and treatment to all patients without fear or favour: they must be allowed to do their work protected from threats and violence, and the healthcare facilities they work in must be shielded from harm. International regulations and the Geneva Convention protecting health facilities and health workers must be respected and enforced.

The people of Ukraine must be provided with the humanitarian aid they are entitled to under international treaties, and they must have ready access to the vital equipment, medicines and supplies that are required to treat all of their healthcare needs, including injuries or illnesses. Refugees from the conflict must be afforded the right of free passage and provided with healthcare and support on their journeys and when they reach a place of safety.

The world's nurses demand that the health and wellbeing of the people of Ukraine is safeguarded and that can only be achieved through lasting peace, because peace and health are inseparable.

To show your support for this statement sign here.

Andréa Sonenberg, PhD, wrote this piece that was featured in the Times Union: https://www.timesunion.com/opinion/article/Provider-shortage-is-bringing-health-care-to-the-16981533.php

Phyllis M. Yezzo, DNP, RN, was named Senior Vice President and Chief Nurse Executive by Westchester Medical Center Health Network. Read more on this here: https://www.beckershospitalreview.com/hospital-executive-moves/new-york-health-network-appoints-chief-nurse-executive.html#:~:text=Valhalla%2C%20N.Y.%2Dbased%20Westchester%20Medical,the%20system%20said%20Feb.%2010

Phyllis M. Yezzo

Dr. Ellen McCabe

Congratulations to **Dr. Ellen McCabe**. Dr. McCabe is an ANA New York member, JANANY editorial board member, and Assistant Professor of Nursing at Hunter College. This June, she will be inducted as a Fellow into the National Academy of School Nursing (FNASN). The honor of Fellow is the most prestigious recognition that members can receive from NASN. Dr. McCabe's contributions have had a significant and enduring impact on the association and, more broadly, school health and student well-being.

No Kidding!

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

What pan do you NOT use in the kitchen? Bedpan

While we nurses certainly know that bedpans don't belong in the kitchen, others aren't so familiar and mishaps have happened more often than you might think. Between bedpans and chamber pots, accounts have been cited in history where they have been mistakenly sold, archived, or used (gross) as kitchen items. Florence Nightingale herself even called bedpans "utensils" throughout her archived notes (McDonald, 2010). Perhaps the most famous bedpan was George Washington's, which just so happens to have been made in New York at the Frederick Bassett company (Mount Vernon Ladies Association, 2020). From the meticulous records kept by the Washington family, this particular bedpan has been archived mistakenly as a kitchen item not once, but twice until it was put on display at the Mount Vernon Ladies Association in Virginia (Good, 2015). Considering that 18th century bedpans looked like thick-rimmed frying pans and were made of pewter, it's no wonder how the mistakes happened (Good, 2015).

As bedpans evolved in the United States (U.S.), the handle disappeared and it moved from being made of metal to the plastic per-patient disposable pink design most of us still see in practice. However, while U.S. nurses rarely have to sterilize bedpans anymore, they are still required to carefully carry (another reason I am thankful for my days as a waitress) and rinse them between uses which is neither pleasant or aligns with infection control principles. Meanwhile 51% of the world was still using steel multi-use bedpans as of 2014, some of which were equipped with lids to make transport less hazardous (Popp, et. al, 2014). Infection control was part of the inspiration for Vernacare, a United Kingdom based company that offers 100% biodegradable medical

pulp toileting products such as bedpans. The premise is that each bedpan is used once, then put into a medical grade macerator connected to a sewer line – that's right, bedpan and its contents go into this foot activated machine (Vernacare, 2021). While I'm not sold that these cardboard bedpans are applicable for our bariatric patients, I do appreciate that they are a step in the right direction considering that "healthcare facilities in the United States generate approximately 14,000 tons of waste per day [and]…25 percent of that 14,000 tons can be attributed to plastic…" (Healthcare Plastics Recycling Council, 2020). To add insult to injury, plastic containers like bedpans can take a shocking 450+ years to break down in our landfills (Vernacare, 2021)! So why haven't more hospitals adopted this biodegradable option? My assumption is a mixture of proof of concept and cost. While start-up cost isn't listed on the Vernacare website, adopting this system would likely involve facility reconstruction to install the macerators on every unit and into sewer systems. The more the healthcare industry is pushed to address climate change, the more we'll need to consider alternate ways of "doing business" (pun intended). But until we have funding solutions, I fear that our plastic waste will increase until we eventually go back in time sterilizing multiple use metal bedpans. In the meantime, we can celebrate those who keep bedpans out of our landfills, like Eric Eakin of Cleveland, Ohio who has collected 250 bedpans so far and nurse educators who use them as candy dishes (Oatman-Stanford, 2014).

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NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

NICHE Nurse Leaders Join Forces to Deliver Geriatric-Specific Staff Education

Jennifer Pettis, MS, RN, CNE, acting director of programs, Nurses Improving Care for Healthsystem Elders (NICHE), NYU Rory Meyers College of Nursing

Continuing professional development (CPD) is vital for nurse satisfaction and patient safety and outcomes. It is directly linked to healthy work environments and staff recruitment and retention (Mlambo, Silén, & McGrath, 2021; Price, & Reichert, 2017). While CPD can take a variety of forms and educators can employ numerous educational strategies and delivery modalities, Mlambo et al. (2021) note the importance of making CPD "more attainable, realistic and relevant" (p. 1). Simulation-based CPD is one such method, and it has been linked to transfer of knowledge to practice. Simulation-based CPD is often combined with other teaching and learning strategies to engage nurses and close the knowing doing-gap (Cant & Levitt-Jones, 2021).

Recognizing the need to educate nurses in the unique needs of older adults while conserving resources, Arlene Stoller MS, RN, ACNS-BC, GERO-BC, CDP, Geriatric Clinical Nurse Specialist and NICHE Program Leader at Lahey Hospital and Medical Center and Suzanna Iannuzzo, MSN, RN, Clinical Practice Specialist and NICHE Coordinator at Winchester Hospital, worked together to develop and deliver a day-long "boot camp" style educational program for registered nurses from their organizations. I had the opportunity to ask them some questions about their program, titled *What's Old is What's New: A Geriatric Resource Nurse (GRN) Class.* In this *NICHE Age-Friendly Nursing Practice Pearls,* I am delighted to share our conversation. I hope that you enjoy learning from these NICHE nurse leaders as much I did!

J. Pettis: Why did you decide to work together to educate your nurses in a single educational session?

A. Stoller: Lahey Hospital & Medical Center (LHMC) is a 335-bed academic medical center that is NICHE recognized since 2010, and Winchester Hospital (WH) is a 200-bed community hospital that is NICHE recognized since 2015. As the NICHE Coordinators from LHMC and WH, Sue and I identified barriers and challenges to growing the NICHE programs at both sites due to system processes and competing priorities. Barriers included limited resources, time limitations, and departments often working in silos.

S. Iannuzzo: The COVID-19 pandemic heightened these challenges, and we noted that both sites had a decrease in the number of Geriatric Resource Nurses (or GRNs). Through NICHE Coordinator collaboration, we were able to share services and mitigate these challenges, while expanding the NICHE programs at both sites, ultimately resulting in improved care for older adults.

J. Pettis: What did you use to determine your agenda and curriculum for the day? What NICHE materials and resources did you use in your programming?

S. Iannuzzo: The curriculum and content for the program was modeled after the *NICHE Geriatric Resource Nurse (GRN) Learning Path* as this is considered the gold standard for evidence-based gerontological nursing practice. Since the timeframe of the class was only eight hours, we decided to offer a brief introduction into the following topics: Age-related Changes; "the 3 Ds": Delirium, Dementia, and Depression; Falls and Function; Nutrition and Hydration; Skin Care and Pressure Injuries; Medications and Pain; Urinary Incontinence; Sleep and the Older Adult; and Concepts in Geriatrics. We selected these topics to serve as the building blocks and foundation for GRN knowledge with plans to augment this with deeper dives into these topics during regularly scheduled GRN meetings.

A. Stoller: In addition, each presenter selected several research articles to support their content. Finally, *Evidence-Based Geriatric Nursing Protocols for Best Practice (6th ed.)* by Boltz and colleagues served as scientific resource with protocols and strategies that nurses could implement into their practice. The protocols in the Boltz et al. text represent the codified evidence about nursing care for older adults. The implementation of these protocols is a key part of any NICHE program, so it is vital that we incorporate them in our education.

J. Pettis: I noticed that there were staff nurses that presented some sessions in the agenda. How did you select and prepare staff nurses to educate their peers?

A. Stoller: An innovative approach to providing the education was the inclusion of GRNs as presenters. The intent of including them was to foster their professional development while increasing their engagement with the goal of boosting staff satisfaction with the hope of improving retention. With this in mind, we sent an email requesting GRN volunteers to serve as presenters, and our GRNs, including Linda Chellali MSN, RN, GERO-BC and Rhonda Glowik BSN, RN, GERO-BC, stepped up to the challenge.

S. Iannuzzo: Rhonda had never created education nor presented in the past. Arlene and I mentored her in this new role, providing her with the tools to be successful. This included collaboration in which Rhonda shared her precious weekend time to work with Arlene to create the class materials and hone her presentation skills. Rhonda was engaged from the beginning. She continually modified her slides and practiced presenting which contributed to her success.

J. Pettis: I know that you were especially excited about the simulation you included in your program. Please tell me about that and the other interactive programming you included in the day.

S. Iannuzzo: Due to post-pandemic staffing strains and role transitions, many of the nurses attending the program were newly licensed nurses. It was imperative to design a course with a pedagogical approach that would meet the style of these millennial learners that included less lecturing and more opportunities to apply the new knowledge. The eight-hour interactive nursing continuing professional development program was designed to meet the needs of these learners. Innovative teaching strategies that allowed real time application of learning included a delirium simulation with an individual playing the role of the delirious patient, allowing the GRNs to recognize and manage delirium while identifying the underlying cause. To augment these concepts in practice, we offered a Delirium Escape Room that reinforced the need for nurses to implement prevention strategies. A mobility simulation helped to highlight the many physical limitations experienced by older adults. In this activity, participants applied knee and elbow immobilizers, wrist splints, and weighted vests. They were then asked to use walkers and walk down the hall which required opening a closed door. Upon return, they had to fold some clothing, some of which was purposely placed on the floor. This exercise simulated some of the many mobility challenges faced by older adults. The GRNs stated a new understanding and respect for the older adults that includes greater knowledge of how to teach patients to be more mobile as well as a new respect for the obstacles they face.

A. Stoller: Finally, we offered a sensory experience exercise that highlighted the many sensory impairments faced by this population. The GRNs were given ear plugs to simulate decreased hearing, slotted glasses that simulated having impaired vision, and large gloves with three fingers taped together simulating fine motor/sensation loss. We then asked them to open different size medication bottles and to find one pink Tic-Tac® candy in a bag full of white navy beans. This simulated finding medications based on color and shape. Throughout the activity, the facilitators used Elderspeak – that is speaking slowly in a high-pitched voice using simplified words as if speaking with young children – with the participants. GRNs noted the burdens of multisensory impairment on social, cognitive, and physical aspects of aging.

J. Pettis: What did the nurses like most about the day and what strategies do you think they will use to integrate this new knowledge about older adults and their care needs into their daily practice?

A. Stoller: Overall feedback was excellent with positive predicted changes in professional practice and patient outcomes. The GRNs enjoyed the mix of traditional presentations interspersed with the interactive activities. Comments included:

"Best course I have taken at Lahey in all my 30 years!"

"Interactive breakout sessions are more memorable. This was an amazing course. I am so glad I was able to participate. I learned a lot and cannot wait to bring my new knowledge to the bedside."

In addition, there was a 25.4% increase in scores between the pre- and post-tests indicating participant application of new knowledge. The facilitators' also noted participants were able to incorporate classroom lessons into simulation activities. Participants described attainment of new knowledge relating to the following domains:

- Age-related changes and the impact on care
- Improved communication skills
- Differentiating, assessing, and managing delirium and dementia symptoms
- Medication barriers faced by older adults
- Care related to mobility, incontinence, and nutrition

J. Pettis: Is there anything that you would do different next time you planned a day-long CPD activity?

S. Iannuzzo: The only thing we may change going forward is to increase the length of the class. It would have been nice to be able to go into greater depth on some of the topics, such as age-related changes and elder abuse. Another thought may be to change the format to a blended approach in which the GRNs had independent prework then participate in the live class. This would allow them to have some foundation of knowledge which could then be further expanded upon during the live class time and allow for incorporation of case studies.

J. Pettis: Thank you so much for sharing your story with the ANA-NY membership and for all that you to improve care for older adults!

A. Stoller: It's our pleasure! We are so proud of how the GRNs enjoyed the training, and we hope that others can learn from our experiences to improve educational offerings in their organizations.

S. Iannuzzo: I agree with Arlene. I also think it is important to again highlight how impactful it was to involve the GRNs in teaching their peers. We hope that others will similarly empower their nurses. Thank you for taking the time to ask us about the training. We hope the ANA-NY members enjoy our story!

To learn more about NICHE and how you can join this innovative group of nurse leaders, visit the NICHE website or call 212-998-5445.

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Member Benefits

American Nurses Advocacy Institute (ANAI)

Each year ANA-NY fully funds two members' attendance to ANAI, a program held in Washington, DC where ANA Government Affairs staff provide a deep dive into legislation and advocacy. Attendees select a project to develop with the support of ANA staff and an ANA-NY mentor.

Annual Conference Registration

ANA-NY holds a three-day annual conference offering an array of CE bearing presentations on current healthcare topics. The conference is open to all. Registration is discounted for ANA-NY members.

Career Center

Visit our Career Center to find opportunities across the state.

comMIt (comprehensive motivational interviewing training) for health care professionals

comMIt is an e-learning program accredited for eight hours of approved continuing education credit for nurses. The learner has three months to complete this highly interactive program and receive CE credit. This unique program uses a sense making approach to motivational interviewing by Drs. Bruce A. Berger and William A. Villaume. The price of this training is typically $125, however please use the Discount code 'ANANY2021' at checkout to receive the training for $80. Please visit https://tinyurl.com/PurdueCE-MI-HCP for more information.

Dual Membership

When you join ANA-NY, you get two great memberships for one low price. Receive all the benefits of ANA's national reach and the personalized local benefits of ANA-NY.

Journal of American Nurses Association – New York (JANANY)

JANANY, an open source, peer-reviewed, scholarly journal is published biannually. Submit manuscripts here. If you are interested in joining our editorial board, visit https://ananewyork.nursingnetwork.com/page/95227-editorial-advisory-board

Lobbyist

Our lobbyist works with ANA-NY Board of Directors and the ANA-NY Legislation Committee to advance ANA-NY's legislative priorities and advocate for nurses on the state level.

Member Awards

Members are eligible for prestigious member awards in the categories of: ANA-NY Hall of Fame, Nursing Practice – Early Career, Nursing Practice, Scholarship, Mentorship, Nursing Education, Nurse Hero, and Policy & Service.

Member Engagement

Involvement in your state professional association can include voting in the annual election, submitting your scholarly work for poster or podium presentations at the annual conference, signing up for and participating in our grassroots advocacy, submitting Bylaws amendments, reading and passing along our newsletter, running for the Board of Directors, participating on committees and/or task forces, following us on social media, and attending state and regional events.

Networking Opportunities

In addition to our Annual Conference, ANA-NY members are notified of events across the state that may be of interest to them.

New York Nurse

Our quarterly newsletter that provides informational articles, news from the nursing field, messages from our President and Executive Director, Continuing Education opportunities, and much more!

Nurses Supporting Nurses

We recognize the stress and stigmas associated with difficult work situations or events. Peer nurse support helps! Nurses Supporting Nurses is comprised of volunteer ANA-NY peer support volunteers with rich clinical experience from diverse practice settings. This opportunity is open to all NY nurses, not just our members.

Nurses looking to volunteer can visit https://ananewyork.nursingnetwork.com/page/96231-volunteer-to-be-a-peer-supporter

Nurses looking for support can visit https://ananewyork.nursingnetwork.com/page/96232-requesting-support

Nursing Services Organization (NSO)

Purchase discounted professional liability insurance through NSO. Click here for more information.

Office Updates

Monthly office updates are sent to all members with information on upcoming events and programs.

Professional Coaching

Sign up to receive free 1-on-1 professional career coaching. Dr. Phyllis Quinlan is offering this 90-minute career coaching session at no charge to our members. The scope of these coaching services includes personal growth, work-life integration, career transition, career and leadership development, support in working through stress, and executive coaching.

Visit https://form.jotform.com/220455390668158 to sign up for your 1-on-1 meeting today.

Project Firstline

Project Firstline is a series of free infection prevention teaching modules offered by ANA and the CDC. These modules are CE bearing, and the program also offers other resources. The modules offered by the CDC are geared toward the general healthcare audience, whereas the modules offered by ANA are nursing focused. For more information on these free modules and resources, visit https://www.nursingworld.org/practice-policy/project-firstline/

Member Benefits continued on page 25

Strategies to Recognize and Address Implicit Bias in Healthcare

Donna J. Craig, RN, JD

Reprint with permission from The Future of Nursing in Michigan, February 2022 issue

We all have developed implicit biases as a result of our environment and life experiences. While healthcare providers exhibit implicit biases to the same degree as the general population, those implicit biases may contribute to health care disparities experienced by individuals who have different race/ethnicity, gender, socio economic status, age, mental illness, weight, AIDS, brain injured patients, intravenous drug users, disability, and social circumstances than healthcare providers. These implicit biases cloud how healthcare providers approach patients and may make it harder to care for patients.

Bias is the negative evaluation of one group and its members relative to another group of individuals. Explicit bias requires that a person is aware of his/her evaluation of a group, believes that evaluation to be correct in some manner, and has the time and motivation to act on it in the current situation. Implicit bias differs from explicit bias in that it operates in an unintentional, even unconscious manner, and can be activated quickly and unknowingly by situational cues (e.g., a person's skin color or accent), silently exerting its influence on perception, memory, and behavior. This causes a dissociation between what a person explicitly believes and wants to act (e.g. treat everyone equally) and negative implicit thoughts and actions (e.g. perceiving certain ethnic group members as less competent).

The implicit biases that may affect patient care are those that operate to the disadvantage of those already vulnerable. For example, if a person is poor, this is a disadvantage in itself but the person may be further disadvantaged when he refrains from seeking health care because of the cost. Failure to seek health care could result in a condition not being diagnosed, further disadvantaging the person.

The extent of implicit bias can be measured and addressed though. The most common measurement tool is the Implicit Association Test (IAT), which is a computer-based program. The IAT operates on the principle that it is easier to make the same response (e.g., a key press) to concepts that are more strongly associated compared to concepts less strongly associated. The strength of association between concepts is determined by the respondents' speed in sorting the items under two different conditions, with faster responses in one condition indicating a stronger association. The larger the performance difference, the stronger the implicit association or bias for a particular person. Demonstrations of this test can be found at https://implicit.harvard.edu/implicit/education.html.

Implicit biases among healthcare providers have been associated with the following negative effects on patient care :

- Inadequate patient assessments;
- Inappropriate diagnoses and treatment decisions;
- Less time involved in patient care; and
- Patient discharges with insufficient follow-up

Research has shown that nurses with implicit biases may demonstrate less compassion for certain patients and invest less time and effort in the therapeutic relationship with them, adversely affecting assessment and care.

Healthcare providers tend to default to their implicit biases in stressful situations such as we have experienced during the COVID pandemic. Both implicit and explicit biases towards unvaccinated hospitalized patients impact the care provided to those patients. Therefore in stressful times it is even more important to recognize the implicit and explicit biases brought to the bedside.

The first step in recognizing implicit biases is to be in touch with one's gut feelings. If healthcare providers experience unpleasant experiences when caring for certain patient groups or they experience anxiety or uneasiness, such feelings may indicate that an implicit bias may be present. In such cases, it would be helpful to conduct some self-reflection.

It is important to remember that patients also may come to a clinical setting with their own biases. In these cases, the biases of one participant may trigger the biases of the other, magnifying the first participant's biased responses and leading to a snowball effect. Past experiences of discrimination may mean a patient comes to the clinical setting with negative expectations. Since stereotype biases or negative expectations can interfere with communication between patients and healthcare providers, interventions that reduce patients' perceptions might lead to more functional behavior for the patients and healthcare providers.

To overcome biases nurses should focus on establishing a therapeutic relationship with the patient. This begins with getting to know the patients, their values, health goals, priorities, challenges, and needs. Focusing on each patient's perspective helps the nurse to assist the patient in meeting his health care goals. Biases can also be overcome by having a collaborative relationship with the patient so that clinical care is coordinated and achieved. Nurses should strive to ensure that patients with differing backgrounds or traits than the caregiver should receive care that is effective and respectful of their differences. Together, these approaches subvert the negative automatic responses that characterize implicit bias, enabling nurses to meet their patients' need for individualized respectful care.

Social scientists have developed strategies to mitigate implicit biases. These strategies include:

Counter-stereotypic Imaging – The nurse recognizes bias, purposely identifies members of a group who counter the stereotypical image of the group and replaces the automatic biased image with the positive image. This strategy is related to mindfulness.

Emotional Regulation – A nurse reflects on "gut feelings" and negative reactions (dislike, fear, frustration) to patients from vulnerable groups. The nurse then intentionally strives to be empathic, patient, and compassionate. Emotional regulation is related to mindfulness and perspective taking.

Habit Replacement – The nurse frame recognized biases as bad habits to be broken and then develops and uses a personal toolkit of self-interventions to replace the bad habit of biased thinking with the good habit of accepting and caring about each patient as an individual. Habit replacement is related to emotional regulation, individuation, mindfulness, and strategies nurses use to help patients change harmful lifestyle behaviors.

Increasing Opportunities for Contact – A nurse seeks to develop relationships with members of a group to which the nurse does not belong, with the goal of dissolving stereotypes.

Individuation – The nurse mindfully seeks to see patients as individuals instead of as members of a stigmatized group. Therapeutic relationship, patient-centered care, and culturally competent care are related to this strategy.

Mindfulness – A nurse purposely takes the time to calm thoughts and feelings by being mindful of the present moment, which can help the nurse act compassionately toward the patient. The specific goal of mindfulness is to empty the mind of distracting thoughts so that the person can focus on the present moment, without assumptions or judgments. This strategy is related to emotional regulation and perspective taking.

Partnership Building – The nurse intentionally frames the clinical encounter as one in which the nurse and patient are equals, working collaboratively towards the same goal.

Perspective Taking – The nurse purposely and empathetically thinks about what the patient is thinking and feeling, stimulating feelings of caring and compassion. Mindfulness and therapeutic relationship are related to perspective taking.

Stereotype Replacement – A nurse reflects on negative reactions to members of vulnerable populations, acknowledges stereotypical responses, considers reason for the feeling, and commits to respond with compassion in the future. This stereotype replacement strategy is related to self-reflection.

Researchers Lai and colleagues found one-time interventions to mitigate healthcare provider biases, though initially effective, did not change behavior over time. Instead, nurses who combine bias-mitigating strategies with changing habits replace implicit biases with new behaviors. A plan to accomplish this could include the following steps:

- Recognize a habit's damaging effects (for example, inequitable health care and disparate patient outcomes);
- Commit to breaking the habit; and
- Use several of the bias-mitigating strategies listed above.

Social scientists Ponte and Koppel suggest using the S.T.O.P. mindfulness technique developed by Elisha Goldstein to become mindful of the assumptions to avoid or the values we want to bring to patients. Before entering a patient's room, a nurse might do the following:

- Stop what you're doing;
- Take some slow, deep breaths;
- Observe your thoughts, feelings, and assumptions; and
- Proceed with patient care.

The strategies presented in this article may be helpful to nurses and ensure patients get the most out of their interactions with the healthcare system.

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Tips for meeting the nurse staffing challenge

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The COVID-19 pandemic has reinforced the need for healthcare and nursing leaders to shift their approach to nurse recruitment and retention, as the exodus of nurses takes its toll on remaining staff and, in some cases, quality of care. These pandemic-related problems are intensified by factors that existed before COVID-19 and that still plague leaders. For example, hospitals in rural areas continue to struggle more than those in urban locations. Generational differences also exist, with Millennials more likely to leave positions compared to Generation Xers and Baby Boomers.

Too often, organizations have viewed nurses primarily as an expense, failing to understand that investing in this workforce yields financial rewards. High-quality nursing care helps to reduce the likelihood of patient safety events and costly medical malpractice lawsuits related to missed errors. Savvy leaders know that ensuring appropriate staffing levels is key to the financial health of the organization, which means engaging in effective recruitment and retention strategies.

Recruitment

You need to work closely with human resources staff to ensure recruitment processes are efficient and effective.

Craft ads that work. First impressions count. Everyone is your competitor for a limited pool of nursing talent, so do what you can to make your organization stand out as an attractive place to work. Be sure images in recruitment ads reflect the organization, particularly when it comes to diversity. Many organizations feature their own nurses in ads, which has the additional benefit of employee recognition.

Reach out early. Ask staff who work with students completing clinical rotations to identify those who might make good employees when they graduate. Then get to know the students and encourage them to apply when the time comes.

Promote digital efforts. Organizations' websites often miss the opportunity to feature nurses. Your facility's website should have a special section highlighting nursing, including stories that feature individual nurses. In addition, your organization's job portal and job application process should not be so cumbersome that potential employees give up in frustration.

Individualize benefits. Avoid a "one size fits all" approach to benefits. Instead, offer a menu that nurses can choose from. For example, a late-career nurse may be more interested in retirement-matching funds, but a newer-to-practice nurse may be attracted to a flexible schedule, tuition or student loan assistance, or child-care benefits.

Provide optimal onboarding. This is often discussed as a retention tool, but it also falls under the recruitment category, as potential employees want to know how supported they will be in their new role. This is particularly true of new graduate nurses, who have seen their recently graduated colleagues rushed into practice as a result of the pandemic. Many organizations are being shortsighted in cutting back on nurse residency programs, which not only attract staff, but also promote a smoother transition into practice, thus increasing retention.

Preceptors should be chosen based not only on their level of expertise, but their effectiveness as educators. Orientees (and preceptors) should know that they can speak up if the match isn't working.

Be sure staff feel warmly welcomed. For example, some organizations send a signed welcome card to the employee's home before their start date. Others post the employee's name and photo in a visible location on the unit.

Check in regularly with new staff to see how they are adjusting, such as weekly for a month, then every other month or so, and then after 6 months.

Retention

The 2021 National Health Care Retention and RN Staffing Report notes that the average cost of turnover for a hospital-based RN was $44,400 in 2020. This makes retention a key part of an organization's staffing strategies.

Conduct "stay" interviews. Stay interviews help you identify employees who might be thinking about leaving the organization and identify what factors are most important for staying. You can use the information to create an individual retention plan and to inform your larger retention efforts for the unit. These questions, from Rose Sherman, EdD, RN, NEA-BC, FAAN, author of *The Nuts and Bolts of Nursing Leadership: Your Toolkit for Success,* can help elicit useful information during stay interviews.

- **What do you look forward to each day when you commute to work?** This question focuses on the present and helps identify factors other than pay and benefits, such as relationships with colleagues.
- **What are you learning here, and what do you want to learn?** This helps leaders focus their career coaching.
- **Why do you stay here?** Staff may have not thought about this before, so help them reflect on their reasons.
- **When is the last time you thought about leaving and what prompted it?** Everyone sometimes thinks about leaving their job, but what prompted those thoughts can be informative.
- **What can I do to make your job better for you?** Once you hear the response, be honest about what you can do and not do.

Employees often think about leaving their positions around their work anniversary date, so leaders should try to conduct stay interviews 60 to 90 days beforehand.

Promote a healthy work environment. For example, implement zero tolerance policies for patient or visitor violence against nurses and policies that discourage providers from bullying their colleagues. Beyond policies, it is also important to ensure lines of communication are open, so your staff feel comfortable speaking with you when they identify problem areas. You can foster open lines of communication by taking time to get to know your staff on a more personal level, without crossing boundaries. For example, asking about a grandchild or a new pet takes little time, but signals your interest.

Make rounds daily and listen to staff closely, even though you're busy and face multiple pressures of your own. Ask them questions such as, "What do you need to do your job more effectively?" If it's something that you can take care of, do so and let them know it's been done. If you can't address the issue, explain why and, if appropriate, note that it may be able to be addressed in the future. For instance, a requested new piece of equipment might have to wait until the next budget cycle.

Avoid sign-on bonuses. Sign-on bonuses may help to ease staffing woes short term, but don't ensure commitment, and can even lead to resentment from current staff. Instead, focus on improving nurses' pay scales or offering retention bonuses to show appreciation for your nursing staff's commitment to the organization.

Recognize employees. Recognition is an easy, but often underutilized, retention tactic. Take every opportunity to offer words of praise. To reinforce the behavior, specify what specifically was done to earn praise; for example, a nurse may have taken extra time to locate a patient's loved one who was out of town. In these days of digital communication, a handwritten note can stand out, particularly if sent to the person's home. Small rewards such as gift cards can also be effective, but try to match them to the individual's interest. For example, a nurse who drinks coffee every day may enjoy a Starbucks card, but one who loves to read might prefer a card from Barnes & Noble.

Support career development. Explore nurses' professional goals and how you can help meet them during stay interviews and other conversations. It's a good idea to keep a mental list of options such as serving on committees, acting as a preceptor, and leading project teams. Offer meaningful opportunities for professional growth based on performance, rather than solely based on tenure. Outline for your staff the types of experiences or skills that are most valuable for advancement and reinforce the value of bedside nursing experience for nurses' long-term career growth.

Consider a job embeddedness approach. Job embeddedness (JE) focuses on why people stay in their jobs as opposed to why they leave. A study by Reitz and colleagues found it's a good predictor of nurses' intent to stay. JE looks at ties related to organizations and the community where they exist. These ties are considered in three dimensions: links (formal and informal connections people have with their organizations or communities), fit (how compatible people feel with their organizations or communities), and sacrifice (material and psychological losses people would experience by leaving their organizations or communities). You can leverage these dimensions to promote retention. For example, to help promote JE with the organization:

- Links: Involve nurses in committees and shared governance.
- Fit: Recruit nurses whose goals align with the organization's goals.
- Sacrifice: Align vacation time and retirement plans with the time of service.

A multifaceted approach

Nurse staffing challenges are unlikely to ease anytime soon. Leaders will need to be creative and take a multifaceted approach to recruitment and retention. These efforts will help gain—and keep—staff. Doing so helps reduce the costs of lawsuits related to errors, but, most importantly, provides optimal patient outcomes.

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CONTINUING EDUCATION

Authenticity in Communication

Continuing Education Instructions

Steps to complete independent study and receive 0.75 contact hours

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Introduction

Authenticity in Communication has many implications in patient care, patient advocacy, interdisciplinary relationships, and critical judgments. Now more than ever, we communicate with others with technology, through interpreters, using verbal, written, or non-verbal methods to facilitate messages reaching an audience. What does it mean to have authenticity in communication? In nursing, we make decisions based on interpretations of messages communicated in the healthcare setting every day, and each of us relies on the authenticity of that communication to ensure that the decisions made are in the best interest of the patient. This article discusses the concept 'Authenticity in Communication.' A literature synthesis of the concept's used in philosophy, psychology, and nursing, is explored, and a case study example of authenticity in communication (AC) is provided.

Method for Concept Analysis of Authenticity in Communication

The methods of concept analysis in the development of theories are foundational for knowledge development in nursing and are similar to positions presented in the development of philosophies. Concepts are a means of relating to things in the world to make sense of what they are (Rodgers & Knafl, 2000). Whether concepts represent objects or ideas, using language can assist in determining the essence or meaning of the concept, connecting it to its appropriate use in context. Descartes thought of concepts as ideas that represent the objects of human thought (Descartes, 1998). Kant (1965) described concepts as existing in mind (a priori) and not necessarily attached to objective reality. In the case of empirics, Kant discussed how knowledge is not specifically defined but is made explicit and revealed through experience and capabilities (concepts) (Kant, 1965). Beth Rodgers (1989) distinguished a method for concept analysis, and this framework is utilized to analyze AC.

Rodger's Concept Analysis Method

The process of concept analysis in nursing typically entails a synthesis of the concept and then distinguishing it from other concepts. Rodgers (1989) developed an evolutionary approach to concept analysis in a method that takes a reductionist view where concepts are fluid and subject to change depending on context and application. For Rodgers (1989), clarifying the current use of the concept in its temporal aspects can create significance to be used as a foundation for further inquiry. There are eight steps in Rodgers method:

1. Identify the concept of interest
2. Identify surrogate terms
3. Identify sample for data collection
4. Identify attributes of the concept
5. Identify references, antecedents, and consequences of the concept
6. Identify related concepts
7. Identify a model case
8. Conduct interdisciplinary and temporal comparisons

Literature Review of Authenticity in Communication

Knowledge development of AC can assist nurses in improving communication with patients and their families throughout the care continuum. To formulate a cohesive definition of AC, the initial strategy includes defining the concept of 'authenticity.' A search of the literature for the concept authenticity included several databases: CINHAL, EBSCO, and PROQUEST. Keyword searches for authenticity, its derivative, authentic, and synonyms such as sincere, sincere, true, real, genuine, and truth-telling are used individually or combined with 'communication' and 'dialogue.' Search results were initially in the thousands, and a strategy for better specificity of results focused only scholarly references with a central theme of authenticity related to communication were included. Targeted disciplines of philosophy, psychology, and nursing provide the most abundant and appropriate use of AC.

Philosophical resources were chosen for their underpinnings in defining the evolution of the concept of authenticity; psychology articles were selected based on their specific relationship with AC. Nursing sources were sought to identify the use of the concept in practice. The literature revealed the concept's attributes, antecedents, and consequences; those referred to with greater frequency in the investigated literature are presented.

The Evolving Concept of Authenticity in Communication

According to the Oxford-English Dictionary (2022), authenticity is the fact or quality of being true or in accordance with fact; veracity; correctness, accurate reflection of real life, verisimilitude; quality of being authoritative; genuineness; sincerity, the quality of being authentic, reliability, dependability, trustworthiness, credibility; accuracy, truth, veracity, fidelity. The American Heritage Dictionary (2021) states that authenticity is the quality or condition of being authentic, trustworthy, or genuine.

In western philosophy, authenticity begins in the seventieth and eighteenth centuries with the notion of authentic self and unique individuality. These concepts evolve as a separation between public and private life. Affirmation of individual identity and personal conviction supersede those of society (Trilling, 2009). During this period of individualism, many self-portraits and autobiographies appear in art. Before the period of individualism, sincerity and authenticity were closely related terms; sincerity is described as an ideal where an honest and sincere person seeks society's common good, and morality is predicated by the approval of others (Golomb, 2012). In The Phenomenology of the Mind, a book by the German philosopher Hegel (1807, (2003)), embracing autonomy is essential to cultivating an authentic self and living an ethical life. Hegel separated the idea of sincerity from the concept of authentic self. For Hegel, freeing oneself from society's norms and from sincerity, promoted individual thought and autonomy. Autonomy becomes a virtue connected to authenticity, being free to be true to oneself, speaking, and making moral decisions based on internal insight and reasoning rather than blindly following society's rules (Kant, 1965). Authenticity in Communication, though not yet explicitly defined in this period, infers thoughtful and genuine expression informed by an internal process of the individual. Authenticity requires inwardness and a reflective nature (Kierkegaard, 1985).

A century later, sincerity is re-examined as an essential condition of virtue. It evolves as a concept with a relationship between true self, best self, and authentic self. In communication, sincerity is positively related to authenticity, not separate from it. Being sincere in communication is different from saying you are sincere: 'I sincerely believe' is less powerful than saying 'I believe.' Authenticity in communication and being is "a more strenuous moral experience than sincerity" (Trilling, 1971). In this way, AC is being sincere, not appearing to be sincere.

In addition to autonomy and sincerity as characteristics of authenticity, the literature reveals that AC involves being true to one's self, removing a 'mask of falsehood,' and being real, (Heidegger, 1962). The opposite of authenticity is falsehood, artifice, and deception, living a lie. "Authenticity is the reduction of phoniness toward the zero point" (Maslow, 1971). The theme of being true to one's self is echoed in the play Hamlet: "This above all: to thine own self be true,/and it must follow, as the night the day,/thou canst not then be false to any man" (Shakespeare, n.d.; *Hamlet*. 1.3.84-86).

The fundamental elements of the concept and analysis of the literature facilitated the identification of substitute terms, attributes, antecedents, and consequences as seen in the table below:

Table 1

Fundamental Elements of Authenticity in Communication	
Substitute Terms	
Authentic Dialogue	Listening into Authenticity
Breaking Bad News	Non-Violent Communication
Cheng (Chinese: 'What is said must be done, and what is done must be brought to fruition.')	Sensitive Communication
Ethical Communication	Supportive Communication
Faithfully Told	Therapeutic Discourse
Honesty	Truth-telling
	Truthfulness
Attributes	
Authentic/ having authenticity	Integrity
Autonomous	Internal Morality
Being real	Inwardness
Being true to one's self	Mask removing
Being Virtuous	Purpose Centered
Emotional Honesty	Sincerity
Ethical	The pose of not knowing
Genuineness	
Antecedents	
Awareness	End of Life Care Ill
Bad news	health Isolation Moral
Paradox	conscience Negative turn
Lies and Omissions	of events/Untoward event
Cancer diagnosis	Reconstruction of an event (memory)
Consequences	
Authentic purpose	Insight
Authentic personhood	Mutuality
Choice based on personality and character	Re-establishing or creating self
Conflict resolution	Respect
Connection: healing connection, social connection	Self-discovery
	Socially Connected
	Therapeutic relationship
Deep understanding	Transcendental reflection
Development of an ethical self	Trusting relationship
	Vitality of the patient
Dignity	
Experiencing a continuity of being	
Healthy self-esteem	
Hope	

Surrogate Terms

Based on the empirical research found, surrogate terms are often used to describe the concept of AC. These associated terms are listed in Table 1, but truthfulness and truth-telling were most frequently used (Barker, 2013; Billow, 2010; Brown, 2011; Chauhan, 2000; Erlen, 2000; Rath, 2012). Chauhan (2000) points out, in the telling of the truth, it is the intention that is important, and although "brusque, unfeeling, and insensitive communication of unpleasant truths can cause acute distress" (p. 982), "communication is the vehicle through which ethics flow and grow" (p. 979). This Implies that AC may cause distress, but the way information is presented can influence understanding and well-being. The research provides models for communication of bad news that need not be insensitive to the individual receiving it (Nosek, 2012). Authenticity in Communication can clarify understanding, utilizing language that builds a trusting and therapeutic relationship.

Attributes

To characterize the concept of AC, much of the literature came from psychology or psychiatric nursing. Having the trait of authenticity, genuineness (being real), and willingness to reveal an authentic self, as well as possessing emotional honesty (sometimes described as 'feeling it') was prevalent in these sources (Barker, 2013; Boccara 2009; Collins, 2011; Henderson, 2010; Heppner, 2008; Lenton, 2013; Loeb, 1992, Nosek, 2012; Pettinato, 2008; Purcell, 1999; Starr, 2008). In addition, the attribute of willingness to be open to the unknown (Purcell, 1999) fosters an environment where the patient can express their true self. These attributes can belong to the person relaying a message or to the listener; there is a benefit for each. Authenticity in Communication in nursing can be a powerful tool for patient advocacy in the clinical setting. These attributes enhance the underpinnings of truth-telling and ethical behavior.

Antecedents

There are several antecedents, which appear to be alongside AC. Sometimes they are difficult patient experiences such as a cancer diagnosis, bad news, end-of-life care, or isolation, to name a few (Brown, 2011; Griffiths, 2015; Jordan, 2001, Wright, 2014). Other times an internal awareness or moral conscience requires Authenticity in Communication to realize an authentic purpose for ourselves or our patients (Keshen, 2006; Loeb, 1992; Pang 1998), or to simply help someone in "putting the pieces back together" (Pettinato, 2008).

Consequences

Consequences are the results of use of the concept in practice (Rodgers & Knafl, 2000). In the case of AC, there are many examples of desirable outcomes with patients such as restoring hope, and dignity, creating a trusting relationship, offering choices based on the patients full self-awareness, and cultivating healing connection that leads to vitality in the patient (Brown, 2011; Boccara, 2009; Loeb, 1992; Nosek, 2012; Rien, 1999).

Case Study

A model case of AC illustrates proper use of the concept and its essential attributes (Rodgers & Knafl, 2000). Undeniably, the truth is an abstract concept of which we shall always have an imperfect grasp; nevertheless, in telling the truth, the intention is all-important (Chauhan, 2000). Furthermore, ethical behavior in exercising AC is protective of the patient and informative (Chauhan, 2000, Erlen, 2000).

In this example, a patient in the Bone Marrow Transplant unit for several weeks receiving chemotherapy in preparation for transplant is just days away from the scheduled treatment. The team enters the room to discuss the transplant and answer questions that the patient may have. J.T. is 21 years old and has acute myeloid leukemia; his mother and father are at the bedside. After the information is given and questions answered, the nurse stays behind with the patient and family. J.T. asks his parents to step out for 15 minutes so that he can take a shower.

When the parents have left the room, the patient asks the nurse if he will die since no one has addressed this. He wants to know the truth. He confides that he has been reading information online and thinks that his prognosis is poor. The nurse has cared for J.T. many times during his hospitalization and realizes that this is the first time he has broached the topic of his mortality. They speak openly, reviewing the information the doctor gave on the statistics for success and the complications of graft vs. host disease and symptom management.

J.T. is hopeful that things will go well for him, but now he asks about wanting to make sure that "if things go south," he does not want a breathing tube or a feeding tube. His parents insisted that he not sign advanced directives since he should "not think negatively." J.T. does not want to die but wants to plan "just in case." He does not want to upset his parents but says he is afraid they will not know what he wants if the transplant is unsuccessful.

The nurse acknowledges that J.T. wants to have advanced directives on his chart. She asks J.T. if it would be all right with him if a family meeting were scheduled with the doctor, social worker, and nurse to facilitate getting the paperwork on the chart and to help with communicating with his parents. He agrees, and later that day, J.T., his parents, nurse, doctor, and social worker meet, and the advanced directives are signed and placed in the chart. After the meeting, J.T. confides that he is relieved and feels ready for whatever the transplant may bring. He resumes his usual joking demeanor with the staff and has a successful transplant days later.

In this example of Authenticity in Communication. Both the nurse and J.T. were being real, genuine, and authentic. J.T. was being true to himself and emotionally honest about his fears and not wanting to disappoint his parents. As J.T.'s advocate, the nurse provided information and recognized J.T.'s autonomy to make decisions about his healthcare options. Standing for the patient's right to choose and acting ethically, the nurse did not shy away from a conversation about J.T.'s needs and wishes that were most essential to who he is as a unique and autonomous individual.

Conclusion

Authenticity in Communication for nursing practice is being truthful, genuine, ethical, and sincere in our interactions with others in a manner that respects the autonomy and internal morality of both the sender and receiver of the message, thereby creating the possibility of insight, hope, connection, dignity, and deep understanding in the pursuit of conflict resolution and vitality of the patient (Griffiths, 2015). In addition, Authenticity in Communication is supportive communication that is therapeutic, relational, and ethical in scope (Griffiths, 2015; Starr 2008).

Implications for Nursing Practice

Authenticity in Communication is a concept with far-reaching implications in nursing, primarily as it can assist in creating understanding and better decision-making for patients. Already in some settings, there are models in place that help in this process, including Nonviolent Communication (Nosek, 2012) and SPIKES, an acronym for presenting distressing information in an organized manner to patients and families. S stands for setting, P for perception, I for invitation or information, K for knowledge, E for empathy, and S for summarizing or strategizing (Kaplan, 2010). However, these and other communication models need further research to validate if they support the concept of AC.

Our healthcare environments are becoming more technologically advanced and may replace direct human interaction, and telehealth is an example. The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient, and professional health-related education, public health, and health administration (HealthIT.gov, 2016) will necessitate AC with the interdisciplinary team so that choices can be made by patients and caregivers with full, truthful disclosure. Reliance on technical data need not supersede the human dimension of communication expressed in language and emotional honesty (Barker, 2013; Lenten, 2013). Nursing will need to participate actively in developing these technologies to help promote AC.

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Overcoming Nursing Barriers to Caring for Patients with Serious Mental Illness

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This RNF feature presents abstracts of research and evidence-based practice (EBP) projects completed or spear-headed by nurses or student nurses in Nevada. The focus is on new evidence (i.e., research) or the translation of evidence (i.e., EBP) in Practice, Education, or Research. Submissions are welcome and will be reviewed by the RNF editorial board for publication; send your abstract submission in a similar format used below to mary.bondmass@unlv.edu

Erin A. Pate, RN, MSN, CCRN, received a BSN at California State University, Stanislaus, an MSN in Leadership and Administration from Ball State University. She is expected to complete her DNP at the University of Nevada, Reno, in December of 2021. Erin started her career as a critical care nurse in 2012. She is a veteran and continues to serve in the United States Air Force; her current position is Chief, Extended Care Mental Health Nursing Service at the VA Sierra Nevada Healthcare Systems, in Reno, NV. In addition to her distinguished career, Erin is a wife and a mom of two beautiful daughters.

Erin's DNP project is described in the abstract below.

Erin A. Pate, RN, MSN, CCRN

Background: Mental illness will likely impact most individuals, with 20% of all people experiencing some form of mental illness in their lifetime and 4% being diagnosed with serious mental illness (SMI). With the prevalence of mental illness, nurses need to feel comfortable and competent in providing care to this population. Unfortunately, research reflects that nursing attitudes are in line with societies, such that many nurses agree there should be social restrictions and distance requirements (i.e., marriage, work, living location, etc.) on individuals with mental illness.

Many nurses carry bias into the patient-care provider relationship when a psychiatric diagnosis is involved. When a patient has a mental health diagnosis, their medical conditions are up to 20% less likely to be correctly identified by nursing staff. The bias affects the identification of needs and where and how this population should be cared for, with 67% of non-psychiatric nurses believing patients with mental illness should be separated from those without mental illness.

Previous research has identified many barriers to non-bias care of patients with SMI by non-psychiatric nurses. For example, nurses identified a lack of knowledge related to mental health as one of the most significant barriers to effectively caring for patients requiring intervention for behavioral concerns.

Purpose/Methods: This project aimed to explore barriers that mental health and non-mental nurses identify in providing care for patients with SMI diagnosis in acute and subacute settings. To this end, the following questions were addressed in this project.

1. What are the barriers for a nurse in providing care for patients with an SMI diagnosis in the acute and subacute setting?
2. Do Psychiatric and Non-Psychiatric Nurses experience different barriers to providing care for SMI patients?
3. What interventions can be implemented to overcome the barriers to caring for a patient with an SMI diagnosis?
4. How does an organization operationalize these interventions in a usable and cost-effective manner?

A pre-post interventional design was utilized for this project. Three theoretical frameworks underpinned the project, including Leininger's Cultural Care Theory, Spradley's Change Model, and Benner's Novice to Expert. The target population and setting respectively, included nurses with and without psychiatric training working in multiple practice areas at a major medical center. A previously validated instrument, the Behavioral Health Care Competency (BHCC), was used to collect data on the barriers to care. Based on an identified knowledge gap in the pre-interventional BHCC surveys, an intervention of an educational toolkit was developed and implemented. After that, a post-intervention BHCC survey was conducted and data were analyzed to assess for change.

Results: Post-intervention, the respondents showed an increased perception of their ability to provide care for patients with SMI in all practice areas. Statistically significant increases ($p = < 0.05$) were seen in four questions on the BHCC, and improvement, although not statically significant, was demonstrated across all other competency categories on the BHCC. Not surprisingly, those who self-identified specifically as mental healthcare unit (MHU) nurses scored higher on the BHCC pre-intervention survey.

Conclusion: Based on the pre-post change demonstrated in this project, it was concluded that the developed tool kit improved this sample's knowledge and perception in their abilities to assess patients for potential psychiatric problems, effectively manage conflicts triggered by patients who have a mental illness, effectively intervene with a hallucinating patient, and use de-escalation techniques and crisis communication to avert aggressive behaviors.

The small sample size limited this project, and future work to validate similar findings is recommended to determine if results may be generalized to other staff and facilities.

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Competencies Post-Interventions

Competencies	Question Range	Non-MHU		MHU		All	
		Mean	StdDev	Mean	StdDev	Mean	StdDev
Assessment	1-9	4.00	0.59	4.46	0.51	4.26	0.60
Practice/ Interventions	10-17	3.86	0.54	4.34	0.59	4.12	0.64
Recommend	18-19	3	0.69	3.44	0.65	3.23	0.70
Resource Adequacy	20-23	4	0.68	4.28	0.80	4.15	0.74
Total		3.72		4.13		3.94	

Post-Intervention Changes

BHHC question items	Non-MHU				MHU				All			
	Mean	StdDev	t-Test	pValue	Mean	StdDev	t-Test	pValue	Mean	StdDev	t-Test	pValue
#1 I can assess patients for potential psychiatric problems	3.86	0.38	1.55	0.14	4.5	0.53	1.44	0.16	4.2	0.56	2.03	0.05
#10 I can initiate appropriate nursing interventions for common psychiatric issues such as depression, bipolar disorder, and psychosis.	3.86	0.69	1.04	0.32	4.25	0.46	1.35	0.19	4.01	0.59	1.75	0.09
#13 I can effectively manage conflicts caused by patients who have mental problems.	3.71	0.49	1.24	0.23	4.38	0.52	1.91	0.07	4.07	0.59	2.18	0.04
#14 I can effectively intervene with a patient having hallucinations.	3.71	0.49	2.39	0.03	4.13	0.64	0.61	0.55	3.93	0.59	2.05	0.05
#15 I am able to use de-escalation techniques and crisis communication to avert aggressive behaviors	3.86	0.69	1.33	0.21	4.5	0.53	2.27	0.04	4.2	0.68	2.42	0.02

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SPEAKHIRE

ANA-NY's partnership with SPEAKHIRE has provided volunteer opportunities to our members to instill an understanding of the nursing field in young adults across the country. SPEAKHIRE is a nonprofit organization whose mission is to develop the social and cultural capital of individuals from immigrant families to become leaders in the workforce.

For more information on this volunteer opportunity and to sign up, please visit https://speakhire.org/champions

Success Pays

You will receive a study guide and two testing attempts for the price of one for ANCC certification through Success Pays. Click here to complete the interest form.

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The last two years have brought unprecedented challenges for nurses. Most feel overworked and stressed out. We get it! To help, ANA-NY has partnered with Terra Firma for Nurses to provide you with a CNE bearing, evidence-based, stress management course.

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A Cautionary Tale

Dr. Jeanine Santelli

As we hear of the unfolding cases in Tennessee, we might react with panic, "could that happen to me?" It is very unlikely that something that extreme would happen in New York; however, let me share a personal story to make a few points.

I had just started a new position when I received a letter from New York State Education Department – Office of Professional Discipline. I did panic! What would my new employer think? What do I do? Who do I call?

The reason I was being investigated came from an occurrence two years prior. The Department of Health and the facility both did an investigation in the days following the occurrence, and I was not found to be at fault. I had assumed that I was in the clear and didn't think any more about the investigation. At the time of the occurrence, my work supervisor had taken me aside and, over coffee, asked what happened. **IMPORTANT POINT: I did not realize that I was giving my statement.** In the course of the "chat" I made some casual remarks (nothing unprofessional or derogatory) that later haunted me.

I reached out to the facility where I had been employed in a variety of roles for over 30 years. They said that their legal team was working on their defense and could not help me with mine. Also, they do not provide support or assistance when an individual's license is under review. **IMPORTANT POINT: Don't count on your employer to have your back.**

I reached out to my professional liability carrier, and they were very supportive and calmed me down a lot. They recommended that I get a lawyer immediately. Of course, I didn't know any malpractice lawyers because I had never been down this road before. So, they recommended a lawyer with whom they had worked who was in my region. They also reimbursed all of the lawyer's expenses. **IMPORTANT POINT: Lawyers are super expensive, but much needed in situations like this!**

When it came time for my hearing, my lawyer had prepped me on how to approach the panel and what to say. He also helped me extricate myself from my casual comments that suddenly had become my statement of the incident. My casual remarks made it appear that I was a sloppy practitioner. He helped me accurately represent my years of safe, professional practice and provide context for the remarks that were being submitted, unknowingly, as my statement. **IMPORTANT POINT: Having a lawyer with me may have saved my license.**

I am relieved to share that I was completely cleared and there were no sanctions on my license. I only share this stressful, and embarrassing piece of my professional life, to help you, my readers and members, protect your professional license. **IMPORTANT POINT: The investigation by the Office of Professional Discipline took two years from when I received the letter to resolution.**

LESSONS LEARNED:

1) **If you are being investigated, for anything remember that "what you say can be used against you."**
2) **Carry your own professional liability insurance. Make sure that your policy not only covers you if you are sued, but also covers you for professional misconduct reviews.**
3) **Have a lawyer with you when its your license, and life, on the line.**

ANA-NY Statement

Dr. Marilyn L. Dollinger, ANA-NY President

Recent events in Tennessee that resulted in the criminal conviction of Nurse RaDonda Vaught, should raise serious questions for nurses and all healthcare providers about the malpractice system in the United States. The conviction of this nurse for a tragic medication error will make all providers worry that reporting errors could move professional disciplinary procedures beyond the administrative/civil system to criminal proceedings. The culture of safety in health care rightfully puts patient safety first and mandates that all errors be reported. Best practices require that the entire process leading to the error undergo an investigation to make sure all gaps in safe process are corrected. Nurses accused of malpractice appropriately undergo an investigation and review by the state authority that governs professional licensing. The individual must accept that outcome. From the beginning, Nurse Vaught admitted the medication error. The professional disciplinary process and eventual administrative action against Ms. Vaught's license are not in dispute. However, the rest of the system failed her. To protect patient safety and create accountability, all stakeholders must be honest and forthright throughout the process. The handling of this case raises troubling questions about every aspect of the investigation, response, and outcome.

ANA Statement in Response to the Conviction of Nurse RaDonda Vaught

SILVER SPRING, MD-Today, a jury convicted former Vanderbilt University Medical Center nurse RaDonda Vaught of criminally negligent homicide and impaired adult abuse after she mistakenly administered the wrong medication that killed a patient in 2017. The following statement is attributable to both the American Nurses Association (ANA) and the Tennessee Nurses Association (TNA):

"We are deeply distressed by this verdict and the harmful ramifications of criminalizing the honest reporting of mistakes.

Health care delivery is highly complex. It is inevitable that mistakes will happen, and systems will fail. It is completely unrealistic to think otherwise. The criminalization of medical errors is unnerving, and this verdict sets into motion a dangerous precedent. There are more effective and just mechanisms to examine errors, establish system improvements and take corrective action. The non-intentional acts of individual nurses like RaDonda Vaught should not be criminalized to ensure patient safety.

The nursing profession is already extremely short-staffed, strained and facing immense pressure – an unfortunate multi-year trend that was further exacerbated by the effects of the pandemic. This ruling will have a long-lasting negative impact on the profession.

Like many nurses who have been monitoring this case closely, we were hopeful for a different outcome. It is a sad day for all of those who are involved, and the families impacted by this tragedy."

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 4.3 million registered nurses. ANA advances the profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of health care for all. For more information, visit www.nursingworld.org. For high-resolution images of the ANA logo or photos of ANA leadership, please click here.

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Donna J. Craig, RN, JD is legal counsel to the ANA-Michigan Chapter and the Michigan Council of Nurse Practitioners. She practiced as a cardiac care nurse for several years before a chance opportunity to audit a graduate course in health care law and ethics changed her career path. That course propelled her to earn her law degree. After law school Ms. Craig joined a medical malpractice defense law firm before transitioning her focus to health care corporate and administrative law matters. For over 20 years she has maintained her private health law practice, representing health care providers and facilities in business, licensure and compliance matters. For her expertise and accomplishments, Detroit's dbusiness Magazine awarded Ms. Craig its Top Lawyer in Health Care Law award on three occasions. Ms. Craig has the distinction and is proud of being a bar member of the Supreme Court of the United States of America. For more information about The Health Law Center, go to www.healthlawcenterplc.com.

ANA-NY/ANA Membership Activation Form

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