Volume 6
Number 3

ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

January 2022

The Official Publication of the American Nurses Association - New York
ANA - New York Nurse will reach over 72,600 New York nurses and schools of nursing.

INDEX

PRESIDENT'S MESSAGE

Marilyn L. Dollinger, DNS, FNP, RN

It was wonderful to see so many of you at the ANA-NY Annual Conference in Huntington, Long Island, October 28-30. If you were not able to make it—we missed you!

I want to take this opportunity to welcome our new Board members: Trudy Hutchinson, Secretary; Giselle Gerardi, Director-at-Large; as well as the re-elected members: Tanya Drake, Vice President; Kim Velez and Susan Chin, Directors-at-Large; and, returning Directors Phyllis Yezzo, Treasurer; James Connolly and Sarah Marshall, Directors-at-Large.

Our thanks go to Verlia Brown and Joanne Lapidus Graham for their years of service on the ANA-NY Board at the completion of their terms.

I am going to take this opportunity to share my remarks from the President's Report at the Governing Assembly:

Thank you for the honor of representing you as president of ANA-NY over the last year.

I want to take just a few moments to look forward. As I mentioned in my opening remarks, I believe in the concept of having a "professional home." A place—separate from your job, where you can seek personal and professional development; take advantage of leadership opportunities; get to know colleagues from across the state and in many other practice areas; discuss and consider other points of view; and, most importantly—**have a voice.**

One of the most important reasons that professionals join associations is to make sure that there are people—like guards on the watch tower—who have the time, networks and expertise to monitor what is going on in health care. Our staff, our lobbyist and the board members—all have opportunities to develop relationships with colleagues across the state and across the nation. We have the ability to monitor and respond to issues that come up and advocate for you and all members. Never has this been more important. The speed of innovation and change that was needed to cope with and survive a global pandemic has been a once in a lifetime experience for most of us. As the global impact continues, it is even more important that nurses advocate for thoughtful and rigorous evaluation of what emergency measures have shown us a new way forward that should be incorporated into the "new" normal, and what things that allowed us to survive should be replaced with more reliable and safe practices.

Other stakeholders in health care may or may not agree with our perspectives and working to designate priorities and prevail is part of what individual members rely on the association to do.

I want to highlight just a few goals for the coming year:

- Successful launch and fundraising for ANA-NY Political Action Committee (PAC)
  - o Let's have 100% member participation and put our PAC on the map!
- Revise and relaunch the Nursing Student Leadership Awards program
- Work to ensure the success of Project Firstline and Nurses Supporting Nurses
- Implement ANA-NY committees goals and deliverables for members
- Celebrate the 10 year anniversary of the founding of ANA-NY in 2022

I look forward to hearing from all of you—"What matters to you"—how can ANA-NY make your professional home the best it can be!

current resident or

Presort Standard
US Postage
PAID
Permit #14
Princeton, MN
55371

MEMBERSHIP APPLICATION ON PAGE 22

FROM THE DESK OF THE EXECUTIVE DIRECTOR

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

And 2022 is off and running!

We sure don't want you to miss a thing and we know that sometimes our emails end up in rude places like your "other," "spam," or even (gasp!) "trash" folders so… here's a list of what to be watching for in the months to come. If you have an eye out for an announcement email and still can't seem to find it, you can always go to our website and see all of the current happenings there.

January - Call to nursing programs for Future Nurse Leader nominations

January - Call for conference poster/podium abstracts

February - Call for Bylaws Amendments

March - Call for Awards nominations

April - Call for Nightingale Tribute names

April - Call to participate in ANAI

April - Call for nominations for Board election

May – Nurses' Month special activities and postings

May through September - Conference room block registration

May through September - Conference registration

August - Voting for Board positions

September - Call for Committee Members

October 27-29 – 10th Annual Conference, Sheraton Niagara Falls

On-going open calls: Journal articles, Nurses Supporting Nurses, Newsletter articles

IN MEMORIAM

On Friday, December 3, 2021, our colleague and very dear friend Mary Nancy Cordaro went to her eternal rest.

Nancy was a Founding member of ANA-NY and attended every Annual Conference except for the 9th Annual Conference. She will be greatly missed.

Article Submission

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

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

Advertising: for advertising rates and information please contact Arthur L. Davis Publishing Agency, Inc., P.O. Box 216, Cedar Falls, Iowa 50613 (800-626-4081), sales@aldpub.com. ANA-NY and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by ANA-NY of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. ANA-NY and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of ANA-Illinois or those of the national or local associations.

www.ana-newyork.org/

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

ANA-NY 9th Annual Conference Recap

After the year of uncertainty, one thing was inevitable, and that it was ANA-NY could not wait to have our members congregating in the same space. To absorb the innovative topics from our excellent speakers, from our pre-conference panel discussion to our keynote speaker. One thing for sure, nothing beats the feeling of seeing a colleague in person after being on that felt like an eternal virtual call. ANA-NY Future Nurse Leader scholarship silent auction was a success; this year, it raised $1,138.00. We also switched it up a bit and had our first annual awards gala, which everyone who attended dressed to the nines. Do not believe us? Look at all the photos from the weekend below. And ANA-NY Board of Directors and Staff can't wait for you to experience Niagara Falls in the full ANA-NY style next year at our 10th Annual Conference. Follow us on social to keep updated with all ANA-NY announcements.

Past ANA-NY board of directors 2020-2021 from left President Marilyn Dollinger, DNS, FNP, RN Vice-President Joanne Lapidus-Graham, EdD, RN, CPNP, CNE, Treasurer Phyllis Yezzo, DNP, RN, CPHQ Secretary Tanya Drake, MS, RN Director Verlia Brown, MA, RN, BC, Director Susan Chin, PhD, RN, NNP-BC, Director James Connolly, MSN, RN Director Sarah Marshall, DNP, MS, RNC, ICCE, CCE, CBC, CLC, Director Kimberly Velez, RN

Current ANA-NY Board of Directors from left, President Marilyn Dollinger, DNS, FNP, RN Vice-President Tanya Drake, MS, RN Treasurer Phyllis Yezzo, DNP, RN, CPHQ Secretary Trudy Hutchinson, DNS, RN, MA, MSIS, CCRN-R, Director Susan Chin, PhD, RN, NNP-BC, Director James Connolly, MSN, RN Director Sarah Marshall, DNP, MS, RNC, ICCE, CCE, CBC, CLC, Director Kimberly Velez, RN Director Giselle Gerardi, PhD, RN, C-EFM, RNC-OB

President Marilyn Dollinger, DNS, FNP, RN speaking to Jose Perpignan, RN.

Director Susan Chin, PhD, RN, NNP-BC speaking to Key-note Speaker Shantay Carter, BSN, RN after the An Inclusive Voice: Microaggression Panel Discussion.

Speaker Phyllis Quinlan, PhD, RN, NPD-BC asking questions during Key-note speaker Shantay Carter, BSN, RN session.

ANA-NY members reviewed the abstract posters session on Saturday while visiting ANA-NY Organization Affiliates tables to learn more.

ANA—NY members enjoying the 1st Annual Award Gala, which happens Friday evening during the Annual Conference. Do not miss out on next year's Award Gala. It will be something never to forget.

BOARD BUZZ

On behalf of our members, the Board of Directors:

- Welcomed new Board Members: Giselle Gerardi and Trudy Hutchinson. Board Orientation conducted by ED Jeanine Santelli.
- In Executive Session, approved the budget for FY 2022. Thanks given to Finance Committee chair Phyllis Yezzo and her committee for all their hard work on this budget.
- Accepted the Committee rosters and Board liaisons determined. ED Santelli reported that some committee have already met.
- Voted to explore reactivation of the *Future Nurse Leader* Award in 2022.
- Received updates on the status of legislative issues around Safe Staffing for Nursing Homes.
- Received updates on the results of the Conference Poll re locations for future conferences.
- Continuing outreach to lapsed members to improve retention and identify reasons for non-renewal.
- Received a robust report from Communications Coordinator Shakira Hernandez about website updates and membership communication endeavors for 2022.
- The search process for a Member Engagement Associate is underway.
- Sponsored the Greater NYC Black Nurses Association Scholarship Gala.
- Continued to participate in virtual leadership activities with ANA and other professional organizations.
- Will develop our organization's Core Values to co-exist with our Mission Statement for discussion at our next BOD meeting
- Hopes to see you at the 2022 Annual Conference in Niagara Falls and the 2023 Conference at the Turning Stone Resort in Verona, NY.

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

No Kidding!

What has pee, but isn't wet? Therapy

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

Therapy is a word often heard in the nursing community, but can be blurry due to overlap of skills. For our patients, it could mean Physical Therapy (PT) or Occupational Therapy (OT). Therapy may also register as a mental health measure, but for this we'll focus on our patient support partners in crime: PT and OT. While we get a quick overview of both PT and OT either on our journey to becoming nurses or through agency orientation, unless we interact with them often they are difficult to keep straight or understand exactly what services they can offer.

A Doctor of Physical Therapy is now the entry-level education for our PT colleagues with an expected job growth of 21% (U.S. Bureau of Labor Statistics, 2021). With a $91,010 median salary, these team members focus on helping inpatients and outpatients improve movement and manage pain (U.S. Bureau of Labor Statistics, 2021). During my time at the bedside, PT and OT were lumped together. They visited patients together, they consulted together, and their notes were all listed as PT/OT. In reality, they are two rather different specialties. While Physical Therapists certainly promote quality of life through restoration of mobility, many of the tools and techniques they use and goals they set closer align with increasing a patient's quantity of life. If a patient can reach the highest mobility possible given their circumstances, some life threatening ailments can be prevented (i.e. bed sores that go septic, pneumonia). In my eyes, Occupational Therapy's true focus is on a patient's quality of life. Occupation in this professional context should be looked at more of a synonym for activity rather than employment. OTs work to improve how patients complete activities of day-to-day life, which typically improves their quality of life. Such tasks as getting dressed, feeding themselves, or using a telephone can improve someone's quality of life through environmental adaptations or equipment which in turn can vastly change a patient's outlook on their self-worth. While a Doctor of Occupational Therapy exists, it isn't an entry-level requirement just yet meaning that the majority of our clinical OT colleagues are master's prepared. They make an average of $86,280 and have a 17% expected job growth (U.S. Bureau of Labor Statistics, 2021). And just to add another layer of confusion to our patient care team puzzle, both PT and OT have assistants.

Unlike the certified nurse aid role that we are perhaps most familiar with, both PT and OT assistants are prepared at the associate degree level from nationally accredited programs from either the Commission on Accreditation in Physical Therapy Education or Accreditation Council for Occupational Therapy Education respectively. Ironically, the median pay for a physical therapy assistant (PTA) is lower ($49,970) than that of an occupational therapy assistant (OTA) by over $10,000 and has a much larger gap in education when moving from a PTA to a PT (U.S. Bureau of Labor Statistics, 2021). Nurses also have assistants, with titles such as certified nursing assistant, aides, patient care technicians, techs, care assistants, and perhaps my favorite: orderlies. While their responsibilities seem endless and certainly a key piece of the patient care puzzle, the outlook for a nursing assistant is not as promising with only an 8% growth rate and an average pay of $30,830 (U.S. Bureau of Labor Statistics, 2021). Unlike their PTA or OTA counterparts, no higher education degree is required and depending on the agency state testing may or may not be required. However, nursing assistants are the ones providing up to 90% of direct care to nursing home residents (Brown, 2020). This was never more evident than now in New York State, where the staffing bill for nursing homes (Senate Bill S6346) is requiring documentation of staffing that can allow for double the number of hours residents spend with assistants (2.2 hours per day) over licensed nurses (1.1 hours per day) (The New York State Senate, 2021). With such a low pay and job growth prediction, is now the time to "up the ante" and develop a higher education pathway similar to their PTA and OTA counterparts? While that can't be an overnight process, perhaps the candidates who complete this pathway will receive higher pay and will stay in bedside positions. With an annual turnover rate of 129%, something has to be done to recruit and retain these valuable members of the healthcare team (Brown, 2020). Perhaps a similar process as the *BS in 10* could allow nursing assistants time and financial assistance from the agencies they work for.

Brown, D. (2020, October 21). CNA staffing, turnover will be a top focus, federal official vows. Retrieved from https://www.mcknights.com/news/cna-staffing-turnover-will-be-a-top-focus-federal-official-vows/

The New York State Senate (2021, April 22). Senate bill s6346. Retrieved from https://www.nysenate.gov/legislation/bills/2021/S6346

U.S. Bureau of Labor Statistics (2021, September 15). Occupational outlook handbook. Retrieved from https://www.bls.gov/ooh/

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.

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


Latisha Russell, RN, CCC
Bronx Campus Nurse

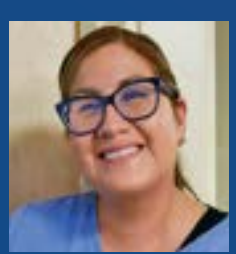

Shawn Boyd, RN
Bronx Campus Nurse


Kevin Nyack, RN
Hospice Nurse


Kelly Saulnier, RN
Hospice Nurse


Elena Filatov, RN, MSN
Brooklyn Campus
Nurse Administrator


Denise Rolle, RN
Hospice Nurse


Virginia Panchana, RN
Hospital Analyst
Bronx Campus Nurse


Lisa Irwin, RN
Hospice Nurse

Be a Calvary In-Patient or Home Hospice Nurse!

Top Pay | Exceptional Benefits | Outstanding Pensions
No Mandatory On-Call | Important Work Life Balance
Up to 12-Hour Shifts for RNs in the In-Patient Program

In-Hospital and Home Hospice RN Opportunities

- Join a family of world-leaders in end-of-life services
- The nation’s only hospital and home hospice dedicated to palliative, hospice care
- Hospitals in The Bronx and Brooklyn
- Hospice in the community in all boroughs (except Staten Island), Westchester, and Long Island. In-patient settings in Manhattan and Queens
- Full & part time positions are available

Desired Skills & Experience

- NYS RN License (License Reciprocity, OK)
- One year RN and Hospice experience preferred
- BSN preferred
- Generous tuition reimbursement

Read more about our nurses
at *calvaryhospital.org*

Join our Calvary family today!

Apply: jobs@calvaryhospital.org
Call: 929-504-3188

CALVARY HOSPITAL
Calvary@Home
Where Life Continues

CALVARY HOSPITAL
Where Life Continues

Reynaldo Rivera, DNP, MA, RN, NEA-BC, FAAN, Director of Nursing Research and Innovation, New York-Presbyterian Hospital, was honored at the Sigma 2021 Biennial Convention as a 2021 International Awards for Nursing Excellence recipient receiving the Founders Award - Marie Hippensteel Lingeman Award for Excellence in Nursing Practice.

Jen Pettis, MS, RN, CNE, Acting Director of Programs, Nurses Improving Care for Healthsystem Elders, NYU Rory Meyers College of Nursing, was honored at the Sigma 2021 Biennial Convention as a 2021 International Awards for Nursing Excellence recipient receiving the Amy J. Berman Geriatric Nursing Leadership Award.

The New York-Presbyterian Hospital Tracheostomy Thursday Team was honored at the Sigma 2021 Biennial Convention as a 2021 International Awards for Nursing Excellence recipient receiving the Helen Henry Excellence in Interprofessional Care Award.

William E. Rosa, PhD, MBE, NP-BC, FAANP, FAAN, Chief Research Fellow, Department of Psychiatry & Behavioral Sciences, Memorial Sloan Kettering Cancer Center, was honored at the Sigma 2021 Biennial Convention as a 2021 International Awards for Nursing Excellence recipient receiving the Research Dissertation Award the *Association of Patients' Analgesic Treatment Beliefs and Trade-Offs with Analgesic Adherence Behaviors Among Outpatients with Cancer Pain.*

Suzanne Bakken, PhD, RN, FAAN, Alumni Professor of the School of Nursing, Columbia University, was honored at the Sigma 2021 Biennial Convention as a 2021 International Awards for Nursing Excellence recipient receiving the Virginia K. Saba Nursing Leadership Award.

Congratulations to the award winners and to Kimberly Velez and William Rosa who were both elected to the Sigma Leadership Succession Committee. ANA-NY is always in the lead!

In Remembrance of the 20th Anniversary of the 9/11 Attacks

Hopefully you were able to visit the 9/11 Remembrance booth in our Annual Conference Exhibit Hall. Laura Kasey shared her scrapbook and projects around this horrible event in our nation's history. Two highlighted projects were **The Tunnel to Towers Foundation** (t2t.org) whose mission is to honor the sacrifice of firefighter Stephen Siller who laid down his life to save others on September 11, 2001 and to honor our military and first responders who continue to make the supreme sacrifice of life and limb for our country and The **NYS 9/11 Scholarship Fund** (nysena.org/scholarships.html) awarded to rescue workers who are obtaining an associates or baccalaureate degree in nursing.

Nurses Middle College Charter High School – Capital Region

Coming soon to the Capital Region, the Nurses Middle College Charter High School!

The growing demand for nurses and health care providers is immense. Improving the health outcomes in the Capital Region comes from having a diverse pipeline of nurses who are from the community, are multilingual, and understand the patient's culture. Identified in the National Academy of Nursing (NAM) report on the Future of Nursing 2020-2030, page 440, Rhode Island Nurses Institute Middle College (RINIMC): A Pipeline to Health Equity, is one of the possible innovative solutions to this healthcare crisis https://nam.edu/publications/the-future-of-nursing-2020-2030/. ANA-NY is proud to endorse the Nurses Middle College Charter High School of the Capital Region (NursesMC-CR), based on the RINIMC model, to help meet this need.

NursesMC-CR is a free college prep high school that prepares high school students from disadvantaged backgrounds for success in nursing school or other college paths leading towards careers in the health professions. The school must meet all the requirements of the Federal and state education departments for secondary education. However, most courses are created through the lens of nursing. So, for example, in English class, an assignment might be an essay on "how you felt the last time you went to your primary care provider," or in art class, making a model of the heart with felt and ribbons. In addition to the high school (HS) curriculum, NursesMC-CR requires that the students take at least three college credits while they are in HS and that they obtain a certification while in HS (CNA or EMT). English as Second Language courses will also be offered in the summer months. Student activities will focus on character development: professionalism, ethics, integrity, and respect. The students are also required to complete authentic internships in healthcare settings, broadly defined as anything from acute care to long-term care to the Red Cross or a foodbank.

NursesMC-CR, which has been approved by the SUNY Charter School Institute effective January 5, 2022, will be located in Albany, but eighth grade students from surrounding towns and cities are invited to submit their names for admission. A lottery will be held for 130 students to ninth grade in Fall 2022. There are no admission criteria. Please see https://nursesmc.org/admission/ for the online application. The deadline to submit for Fall 2022 is Friday, April 1, 2022 by 5 pm.

For more information or to explore having a Nurses Middle College Charter High School in your region visit: https://nursesmc.org/

Dr. Susan Birkhead, left, and Dr. Brenda Robinson at Washington Park on Thursday, Nov. 18, 2021, in Albany, N.Y. Photo: Paul Buckowski/Times Union

LEGISLATIVE UPDATE

By Amy Kellogg

The 2022 legislative session will begin on January 5, 2022, when Governor Kathy Hochul delivers her first state of the state address. A few short weeks later, she will unveil her proposed budget, and we will be working on budget issues until the April 1 budget deadline. Once the budget is complete, we will exclusively focus on non-budget issues until the conclusion of the legislative session in mid-June. It is likely that the 2022 legislative session will be overshadowed by the political landscape next year.

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 and seeing a significant population shift that will necessitate changes to current legislative and House district lines.

With the resignation of former Governor Andrew Cuomo in August, the race for Governor of New York is wide open next year. Current Governor Kathy Hochul is seeking election to her own four-year term. At present, there are three other announced candidates for the Democratic gubernatorial nomination. In addition, given that one of the announced candidates is current Attorney General Tish James, there will also be a multi-way Democratic primary for that race as well. Critically, most of the announced candidates are current state legislators, who will have to give up their Senate or Assembly seats to run for Attorney General. On the Republican side, there are three announced candidates for the gubernatorial nomination, and it is likely there will be multiple candidates for Attorney General as well.

At the annual meeting at the end of October, the membership approved the 2022 legislative priorities, which will shape the work we do for the upcoming legislative session. Importantly, this year's legislative priorities added a new focus on public health and health equity prioritization. We know that registered nurses are the single most important influence in the delivery and management of care for patients. Ensuring a robust patient experience means that registered and advanced practice nurses must play a pivotal role in public health. The addition of this area to the legislative priorities will allow us to ensure that nursing voices are heard in the areas where they are most needed.

To this end, ANA-NY submitted written testimony for the record when the New York State Assembly held a hearing on the delivery of health care professional services; lessons from COVID-19. The testimony focused on the challenges facing the profession as a result of staffing shortages and the need to ensure that New York removes unnecessary practice barriers for the profession, especially for advanced practice nurses in New York. The testimony also noted that there must also be a recognition of the role that registered nurses play in the public health space and a focus on strengthening public health infrastructure as well as streamlining educational and clinical requirements and providing additional resources to those who served as essential workers during the pandemic. Finally, the testimony also discussed how there must be a clear and sharp focus on the mental health issues that are facing all healthcare workers, particularly nurses.

As we begin the 2022 legislative session, there will be no shortage of issues facing the profession, and we stand at the ready to address these issues. In addition to the topics outlined above that we will be working on, we are anticipating that we will once again be working closely with our coalition allies on immunization and vaccine issues as that is likely to be a hot topic.

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.

Think like an expert witness to avoid falls liability

Georgia Reiner, MS, CPHRM, Senior Risk Specialist, Nurses Service Organization (NSO)

An 88-year-old patient slips on the floor, falling and breaking his hip. Your immediate concern is getting him the help he needs, but you also wonder if you could be legally liable for what happened. By thinking like an expert witness, you can help determine if this concern is valid and whether you could have taken steps to avoid the situation in the first place. But first, you need to understand some background information.

Falls facts

From 2007 to 2016, the fall death rate for older adults in the United States increased by 30%, according to data from the CDC. Each year, 3 million older adults are treated in emergency departments (EDs) for fall injuries, and more than 800,000 people are hospitalized each year because of injuries related to a fall. These falls extract a high price—more than $50 billion for medical costs in a single year.

Nurse professional liability claims involving falls are identified in the Nurse Professional Liability Exposure Claim Report: 4th Edition. The report notes that many of the closed claims analyzed in the report dataset which involved falls occurred because the nurse failed to follow fall-prevention policies and procedures. Further, the report states that falls most frequently occurred in inpatient hospital, surgical services, and aging services settings, as well as in patients' homes.

Given the statistics and the many places falls can occur, a fall is not an uncommon occurrence in a nurse's career. A fall does not automatically mean the nurse is liable; for that to happen, key elements of malpractice need to be present.

Elements of malpractice

To be successful in a malpractice lawsuit, plaintiffs must prove four elements:

1. **Duty.** A duty existed between the patient and the nurse: The nurse had a responsibility to care for the patient.
2. **Breach.** The duty to care was breached; in other words, the nurse may have been negligent. To determine if negligence occurred, the expert witness would consider whether the nurse met the standard of care, which refers to what a reasonable clinician with similar training and experience would do in a particular situation.
3. **Injury.** The patient suffered an injury. Even if a duty existed and it was breached, if no injury occurred, it's unlikely the lawsuit would be successful. Keep in mind, however, that injury can be defined as not only physical injury, but also psychological injury or economic loss.
4. **Causation.** The breach of duty caused the injury—the injury must be linked to what the nurse did or failed to do. This can be summed up in one question: Did the act or omission cause the negative outcome?

Expert witnesses will consider these four elements as they review the case, and they'll ask multiple questions (see *Was there liability?*). The questions primarily address prevention and what was done after the fall occurred.

Prevention

The following steps can help prevent falls and, if documented correctly, prove that the nurse took reasonable steps to protect the patient from injury:

Take a team approach. Registered nurses, licensed practical/vocational nurses, and certified nursing assistants are ideal members for a team dedicated to creating a falls reduction plan for each patient.

Assess the risk. Whether in the hospital, rehabilitation facility, clinic, or home, a comprehensive assessment is essential to identify—and then mitigate—falls hazards. This starts with assessing the patient for risk factors such as history of a previous fall; gait instability and lower-limb weakness; incontinence/urinary frequency; agitation, confusion, or impaired judgment; medications; and comorbid conditions such as postural hypotension and visual impairment. It's also important to consider the environment, particularly in the home setting. For example, throw rugs are a known falls hazard.

An excellent resource for assessing community-dwelling adults age 65 and older is the CDC's STEADI (Stopping Elderly Accidents, Deaths & Injuries) initiative, which is an approach to implementing the American and British Geriatrics Societies' clinical practice guideline for fall prevention. The initiative provides multiple resources for clinicians, such as a fall risk factors checklist with the categories of falls history; medical conditions; medications; gait, strength, and balance (including quick tests for assessing); vision; and postural hypotension. Keep in mind that assessment should be ongoing during the patient's care because conditions may change.

Develop a plan. Once the assessment is complete, the patient care team, including the patient and their family, can develop a falls-reduction plan based on the patient's individual risk factors. The plan should address locations that are at greatest risk, such as bedside, bathrooms, and hallways, and detail action steps. Sample action steps include giving patients nonslip footwear, making sure call lights are within reach, removing throw rugs from the home, and providing exercises to improve balance.

Communicate. It's not enough to create a plan; communication is essential for optimal execution. All care team members, including patients and their families, need to be aware of the patient's fall risk and the falls reduction plan.

Communication also includes education. The STEADI initiative has falls prevention brochures for patients and family caregivers at www.cdc.gov/steadi/patient.html. Families often are underutilized as a resource for helping to prevent falls. They may know the best way to approach patients who are reluctant to follow falls-reduction recommendations and can take the lead to reduce home-related risks. The falls risk reduction plan, communication with others, and education provided should all be documented in the patient's health record.

Was there liability?

If a patient falls, an expert witness will likely want to know the answers to the following questions (developed by Patricia Iyers) when deciding if liability may exist:

Before the fall:

- Was the patient identified as being at risk for falls? How was that risk communicated to others?
  - What medications did the patient receive? Do they have side effects that may increase the risk of a fall?
  - Were there specific conditions present that could increase the risk of a fall?
- Were measures implemented to prevent falls?
  - Was the patient capable of using the call light and was it used to call for assistance?
  - Was the bed in the lowest position?
  - Were the lights on in the room or under the bed to help light the area at night?
  - Was the patient given antiskid slippers?

Immediately after the fall:

- How soon was the individual found after he had sustained a fall (it's not always possible to establish an exact time)?
- What was done at the time of the fall?
- Was the patient appropriately monitored after the fall to detect injuries?
- What did the assessment (including vital signs) reveal?
- Did the nurse communicate the findings to the patient's provider?
- Were X-rays ordered and performed?
- Was there an injury? If so, how soon was it treated?
- If the patient hit their head, was the chart reviewed to determine if mediations included an anticoagulant? If on anticoagulant, was this information communicated to the provider so head scans could be performed to check for cranial bleeding?

Following up after a fall:

- Was there a change in mental status after the fall?
- Were additional assessments and monitoring done as follow up?
- Was the patient's risk for falls reassessed after the fall and the plan of care revised to minimize the risk of future falls?

If a fall occurs

Despite nurses' best efforts, a patient may fall. An expert witness will scrutinize how the nurse responded to the event. The following steps will help to reduce the risk of a lawsuit or the chances that a lawsuit is successful:

Assess the patient. Examine the patient for any obvious physical or mental injuries. For example, check vital signs; look for bleeding, scrapes, or signs of broken bones; ask the patient about pain; and check mental status. Do not move the patient if a spinal injury is suspected until a full evaluation can be made. Be particularly alert for possible bleeding if the patient is taking anticoagulants. When appropriate, ask patients why they think they fell and continue monitoring at regular intervals.

Communicate assessment results. Notify the patient's provider of the fall and results of the assessment. The provider may order X-rays for further evaluation. Remember to mention if the patient is taking anticoagulants, particularly in the case of a potential head injury, so the appropriate scans can be ordered.

Revise the plan. As soon as possible after the fall, work with the team to reassess risk factors, revisit the falls reduction plan, and revise the plan as needed. For example, footwear may need to be changed, the amount of sedatives the patient is receiving may need to be reduced, or more lighting may need to be added to a hallway. It's important that actions are taken to prevent future falls.

Document. Each step should be documented in the patient's health record, especially all assessment results and provider notifications. The expert witness can then see that the nurse followed a logical progression, with thorough evaluation and follow-up. Never alter a patient's health record entry for any reason, or add anything to a record that could be seen as self-serving, after a fall or other patient incident. If the entry is necessary for the patient's care, be sure to accurately label the late entry according to your employer's policies and procedures.

Reducing risk

Unfortunately, patient falls are not completely avoidable. However, developing a well-conceived prevention plan can help reduce the risk, and taking appropriate actions after a fall can help mitigate further injury. Both prevention and post-fall follow up not only benefits patients, but also reduces the risk that the nurse will be on the losing side of a lawsuit.

RESOURCES

Bono MJ, Wermuth HR, Hipskind JE. Medical malpractice. StatPearls. 2020. www.ncbi.nlm.nih.gov/books/NBK470573.

Centers for Disease Control and Prevention. Important facts about falls. www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html.

Centers for Disease Control and Prevention. STEADI: Materials for healthcare providers. 2020. www.cdc.gov/steadi/materials.html.

CNA, NSO. Nurse Professional Liability Exposure Claim Report: 4th Edition. 2020. www.nso.com/nurseclaimreport.

Dykes PC, Adelman J, Adkison L, et al. Preventing falls in hospitalized patients. Am Nurs Today. 2018;13(9):8-13. https://www.myamericannurse.com/preventing-falls-hospitalized-patients.

Iyer P. Legal aspects of documentation. In: KG Ferrell, ed. Nurse's Legal Handbook. 6th ed. Wolters Kluwer; 2015.

Van Voast Moncada L, Mire GL. Preventing falls in older persons. Am Fam Physician. 2017;96(4):240-247. https://www.aafp.org/afp/2017/0815/p240.html.

FROM THE DESK OF THE HISTORIAN

WOW! That's a Hero!!

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

As I sit down to pen this column, 2021 is rapidly closing and we are still dealing with SARS-CO-2 – looking at the Omicron variant hitting populations worldwide – and asking nurses to continue on the front lines. Nurses are leading as they advocate for their patients, for improvements to the system(s) of healthcare delivery, and for themselves. As we are rightly supporting and thanking our modern-day COVID-19 nursing heroes, my thoughts are wandering back to other times when nurses quickly answered the call to lead and put themselves and their careers on the line to help others. One such nurse was Clara Louise Maass.*

Clara Louise Maass was a servant leader before Robert Greenleaf coined the term of Servant Leadership in 1970. She was born on June 28, 1876 in East Orange, NJ. As a youngster, she cared for children as an au pair. In exchange, she received room and board, time off for her elementary education and a small stipend (which she gave to her parents). Upon hearing of the work of Florence Nightingale during the Crimean War, she became enamored with the nursing profession. At the age of 17, she entered the fledgling nursing program at The Christina Tref Training School for Nurses at Newark [NJ] German Hospital, which opened in 1891. Upon graduation in 1895, she started her nursing career at the Newark German Hospital rising, on merit, to position of Head Nurse.

With the outbreak of the Spanish-American War in 1898, Maass knew she needed to care for soldiers, but as a woman, she could not join the military. Her only choice was to apply for a position as a contract nurse to the U.S. Army to care for soldiers ill with Yellow Fever. To her chagrin, her application was rejected; but Maass was persistent and started a letter writing campaign to Dr. Anita Newcomb McGee, the Assistant Surgeon General and Vice President General of the Daughters of the American Revolution who recruited DAR nurse members to care for Yellow Fever patients. Clara Maass finally inked her one-year contract with U.S. Surgeon General George M. Sternberg and commenced nursing soldiers and sailors with in Santiago and Havana, Cuba. At the end of her contract, she resumed nursing civilians while hoping to travel to Manila, PI as the war raged on. Once again, she launched another letter writing campaign to Dr. McGee; and in early 1900, she arrived at the Reserve Hospital in Manila.

From January to March 1900, Maass cared for an overwhelming number of Yellow Fever patients, witnessed massive amounts of death, and suddenly asked for a release from her contract due to ill health. Researchers vary on reasons for her request, however she returned to the United States by mid-1900. One might think that Clara Maass' career as a fever nurse was over, but that is not the case. In August 1900, she became a volunteer for an inoculation study sponsored by the government-endorsed the international, multi-disciplined U. S. Army Yellow Fever Commission. Back to Cuba she went.

Maass interviewed with Commission members and observed their research methods. Enticed by a $100 volunteer fee sent to her parents, she stepped forward to receive the sting from an infected mosquito. Despite others contracting yellow fever, Maass did not. Uncertain of her immunity status, she once again volunteered to receive bites. This time, her mosquito inoculator was one that produced lethal results to one child and three adult volunteers. Once again, that mosquito did its job. This time Maass' outcome was different. She did not escape the fever. Three days post-inoculation, she displayed extreme symptoms and succumbed to yellow fever on August 24, 1901.

As with our current pandemic, no family members attended her bedside during her final hours and burial in a lead-lined coffin was swift at the Colon Cemetery in Havana, Cuba. Her first final resting place was not her final one. The following year, 1902, the U.S. Army moved Maass' lead casket and escorted her remains to Fairmount Cemetery, Newark, NJ. She was laid to rest with full military honors. Other posthumous honors bestowed on Maass included: a named sitting room in her training hospital, issuance of commemorative postage stamps, headstone care, renaming an extant hospital (Lutheran Memorial) in honor of her, and ultimately during the centennial year of her birth, induction into the ANA Hall of Fame as a member of its inaugural class.

*Author Carol Emerson Winters contributed a chapter on Clara Maass in David Anthony Forrester's (ed.) book, *Nursing's Greatest Leaders: A History of Activism* (c. 2016).

†Image of C. Maass – aahn.org;

CONTINUING EDUCATION

Opioid Prescribing for Chronic Pain

Adriana Pereira & Naomi Paul
Manhattanville College
Joanne Lapidus-Graham Ed.D, RN, CPNP, CNE,
editor, ANA-NY Consultant to NSANYS

Steps to complete independent study and receive 0.75 contact hours

- Read the article.
- Complete the post-test, evaluation, and registration form online at https://form.jotform.com/213536735605154
- Fee of $7.00 for non-members, ANA-NY members are free.
- Certificates will be emailed after a passing score of 75% or higher is achieved.
- There is no conflict of interest or commercial support for this offering.
- This enduring continuing education offering expires on 03/31/2022.
- Learning outcome: Participating nurses will be able to expand their understanding of the current issues influencing the profession of nursing and be prepared to perform at their highest professional level in a rapidly changing practice environment.
- This nursing continuing professional development activity was approved by American Nurses Association Massachusetts, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Introduction

Over the past decade, there has been a significant increase in the amount of healthcare professionals who have prescribed opioids to patients. Medical providers may prescribe opioids to relieve the patient's pain and suffering postoperative from surgery, to relieve pain resulting from their medical diagnosis, and as palliative or end-of-life care. However, many patients were not made aware of the risks of taking opioids. Opioids are medications that are often prescribed because they relax the body and can relieve pain. Prescribed opioids are mostly used to treat moderate and severe pain, especially in those patients suffering from chronic pain. A topic of controversy with opioids is whether healthcare professionals should prescribe opioids to patients who live with chronic pain. The ethical dilemma of when to prescribe opioids has many pros and cons. One question the health professional needs to ask is: do the benefits outweigh the risks or do the risks outweigh the benefits?

Background & Ethical Dilemmas

Healthcare professionals play a huge role in facilitating the proper use of opioids. Opioids relieve pain by binding to receptors in the brain or body and subsequently reduce the intensity of those pain signals that reach the brain. Health Care providers prescribe opioids such as oxycodone, hydrocodone, and morphine to treat acute pain or chronic pain which is pain that lasts more than 3 months (Scott & Lewis, 2016). Health care providers must assess when to safely and responsibly prescribe opioids in order to treat pain. Because of the opioid epidemic, healthcare professionals must carefully and realistically assess both the risks and harm to the patient. A multi-disciplinary approach to prescribing opioids is essential in preventing opioid overdose deaths. Evidence-based clinical guidelines are set in place and are available for patients with chronic pain in order for healthcare professionals to make effective pain management decisions. .The CDC considers factors from the epidemiology research, such as: the benefits and harms related to specific opioids and formulations, the risks associated with high dose therapy of opioids, the risks of co-prescription with other controlled substances, the expected duration of use, and any special populations who require a particular approach (Dowell, Haegerich, Chou, 2016). Opioid prescribers can play a key role in stopping the opioid overdose epidemic by following and adhering to the proper guidelines.

Pros of opioid use

Patients who suffer from chronic pain deal with the constant struggles of feeling recurring pain that they can't get rid of. Chronic as pain that typically lasts greater than 3 months or past the time of normal tissue healing. Chronic pain may result from: an underlying medical disease or condition, injury, post-op from surgery, inflammation, or can be idiopathic. Although the exact number of people suffering from chronic pain is unknown, the number of people suffering in the United States may be substantial (Dowell, Haegerich, Chou, 2016).

Chronic pain interferes with an individual's daily life, limits their activities, and overall affects their well-being. Opioids are effective in treating severe, persistent, and chronic pain. Severe or chronic pain may not be relieved by over-the-counter pain relievers; therefore, health care providers may need to prescribe a stronger alternative in the form of narcotics or opioids. The need for these therapies is the backdrop for the expanding use of opioid drugs. Clinical studies have shown that long-term opioid therapy is able to help selected patients have a better quality of life, to help patients to need less extended health care, and improve the patient's overall productivity (Rosenblum, Marsch, Joseph, Portenoy, 2008).

Pros of opioid use

Educating patients is essential when prescribing opioids. Patients who are prescribed opioids must be aware of the actions, and the adverse/side effects of opioids. Comprehensive education helps the patient to better understand the medication, to more effectively monitor for side effects, and assists with the knowledge of when to notify their health care provider. Patients also should be instructed to inform their health care provider when there are changes in their pain level, The ultimate goal of treatment with opioids should be an overall improvement in the patient's quality of life. Guidelines for opioid treatment of chronic pain must incorporate both the principles of prescribing, and the approaches to risk assessment and management.

In the past decade, prescription drug abuse has increased as a result of the increased use of opioid therapy by primary care providers and pain specialists. To reduce the opioid crisis, health care providers must collaborate together to refine the guidelines, identify the subpopulations that can be managed by primary care providers, and discover safer strategies that may yield treatment opportunities to larger numbers of patients (Rosenblum, Marsch, Joseph, Portenoy, 2008).

Assessing the risk and addressing harms of opioid use is important, hence, patients must follow up with health care providers frequently. Health care providers should start prescribing opioids at the lowest effective dose and closely monitor for the effectiveness of the medication. Opioids are given to relieve pain; therefore, medical providers want to slowly increase the dose in order to relieve the pain or to help the patient cope more effectively with the pain. The health care provider should also evaluate the benefits vs the harm to patients within 1 to 4 weeks of starting opioid therapy for chronic pain or after a dose escalation, and every 3 months or more thereafter, or more frequently if needed. If the benefits of the opioids do not outweigh the harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (Centers for Disease Control and Prevention, 2021). Continuous follow up and communication between the patient and the health care provider will allow the patient to feel more comfortable and at ease. The goal of healthcare professionals is to relieve the pain of those patients with chronic pain and do so in a safe manner.

Cons of opioid therapy

The magnitude of the opioid crisis is incredible. In 2019, nearly 50,000 people in the United States died from opioid-involved overdoses. Opioid misuse including prescription pain relievers, heroin, and synthetic opioids such as fentanyl is a severe national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement (Smith, 2020). Health care providers who prescribe opioids for pain management may not realize the ramifications of their actions. The real question the health care provider should ask, is it ethical to prescribe a medication when you know there is a very high potential for addiction? Pain management is essential in patient care. There are patients who endure true pain and suffering. The effects of pain creates a physiological response that increases heart and breathing rates. It is crucial for patients to experience pain relief, however, does the benefit of pain relief equate to the risk of dependence and addiction?

Health professionals strive to aid patients in their pain distress and to do all they can to help patients. However,

what is the price paid for pain relief? “Clinicians wish to ease suffering, but their prescription pads are a source of potentially dangerous and addictive drugs” (Jackson, 2020). Opioid prescribing involves ethical dilemmas that must be considered in the face of the growing opioid epidemic. “Opioid misuse has become one of the gravest and most consequential public health threats facing the United States today” (Smith, 2020). In 2018, there were 67,367 drug overdose deaths in the United States, 70% of which involved opioids (CDC, 2020). Seventy percent of 67,367 is 47,156; which means 47,156 people died in 2018 not from cardiac issues or infection but opioid drug overdose. Although fatal drug overdoses have been a growing problem, since the Covid-19 pandemic began in March 2020, there has been an increase in the amount of opioid-related deaths. In December 2020, the US Centers for Disease Control and Prevention (CDC) issued an advisory that overdose deaths had reached an all-time high, citing increasing synthetic opioid–related deaths (Appa, et al., 2021).

What are the effects of opioids in the body? Opioids block pain receptors and release large amounts of dopamine in the body. These releases of large amounts of dopamine can elicit an euphoric experience making users want more and more; thus releasing pain and making people feel good. Opioids can cause drowsiness, constipation, confusion, slowed breathing and euphoria (NIDA, 2021). Some people develop a tolerance for opioids, requiring more and more in order to elicit a euphoric experience. Others develop a dependence on it, making the body think it needs it to function. When the drug is not taken, several physiological reactions occur, ranging from mild withdrawal symptoms in the case of caffeine, to potentially life threatening reactions, such as with heroin. Some chronic pain patients are dependent on opioids and require medical support to stop taking the drug (NIDA, 2021).

Opioids may be dangerous and ethically immoral to prescribe to certain patients. The rules of beneficence states we must “protect and defend the rights of others, prevent harm from occurring to others, remove conditions that will cause harm to others and rescue persons in danger” (Butts & Rich, 2020, p.39). We are not acting in a beneficent way when we allow high risk patients to take opioids knowing that they may cause harm to their body. When we prescribe opioids to patients, we must assess what is in the patient’s best interest and prevent harm from happening to the patient. We may be prescribing them their prescription for addiction, harm and premature death. When a person overdoses on opioids it can produce life threatening symptoms; in fact their breathing can slow down so significantly it can cause brain damage (NIDA, 2021). The bioethical principle of nonmaleficence states to do no harm. Is prescribing opioids causing harm to patients? Yes, due to high correlation of affliction and potential for abuse. Opioid use even for a short time can cause addiction, therefore putting patients who takes opioids at risk for developing an addiction (Mayo, 2021). There are certain risk factors for addiction, such as those of lower economic status, however anyone can become addicted when misusing opioids. The same receptors that are responsible for the analgesic effects of opioids are also responsible for the addictive properties and dangerous side effects.

Health care providers must be sensitive to balance treating a patient’s pain, but also to circumvent substance use disorder and addressing tolerance to the medication. It is imperative that doctors and medical providers understand a patient who has developed tolerance to their opioid medication can show behaviors no different from those who are addicted to opioids and have a substance use disorder. Due to tolerance and the abuse of opioids, medical providers must ensure that patients are on the correct dose and that they are screened for substance use disorders (Smeltzer, et al., 2017). There are prescribers that prescribe opioids for all types of pain and by doing so inflict harm to their patients through the dangers of prescription opioid medications.

The question that should be asked is, are opioids the only solution for pain management? No, there are non-opioid alternatives for pain management which include acupuncture, massages, and yoga, to name a few modalities. Integrative medicine incorporates pharmacological, complementary, and alternative medicine which has been proposed as an opioid alternative for chronic pain treatment (Hassan, et al, 2020). Studies have shown that programs such as integrative medicine have reduced opioid use. “Prescription drug abuse and overdose is a serious public health problem in the United States. Drug overdose death rates in the U.S. increased five-fold between 1980 and 2008, making drug overdose the leading cause of injury death. In 2013, opioid analgesics were involved in 16,235 deaths — far exceeding deaths from any other drug or drug class, licit or illicit” (Alexander, Frattaroli, Gielen, 2015). There are other methods to pain management that do not cause drug abuse, death, addiction, physiological and psychological harm. It is vital to overcome the barriers and misconceptions of these holistic modalities in the fight against opioid misuse. The opioid epidemic can be fought if prescription opioids are not the first line of treatment.

Conclusion

For many years now, patients with chronic pain have been prescribed opioids for pain management. In order to relieve their pain and suffering they continue to take opioids, although there are countless alternative remedies for pain. This ethical dilemma is one that has been talked about and debated for years. Public health responses to the opioid crisis must focus on preventing new cases of opioid addiction, with early identification and ensuring effective treatment of opioid addicted individuals, while at the same time continuing to safely meet the needs of patients experiencing pain (Alexander, Frattaroli, Gielen, 2015). The opioid epidemic has truly impacted the health of millions. This debate of prescribing opioids to patients with chronic pain stems from relieving their agony, however, health care professionals need to be aware of screening patients with chronic pain for substance abuse disorder and also educating them about the risks that opioids may bring.

References

Alexander G.C, Frattaroli S., Gielen A.C, et.al. (2015, November). *The Prescription Opioid Epidemic: An Evidence-Based Approach.* Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland. https://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/

Appa A, Rodda LN, Cawley C, et al. Drug Overdose Deaths Before and After Shelter-in-Place Orders During the COVID-19 Pandemic in San Francisco. *JAMA Network Open.* 2021;4(5):e2110452. doi:10.1001/jamanetworkopen.2021.10452

Butts, J.B., & Rich, K.L. (2020). *Nursing ethics: Across the curriculum and into practice.* Jones & Bartlett Learning.

Centers for Disease Control and Prevention. (2021, February 17). *About CDC's Opioid Prescribing Guideline.* Centers for Disease Control and Prevention. https://www.cdc.gov/opioids/providers/prescribing/guideline.html.

Centers for Disease Control and Prevention. (2020, March 19). Opioid overdose—understanding the epidemic. https://www.cdc.gov/drugoverdose/epidemic/index.html.

Dowell, D., Haegerich, T. M., & Chou, R. (2016, March 18). *CDC guideline for prescribing opioids for chronic pain - United States, 2016.* Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

Ethical Considerations in Prescribing or Withholding Opioids for Chronic Pain. *Osteopathic Family Physician, 9*(3). Retrieved from https://www.ofpjournal.com/index.php/ofp/article/view/503

Hassan S, Zheng Q, Rizzolo E, Tezcanli E, Bhardwaj S, Cooley K. Does Integrative Medicine Reduce Prescribed Opioid Use for Chronic Pain? A Systematic Literature Review. Pain Med. 2020 Apr 1;21(4):836-859. doi: 10.1093/pm/pnz291. PMID: 31755962.

LeShaundra Cordier Scott, M. P. H. (2016, April 19). *Opioids for chronic pain.* JAMA. https://jamanetwork.com/journals/jama/fullarticle/2503507.

Middleton C. (2003, September). Understanding the physiological effects of unrelieved pain. *Nursing Times. 99*(37):28-31. PMID: 14533321.

NIDA. 2021, June 1. Prescription Opioids DrugFacts. Retrieved from https://www.drugabuse.gov/publications/drugfacts/prescription-opioids

Rosenblum, A., Marsch, L. A., Joseph, H., & Portenoy, R. K. (2008, October 16). *Opioids and the treatment of chronic pain: Controversies, current status, and future directions.* Experimental and clinical psychopharmacology. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711509/

Smeltzer, MS, OMS IV, K. E., Desai, DO, FACOFP, G. J., & Johnson, MA, PhD, JD, B. (1).

Smith, H (2020) Ethics, Public Health and Addressing the Opioid Crisis *AMA J Ethics. 22*(8):E647-650. doi: 10.1001/amajethics.2020.67.

NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

Our Journey to Becoming an Age-Friendly Health System

Cassandra [Sandi] Vonnes, DNP, GNP-BC, APRN, AOCNP, CPHQ, FAHA
Geriatric Nurse Specialist and NICHE Coordinator
Moffitt Cancer Center, Tampa, FL
813-745-2478
Cassandra.vonnes@moffitt.org
&
Tina M. Mason, PhD, APRN, AOCN, AOCNS, FCNS
Nurse Scientist
Moffitt Cancer Center, Tampa, FL
813-745-1793
Tina.mason@moffitt.org

Column Editor's Note: In this month's column, I am delighted to share an article by my colleagues, Cassandra [Sandi] Vonnes, DNP, GNP-BC, APRN, AOCNP, CPHQ, FAHA, Geriatric Nurse Specialist and NICHE Coordinator, and Tina M. Mason, PhD, APRN, AOCN, AOCNS, FCNS, Nurse Scientist, from Moffitt Cancer Center, Tampa, FL. These visionary nurse leaders sat down together to reflect on Moffitt's success in becoming an Age-Friendly Health System and how their robust Nurses Improving Care for Healthsystem Elders (NICHE) program, including nurse-initiated clinical protocols and specialty trained Geriatric Resource Nurses and Geriatric Patient Care Associates, supported their organization to become recognized as an Age-Friendly Health System. I hope you enjoy reading excerpts from their conversation in this month's NICHE Age-Friendly Nursing Practice Pearls column.

--- Jennifer L. Pettis, MSN, RN, CNE, Acting Director Programs, NICHE

The demand for health care among older adults is expected to grow tremendously as the population of people over the age of 65 is projected to nearly triple during the next four decades (Institute for Healthcare Improvement [IHI], 2017). Half of all cancers occur in people aged 70 and older, and 60% of all cancer deaths occur in this population (American Cancer Society 2019). Older adults with cancer tend to have complex health problems, multiple chronic conditions, and various social needs. They also may experience and suffer from cognitive and physical limitations (Institute of Medicine, 2013).

Exhibit 1: NICHE Implementation Framework Dimensions

Guiding principles
Organizational structures
Leadership
Geriatric staff competence
Interdisciplinary resources and processes
Patient and family-centered approaches
Environment of care
Quality

Moffitt Cancer Center in Tampa, FL is a Magnet® and National Cancer Institute (NCI) designated comprehensive cancer center. The Center has 217 designated inpatient beds, and 34 ambulatory units provide nearly 450,000 clinic visits yearly, 47% of which are for patients over age 65. Moffitt is a long-time Nurses Improving Care for Healthsystem Elders (NICHE) member organization. Our NICHE team, led by Dr. Vonnes, has achieved Exemplar Recognition from NICHE acknowledging our robust implementation of the NICHE nursing practice model in each of eight dimensions in the NICHE Implementation Framework (see Exhibit 1).

In 2018, Moffitt Cancer Center was one of 100 hospitals across the country and the only one in Florida selected by The John A. Hartford Foundation (JAHF, 2021) and the IHI (2019) to participate in an Age-Friendly Health Systems initiative as part of their first cohort. Our journey to achieving recognition as an Age-Friendly Health System has been an exciting one, and we are delighted to share it. We took some time to sit down to discuss our age-friendly work, and, in this article, we share excerpts of our conversation.

Mason: What is an Age-Friendly Health System, and what was involved in obtaining this designation?

Vonnes: Moffitt Cancer Center was selected to participate because of our expertise in geriatric oncology. When it comes to treating patients with chemotherapy, radiation, and surgery, a 55-year-old is going to respond differently than a 75-year-old. The Age-Friendly Health System initiative seeks to improve the overall quality of care provided to older adults by ensuring that all clinicians are familiar with principles of geriatrics and that care is designed to offer older adults and their families best practice care consistently and reliably.

As a long-time NICHE member hospital, the nursing workforce at Moffitt was well placed to advance the goals of age-friendly care in our hospital. One focus of the geriatric oncology program is empowering nurses, who are the backbone of care delivery for older adults. We empower our nurses through the NICHE Geriatric Resource Nurse (GRN) clinical leadership role. GRNs are nurses specially trained in the care of the older adult. They lead care planning discussions, coach peers on best practices, and create an environment where the unique needs of older adults are valued. The Cancer Center has 90 GRNs and 104 Geriatric Patient Care Associates (GPCAs), who are unlicensed nursing staff with enhanced training in caring for older adults. These specially trained professionals care for the 43% of Moffitt patients that are over the age of 65 across the continuum.

Building on our nursing expertise, the Age-Friendly Health System initiative, enabled us to extend our reach by integrating the 4M model into our care protocols used by all staff, including GRNs and GPCAs.

Mason: Tell me more about the 4Ms.

Vonnes: The IHI (2017) has identified four essential elements of an Age-Friendly Health System. The 4M model was developed through an extensive review of the geriatric care models and clinical assessment strategies focused on older adult's unique health needs. The 4Ms are a common component across the geriatric models and serve as a framework for clinicians to gather data and formulate care plans and interventions for older adults.

The 4Ms are:

1. **What Matters:** Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care across settings of care.
2. **Medication:** If medication is necessary, use age-friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.
3. **Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.
4. **Mobility:** Ensure that older adults move safely every day in order to maintain function and do What Matters Most.

Mason: Recently you worked with GRNs, GPCAs, and other interprofessional team members in addressing "What Matters Most" for the older adult with cancer. How did you begin to operationalize this vital aspect of Age-Friendly care?

Vonnes: Moffitt's Senior Adult Oncology Program is unique with its focus on cancer care for adults aged 70 and older. The interdisciplinary team that includes oncology nurses, a dietitian, a pharmacist, a social worker, a geriatric oncology nurse practitioner, and geriatric oncologists leads a cancer assessment and treatment service to tailor cancer treatments to each older adult. The program provides an innovative approach and is built around the belief that older persons benefit from cancer treatment. However, cancer treatment is difficult and needs to be considered with other conditions that may affect older people, including concomitant diseases, limitations on activity, transportation problems, medications, nutritional problems, memory decline, and depression. Our holistic approach enables us to shape care using the 4M models guided by other assessment strategies to address cancer care and medical and functional issues that are prevalent among older adults with cancer.

Our team targeted the Senior Adult Oncology Program and the Gastrointestinal Clinic to implement the Age-Friendly Health System initiative. These units were identified because a large portion of the registered nurses working on them are GRNs, and 100% of the medical assistants working on these units are GPCAs. An infrastructure of geriatric experts can enable an easier implementation and testing of new practices using rapid tests of change (that is, plan-do-study-act [or P-D-S-A] cycles). The team focused on addressing "what matters most" during each clinic visit and extended the initiative to the inpatient units by adding this care planning question to the whiteboards in patient rooms. By determining what matters most to the patient, all direct care team members can understand the patient's goals of care and truly individualize their plan of care. Another initiative led by GRNs was focused on advanced care planning to increase the number of advanced directives and surrogate decision makers or the documentation of such discussion in the health record. GRNs taught a series of sessions to their peers to increase knowledge and comfort with beginning these conversations with older adults and their family caregivers. This resulted in an increase in knowledge and comfort of the RN staff in discussing advance care plans, higher numbers of advance directives in the electronic health record, and RNs themselves creating their own advance care plans.

Mason: How do nurses and medical assistants become GRNs and GPCAs at Moffitt?

Vonnes: Potential GRNs self-identify on units in which over 40% of patients are older adults. With manager approval and outreach by myself, RNs begin the online modules and are included in the monthly NICHE meetings. The online NICHE modules represent the core curriculum of geriatric nursing principles and address conducting comprehensive assessment and implementing evidence-based nursing principles to ensure the best possible outcomes for older adults. We also integrate the NICHE protocols published in *Evidenced-Based Geriatric Protocols for Best Practice* (6th ed) (Boltz et al., 2020) to shape our practice at the bedside. These continuing professional development opportunities lay the foundation for the GRNs to function as clinical champions on their units. Similarly, potential unlicensed direct care team members are identified by their managers for the learning experiences. The GPCA course includes a combination of NICHE online learning modules and competencies development workshops delivered by GRNs and interprofessional representatives.

Mason: Can you describe the key roles GRNs and GPCAs play in initiatives centered around improving care for older adults with cancer?

Vonnes: Having an infrastructure of direct care experts in geriatric care helps operationalize the Age-Friendly Health System concepts. GRNs and GPCAs, within their scope of practice, step up to ask and address "what matters most," evaluate potentially inappropriate medications, help identify delirium, implement falls and injury prevention measures, and promote mobility. Our advance care planning initiative was identified by our GRNs as an improvement opportunity prior to us adopting the Age-Friendly principles.

Mason: You mentioned the GRNs' and GPCAs' roles in addressing the three other Ms (mentation, medication, and mobility). Can you tell us more about how they support older adults in these three areas? Are there assessment tools that the GRNs use to guide their care focusing on mentation, medication, and mobility?

Vonnes: Our inpatient GPCAs focus on early mobility to reduce delirium and falls. Outpatient GPCAs are included in competencies that include the Timed Up and Go (TUG) test to evaluate fall risk and functional status. In some clinics, the GPCAs administer the Mini-Cog that is scored by the registered nurse for cognitive screening. The GPCAs staffing the outpatient clinics also play an active part in obtaining medication lists that are validated by history and then reconciled by providers and pharmacists.

Mason: NICHE and the Age-Friendly Health System initiative are guided by principles and practices of quality improvement. Can you tell me more about the changes in clinical outcomes that you've seen by using these two geriatric-focused care models at Moffitt Cancer Center?

Vonnes: My interest in fall and injury prevention and delirium in the acute care of older adults formed a foundation for an age-friendly cancer care project (Vonnes & Mason, 2021). Implementation of routine screening for delirium, remote visual monitoring, and pharmacy collaboration has reduced falls related to delirium.

Mason: Thank you for your work to improve clinical practice and the care experience for the older adults in our care at Moffitt Cancer Center. It is so important to have experts at the bedside to serve as advocates and clinical experts in the healthcare system.

Vonnes: Thank you for highlighting some of our efforts at improving care for older adults with cancer.

References

American Cancer Society. (2019). *Cancer facts & figures 2019.* https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2019.html

Boltz, M., Capezuti, E., Fulmer, T., & Zwicker, D. (Eds.). (2020). *Evidence-based geriatric nursing protocols for best practice* (6th ed.). Springer Publishing Company, LLC.

Institute for Healthcare Improvement (2017). *The 4Ms Age-Friendly framework* http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx.

Institute for Healthcare Improvement. (2019). *Age-friendly health systems: Guide tousing the 4Ms in the care of older adults.* http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

Institute of Medicine. (2013). *Delivering high-quality cancer care: Charting a new course for a system in crisis.* National Academies Press.

Nurses Improving Care for Healthsystem Elders. (n.d.). https://nicheprogram.org/

The John A. Hartford Foundation. (2021). *Age-Friendly Health Systems initiative.* https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative

Vonnes, C. & Mason, T. M. (2021). Crafting age friendly cancer care: A model for improvement utilizing the 4Ms framework across the continuum of an NCI-designated Cancer Center. *Journal of Geriatric Oncology, 12*(1), 152-156. https://doi.org/10.1016/j.jgo.2020.06.007

Nurses Educational Funds, Inc.
Scholarship for Leadership

Nurses Educational Funds (NEF) Scholarship Application Process Begins On October 1, 2021

October 1, 2021 Nurses Educational Funds opens its online application process for professional nurses in master's or doctoral nursing programs. NEF is the largest professionally endorsed source of scholarships for advanced nursing study in the US.

The need for nurse leaders is critical. NEF- funded scholars have become outstanding faculty and deans of schools of nursing, renowned researchers, and experts in healthcare delivery, administration, and policy – all leading change in every arena across the country and globally. Funding scholarships for graduate nursing education is an ongoing and challenging process that has been the key focus of NEF's volunteer board of directors.

If you are seeking to elevate your career by returning to school for a master's or doctoral degree and seek financial assistance, our annual completely online application process is located at www.n-e-f.org under "How To Apply." The scholarship application opens on October 1 each year and closes on February 1 of the following year. A description of the requirements for NEF Scholarship application follow:

About the Scholarships:

- Scholarships are based on academic performance, a personal essay, reference letters, and validated study already in progress in graduate programs throughout the United States.
- Scholarships are provided directly to students for their use in supporting their studies.
- Since 1912 over 1300 professional nurses have received a Nurses Educational Funds, Inc. Scholarship.
- Each student's application is reviewed and scored by two separate nurse reviewers from NEF Board of Directors who do not consult with each other regarding their reviews. The review scores are then tabulated by the Criteria and Eligibility Committee nurse members, for the final scholarship application determination.

About the criteria:

- GREs are not required as part of the application process.
- Student applicants must be licensed registered nurses in the United States with a bachelor of science in nursing degree (or the equivalent accredited nursing program requirement).
- References are required from the student's academic, employment, and professional colleagues.
- Scholarship awards are given to students in nursing education, advanced clinical practice, research, health policy, and administration.

Nurse Philanthropy:

Since 1912, Nurses Educational Funds, Inc. has depended solely on donations to advance our only mission, to promote leadership through scholarship support for professional nurses seeking masters and doctoral degrees in nursing education, advanced clinical practice, research, health policy, and administration. You can read about our work on our website: www.n-e-f.org. Charitable contributions to NEF are tax deductible to the extent allowed by law.

As professionals, we can also be philanthropists, while helping others understand the need for philanthropy. Nurses Educational Funds, Inc. will only continue to be a successful graduate nursing scholarship provider if we can mobilize a giveback spirit among our colleagues. Individual nurses can give as part of their legacy. Nurses are essential to their communities and health care and the need to help their communities understand their vital health care delivery contributions is paramont.

It is imperative that NEF continue to expand the number of graduate nursing scholarships if we are to facilitate and sustain nursing faculties, nurse researchers, and nursing leaders. With a give-back spirit nurses can greatly contribute to graduate nursing scholarship support.

For further information about Nurses Educational Funds, Inc., please see our web site at: www.n-e-f.org or contact our Executive Director, Jerelyn Weiss, at: jweiss@n-e-f.org, (917) 524-8051, Nurses Educational Funds, Inc., 137 Montague Street, Ste. 144, Brooklyn, NY 11201.

Resources:

Jerelyn Weiss, Executive Director

Bowar-Ferres, S., Fitzpatrick, M.L., McClure, M.L. (2014, October). One hundred years and still counting, The story of NEF: yesterday, today, and tomorrow. Nursing Administration Quarterly, 38, (4) 303-310.

ANA-NY Looks Toward the Future of the Nursing Field

ANA-NY has partnered with SPEAKHIRE in order 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 2020 to June 2021, 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 are looking for around 10 ANA-NY Members to volunteer time as a Career Pathways Champion, to speak with these young adults about the nursing field. Please email Phil Meher, ANA-NY Program Manager, at programassocaite@anany.org for more information on how to get involved.

ANA-NY Night at MSG

ANA-NY was able to take part at both nights of Madison Square Garden Nurse Appreciation Event. ANA-NY members enjoyed the free personalized MSG Team Nurse Scrub top and credits to use the snack bar. What a great benefit of being an ANA-NY member! Members who attend this event won tickets at our 9th Annual Conference Nurse: A Voice to Lead during our many raffles during the conference.

Current board member Kimberly Velez and ANA-NY member Lukmon Kalejaiye, MS, RN-BC, CNS.

Here you can see everyone cheering as the Ranger's scored a goal. ANA-NY hopes to attend more Madison Square Garden Nurses Appreciation nights in the future.

COMMITTEE SPOTLIGHT

Nominations and Elections Committee

Grace Anne Crockett

My name is Grace Anne Crockett and I am the chair of the Nominations and Elections Committee. I am looking forward to chairing the committee this year to find some competitive candidates to fill our vacant positions and to encourage more members to vote in our election! I am a BSN prepared RN and after working two and a half years in the inpatient hematology/oncology unit I transferred to the PICU at Memorial Sloan Kettering Cancer Center (MSKCC). I am also conducting research at MSKCC within the Nursing Research fellowship. I look forward to advancing my career in the near future and going back to school to become a Pediatric CNS. Some of my hobbies include hiking, snowboarding and traveling around the world.

Kerlene Richards

Dr. Kerlene Richards, DNP RN NE-BC CCRN

An innovative doctorate prepared Nurse Leader with over 20 years experience, currently a Nurse Manager of a 31 bed Medical Surgical Unit at a community hospital. Adept at managing progressive nursing programs with an exemplary record of leadership in Medicine-Surgery, Telemetry and Cardiothoracic ICU. Extensive knowledge of training and mentoring programs with the demonstrated ability to build nurses' capacity, confidence and understanding of ethical matters while developing essential leadership skills. Proven ability to collaborate with cross-disciplinary teams to foster a healthy work environment and cultivate collaborative multidisciplinary community relationships. Active member of local and national Nurses Organizations; Poster and podium presenter at local, national and international nursing conferences.

Margaret Franks

Margaret is a Registered Nurse currently working at Vassar Brothers Medical Center in Poughkeepsie, NY. She has worked as a Med Surg nurse for the last five years and as a Covid Med Surg nurse since the start of the pandemic. She has seen firsthand not only the incredible work done by fellow nurses, but also the resulting stress and burnout experienced by many. She is a member of the NYSNA Executive Committee at Vassar, the Vassar Political Action Team, and Secretary of the Dutchess County CLC, and hopes to improve the working experience for all nurses. She would like the nurses of the Hudson Valley to have a voice and representation in ANA-NY as their local issues are similar to those faced by nurses statewide and nationally.

Megan Scali

My name is Megan Scali and I am a member of the nominations and elections committee. I graduated from Molloy College in 2019 and began my career in the CCU at NYU Langone Hospital. This summer, I made the switch over to NYU Long Island to be one of the Assistant Nurse Managers in the SICU and love that I get to be a leader and mentor to the staff. In my free time, I enjoy running and knitting! I am looking forward to working on the committee in the year ahead!

Winnie Kennedy

I was born and raised in Camillus, daughter of Helen and Al Myrdek, former Mayor of Camillus in the "60's." My grandparents worked and retired from the Camillus Cutlery.

I graduated from West Genesee Sr. High School in 1964, received a Bachelor's degree in Nursing from Niagara University, a Master's in Adult Education from Morehead State University and graduate credits in Business Administration from Chapman College.

Prior to retiring from the NYS Department of Health after 27 years in March 2003, I participated in the development of the Bioterrorism Preparedness Plan and the implementation of the smallpox plan for CNY.

I served on active duty during the Vietnam era from 1966-73 in the US Army Nurse Corps. After serving on active duty I joined the reserves and in 1994 retired from the 376th Combat Support Hospital Reserve Unit as a Lieutenant Colonel. I served a combined total of 24 years in the Army reserve and on active duty.

Currently I am active in the American Legion – Knifetown Post #1540; the Central Counties Professional Nurses Association, serve as a member of the Council on Legislation of the NYS Nurses Association, on the Board of Directors of the Syracuse Metro League of Women Voters as Secretary, CNY NOW Board of Directors and the Onondaga and Camillus Democratic Committees.

I have been involved in the political process since elementary school, either working on my father's campaigns, other campaigns or my own. I served six years as a Camillus Town Councilor (2002-2007).

The future of this county and the impact the political process has on that outcome is very important to me. Change will come through hard work and perseverance. All politics are local and I encourage everyone to take an active role in shaping the future.

I have used the quote below several times – it's simple but says a lot.

"The future belongs to those who believe in the beauty of their dreams"

~ Eleanor Roosevelt.

The future is ours, and the dream is victory in November. What could be more beautiful?

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) -

International Society of Nurses in Genetics (ISONG)

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)

Northern Adirondack Nurses Association (NANA)

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

Philippine Nurses Association of New York, Inc.

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)

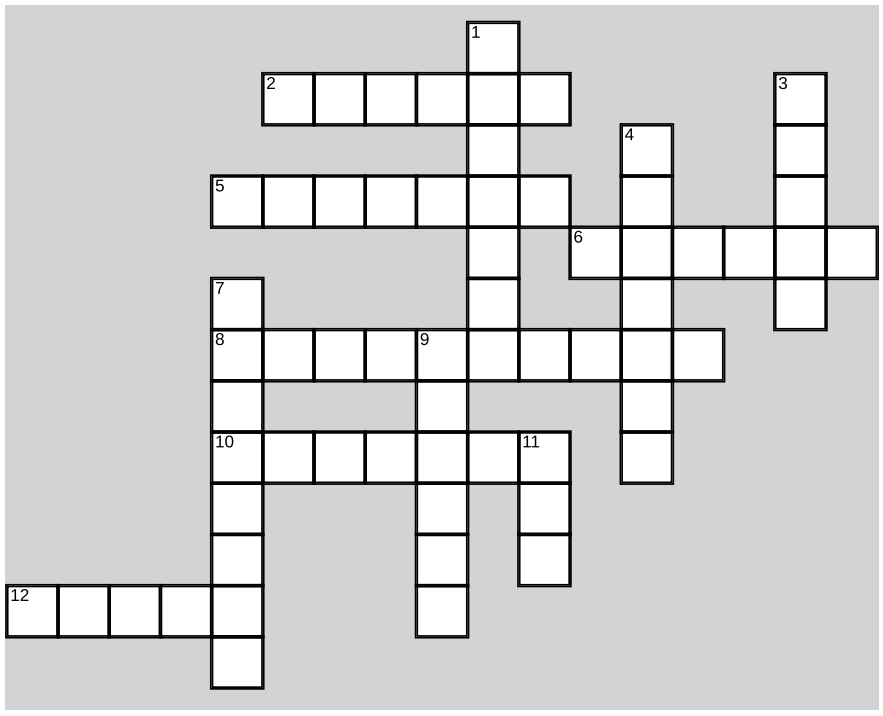
Are You A Member of a Nursing Group that Should Become an organizational Affiliate?

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.

January 2022 Newsletter Crossword



Across

2 Last name of the 9th Annual ANA-NY Conference Keynote Speaker

5 Last name of the 9th Annual ANA-NY Conference Speaker "A Compassionate Voice: Is It Time For Your Organization to Have an Internal Professional Coach?"

6 Last name of the 9th Annual ANA-NY Conference Speaker "A Voice at the Bedside: High-Stakes Performance Art: The Art of Nursing"

8 Last name of ANA-NY 2022 Board Secretary

10 Last name of the 2021 ANA-NY Scholarship Award

12 Last name of the 9th Annual ANA-NY Conference Speaker "A Voice of Experience: Malpractice Insights: Top Nurse Liability Concerns"

Down

1 Last name of newly elected ANA-NY 2022 Director-At-Large

3 Last name of the 9th Annual ANA-NY Conference Speaker "The Voice of the Patient: Improving Patient Satisfaction During a Pandemic"

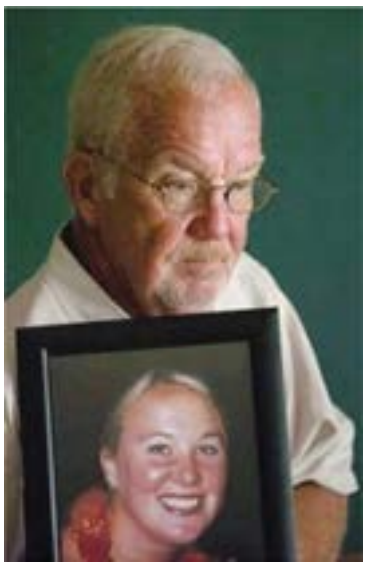
4 Last name of the 9th Annual ANA-NY Conference Speaker "Our Members' Voice: Albany Update"

7 Hotel where 10th Annual ANA-NY Conference will be held

9 Hotel where 9th Annual ANA-NY Conference was held

11 9th Annual Conference Platinum Level Sponsor

Sepsis Alliance



Sepsis Alliance, the first and leading sepsis organization in the United States, was born out of a tragedy. Dr. Carl Flatley lost his healthy 23-year-old daughter Erin to sepsis resulting from a routine outpatient procedure. At the time, Dr. Flatley had been practicing dentistry for many years, but he had never heard the term "sepsis" — it was still too under-discussed. From the moment he lost Erin, Dr. Flatley made combatting sepsis and raising public awareness of its dangers his life's mission. "All I could do was make myself a promise when she left us that early April morning," Dr. Flatley wrote in the *Tampa Bay Times*. "'No more Erins.'" In 2007, he founded Sepsis Alliance to educate the public about sepsis and advocate for sepsis patients and survivors across the country.

In 2019, Sepsis Alliance created the Sepsis Alliance Institute to address the need for easily accessible and robust provider education around sepsis and related topics. The Sepsis Alliance Institute now serves as a hub for free online instruction for healthcare providers across the continuum of care. It has registered more than 20,000 learners, awarded more than 42,000 free continuing education credits, and shared over 100 enduring courses since its creation.

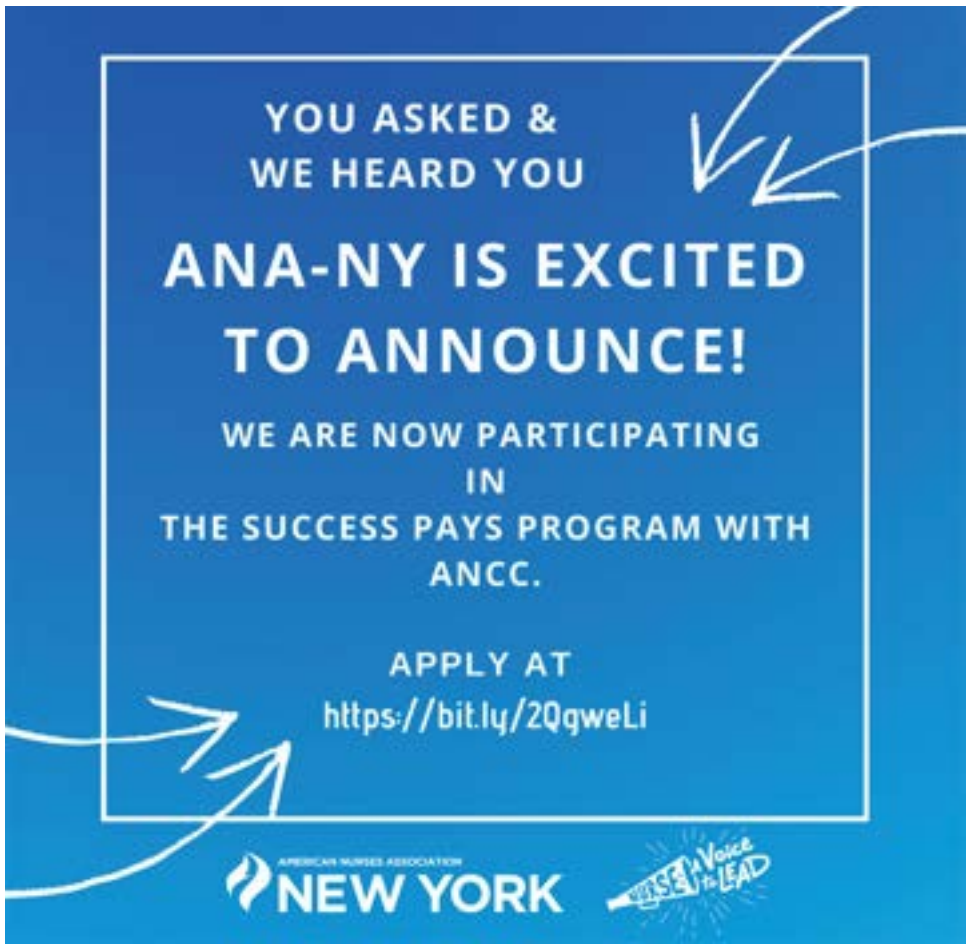
Sepsis Alliance also created the Sepsis Alliance Clinical Community, a peer-to-peer network of sepsis coordinators and other healthcare professionals connecting virtually to share sepsis best practice resources and guidance. **New to the Sepsis Alliance Clinical Community:** the "Topic of the Month" section, where members can receive focused feedback and dive deep into clinical questions on rotating sepsis-relevant subjects. Upcoming topics include:

- January 2021: Sepsis Program Performance Improvement - Tools & Strategies
- February 2021: Post-Sepsis Syndrome
- March 2021: Sepsis and Patient Safety

To learn more about the work Sepsis Alliance does to raise sepsis awareness and improve sepsis care, please visit Sepsis.org.

To learn more about Sepsis Alliance Institute programming, including its free library of enduring courses for healthcare providers, please visit SepsisInstitute.org.

To sign up for the Sepsis Alliance Clinical Community and discover free peer-to-peer resources, please visit SepsisCoordinatorNetwork.org.



Speakers Bureau

Did you know that ANA-NY has a Speakers Bureau? Currently available topics include:

- Archiving
- Bedside Care
- Challenging Conversations
- Change
- Civic Engagement
- Clinical Nurse Leader
- Compassion Fatigue
- Continence Care
- Disaster Education
- Diversity in Nursing Education
- Drugs of Abuse
- Employee Engagement
- Future of Nursing
- Geriatrics
- Health Disparities
- Health Promotions
- Homeland Security
- Informatics
- Labor & Delivery
- Leadership
- Learning Methodologies
- Long Term Care
- Magnet Journey
- Neonatal Abstinence Syndrome
- Neonatal Palliative Care
- NICU
- Non-profit Governance
- Nurse Entrepreneurship
- Nurses on Boards
- Nursing Education
- Nursing History
- Nursing Leadership
- Nursing Workforce Data
- Nutrition
- Oral History
- Organ Donation
- Ostomy Care
- Palliative Care
- Patient Safety
- Policy & Advocacy
- Population Health
- Public Health
- Quality Improvement
- Rapid Response Teams
- Regulations
- Research
- Self-care
- Simulation
- Skin Cancer
- Social Determinants of Health
- Team Building
- Telehealth
- Toxicology
- Work Environment
- Wound Care

See something you like? Need a speaker for your upcoming event, reach out to executivedirector@anany.org with your request and we will do our best to make a match!

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.

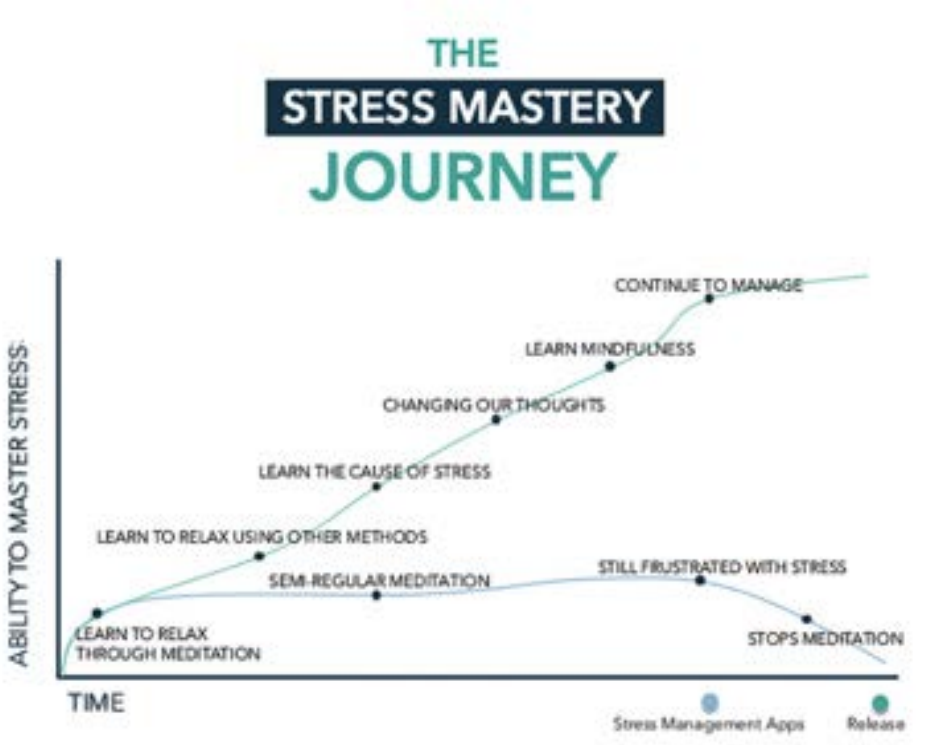
ANA-NY Works to Reduce Stress for All New York Nurses

ANA-NY has partnered 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."

As stated previously, ANA-NY has partnered with Dr. Olpin and Dr. Greg Waddoups to make this offering available to all New York Nurses. Please email Phil Meher, ANA-NY Program Manager, at programassocaite@anany.org for more information on this offering.

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

Self-Care During the COVID-19 Pandemic

Elizabeth Fountain, DNP, RN, ANP-C, WHNP-BC

Reprinted with permission from Mississippi RN, December 2021

According to World Health Organization (2021), self-care is the ability to encourage health, prevent disease, and manage disability with or without the help of a health care provider. This article aims to address how self-care can improve the impact of the COVID-19 pandemic on physical, mental, and emotional health.

At the height of the COVID-19 pandemic, many facilities lacked staffing and personal protective equipment. Some facilities did not have enough mechanical ventilators to meet the demand. Many health care workers experienced stress and overwhelm during the pandemic, which increases the risk of developing compassion fatigue, burnout, and post-traumatic stress disorder (PTSD). Compassion fatigue and burnout are often linked to the feeling of being unable to relieve suffering. Health care workers experiencing compassion fatigue are at a higher risk to engage in overeating and excessive alcohol use, which can affect physical and mental performance. Burnout can lead to medical errors and lower quality of care. Compassion fatigue and burnout can be linked to missed work, staff turnover, and low morale (Alharbi et al., 2020).

One way to decrease the risk for these conditions is to make sure adequate rest is achieved. Sleep deprivation and stress make the body more susceptible to disease and make it more difficult to manage emotions. In order to improve sleep, it is recommended to obtain natural light throughout the day, avoid bright lights in bedroom, and avoid excessive consumption of caffeine. By limiting excessive media coverage regarding COVID-19, stress levels may decrease (de Almondes et al., 2021).

A healthy diet of lean proteins, complex carbohydrates, fruits, and vegetables is recommended in order to promote optimal health. Avoiding processed foods and refined sugars can also help to maintain a healthy weight (Sarris et al., 2012). Because many people were working from home or unemployed during the pandemic, inactivity became a health risk. Exercise activates the immune system and decreases inflammatory processes in the body. Exercise increases dopamine, serotonin, and endorphins, which in turn promote feelings of well-being (Khoramipour et al., 2021).

Quarantine can increase risk for anxiety and depression due to feelings of loneliness, boredom, and isolation. During lockdown, many people struggled with loss of connection to others. Fear, anxiety, and PTSD decrease the immune system making the body more susceptible to disease (Khoramipour et al., 2021). One way to decrease these risks is to regularly talk to friends and family (Rodriguez dos Santos, 2021). Deep breathing, mindfulness, and support from others can improve mental health (Alharbi, 2020). Other ways to practice self-care in order to improve mental health include maintaining a routine, focusing on what can be controlled, practicing gratitude, using entertainment, such as books and television, to lift mood, engaging in spiritual worship and prayer, and staying engaged with others, even if that requires the use of technology (Reichert, 2020).

Another way to practice self-care is to engage with the local community to form connections and improve mental and emotional wellbeing. Ways to help the community include participating in blood drives, donating to food pantries, and checking on neighbors (Reichert, 2020).

Self-care practices can improve physical, mental, and emotional wellbeing during the COVID-19 pandemic. While these measures are very beneficial, if a person feels hopeless, out of control, anxious, or is unable to manage emotions, it is imperative that they seek professional mental health.

References

Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *Journal of Clinical Nursing, 29*(15-16), 2762–2764. https://doi.org/10.1111/jocn.15314

De Almondes, K. Agudelo, H., Jimenez-Correa, U. (2021). Impact of sleep deprivation on emotional regulation and the immune system of healthcare workers as a risk factor for COVID 19: Practical recommendations from a task force of the latin American association of sleep psychology. *Frontiers in Psychology, 12*, 1-10.

Khoramipour, K., Basereh, A., Hekmatikar, A., Castell, L., Ruhee, R., & Suzuki K. (2021). Physical activity and nutrition guidelines to help with fight against COVID-19. *Journal of Sports Sciences. 39* (1), 101-107. https://doi.org/10.1080/02640414.2020.1807089

Reichert, S. (2020). Self-care tips during the COVID-19 pandemic. https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/self-care-tips-during-the-covid-19-pandemic

Rodrigues dos Santos, K. M., Rodrigues Galvão, M. H., Marcelino Gomes, S., Araujo de Souza, T., de Almeida Medeiros, A., & Ribeiro Barbosa, I. (2021). Depression and anxiety in nursing professionals during the covid-19 pandemic. *Anna Nery School Journal of Nursing / Escola Anna Nery Revista de Enfermagem, 25*, 1–15. https://doi-org.libprxy.muw.edu/10.1590/2177-9465-EAN-2020-0370

Sarris, J., Moylan, S., Camfield, D., Pase, M., Mischoulon, D., Berk, M., Jacka, F., & Schweitzer, I. (2012). Complementary medicine, exercise, meditation, diet, and lifestyle modification for anxiety disorders: A review of current evidence. *Evidence-Based Complementary and Alternative Medicine, 25*, 1-20. https://doi.org/10.1155/2012/809653

World Health Organization. (2021). What do we mean by self-care?. https://www.who.int/reproductivehealth/self-care-interventions/definitions/en/

Traumatic Stress Among Nurses: Knowing the Signs and Support Available

Kristen Munyan, DNP, RN, FNP-BC, Kelly Shakoor, DNP, RN, FNP-BC, Erin Kennedy, DNP, RN, Patrick Kennedy, DNP, RN, ACNPC-AG

Reprinted with permission from Future of Nursing in Michigan, December 2021

Nurses and allied health professionals have experienced unprecedented stress since the onset of the COVID-19 pandemic. Traumatic stress is considered "a normal reaction to an abnormal event" (APA, 2021). While traumatic stress does resolve in most individuals, unresolved traumatic stress can put an individual at risk of mental health issues, including post-traumatic stress disorder (PTSD), anxiety or depression. In a study completed during April and May 2020 of frontline American nurses, 58.7% of nurse participants had a positive score on the Trauma Screening Questionnaire (TSQ), an instrument used to detect traumatic stress and identify those at future risk of developing PTSD (Hernandez et al, 2021). Traumatic stress in nurses presents a real threat to nurse retention and long-term challenges for our profession and inevitably the public health of our communities. American nurses have most certainly been impacted by the events of the past year and require support and awareness as we continue to navigate the stresses of the pandemic.

Signs and Symptoms of Traumatic Stress

Traumatic stress is different from anxiety or depression, and usually presents in the first few weeks after experiencing a trauma. How an individual processes traumatic stress is unique to each person but can include signs and symptoms such as anger or irritability, difficulty sleeping, feeling triggered by situations or events that remind a person of their stress, sadness or being more emotional than usual (APA, 2021). Other possible signs or symptoms of traumatic stress may include difficulty concentrating, feeling overly aware of your surroundings, feeling like you cannot experience positive emotions, or repeatedly thinking about the traumatic event. These signs and symptoms are often self-limiting and resolve over time. The American Psychological Association (2021) states people that have experienced traumatic stress should consider seeking professional help when their symptoms persist, fail to improve or interfere with their daily activities.

Screening

We can screen for traumatic stress among nurses and allied health professionals using the TSQ. The TSQ (Brewin, 2002) provides a well-validated instrument that identifies individuals at risk for developing PTSD. The tool includes 10 items and is considered positive when someone answers "yes" to at least six of the items. It is available without cost and can be self-administered. It is important to note that the TSQ is a screening instrument and does not diagnose PTSD. Nurses who believe they are experiencing symptoms related to traumatic stress should seek out supportive resources and talk with their healthcare provider for diagnosis.

Managing Traumatic Stress

Most traumatic stress symptoms will resolve over time with supportive measures such as rest, talking to a trusted confidant or practicing self-care (APA, 2021). If symptoms continue and become bothersome, professional help may be needed. There are resources available to nurses who have experienced occupation-related traumatic stress. The American Nurses Association (2021) offers a comprehensive Mental Health Help for Nurses page, including how to start a screening program in your workplace and tips for managing stress. As nurses, being aware of the signs and symptoms of traumatic stress can help us to identify it in ourselves and those around us and provide support to each other. Mental Health First Aid (2021), a widely offered evidence-based program, can offer additional training on identifying early signs of mental health issues and connects colleagues in need to professional help. The American Psychiatric Nurses Association has also published a COVID-specific guide for nurses entitled "Managing Stress & Self Care during COVID-19: Information for Nurses."

As we move forward as a profession, we must start normalizing conversations about occupational stress, trauma and nurse mental health. Efforts to implement screening of nurses using the TSQ in high-risk nursing settings should be a priority. In addition, having accessible support and resources available to health care professionals is essential. Prioritizing nurse mental health is an imperative component of efforts to retain skilled nurses who can go on to provide the best care for our patients and community.

References

American Nurses Association (2021). Mental health help for nurses. Retrieved from https://www.nursingworld.org/practice-policy/hnhn/2017-year-of-the-healthy-nurse/mental-health-wellness/.

American Psychiatric Nurses Association. (2021). Retrieved from https://www.apna.org/covid-resources/?pageid=6685.

American Psychological Association (2021) How to cope with traumatic stress. Retrieved from https://www.apa.org/topics/trauma/stress.

Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S., Foa, E. B. (2002). Brief screening instrument for post-traumatic stress disorder. *The British Journal of Psychiatry, 181*, 158-162.

Mental Health First Aid. (2021). Get trained. Retrieved from https://www.mentalhealthfirstaid.org/take-a-course/.

Ventilator Care: How Nurses Can Reduce VAEs Amidst a Pandemic

Kellie Ashburn, MSN, RN

Reprinted with permission from Tennessee Nurse, November 2021

Kellie Ashburn

If you have worked in a hospital setting since the start of the COVID-19 pandemic, you are aware of an increase in invasive device utilization (e.g. central lines, urinary catheters, ventilators) amongst the patients. In fact, a 31% increase in ventilators was noted across the United States in the latter half of 2020. With an increase in invasive devices, comes an increase in healthcare associated infections. Per the Centers for Disease Control, significant increases were reported for catheter associated bloodstream infections (CLABSIs), catheter associated urinary tract infections (CAUTIs), and ventilator-associated events (VAEs) in 2020.

In addition to the increase in devices and healthcare associated infections, one must also consider the ramifications in conjunction with the cause of the pandemic, COVID-19. Ventilator-associated events are noted as being especially significant during the COVID-19 era because patient mortality is three times greater for COVID-19 patients who experience VAEs versus those without VAEs.

As healthcare providers, nurses can help prevent VAEs by learning the definition of a ventilator-associated event, knowing which interventions to use, and how to advocate for your patient and his/her care. Taking these steps could help save your patient's life.

VAEs Defined

In 2013, the CDC implemented a change in ventilator infection reporting. What was once known as ventilator-associated pneumonia (VAP) transformed into a ventilator-associated event. Unlike ventilator-associated pneumonia, the term ventilator-associated event groups all conditions that result in a significant and sustained deterioration in oxygenation, caused by either an infectious or noninfectious condition together. This altered the focus from a lung infection to a deterioration in respiratory status. When dealing with ventilators, a deterioration in oxygenation is defined as a greater than 20% increase in the daily minimum fraction of inspired oxygen (FiO2) or an increase of at least 3 cm H2O in the daily minimum positive end-expiratory pressure (PEEP) to maintain oxygenation.

The transition from VAPs to VAEs was intended to provide a consistent description throughout all hospitals. The ventilator-associated event definition was designed to be objective, reproducible, automatable, and a strong predictor of poor outcomes. You can access the National Healthcare Safety Network's (NHSN) Ventilator-Associated Event (VAE) Calculator at https://nhsn.cdc.gov/VAECalculator/vaecalc_v8.html.

Nursing Interventions

Due to the increase in ventilator usage, and an overall increase in hospital population, staff members are currently dealing with ventilators more frequently, while being busier than ever. In addition, many rural hospitals are caring for more ventilator patients than ever before due to overburdened, larger urban hospitals being at capacity. Going "back to the basics" with ventilator care, also known as ventilator care bundles, can prove to be helpful for hospital staff and result in fewer patient ventilator-associated events. Nurse knowledge and use of ventilator care is critical for improved patient outcomes.

Nursing ventilator care bundles consist of head of bed elevation between 30º to 45º, daily chlorhexidine oral care, sedative interruption to assess readiness to extubate, gastrointestinal prophylaxis, and deep venous thrombosis prophylaxis (Table 1). Other items that are equally as important to improve patient-ventilator outcome include early mobilization, early discontinuation of mechanical ventilation, appropriate analgesia and sedation, low tidal-volume ventilation, and balanced intravenous fluid administration.

Although well documented and evidence-based, ventilator care bundles are poorly implemented in most critical care areas, which in a time with increased ventilator patients results in an increase in VAEs. Patients who experience a ventilator-associated event are more likely to have an increased length of hospital stay, increased medical bill, and have an increased risk of death. By altering this mindset and making ventilator care bundles a care standard, nurses can be on the forefront of change.

Patient Advocacy

By promoting not only a ventilator care bundle, but also suggesting other items that encourage improved patient outcomes, nurses are effectively advocating for their patients. By being the one at the bedside, nurses must be the voice of their patients. The American Nurses Association (AHA) identifies advocating for the health, safety, and rights of patients as part of a nurse's professional and ethical duty. Be an informed nurse and understand the repercussions of VAEs. This will give you the tenacity to speak up and best serve your patient.

Next time you care for a ventilated patient or audit a ventilator chart, use the ventilator care bundle and consider the other interventions that improve ventilator patient outcomes. By holding yourself and your facility at a higher standard, together nurses can decrease VAEs, therefore increasing the patient's chance of survival. Let us change the narrative for the future and decrease ventilator-associated events.

Ventilator Care Bundle

Patient: _____
Admit Date: _____

	ICU Date 1	2	3	4	5	6	7
1. Head of bed 30° to 45°							
2. Daily Oral Care with Chlorhexidine							
3. Sedative Interruption to Assess Extubation Readiness							
4. Gastrointestinal Prophylaxis							
5. Deep Venous Thrombosis Prophylaxis							

Table 1 Ventilator Care Bundle (Adapted from Institute for Healthcare Improvement Ventilator Bundle Checklist)

References

Aziz, Zu., Kausar, S., Zahid, S., Farooqi, S., Aziz, Za., & Altaf Ahmad, R. (2020). Knowledge and practice of ventilator care bundle for preventing ventilator associated pneumonia in ICU nurses of tertiary care hospitals of Lahore. *Anesthesia, Pain & Intensive Care, 24*(4). http://doi.org/10.35975/apic.v24i4.1315.

Center for Disease Control (2021). *COVID-19 Impact on HAIs in 2020.* https://www.cdc.gov/hai/data/portal/covid-impact-hai.html

He Q, Wang W, Zhu S, Wang M, Kang Y, Zhang R, Zou K, Zong Z, Sun X. (2021). The epidemiology and clinical outcomes of ventilator-associated events among 20,769 mechanically ventilated patients at intensive care units: an observational study. *Crit Care. 2;25*(1):44. doi: 10.1186/s13054-021-03484-x. PMID: 33531078; PMCID: PMC7851639.

Klompas, M. (2019), Ventilator-Associated Events: What they are and what they are not. *Respiratory Care. 64* (8) 953-961; DOI: https://doi.org/10.4187/respcare.07059.

Rahimi-Bashar, F., Gohari-Moghadam, K., & Vahedian-Azimi, A. (2021). Effective Implementation of Ventilator Care Bundles in Improves Outcomes: A Multicenter Randomized Controlled Clinical Trial. *Critical care explorations, 3*(9), e0509. https://doi.org/10.1097/CCE.0000000000000509

Raoof, S. & Baumann, M.H. (2014). Ventilator-Associated Events: The New Definition. *American Journal of Critical Care, 23*(1), 7-9. http://doi.org/10.4037/ajcc2014469

Zolnierek, C. D. (2012). Beyond Rhetoric: Supporting Patient Advocacy in Nursing Practice, *Perioperative Nursing Clinics. 7*(4); 379-387. https://doi.org/10.1016/j.cpen.2012.08.009.

Institue for Healthcare Improvement Ventilator Bundle Checklist. http://www.ihi.org/resources/Pages/Tools/VentilatorBundleChecklist.aspx?PostAuthRed=/resources/_layouts/download.aspx?SourceURL=/resources/Knowledge%20Center%20Assets/Tools%20-%20VentilatorBundleChecklist_8b5eeefe-7d5a-470b-ad48-37dbc1767dfb/VentilatorBundleChecklist_revMay10.doc

ANA-NY/ANA Membership Activation Form

AMERICAN NURSES ASSOCIATION NEW YORK ANA AMERICAN NURSES ASSOCIATION

Essential Information

First Name/MI/Last Name

Mailing Address Line 1

Mailing Address Line 2

City/State/Zip

County

Date of Birth

Gender: Male/Female

Credentials

Phone Number *Check preference:* ☐ Home ☐ Work

Email address

Professional Information

Employer

Type of Work Setting: (eg: hospital)

Practice Area: (eg: pediatrics)

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

Current Position Title: (eg: staff nurse)

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

- ☐ Clinical Nurse/Staff Nurse
- ☐ Nurse Manager/Nurse Executive (including Director/CNO)
- ☐ Nurse Educator or Professor
- ☐ Not currently working in nursing
- ☐ Advanced Practice Registered Nurse (NP, CNS, CRNA)
- ☐ Other nursing position

Ways to Pay

Monthly Payment $15.00

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

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

☐ Credit Card

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

Monthly Electronic Deduction | Payment Authorization Signature

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

Annual Payment $174.00

☐ Check ☐ Credit Card

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

Membership Dues (Price reduced to $15 monthly/ $174 annually)

Dues: .....$

ANA-PAC Contribution (optional) .....$

American Nurses Foundation Contribution (optional) .....$

Total Dues and Contributions.....$

Credit Card Information ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

Credit Card Number

Expiration Date (MM/YY)

Authorization Signature

Printed Name

Credit Card Billing Address

City, State

Zip

For assistance with your membership activation form, contact ANA's Membership Billing Department at (800) 284-2378 or e-mail us at memberinfo@ana.org

Online
Join instantly at
JoinANA.org

Mail
ANA Customer & Member Billing
PO Box 504345
St. Louis, MO 63150-4345

Phone
1 (800) 284-2378

Fax
(301) 628-5355

Registered Nurse Career Opportunities in Upstate New York

At Guthrie, our nursing teams can tackle any challenges together, including full moons.

Patient-centeredness, teamwork, and excellence are our way of life. At Guthrie, you're more than just co-workers, you're family.

And we get it, everyone is hiring! But here is why you should consider Guthrie.

- Up to $25,000 sign-on bonus
- Relocation assistance
- Tuition reimbursement
- Career advancement opportunities
- Excellent benefits
- Competitive salary
- And a sense of humor

Let's discuss an opportunity that fulfills your personal passion and supports your professional development goals.

Visit **www.Guthrie.org/WeBelieve** today!

GUTHRIE

ANA
AMERICAN NURSES ASSOCIATION

MEMBERS
20%* OFF TUITION

Advance your nursing practice with an advanced nursing degree.

In Excelsior College master's in nursing programs, students learn how to be leaders in their field and in patient care.

MEMBERS OF ANA CAN TAKE ADVANTAGE OF:

- *Tuition discounts of up to 20% and no application fee
- Financial aid, scholarships, and deferred tuition
- Credit awarded for RN licensure, nursing certifications, and previous college-level general education courses

EXCELSIOR COLLEGE

LEARN MORE ↗ excelsior.edu/ana