Volume 6
Number 2

ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

October 2021

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

ANA-NY Announces Results of 2021 Election

Thank you for taking the time to cast your votes. The election results:

Vice President and Membership Assembly Alternate to the President

Tanya Drake, MS, RN, Haverstraw, NY

Secretary

Gertrude "Trudy" Hutchinson, DNS, RN, MA, MSIS, CCRN-R, Altamont, NY

Membership Assembly Representatives

Elisa "Lee" Mancuso, RNC-NIC, MS, FNS, AE-C, Islip Terrace, NY

Kerlene Richards, DNP, RN, NE-BC, CCRN, Jamaica, NY

Kimberly Velez, MSN, RN, Brooklyn, NY

Director-at-Large

Kimberly Velez, MSN, RN, Brooklyn, NY

Susan Chin, PhD, RN, NNP-BC, Glen Head, NY

Giselle Gerardi, PhD, RN, C-EFM, RNC-OB, Commack, NY

Verlia Brown, MA, RN, BC, Wantagh, NY

Savannah Woods, BSN, RN, New York, NY

Nominations & Elections

Kerlene Richards, DNP, RN, NE-BC, CCRN, Jamaica, NY

Margaret Franks, BSN, RN, MEDSURG-BC, Beacon, NY

Membership Assembly Alternates

Giselle Gerardi, PhD, RN, C-EFM, RNC-OB, Commack, NY

Margaret Franks, BSN, RN, MEDSURG-BC, Beacon, NY

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PASS THIS NEWSLETTER ALONG TO A NURSE COLLEAGUE

MEMBERSHIP APPLICATION ON PAGE 27

FROM THE DESK OF THE EXECUTIVE DIRECTOR

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

Do you ever wonder what the office team does all day? Are you wondering how to get the full value of your membership dollars? Do you want to become more involved? Here's a brief description of the benefits, activities, and services provided by ANA-NY (for more details go to our website):

- Five Standing Committees
  - o Audit
    - Review the year-end financials
    - Select the auditor for the annual financial review
    - Review the financial letter
    - Review the 990
  - o Bylaws
    - Review the Bylaws
    - Review the proposed amendment submissions from members
    - Propose the Bylaws amendments for Governing Assembly vote
  - o Finance
    - Monitor the monthly Profit and Loss statements
    - Prepare the annual budget for Board approval
  - o Legislation
    - Track relevant bills and provide feedback to the lobbyist
    - Issue memorandums of support or opposition
    - Propose the Legislative Priorities for Governing Assembly vote
  - o Nominations and Elections
    - Review nominations for open positions
    - Prepare the ballot
    - Report the results of the ballot at Governing Assembly
- Currently we have three other committees
  - o Awards
    - Review nominations
    - Propose award recipients to the Board
  - o Nursing Education
    - Identify and discuss current issue in Nursing Education in NYS
    - Contribute the CE article for ANA-NY Nurse newsletter
  - o Program
    - Implement member programs across the state

- Quarterly electronic and print issues of ANA-NY Nurse newsletter
- Monthly electronic issues of Office Update
- Discounted liability insurance through Nursing Services Organization (NSO)
- Discounted CE credits through Elite Healthcare
- Study guide and two attempts for the price of one for ANCC certification through Success Pays
- Below cost registration for ANA-NY annual conferences
- Priority submission to the Journal of the American Nurses Association
- Access to Members-only information on our website
- Eligible for ANA-NY member awards
- Eligible to represent ANA-NY at ANA Membership Assembly
- Eligible to run for ANA-NY office
- Eligible to attend ANA-NY Lobby Day
- Eligible to be ANA-NY sponsored attendee to American Nurses Advocacy Institute
- Eligible to be a Nurses Supporting Nurses Peer Supporter
- Access to all of the ANA benefits as a dual member of ANA-NY and ANA

All of this, with more to come, for less than what you spend at Starbucks (or Dunkin) a month!

ANA-NY IS 8,400 MEMBERS STRONG

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Follow us on Instagram: @ana_ny2019

Followus on LinkedIn: American Nurses Association-New York

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

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

www.ana-newyork.org/

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

PRESIDENT'S MESSAGE

Marilyn L. Dollinger, DNS, FNP, RN

In August, ANA-NY was awarded a $10,000 grant from ANA to participate in a national effort to disseminate infection prevention and control (IPC) training to the nation's nurses. This initiative, called Project Firstline, is a Centers for Disease Control and Prevention (CDC) collaborative of diverse healthcare and public health partners. The Project First Line's goal is to provide "engaging, innovative and effective" infection prevention and control training to more than 6 million U.S. health care personnel. ANA's goal in awarding these grants is to support training for over 4 million nurses as part of this target group.

There are three separate components to Project Firstline: https://www.nursingworld.org/practice-policy/project-firstline/

1. On-The-Go-Resources that include videos, resource links and infographics that can be downloaded now and available to anyone.
2. CNE training courses developed by ANA and CDC by IPC experts.
   a. Eight modules are available now for downloading. Use the link above to see the titles.
   b. Six modules are scheduled for release this fall focused on skills related to vaccination administration, disaster preparedness, PPE, IPC basics, other safety procedures, and IPC as self-care.
3. Project ECHO (Extension for Community Healthcare Outcomes) which will provide local communities all over the world with the resources to provide "best practice" care to the most vulnerable populations. These are interactive session using a facilitator to leverage technology to share knowledge to underserved and rural communities.

Additional content is also available now online:

- Inside Infection Control through the You Tube Video series (14 episodes)
- CDC platform CDC TRAIN TCEO (7 courses)
- Facilitator Toolkit Guides for sessions of varying length (10 topics)

ANA-NY members will be working with colleagues across the state in all settings: hospitals, long term care facilities, schools of nursing, school-based health centers, community-based health centers, home care providers—anywhere that care is delivered and health care personnel of any kind could benefit from these programs. We will be networking with colleagues in all New York State professional nurses associations to leverage and amplify the outreach.

If you are nursing students or faculty in a nursing program, the resources are excellent for both instruction and review of nursing care skills.

When the pandemic started there was chaos and uncertainty across the country and around the world—with nurses and all frontline providers asking themselves "what works best", what are the "best practices" in dealing with this global pandemic. With widespread dissemination of the Project Firstline training and resources, we will never be caught this unprepared again.

As the grant activities get underway this fall, we will send you updates and information about how to get involved.

Meet Your 2022 ANA-NY Board of Directors

President
Marilyn Dollinger, DNS, FNP, RN, Rochester, NY

Vice President
Tanya Drake, MS, RN, Haverstraw, NY

Secretary
Gertrude "Trudy" Hutchinson, DNS, RN, MA, MSIS, CCRN-R, Altamont, NY

Treasurer
Phyllis Yezzo, DNP, RN, CPHQ, Eastchester, NY

Directors-at-Large

Susan Chin, PhD, RN, NNP-BC, Glen Head, NY

James Connolly, MSN, RN, Levittown, NY

Giselle Gerardi, PhD, RN, C-EFM, RNC-OB, Commack, NY

Sarah Marshall, DNP, MS, RNC, ICCE, CCE, CBC, CLC, Garden City, NY

Kimberly Velez, MSN, RN, Brooklyn, NY

BOARD BUZZ

On behalf of our members, the Board of Directors:

- Welcomed new Program Manager, Phil Meher.
- Approved adding a new position of Member Engagement Manager to the office team to better meet member needs and expectations.
- Accepted the Legislation committee's proposed 2022 Legislative Priorities to present to the Governing Assembly.
- Submitted a successful $10,000 grant application co-authored by President M. Dollinger, ED J. Santelli and member S. Birkhead to participate with ANA in the CDC's Project Firstline.
- Issued position statements, MOS and MOO for proposed legislation and DOH regulations as guided by ANA-NY's Mission Statement and in consultation with Lobbyist A. Kellogg.
- Began reaching out to lapsed members to improve retention and identify reasons for non-renewal.
- Participated in ANA-NY's first member mixer at Nittis in Manhattan.
- Sponsored the Nurses House Dolphin Awards Ceremony.
- Co-sponsored multiple professional events throughout the state.
- Revised policies and procedures to facilitate effective operations.
- Donated to disaster relief organizations.
- Continued to participate in virtual leadership activities with ANA and other professional organizations.
- 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.

2021 Class of American Academy of Nursing Fellows from ANA-NY

Please join the ANA-NY Board of Directors in congratulating the following distinguished New York nurse leaders who were inducted as Fellows into the American Academy of Nursing for 2021:

Valerie Aarne Grossman, MA, RN, NE-BC, FAEN, FAARIN – Highland Hospital (University of Rochester Medical Center)

Kellie Bryant, DNP, WHNP, CHSE – Columbia University

Jane Carmody, DNP, MBA, RN, CENP, NEA-BC – The John A. Hartford Foundation

Natalia Cineas, DNP, RN, NEA-BC – NYC Health & Hospitals

Ana Maria Kelly, PhD, RN – Columbia University

Irene Macyk, PhD, RN, NEA-BC – North Shore University-Northwell Health

Ruth Masterson Creber, PhD, MSc, RN – Weill Cornell Medicine

Allison Andreno Norful, PhD, RN, ANP-BC – Columbia University

Pamela Paplham, DNP, AOCNP, FNP-BC, FAANP – University at Buffalo

Rhoda Redulla, DNP, RN, NPD-BC – NewYork-Presbyterian/Weill Cornell Medical Center

Sarah Collins Rossetti, PhD, RN, FACMI, FAMIA – Columbia University

Meghan Underhill-Blazey, PhD, APRN – University of Rochester; Wilmont Cancer Institute

Courtney Vose, DNP, MBA, RN, APRN, NEA-BC – NewYork-Presbyterian Hospital

American Academy Living Legend

The American Academy of Nursing officially designated four extraordinary nurse leaders as Living Legends this fall. Drs. Betty Ferrell, Terry Fulmer, Susan Hassmiller, and Marla Salmon were honored at the Living Legends Ceremony held during the Academy's annual Health Policy Conference, on October 7-9, 2021. Through their influence in leadership, innovation, and science, these individuals have made a lasting policy impact and significantly advanced the public's health. We are very proud to recognize and honor an ANA-NY member, Dr. Terry Fulmer!

Terry Fulmer, PhD, RN, FAAN, is a leading expert in the field of gerontological nursing and has dedicated her career to improving the care and quality of life for older adults. She was the first nurse to serve as president of the Gerontological Society of America and as a Board Member of the American Geriatrics Society, paving the way for nurses in the field. Dr. Fulmer has been a passionate mentor to many seeking to eradicate elder abuse, her primary area of research. Dr. Fulmer remains actively engaged in health policy, serving on the U.S. Department of Health and Human Services' National Advisory Council on Aging, Veterans Health Administration Special Medical Advisory Group, and the National Academy of Medicine Forum on Aging, Disability, and Independence. Dr. Fulmer is the President of The John A. Hartford Foundation where she led the creation of the Age-Friendly Health Systems movement, which has to date engaged over 2,300 hospitals, practices, and nursing homes in the reliable delivery of evidence-based care focused on what matters most to older adults and their caregivers.

Jennifer Pettis

Jennifer Pettis, MS, RN, CNE, ANA-NY member and regular newsletter contributor was recently a Spotlight Member of the Capital Region Women@Work. She was nominated in recognition of her outstanding advocacy on behalf of individuals and families living with Alzheimer's and other dementias. Jen works tirelessly to develop and advance policies to overcome Alzheimer's disease through increased investment in research, enhanced care and improved support. She pushes to ensure that health systems are prepared to provide person-centered, quality care to individuals living with Alzheimer's and other dementias.

Northwell Nurses Choir on AGT

And lest we forget The Northwell Nurses Choir on AGT!

We are super proud of all of our colleagues in the choir, but want to give a special shout out to our ANA-NY member, Shonda Ramirez, RN, Nurse Case Manager, Long Island Jewish Forest Hills!

Welcome Phil Meher, ANA-NY Program Manager!

We have a new face in the office. Phil Meher has joined us as our new Program Manager. Phil grew up in the Capital Region. He did, briefly, venture out to Buffalo for college, but returned to the Capital Region. He has Program Management experience in a medical practice and a renewable energy company. He has additional familiarity with health care through his work at Albany Medical Center as an Administrative Support Associate and Patient Care Associate. He is currently working toward a degree in Business Administration.

Phil already is getting a feel for the programs that we offer our members and is looking for creative and valuable additions to our member benefits portfolio. Be sure to say "Hi" when you see him at our conference in October. His email is programassociate@anany.org

IN MEMORIUM – BILL DONOVAN, MA, RN

Bill was a founding member of ANA-NY and served for several years on the ANA-NY Board of Directors including the office of vice-President. He was also a long-standing member of the Nurses House Board including the offices of Treasurer and President. He earned his BS in Nursing from Adelphi and an MA in Nursing from New York University. He worked at Mount Sinai Health System for 34 years as an RN. He was adjunct faculty for Rutgers University, Excelsior College, and Pace University. He was a long-standing pillar of the Nursing community and will be greatly missed.

COMMITTEE SPOTLIGHT

Awards Committee

The Awards Committee is responsible for reviewing each year's nominations and submitting their recommendations to the Board. This year the Committee, under the direction of the Board, created two new, enduring awards: Nurse Hero (recognizing an individual ANA-NY member) and Nurse Heroes (recognizing a group).

The Awards Committee members for 2021 are:

- Jennifer Morrison-Nahum, RN – Chair
- Linda Millenbach, PhD, RN
- Lynn James, RN
- Priscilla Worral, PhD, RN
- Amy Nugent, RN
- Liz Catherine Cory, RN
- Jacob Wilkins, RN
- Karine Austin, RN
- Heather Simpson, RN
- Karen Ballard, MA, RN
- Cathy Sullivan, RN
- Karen Iapoce, RN
- Irene Macyk, MS, RN, PCNS-BC
- Maria Scheilla, RN
- Verlia Brown, MA, RN. BC – Board Liaison

NICHE AGE-FRIENDLY NURSING PRACTICE PEARLS

Imagine a World Without Alzheimer's and Other Dementia

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

In the United States, 11% of older adults (i.e., those 65 years old or older) have dementia which results in symptoms including memory loss, speech or writing difficulties, and difficulty problem solving, among others (Alzheimer's Association, 2021a, 2021b). Alzheimer's disease is the most common cause of dementia, and 6.2 million older Americans have Alzheimer's. As the Baby Boomers continue to age, this number will more than double by 2060, when it is expected that 13.8 million Americans will have Alzheimer's. While younger individuals are diagnosed with Alzheimer's, it is much more common in older adults. In fact, as an individual ages, their risk of Alzheimer's drastically increases. Just over 5% of people age 65 to 74 have Alzheimer's; this percentage increases to 13.8 for people age 75 to 84 and 34.6 for people 85 years old or older. Women are approximately twice a likely as men to be diagnosed with Alzheimer's, and the disease disproportionately afflicts Black and Hispanic individuals. One in three older adults dies with Alzheimer's disease (Alzheimer's Association, 2021b).

In addition to the human costs of the disease, the financial costs associated with Alzheimer's disease are staggering. Family caregivers provide unpaid care worth $256.7 billion, and many caregivers experience negative physical, mental, and emotional impacts of doing so. Additionally, these caregivers often miss time from work, turn down opportunities for advancement at work, or give up working entirely. Total healthcare spending to care for individuals with Alzheimer's and other dementias in 2021 is expected to reach $355 billion (Alzheimer's Association, 2021b).

Now, imagine "a world without Alzheimer's and all other dementia" (Alzheimer's Association, 2021c). This is the vision of the Alzheimer's Association, and the organization works to achieve this vision through three levers: care and support, research, and advocacy. I am a volunteer educator and board member with my local chapter, the Alzheimer's Association Northeastern New York, and I am honored to serve as the Alzheimer's Ambassador to Senate Majority Leader Chuck Schumer. The organization does tremendous work supporting individuals with Alzheimer's and other dementias and their loved ones. In this NICHE Age-Friendly Nursing Practice Pearls column, I am delighted to share my recent interview with Elizabeth Smith-Boivin, executive director of the Alzheimer's Association Northeastern New York and a Research Champion for the Association.

J. Pettis: There is so much exciting research happening around Alzheimer's disease, including around the new treatment, aducanumab. What can you share with my nurse colleagues about this medication?

E. Smith-Boivin: The Alzheimer's Association welcomes the historic FDA approval of aducanumab (Aduhelm™), the first FDA-approved treatment in its class. While existing therapies may temporarily address some symptoms, this is the first approved treatment that removes amyloid — a hallmark of Alzheimer's — from the brain, and delays clinical decline in people living with the disease. The approval of this treatment makes early detection of Alzheimer's and access to care more important than ever. The Alzheimer's Association will do everything in its power to ensure access to the drug, any tests needed during the treatment process, and other associated costs for all who will benefit.

J. Pettis: In addition to focusing on ensuring quality care and support for individuals with Alzheimer's and other dementias, the Association focuses a great deal on reducing risks associated with Alzheimer's and early detection. What does the research tell us about the risks of Alzheimer's, including those that are modifiable risks?

E. Smith-Boivin: I very much appreciate this question as new information about risk reduction empowers us all. The greatest risk factor for developing Alzheimer's disease continues to be age and this, of course, is nonmodifiable. However, in recent years, we have learned a great deal about other very significant risk factors including cardiovascular health and Type II diabetes. We've also learned a great deal about the importance of embracing a healthy lifestyle, including eating a heart-healthy diet, engaging in moderate to vigorous exercise, avoiding smoking, ensuring cognitive stimulation, and limiting alcohol consumption. When individuals adopt four or five of these practices, they may reduce their dementia risk by as much as 59% while those that adopt just two or three may reduce their risk by 39%. This is exciting news and has significant public health implications.

J. Pettis: Next, let's talk a little bit about early detection. Why is early detection and diagnosis so important?

E. Smith-Boivin: First and foremost, the approval of a new treatment for Alzheimer's makes early diagnosis vital. It will ensure individuals receiving the treatment get the most benefit at the earliest possible time. In addition, obtaining an early and accurate diagnosis ensures that potential reversible causes of cognitive decline are treated and that access to clinical trials is an option. Lastly, securing an early diagnosis provides persons affected and their care partners the time and ability to complete their personal, financial, and legal planning.

J. Pettis: In the past, we would hear that Alzheimer's could only be diagnosed through autopsy but that is no longer the case. Patients and their families may ask their nurse about this. What should a nurse tell them about the diagnostic process?

E. Smith-Boivin: That's correct, we do not need an autopsy to make a diagnosis of Alzheimer's. We recommend that nurses advise their patients to see either their PCP or a neurologist to complete the comprehensive evaluation developed by the National Institutes of Health (NIH)/Alzheimer's Association in 2011. That evaluation includes a brain scan (PET, MRI, or CAT), blood work, a physical evaluation, a comprehensive family history and assessment, and several neuropsychological tests. As you can see, that diagnostic process may be a somewhat laborious one but, when completed, it provides highly accurate results. The Alzheimer's Association is also advocating for and investing in the development of a widely available, affordable and non-invasive biomarker test. A biomarker is, of course, that objective measure of disease and while there are two approved by the FDA – an Amyloid PET scan and an analysis of cerebral spinal fluid obtained during a lumbar puncture – they are not easily accessible. The development and approval of a biomarker, such as a blood test which quickly measures blood sugar and aids in the prompt identification of diabetes, would change the trajectory of Alzheimer's diagnosis and treatment and is one of the Association's highest priorities.

J. Pettis: Earlier this year, the Alzheimer's Association issued a special report titled Race, Ethnicity and Alzheimer's in America. What were some key findings in that report?

E. Smith-Boivin: Findings from two national surveys appearing in the special report reveal that discrimination is a barrier to Alzheimer's and dementia care. More than one-third of Black Americas (36%) and nearly one-fifth of Hispanic Americans (18%) and Asian Americans (19%), believes discrimination would be a barrier to receiving Alzheimer's care. Non-White racial/ethnic populations have less trust in medical research and are less confident that they have access to health professionals who understand their ethnic and racial background and experiences. In addition, half or more of non-White caregivers say they have experienced discrimination when navigating heath care settings for their care recipient. Clearly, despite ongoing efforts to address health and health care disparities in Alzheimer's and dementia care, there is much work to do.

J. Pettis: How is the Association addressing those findings, including here in New York?

E. Smith-Boivin: A critical first is building and restoring trust in underrepresented communities. One way to do so is through community-based organizations (CBOs) and other respected local partners. The Alzheimer's Association is working with several CBOs and other groups to educate and engage diverse communities about Alzheimer's disease and care and support services it provides. Local chapters, like Northeastern New York, work with various nearby groups to engage diverse communities. We also provide ongoing community forums, co-sponsor education that focuses on the disparities, and provide support groups in Spanish. Furthermore, future Alzheimer's and dementia research can be strengthened by increasing the diversity of investigators and professionals who conduct clinical trial and population health research. The Alzheimer's Association and NIH are co-funding the Institute on Methods and Protocols for Advancement of Clinical Trials in Alzheimer's disease and related dementias (IMPACT-AD) program – an innovative program to increase diversity in dementia research launched in fall of 2020.

J. Pettis: One federal legislative priority of the Association is the bipartisan Comprehensive Care for Alzheimer's Act (S. 1125 / H.R. 2517). I think that nurses might be especially interested in this Act. If this becomes law, how will it change dementia care?

E. Smith-Boivin: The Comprehensive Care for Alzheimer's Act would ask the Center for Medicare and Medicaid Innovation (CMMI) to test a better payment structure for dementia care management.

This model would:

- Provide critical services such as the development of a personalized dementia care plan, ongoing care coordination and navigation, and caregiver education and support,
- Ensure that patients have access to an interdisciplinary team of providers with dementia care expertise and, lastly,
- Reimburse providers through a capitated payment and an incentive payment based on performance.

J. Pettis: How can nurses connect patients and their families to the services offered by the Alzheimer's Association?

E. Smith-Boivin: The best two ways to connect with the Alzheimer's Association are by logging on to our website (www.alz.org), where one can easily find disease related information or locate their nearest chapter, or by calling our free, 24 hour/7 day per week Helpline at 800-272-3900.

J. Pettis: How can nurses get involved with the Association?

E. Smith-Boivin: This is a question that can be perfectly answered by a dedicated volunteer like you! The Alzheimer's Association welcomes and appreciates volunteers who serve as board and committee members, advocates (both state and federal), educators and community representatives (folks that assist with tabling at health fairs and forums). We are also in need of volunteers to assist with the planning and delivery of events like our Walk to End Alzheimer's.

J. Pettis: I can't thank you enough for your time and for all the great information you have shared. The Association does such great work, and I am thrilled to share all this information with my nurse colleagues around New York State!

E. Smith-Boivin: Thank you, Jen, for providing me with this opportunity and for all you do for the Alzheimer's Association and those we serve. Additional thanks to your nurse colleagues for the work that they do each and every day.

References

Alzheimer's Association. (2021a). *10 early signs and symptoms of Alzheimer's.* https://www.alz.org/alzheimers-dementia/10_signs

Alzheimer's Association. (2021b). *2021 Alzheimer's disease facts and figures.* https://www.alz.org/media/documents/alzheimers-facts-and-figures.pdf

Alzheimer's Association. (2021c). *Our impact.* https://www.alz.org/about/our-impact

Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). Alzheimer's Association dementia care practice recommendations. *The Gerontologist, 58*(suppl_1), S1–S9. https://doi.org/10.1093/geront/gnx182

2021 ANA-NY Awards

Nursing Practice
Insook Yoon, RN, MA

Ms. Yoon is a true example of an "unsung Hero" who has touched many Asian Americans, especially Korean Americans in New York. Her work includes providing health care, advisement, and health-related information to this community. Ms. Yoon's dedication and commitment to patient care as well as being a nurse advocate was recognized with the 2003 Nightingale Award from the Overseas Korean Nurses Association and in 2017 by the New York Korean Nurses Association.

Scholarship
Rhoda Redulla, DNP, RN, NPD-BC, FAAN

Dr. Redulla has authored a book entitled Fast Facts for Making the Most of Your Career in Nursing which was released to coincide with the 2020 International Year of the Nurse. She has authored several articles on gastroenterology nursing. She has also published a joint reference book for nurses and doctors in the Philippines. All told she has contributed to over 60 book chapters, peer-reviewed and feature articles; and national and international presentations. She has also mentored over 600 nurses in EBP and research as a nursing faculty member.

Nursing Education
Fidelindo Lim, DNP, CCRN

Dr. Lim is known for his outstanding student-centered teaching strategies which makes him a much sought-after mentor. He volunteer's countless hours to curate robust extracurricular programming to promote academic excellence including professional development events, museum visits, theatrical performances, walking tours, and narrative experiences to enhance competence in responding to the human condition. His commitment to promoting nursing extends to programming for elementary and middle school students. He also founded the New York City Men in Nursing chapter of the American Association of Men in Nursing.

Nurse Hero - Individual
For the inaugural year of this award, we have two awardees:

Noreen Brennan, PhD, RN-BC, NEA-BC

During the COVID-19 Pandemic, New York faced a challenge unlike any other. As information was emerging and the gravity of the situation was developing, Dr. Brennan made sure every day in and day out that she was present, rounded on her nurses. Even one day, when the staffing was particularly short, she put on scrubs, personal protective equipment and ensured that no patients were not left without a nurse. When personal protective equipment was becoming a growing concern, her stance was always to provide all who needed it had the resources they wanted to protect themselves. She never turned away staff or denied personal protective equipment. Even when times were potentially looking like they were running short, she maintained a close watch and never ended up running out of personal protective equipment.

She is a resilient leader who supports her staff, a respected scholar, and a dedicated educator embodying all of the traits outlined within ANA's Scope and Standards of Practice.

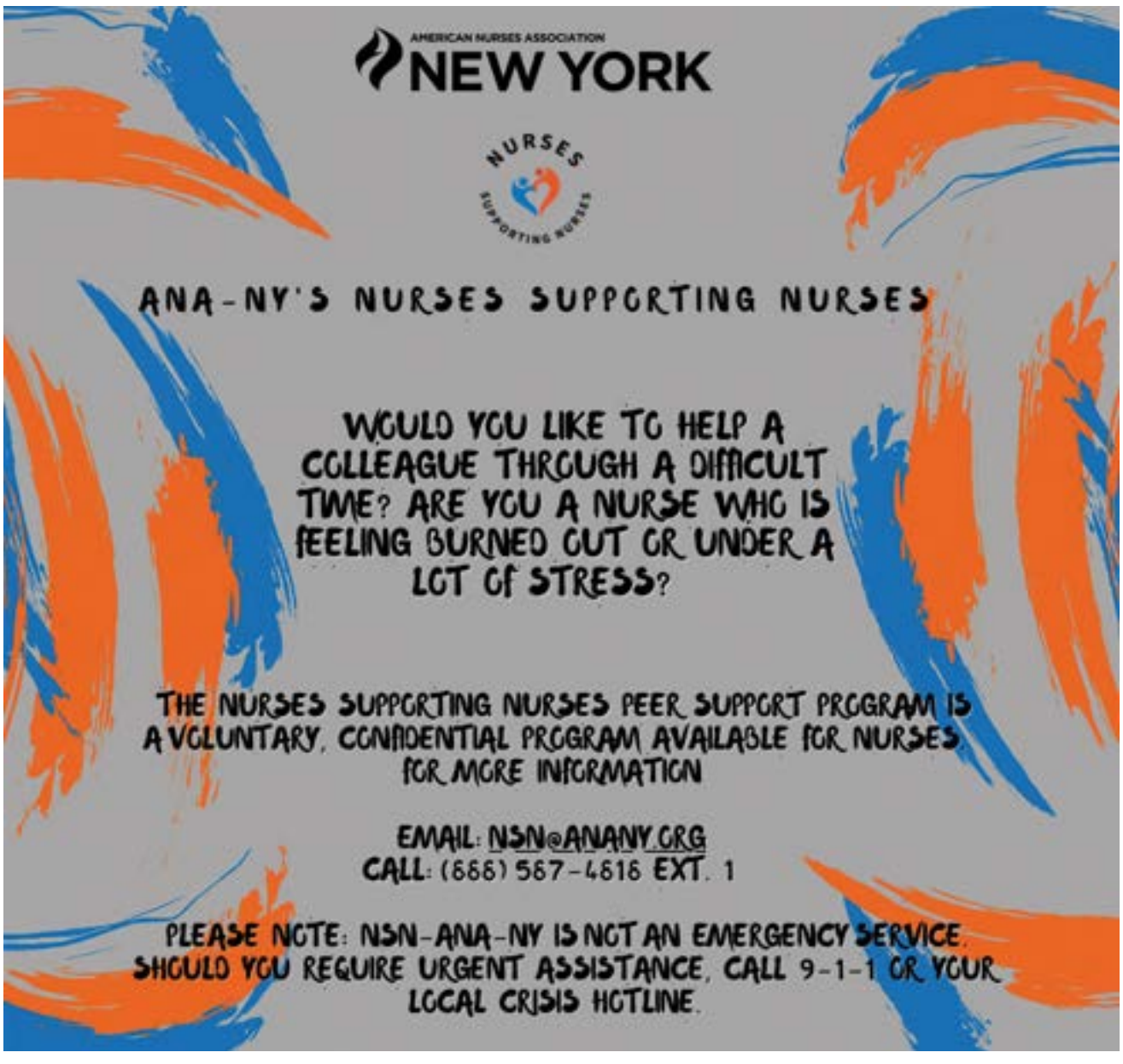
Leon Chen, DNP, AGACNP-BC, FCCP, FAANP, FNYAM

Dr. Chen demonstrated a particular interest and tenacity that went above and beyond to develop and improve our approach to the COVID-19 patient. In addition to his tenure at Memorial, he volunteered his time to NYU Medical Center, developed mechanical ventilator modules for US Public Health Service Corps and, in the Journal of American Association of Nurse Practitioners, published a very relevant case for expansion of the AGACNP skill set in point-of-care ultrasound (POCUS) in the age of a pandemic. In addition to his academic and clinical contributions, while having contracted the Covid-19 virus himself, he donated his convalescent plasma and quarantined separate from his family, including his infant son; demonstrating a huge personal sacrifice for those around him and for the greater good.

Nurse Heroes – Group
Strong Memorial Hospital Nursing Recruitment Department

The Nursing Recruitment Department supported their employees, including nurses, and patient care technicians throughout the COVID-19 pandemic. They served as the central clearing house for all nursing staffing and creatively recruited retried nurses and other healthcare providers. They designed quick training and educational interventions to help speed up competency and then effectively matched skilled sets with unit needs. The support may focus on mental health, physical health, family support, shelter, and/or food.

The Recruitment Department's herculean effort to recruit, hire, orient and deploy hundreds of nurses at the University of Rochester medical Center supported thousands of nurses on the frontlines with compassion, humanity, and resilience. They were steadfast and persistent in ensuring creative nursing models to deliver high quality care to our patients while providing the support the bedside nurses needed. Recruitment really cared for clinical nurses around the clock so that they were able to perform their responsibilities without worry for their own safety.



DONATE LIFE NEW YORK STATE

Milinda Mejorado, who was inspired by her son Tyler's lifesaving organ transplant and the incredible nurses on his medical team, went from Operations Supervisor at GAP to obtaining her RN and working as Transplant Coordinator.

Tyler, the third of four siblings, was diagnosed with Cirrhosis of the liver in 2006. His liver was failing and doctors informed the family the only treatment would be a transplant. The next few years of his life were spent in and out of the hospital. In 2009, he ended up in the ICU with internal bleeding; spending several consecutive months in the hospital. Just as the family thought he was coming home, Tyler had a seizure, coded, and was moved back to the ICU and placed in a medically-induced coma. The doctors and family were uncertain if he would be strong enough to survive the long wait for a new liver.

The time in the hospital was filled with chaos and confusion for Milinda. Eager to comprehend what was going on inside of her son's body and the life-saving decisions being made by his medical team, she asked countless questions. She recalls the deep gratitude she had for the kindness and patience Tyler's nurses showed her in the ICU.

One nurse, in particular, spoke with her at length and urged her to enroll in medical school. "I want to do this," Milinda recalls thinking. The more time she spent in the ICU with Tyler, the more she was convinced, "I am going to be a nurse."

Life was moving fast with many fluctuations of highs and lows for the Mejorado family. While caring for her son and family, Milinda began taking nursing classes. The schedule and demands were rigorous, but she was determined to become a member of this community of healers.

In 2011, the Mejorados received the call that they had been waiting for; there was a liver for Tyler. His donor was a six-year-old boy. The knowledge that another family chose to make this gift of life in their darkest moment was not lost on Tyler and his family. Their hearts were filled with gratefulness to their "forever-hero" and continue to be each and every day.

The nursing staff, pleased by the outcome of the surgery, encouraged Milinda to see Tyler while he was recovering. For so long, his complexion was grey and sallow and now his face was a healthy, warm pink; it was the first deep breath Milinda had taken in three long years.

Tyler is now entering his senior year at Fordham University. He is double majoring in Political science and Theology and plans on attending law school after graduation. He is a lector at his local church and a godfather to his six-year-old nephew and best friend's one-year-old son.

Milinda obtained her RN in 2015 and has worked in the PICU at both Westchester Medical Center, where her son's liver transplant took place, and Mount Sinai. In January 2021, she returned to Westchester Medical Center as a Transplant Coordinator. Tyler lives because of the amazing generosity of his donor and the gifted nurses and doctors who nurtured him back to health. "To be able to work alongside the nurses who inspired me and with the team that saved Tyler's life is an entirely new level of gratitude."

Milinda brings a unique and personal perspective to the role because she knows what it's like to be in the shoes of the patient's parents. She understands their uncertainty and fear and is committed to supporting them through the long journey ahead. Her greatest joy is being able to call patients and let them know their lifesaving gift has arrived. Milinda relates to the relief and overwhelming gratitude that comes at this moment.

From recipient mom to Transplant Coordinator, Milinda will never take for granted the second chance that Tyler received. "Donation is in my blood. It is my passion. I just want everyone to understand what an amazing gift it is."

To register as an organ and tissue donor go to www.donatelifenys.org/register.

No Kidding!

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

How does a vampire know he's hungry? Low blood pressure

While vampires don't exist, phlebotomists who are often referred to as vampires do. While we see these colleagues draw blood and rely on them to gain access to critical patient information, how did they get their name, what is their scope of practice, and how do they maintain their skills? Phlebotomy comes from the Greek word Phlebos, which means "vein" and "to cut" and their practices started over 3,000 years ago in Greece (Medical News Today, 2004-2021). Phlebotomy training typically takes 200 total hours split between theory and hands-on practice and can be done in a hospital-run program or technical training center, such as BOCES (Erie Boces, 2019). Program graduates can gain employment as a phlebotomist with a certificate of program completion or choose to sit for a certification. The Phlebotomy Technician certification is an 80 question exam through the American Society for Clinical Pathology and allows PBT to be listed after their name similar to ANCC certifications in nursing (Senchel Ventures, 2015-2021). However, only California, Louisiana, Nevada, and Washington require phlebotomists to be certified to practice (Senchel Ventures, 2015-2021). Also similar to nursing certifications, this certification requires continuing education and promotes professional development for renewal every 3 years. Since certification and accreditation is optional, New York State doesn't dictate a scope of practice or register phlebotomy programs. Therefore, hiring agencies dictate their practice and title leaving skills to be maintained on the job.

While the practice of drawing blood now consists of taking only 3-10mls of blood from a patient at a time, the process itself stemmed from bloodletting which historically was believed to cure various ailments from acne to diabetes (Skills Platform, 2018). Bloodletting was a tricky practice and at one point was performed by barbers, which is still symbolized through the red stripes on a traditional barber pole (Skills Platform, 2018). Over time, it was realized that physicians needed to remain responsible for the skill to prevent the spread of infection via blood exposure; although it is believed that physicians were responsible for the death of George Washington after using bloodletting for a sore throat too many times (Mount Vernon's Ladies Association, 2021). Not only was much learned from bloodletting as far as how much blood the body needs to survive, but knowledge was gained about how the body circulates blood. By the 1400s enough data was gathered about blood loss that blood transfusions began in Europe (Medical News Today, 2004-2021). These days, diagnostic blood draws and blood transfusions are common practice and safe ones at that, thanks to what was learned from bloodletting. Bloodletting isn't completely gone, but now is considered an alternative medicine practice often done via leeches and known as hirudotherapy likely because calling it leech therapy evokes a rather creepy crawly response. Hirudotherapy, approved by the FDA in 2004, is now used for prevention of tissue death by improving blood flow in instances such as reattachment operations (University Hospitals, 2020). So a big thank you to these medical vampires for the work they do now and have done for the advancement of medicine.

Erie Boces (2019). *Phlebotomy*. Retrieved from https://www.e1b.org/en/adult-career-training/phlebotomy.aspx

Medical News Today. (2004-2021). *Bloodletting: Why doctors used to bleed their patients for health*. Retrieved from https://www.medicalnewstoday.com/articles/bloodletting-why-doctors-used-to-bleed-their-patients-for-health

Mount Vernon Ladies Association. (2021). *The death of George Washington*. Retrieved from https://www.mountvernon.org/library/digitalhistory/digital-encyclopedia/article/the-death-of-george-washington/?gclid=EAIaIQobChMIqqXP49S_8gIVCm-GCh3JHgj6EAAYASAAEgI-6_D_BwE

Senchel Ventures. (2015-2021). *Phlebotomy technician PBT (ASCP) certification-eligibility & testing*. Retrieved from https://www.medicaltechnologyschools.com/phlebotomist/phlebotomy-certification

Skills Platform. (2018, July 9). *A brief history of phlebotomy*. Retrieved from https://www.skillsplatform.org/blog/a-brief-history-of-phlebotomy/

University Hospitals. (2020, March 23). *How leeches can save lives and limbs for some patients*. Retrieved from https://www.uhhospitals.org/Healthy-at-UH/articles/2020/03/how-leeches-can-save-lives-and-limbs-for-some-patients

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.

Masks that Protect Against Wildfire Smoke Exposure

Marcy Ballman, PhD, Division Director at the American Lung Association.

Telling our patients to "Wear a mask" has entirely different connotations today than it did pre-pandemic. In addition to protecting against infectious respiratory diseases, wearing a mask can be the best defense against air pollution and wildfire smoke for people with lung disease when they are out and about. We know that climate change is contributing to more frequent and intense wildfires, and longer wildfire seasons. These wildfires affect people hundreds and sometimes thousands of miles away, since smoke can travel very far distances. Consequently, it is increasingly important that we know the difference between certain types of masks and what will work to protect the lungs of our patients from wildfire smoke and other sources of air pollution.

N95 masks are designed to be tight-fitting and have received the N95 designation from the Occupational Safety and Health Administration (OSHA), meaning that they can filter the tiniest airborne particles, called PM2.5, from the air. They get the "95" in their name from the fact that N95 masks have a 95% efficiency for particles that are larger than 0.3 microns in size. The 2.5 in PM2.5 stands for 2.5 microns. Particles this size can come from vehicle exhaust, industrial sources, and wildfire smoke. Regardless of the chemical makeup of the particles, they are known asthma triggers and associated with increased hospitalizations and even deaths.

Some helpful tips to share when educating patients and community members about proper mask usage and how to protect themselves from wildfire smoke exposure include:

1) Be mindful on your trip to purchase a mask at the hardware store because dust masks and N95 masks look almost identical. N95 masks will typically have a stamp indicating their N95 designation and will be a little more expensive. Dust masks are really for potentially dusty tasks like mowing, gardening, sweeping, and dusting, but will not filter the smaller and more harmful PM2.5 from the air.
2) The typical cloth COVID mask, on the other hand, is effective by capturing respiratory droplets that we breathe out, thereby reducing virus transmission. These masks are not effective in filtering particles from the air as we breathe in and don't do much more than a t-shirt or bandana during poor air quality events, which is to say, they don't do much to protect our lungs from the potentially dangerous very small particles. Surgical masks work a little better, but not much.
3) For people with lung disease, wearing a properly fitted N95 mask during poor air quality events can make it difficult to breathe in general. The diaphragm and accessory muscles must work extra hard to pull and push air through the tightly woven mask in order to catch those harmful tiny particles. For someone with lung disease, this might be extremely uncomfortable. There are N95 masks with exhalation valves that can make it easier to exhale but the same effort is required to inhale. We should not advise anyone to wear an N95 mask in an effort to protect their lungs if it hinders their breathing to the point they are uncomfortable. They also may not be advised for people with uncontrolled hypertension. N95 masks are not an option for adults with facial hair or children because they will not seal properly around the mouth and nose.
4) N95 masks can be the best option when someone must be outside but the gold standard advice for people with lung disease who are experiencing poor air quality is to create a clean air space where they live. Portable HEPA air filter units (ones that don't create ozone) work amazingly well to capture PM2.5 and help "clean the air" as long as they are equipped to work in the given square footage of the room they are used in (it should say the square footage range right on the box).

Armed with a clarified understanding about masks and a designated clean air space where they can spend most of their time, people with lung disease can take steps to protect themselves during poor air quality events.

Beyond individual actions to help minimize risk, climate change must be addressed in order to avoid the worst health impacts from wildfires, worsening air quality, and more. It is important to encourage decision-makers and elected officials to tackle the public health crisis that is climate change.

FROM THE DESK OF THE HISTORIAN

"Where Would We Be Without Nursing Organizations?"

Gertrude B. Hutchinson, DNS, RN, MA, MSIS, CCRN-R

Welcome to this month's column. You are reading this in October as many prepare to join other ANA-NY members on Long Island for the 9th annual ANA-NY conference; however, I am writing this as Russell Sage College has resumed classes for the fall 2021 semester! Seeing students in person after 18 months of virtual classes is a real energizer and I hope that increased vaccination and adherance to CDC and state guidelines will allow this to continue. But, I digress for the column at hand.

Fall signals new starts for school years and many organizations resume activities after a summer hiatus, so my mind now turns to the question: Where would we be without nursing organizations? In addition, how many nursing organizations are there worldwide and how did many of these organizations start? What are their missions? and finally, WHY is it important that we belong to professional nursing organizations?

For 125 years, nursing organizations have been forming to meet the needs of nurses in various practice settings and levels of education. The year 1893 saw people from all over the world gather in Chicago for the World's Columbian Exposition – known in the 20th and 21st centuries as The World's Fair. Nurses from all over the world traveled to the Exposition to meet and discuss issues common to all nursing schools and graduates of the time. Mrs. Isabel Hampton Robb, a Bellevue Traning School for Nurses graduate and the most recent past director of the Johns Hopkins School of Nursing chaired the first meeting of nurses from Canada, the United States, and Britain. A missive written by Miss Florence Nightingale was read and Ethel Gordon Fenwick attended representing the British nurses and their then 6-year battle to support the registration and licensure of nurses.

At that same meeting, superintendents representing the growing number of nursing schools around our nation gathered to discuss their specific educational needs moving forward. Hence was born the **American Society of Superintendent of Training Schools for Nurses** – the ancestor of the **National League for Nursing Education** (NLNE). Today, we know it as the **National League for Nursing (NLN)**.

For many years, these nurses came together to meet and their membership grew as issues to educational requirements, work hours, working conditions, stipends, housing, and legislative issues were discussed. However, by 1896, nurses in Canada and United States realized they had different issues to discuss. Each mutually decided to form their own national organizations. The **American Nurses Association** (ANA) was formed in 1896 and the **Canadian Nurses Association** formed 12 years later.

As the 19th century waned, 1899 saw the formation of the International Council of Nursing (ICN). Lavinia Dock, a Bellevue graduate and a staunch Suffragette served this organization as its secretary. Today the ICN functions as a federation of more than 130 national nursing associations and 27 million nurses worldwide. Representatives from ANA will be attending the ICN conference in the beginning of November 2021.

In 1908, Martha Franklin founded the National Association of Colored Graduate Nurses to address issues unique to Black nurses living and working in a segregated society. In 1958, this organization disbanded as a result of the actions of nurses like Mary Elizabeth Carnegie who as a NACGN representative to the Florida State Nurses Association ran for and won election to FSNA board. As an integrated state affiliate of the national organization, ANA then become integrated and Mabel Keaton Staupers, NACGN President, presided over NACGN's closure.

Our Native American sister and brother nurses belong to many of the organizations named in the next paragraph, they have an association that honors the native traditions of health, healing, "to rekindle the spirit" and "reconnect the circle." The National Alaska Native American Indian Nurses Association (NANAINA) was reorganized in 1993 was reorganized out of the American Indian Nurses Association (https://nanaina.org/).

As the diversity and size of the nursing profession grew, so to has the number of nursing organizations. ANA-NY charted in 2012. The New York League for Nursing (NYLN) is a consituituent of the NLN. Advanced practice nurses and nurse practitioners' organization is the American Association of Nurse Practitioners (AANP). Whatever your specialty area: orthopedics, rehabilitation, OR, ED, public health, hospice/palliative care, parish nursing, education, OB/Gyn … the list goes on and on … there is a nursing organization for you.

As professionals, we have a responsility to belong to our organizations. Membership allows all to keep up on the latest news, changes to the standards of practice, ongoing education, attendance at conferences or taskforces (virtually or face-to-face), grow leadership skills – as all nurses are leaders to one degree or another – and finally, membership gives you a voice in the workings of your organizations through voting for your officers. If you are new to the profession, get involved! If you are a member of an organization with only tangential involveent – if able, increase your involvement by volunteering for a taskforce or membership on a committee of your interest. You will reap great rewards!

LEGISLATIVE UPDATE

Amy Kellogg

The last newsletter contained a legislative update that was a summary of what had happened during the 2021 legislative session with a look forward to 2022. Since the writing of that update, much has changed in Albany. On Tuesday, August 3, 2021, Attorney General Leticia James' office released a report that outlined their findings into an investigation of sexual harassment charges against Governor Andrew Cuomo. The investigation reviewed the allegations of 11 women and found their accusations to be credible. The New York State Assembly, which had been conducting their own investigation into these and other allegations, announced that as a result of the Attorney General report, they were going to begin impeachment proceedings against Governor Cuomo. While Governor Cuomo initially said that he was going to fight the allegations and impeachment attempt, on Tuesday, August 10, 2021, Governor Cuomo announced that he would be resigning as Governor effective August 24, 2021.

Upon his resignation, his Lieutenant Governor, Kathy Hochul became Governor. At 12:01 a.m., on August 24, 2021, Kathy Hochul was officially sworn in as the 57th Governor of New York State. She is the first woman to ever hold this position. Governor Hochul had been the Lieutenant Governor since 2015. She is an attorney, who hails from Western New York. She has a long history of public service beginning almost 30 years ago when she was first elected as a board member on the Hamburg Town Board, where she served from 1994 - 2007. She then served as the Erie County Clerk from 2007 - 2011 when she was elected as the Congresswoman for the 26th Congressional District. She served one term in Congress and was defeated by now-former Congressman Chris Collins. She is the first Governor from outside of the New York City area since 1920.

Upon taking office, Governor Hochul addressed New Yorkers and laid out her immediate priorities, which were focused on proactively addressing the COVID-19 situation in New York and ensuring that all New Yorkers had access to the vaccine boost shot as needed. She also outlined her desire to ensure the flow of COVID assistance to all New Yorkers who are eligible. In particular, this meant getting COVID relief funds to landlords and tenants to ensure that no one lost their housing. Finally, she talked out her goal of changing the culture in Albany going forward to ensure a healthy and safe work environment for all workers who work for the State.

Shortly after taking office herself, Governor Hochul announced that Senator Brian Benjamin was her pick to replace her as Lieutenant Governor in New York. Senator Benjamin was a Senator from Harlem and is the second Black man to hold the position of Lieutenant Governor.

As with any Gubernatorial transition in New York, there will be new faces and players to get to know. We will continue to build and develop relationships with the new individuals and brief them on the ANA-NY legislative agenda and priorities. 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. This year's priorities followed the new model of being focused on areas of importance rather than listing specific bills. Bills can be amended and changed in a way that may change our position. Listing the areas of support rather than specific bill numbers gives us the ability to respond to legislation in a proactive and collaborative way and allows us to continue to grow your voice and presence in Albany. Importantly, this year's legislative priorities has 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.

As I indicated in the last update, for the 2022 legislative session, we will continue to work on other key issues including exploring a continuing education bill, ensuring that all nurses are working to the top of their licensure and supporting legislation to recognize those who were essential workers during the pandemic. We will also continue our coalition work on key issues related to a smoke free New York and vaccinations. Finally, as the safe staffing bill was passed and signed into law this year, there will now be an implementation process. We will be monitoring this process and will work on any legislative or regulatory changes that may be needed as the law is put in place.

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.

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.

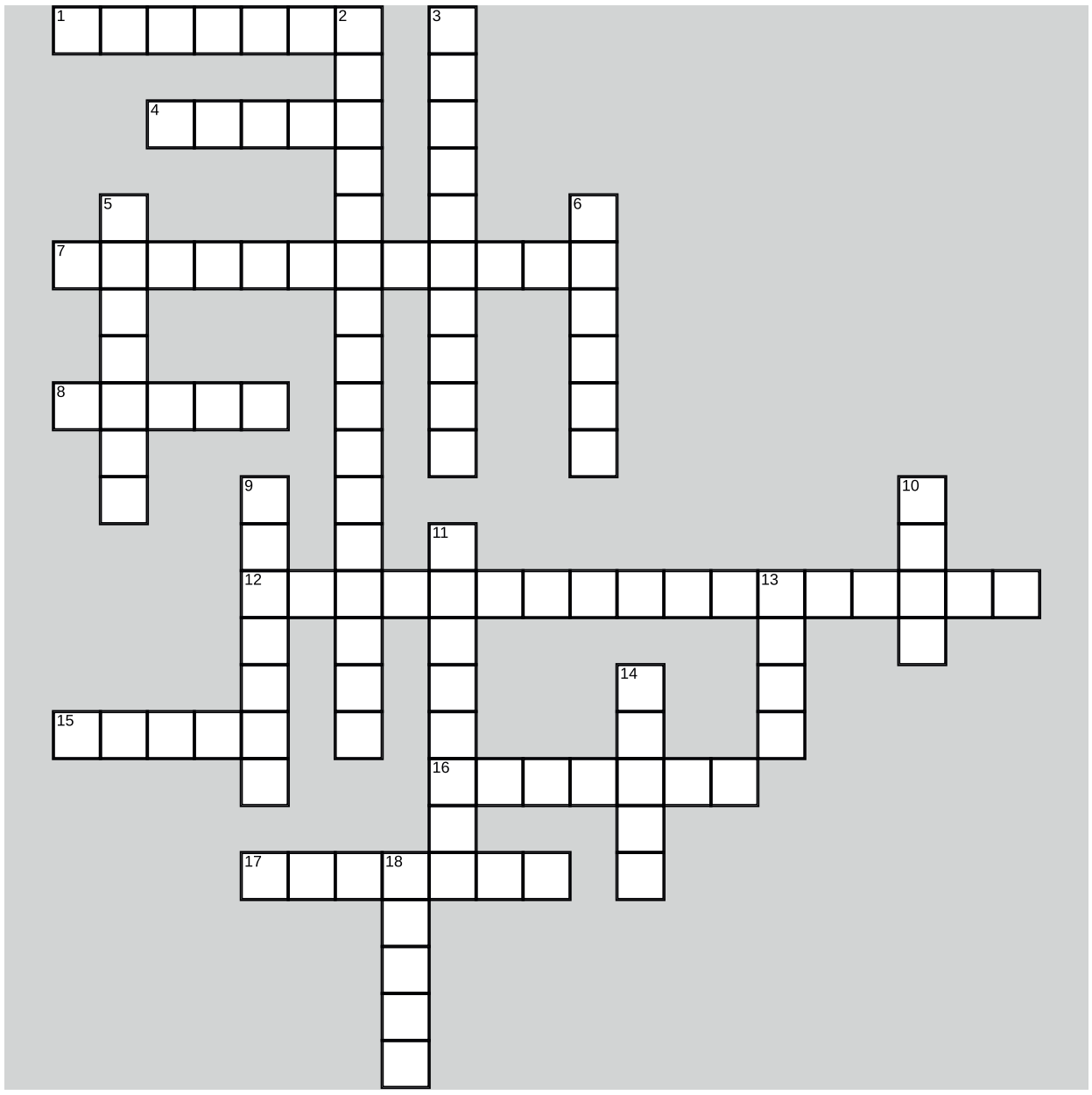
As professionals, we can also be philanthropists, while helping others understand the need for philanthropy. Nurses Educational Funds, Inc. will only continue to be a successful graduate nursing scholarship provider if we can mobilize a give- back spirit among our colleagues. Individual nurses can give 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.

Crossword Puzzle



Across

1 Nurse Hero Individual Last Name

4 New Program Manager at ANA-NY Last Name

7 How You Doin'?

8 2022-2023 Membership Assembly Representative Last Name

12 Award for Fidelindo Lim

15 2022-2023 Membership Assembly Representative Last Name

16 Scholarship Award Winner Last Name

17 1st New Yorker to receive the COVID-19 Vaccination Last Name

Down

2 Award for Strong Memorial Hospital Nursing Recruitment Department

3 2022-2023 Secretary Last Name

5 2022-2023 Director-At-Large Last Name

6 2022-2023 New Member of the Nominations and Elections Committee Last Name

9 2022-2023 Membership Assembly Representative Last Name

10 2022-2023 Director-At-Large Last Name

11 2022-2023 Membership Assembly Representative and Chair Elect for the Nominations and Elections Committee Last Name

13 Nurse Hero Individual Last Name

14 2022-2023 Director-At-Large and Membership Assembly Representative Last Name

18 2022-2023 Vice President Last Name

WORD LIST:

BRENNAN	FRANKS	MEHER	RICHARDS
BROWN	GERARDI	MEMBER_MIXER	VELEZ
CHEN	HUTCHINSON	NURSE_HERO_GROUP	WOODS
CHIN	LINDSAY	NURSING_EDUCATION	
DRAKE	MANCUSO	REDULLA	

Nurses Educational Funds, Inc.
Scholarship for Leadership

Professional Development Opportunities at Home

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

Clinical Education Initiative (CEI), an organization that provides free in-person trainings and webinars with CNE credit, has a diverse list of topics ranging from Acute HIV Infection to Treatment of Alcohol Use Disorder.

The Program Committee recommends Transgender-Affirming Primary Care which can be found at https://ceitraining.org/courses/course_detail.cfm?mediaID=753#.YUEWxZ1KiUk

The complete list is available on the CEI website: https://ceitraining.org

We encourage our members to take advantage of these exciting and relevant free, CE bearing webinars.

CONTINUING EDUCATION

Monitoring Gastric Residual Volumes: Research Recommends a Nursing Practice Change

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/212594504287157
- Fee of $7.00 for non-members, ANA-NY members are free.
- Certificates will be emailed after a passing score of 75% or higher is achieved.
- There is no conflict of interest or commercial support for this offering.
- This enduring continuing education offering expires on 12/31/2021.
- Learning outcome: 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.

By Shannon O'Grady BS, RN and Gina Myers PhD, RN

Critically ill mechanically ventilated adults require specialized care in a multidisciplinary framework that fosters positive outcomes and a return to baseline health. Providing adequate nutrition to these patients to support the healing process is a crucial piece of the puzzle. Severe illness causes a systemic stress response, resulting in protein loss and inflammation. Optimal protein and energy are required to enhance a patient's recovery and survival in the ICU (Wiese et al., 2018). The World Health Organization defines malnutrition as the imbalance, deficiency, or excess of a person's intake of nutrients. Wang et al. (2018) estimates the incidence of malnutrition in intensive care units to be 50% or higher. Malnutrition increases the risk for infection and pressure-related injuries, depresses the immune system, cardiac, and respiratory functions, and can contribute to a longer duration of mechanical ventilation (VanBlarcom & McCoy, 2018). Identifying risk for malnutrition in early hospitalization and providing nutritional support through enteral nutrition can reduce the body's metabolic response to stress and decrease inflammatory response and cellular injury (McClave et al., 2016). However, the therapeutic nutritional goals of enteral nutrition are seldom achieved in intensive care settings due to delayed initiation of feedings or frequent withholding of feeding for procedures or suspected intolerance (Orinovsky & Raizman, 2018).

There are two forms of nutrition that can be utilized in mechanically ventilated patients: enteral nutrition and parenteral nutrition. Enteral nutrition (EN) is a complete nutritional formula or tube feeding that is fed through an enteral access device such as a nasogastric or orogastric tube. Parenteral nutrition (PN) is also a complete nutritional formula administered through a central access device directly into the bloodstream (VanBlarcom & McCoy, 2018). While both methods provide the nutritional support required by critically ill patients, EN is the preferred and suggested route by the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.). Previous research has shown a consistent decrease in ICU length of stay and reduction in infectious morbidity when EN is used over PN (McClave et al., 2016). Early introduction of nutritional support to critically ill adults via the enteral route (usually within 24-48 hours after ICU admission) helps maintain gastrointestinal integrity and supports the immune system (Elke et al., 2014). This proactive strategy has been associated with a reduction in disease severity, shortened length of stay in the ICU (McClave et al., 2016), fewer infectious complications, and an overall reduced mortality (Orinovsky & Raizman, 2018).

A roadblock to providing nutrition to mechanically ventilated ICU patients is gastrointestinal motility disorders. GI dysfunction such as gastric emptying impairment and intestinal dysmotility are widespread events in the ICU population, affecting up to 80% of patients (Kuppinger et al., 2013). There are a combination of internal and external factors contributing to GI dysfunction, most of which are complex and difficult to avoid in the ICU setting such as use of sedatives, opioids, and vasopressors, or decreased gastric tissue perfusion secondary to circulatory shock (Elke et al., 2014). Critical care nurses are trained to monitor for signs of gastrointestinal dysfunction such as abdominal distension, vomiting, diarrhea or constipation, and high gastric volume residuals (Kuppinger et al., 2013); not all methods are evidence based. ICU nurses play a key role in initiation and administration of EN (Orinovsky & Raizman, 2018) and therefore should be properly educated on the most current evidence-based practice.

Gastric residual volume (GRV) is the volume of fluid in the stomach aspirated through the enteral tube using a syringe. GRV has commonly been used by critical care nurses as a parameter for GI dysmotility (Wang et al., 2019). The American Association of Critical Care Nurses (AACN) found that more than 97% of ICU nurses report measuring GRV and interrupting feedings for volumes of 200-250 ml (Elke et al., 2014; Kuppinger et al., 2012). However, research has shown little evidence to support using GRV to accurately determine feeding intolerance (Wang et al., 2018). Further, the clinical practice guideline published by A.S.P.E.N. and the Society for Critical Care Medicine (SCCM) in 2016 does not advise using GRV as an indication of GI dysmotility or feeding intolerance (McClave et al., 2016). Yet, this practice persists.

The disconnect between research and practice led to the development of the PICO question "In intubated adults receiving enteral nutrition, does monitoring gastric residual volumes decrease the likelihood of developing aspiration pneumonia or aspiration related mortality versus not checking GRV over the course of mechanical ventilation?" To answer this question, a search of the electronic databases CINAHL, EBSCOhost, and Cochrane Library was performed to identify relevant literature. Terms searched included gastric residual volume (stomach volume/GRV), critical care (ICU/intensive care), and mechanical ventilation (intubated/invasive ventilation). The setting was limited to intensive care, and the participants were narrowed down to adults >18 years of age. Literature selected was limited to clinical practice guidelines, systematic reviews, and randomized controlled trials published within the last ten years. This literature synthesis and suggested practice change are based on the findings from a clinical practice guideline from the SCCM and the A.S.P.E.N. (2016), a systematic review with meta-analysis by Wang et al. (2018), and two randomized controlled trials by Ozen et al. (2016) and Reignier et al. (2013).

The evidence reviewed found GRV provides little to no clinical data about gastric motility or the nutritional tolerance of the patient. Research from Wang et al. (2018), Ozen et al. (2016), and Reignier et al. (2013) found that ICU length of stay, duration of mechanical ventilation, or 90-day mortality did not differ between patients receiving routine GRV monitoring compared to those who did not. While both Wang et al. (2018) and Reignier et al. (2013) did report an increase in vomiting rates when GRV is not monitored, it was not linked to higher rates of Ventilator Associated Pneumonia (VAP) or mortality in either study. Additionally, Ozen et al. (2016) and Reignier et al. (2013) found that not monitoring GRV was associated with a higher caloric intake and a decreased cumulative calorie deficit in patients when compared to those receiving routine GRV monitoring. Further, the systematic review conducted by Wang et al. (2018) found a decrease in feeding intolerance in patients who did not receive routine GRV monitoring.

The clinical practice guideline from SCCM and A.S.P.E.N. (2016) states that routinely monitoring GRV leads to increased rates of enteral access device clogging, consumption of nursing time, inappropriate cessation of EN, and allocation of healthcare resources including gastrointestinal specialty consults and time-consuming scans that may adversely affect patient outcomes through reduced EN volume delivered to the patient. GRVs are not correlated with incidences of pneumonia or aspiration and are poorly correlated with gastric emptying time. The guideline recommends eliminating the practice of monitoring GRVs and instituting alternative strategies to monitor critical patients receiving EN. These strategies include thorough head-to-toe assessments every shift, reviewing abdominal radiologic films, and evaluating for clinical risk factors for aspiration on an individual basis. All critical care units should establish protocols to decrease risk of aspiration pneumonia and promote feeding in critically ill populations (McClave et al., 2016). In patients deemed high risk for aspiration or showing clinical symptoms of gastric feeding intolerance, GRV measurement can be used as a concurrent tool. Cessation of EN should not occur based on GRV measurement alone (McClave et al., 2016).

The body of evidence available strongly supports disregarding GRV as a diagnostic tool for gastric feeding intolerance and risk of aspiration. When GRV monitoring is removed in adult medical intensive care patients receiving EN, the risk of aspiration pneumonia and aspiration- related mortality is unchanged. While the risk of vomiting does increase when GRV is not being monitored, this is not affiliated with increased aspiration. Research suggests monitoring mechanically ventilated patients for clinical signs and symptoms of gastric feeding intolerance and if the clinical presentation supports feeding intolerance, GRV measurement can be used to confirm findings and adjust EN rate to reduce aspiration risk. It must be noted that limited studies on this topic have included surgical patients and those with known gastrointestinal disorders.

SCCM and A.S.P.E.N. (2016) recommend implementing a nurse-driven feeding protocol to allows bedside nurses to work within their scope of practice by performing frequent gastrointestinal assessments to decrease aspiration in intubated adult patients which avoids unnecessary interruptions in feedings caused by routine GRV monitoring (McClave et al., 2016; Orinovsky & Raizman, 2018). This will improve patient nutritional status and overall outcomes. To overcome barriers to practice change, critical care nurses need to be educated on the most evidence-based practice to optimize delivery of enteral feedings. Frequent gastrointestinal assessments will lead to early identification of signs and symptoms of feeding intolerance, allowing for prompt treatment before the patient becomes high risk for aspiration related mortalities. Disbanding GRV monitoring and using a nurse-driven EN protocol is a low-cost practice change that allows registered nurses to work within their scope of practice to achieve their patients' nutritional goals.

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References

Elke, G., Felbinger, T. W., & Heyland, D. K. (2014). Gastric residual volume in critically ill patients: A dead marker or still alive? *Nutrition in Clinical Practice, 30*(1), 59-71. doi: 10.1177/0884533614562841

Kuppinger, D.D., Rittler, P., Hartl, W. H., & Ruttinger, D. (2013). Use of gastric residual volume to guide enteral nutrition in critically ill patients: A brief systematic review of clinical studies. *Nutrition, 29*, 1075-1079. Retrieved from http://dx.doi.org/10.1016/j.nut.2013.01.025

McClave, S. A., Taylor, B. E., Martindale, R. G., Warren, M. M., Johnson, D, R., Braunschweig, C., McCarthy, M. S., Davanos, E., Rice, T. W., Cresci, G. W., Gervasio, J. M., Sacks, G. S., Roberts, P. R., & Compher, C. (2016). Guidelines for the provision and assessment of nutrition support therapy in the adult critically ill patient: Society of critical care medicine (SCCM) and American society for parenteral and enteral nutrition (A.S.P.E.N.). *Journal of Parenteral and Enteral Nutrition, 40*(2), 159-211. doi: 10.1177/0148607115621863

Orinovsky, I., & Raizman, E. (2018). Improvement of nutritional intake in intensive care unit patients via a nurse-led enteral feeding protocol. *Critical Care Nurse, 38*(3), 38-44. Retrieved from https://doi.org/10.4037/ccn2018433

Ozen, N., Tosun, N., Yamanel, L., Altintas, N, D., Kilciler, G., & Ozen, V. (2016). Evaluation of the effect on patient parameters of not monitoring gastric residual volume in intensive care patients on a mechanical ventilator receiving enteral feeding: A randomized clinical trial. *Journal of Critical Care, 33*, 137-144. Retrieved from http://dx/doi.org/10.1016/j.jcrc.2016.01.028

Reignier, J., Mercier, E., Le Gouge, A., Boulain, T., Deschy, A., Bellec, F., Clavel, M., Frat, J. P., Plantefeve, G., Quenot, J. P., Lascarrou, J. B., & Clinical Research in Intensive Care and Sepsis (CRICS) Group. (2013). Effect of not monitoring residual gastric volume on risk of ventilator-

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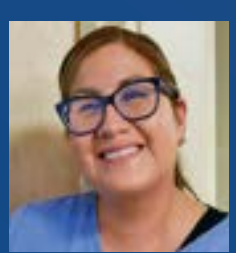
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Nurse Educators: Essential to the Recovery of the Healthcare System Post The COVID-19 Pandemic

Brittany Richards, DNP, FNP-BC, RN-BC, NEA-BC, Assistant Professor CUNY- New York City College of Technology

Background: This article is a commentary on the importance of the preparedness of the next generation of Registered Professional Nurses for a Health care system recovering from the COVID-19 Pandemic.

Purpose: The goal is to emphasize the need for nurse educators to equip novice nurses to deliver safe and quality care post pandemic.

Discussion: Through a review of literature, the common theme amongst newly licensed Registered Nurses in Acute Care, is lack of confidence in preparation to care for patients, and difficulty transitioning into practice. Ultimately nursing education affects nurses' resiliency and retention. It is necessary to bridge the gap in the healthcare system by providing realistic expectations to nursing students prior to them becoming newly licensed registered nurse

Conclusion: This article attempts to bring awareness to the correlation between nursing educator and their unique role in the growth and development of the nursing team post-pandemic.

Key Words: Novice Nurse, Transition-to-Practice, Nursing student, Nursing Education, Simulation, COVID-19 Pandemic

COVID-19 and Academic Challenges in Nursing Education

The future of the healthcare system relies heavily on nurse educators, preparing the next generation of nurses, as we face unprecedented challenges. nursing faculty members are often student nurses' first interaction with nursing, and are in a unique position to set the tone for a new graduate's career. Newly licensed registered nurses today, will begin their careers in a world that is recovering from the COVID-19 Pandemic, which entails a workforce that may be experiencing caregiver burnout, as well as patients who may have lost trust in our healthcare system. This is in addition to the academic challenges faced during the pandemic. Nursing schools had to move to a virtual learning environment for the didactic, and clinical components of nursing education, and these interruptions are particularly concerning to students, as they fear that they will not be ready for their roles as registered nurses (Dewart, Corcoran, Thirsk, & Petrovic, 2020).

Novice Nurses Transition into Practice

Prior to the COVID-19 Pandemic, it was noted that new nurses faced challenges while transitioning to their roles as registered nurses (Labrague, & De Los Santos, 2020). Studies conducted before the pandemic of novice nurses' experiences during their first year in their profession revealed common themes, such as a lack of competence in nursing skills, inability to handle the acuity of the patients in their workload, and the need for guidance to provide the best evidence-based care (Labrague & McEnroe-Petitte, 2018). There are a lot of adjustments that take place during the first year of professional practice, and nurse educators have the ability to empower new nurses, by equipping them with the tools deemed necessary to successfully transition (Hampton, Smeltzer, & Ross, 2021). The ease of this transition period is especially important, as this is when new nurses' develop their perceptions about nursing, and it also serves as a deciding factor if they will remain committed to their organizations (Labrague, & De Los Santos, 2020).

Critical Nursing Shortage that affects patient outcomes

The World Health Organization estimated in 2013, that by 2023 there would be a shortage of approximately 12.9 million nurses, due to retirement (WHO, 2013). After the effects of the pandemic, this number is expected to increase, furthering the shortage of nursing staff. The need to fill the gaps in nursing is evident, as short staffing can impede patient care, and negatively affect patient satisfaction and outcomes. Providing nursing students with realistic expectations is especially important when discussing nursing retention, which is essential during the recovery phase of our healthcare system.

Nursing in the midst of a global pandemic

Throughout the Pandemic, nurses were recognized for their continued commitment to their patients. As the heartbeat of healthcare, their bravery while on the frontlines battling the unknown depicted heroism, and had a profound effect on the world. Nurses who are beginning their careers post pandemic, will need to have a foundation embedded in critical thinking, communication and technical skills. First year graduate nurses who are ill-prepared, and lack the ability to critically analyze, compromise patient safety, and deliver subpar care. This has legal, and financial ramifications for healthcare organizations.

The need for Innovative Techniques in Nursing Education

Nursing schools often primarily focus on the didactic component of educating nurses, to prepare their graduates to pass the National State Board Examination; however, once a graduate becomes a newly licensed registered professional nurse, there are more challenges that lie ahead. The post-Pandemic transition into practice from a nursing student to a novice nurse, will require some preemptive understanding of what nursing really entails. There is a high demand for nursing faculty to utilize innovative techniques, such as simulation, and skills laboratory sessions. These strategies will be helpful in assisting to educate nursing students for post COVID practice.

Utilization of Clinical Simulation & Skills Lab to Build Stronger Skill-Sets and Critical Thinking

Simulation is an effective delivery mode of clinical education which provides a non-threatening environment for students to practice scenarios that they may face in the clinical area without fear of harming patients

(Padilha, Machado, Ribeiro, Ramos, & Costa, (2019). The intentional design of case scenarios provides students with the exposure to situations that might not be offered on the clinical unit (Ortiz, 2016). Through debriefing, students are guided through the nursing process, and provided with rationales on best practices, based on research.

The skills laboratory sessions provide nursing students with opportunities for validation, and honing in on their skills before they are in patient care areas. These mechanisms help to build confidence in nursing students, which ultimately translates into comfortability in a new graduate nurse's skillset. Promoting the establishment of a work-life balance, and work readiness in newly graduated nurses may potentially reduce the occurrence of missed nursing care and adverse events (Labrague, & De Los Santos, 2020).

Adjustment of Nurse Residency Curriculum to Address Post-Pandemic State

Although healthcare organizations have invested in the development, and facilitation of nursing residency programs to assist new nurses in adapting to their roles and responsibilities, the curriculum will need to be adjusted to address the post pandemic state of healthcare. These changes will help to guide new nurses in understanding the realities of the hardships their colleagues who were serving on the frontlines of the pandemic faced, and how that may potentially shape their outlook on nursing. At this point, many nurses are overwhelmed as they worked endlessly throughout a global pandemic. This may translate to compassion fatigue. We need new nurses to be empathetic to the needs of their senior colleagues as they reconcile and rebuild resiliency from the devastation of the pandemic.

Collaboration between Clinical and Academic Nurse Educators

The anticipated long- lasting impact of this Pandemic will require adjustments to be made in nursing education, in academia as well as the clinical setting. The partnership between nurse educators in the academic and clinical setting will be pertinent to bridge the gap between knowledge and application to practice. It is imperative that nursing faculty seek the guidance of clinical nurse educators as they prepare nursing students to meet the needs of the healthcare workforce.

It is common practice to have nursing leadership join the advisory boards of nursing schools, and while this is important there is also a need to welcome nurse educators who can give insight to where knowledge deficits may occur. This collaboration will assist to equip new registered nurses with the foundation needed in order to thrive, and will support quality care in the midst of restoring the fragile health care system. Through a review of literature, it is noted that currently there is a gap between theory and practice (Murray, Sundin, & Cope, 2018). Now more than ever, nursing educators will need to work together to promote a change in the culture surrounding the preparation of new nurses, in order to better support them, and develop professional confidence as they navigate through their first year of practice.

Establishment of Dedicated Education Units

The transformation of clinical units into Dedicated Education Units (DEU), would promote an environment conducive to clinical education, and would assist nursing students with establishing rapport with the staff and patients.

Development of Preceptorship-Based Placement

One of the effects of COVID-19 in clinical education is that many healthcare facilities have reduced the number of students they will accept in a group. Preceptorship based placements during the final semester of nursing school could help with this change, as this provides a more realistic approach to how care is delivered at the bedside. While working with a preceptor to effectively manage their time, this form of learning provides nursing students with increased autonomy, confidence, and competence which may facilitate a smoother transition into practice. Hospital educators can also assist in the implementation of a preceptorship training program which would recruit nurses interested in becoming preceptors (Ortiz, 2016).

It is beneficial for patients when nurse educators assist with the development of nurses with a strong understanding of the nursing process; this will in return help to strengthen our system, and benefit the patients in their care. nurses often serve as the first and last line of defense for a patient. We need nurses to be able to analyze changes in their patients' conditions, and actively seek assistance to prevent negative outcomes. Registered nurses are also advocates for their patients, but need to feel confident in their practice in order to do so. When new graduate nurses are prepared and feel supported this will lead to positive patient outcomes and job satisfaction in their nursing careers (Doughty, McKillop, Dixon, & Sinnema, 2018).

References

Dewart, G., Corcoran, L., Thirsk, L., & Petrovic, K. (2020). Nursing education in a pandemic: Academic challenges in response to COVID-19. *Nurse education today, 92*, 104471. https://doi.org/10.1016/j.nedt.2020.104471

Doughty, L., McKillop, A., Dixon, R., & Sinnema, C. (2018). Educating new graduate nurses in their first year of practice: The perspective and experiences of the new graduate nurses and the director of nursing. *Nurse education in practice, 30*, 101–105. https://doi.org/10.1016/j.nepr.2018.03.006

Hampton, K. B., Smeltzer, S. C., & Ross, J. G. (2021). The transition from nursing student to practicing nurse: An integrative review of transition to practice programs. *Nurse education in practice, 52*, 103031. https://doi.org/10.1016/j.nepr.2021.103031

Labrague, L. J., & De Los Santos, J. (2020). Transition shock and newly graduated nurses' job outcomes and select patient outcomes: A cross-sectional study. *Journal of nursing management, 28*(5), 1070–1079. https://doi.org/10.1111/jonm.13033

Labrague, L. J., & McEnroe-Petitte, D. M. (2018). Job stress in new nurses during the transition period: an integrative review. *International nursing review, 65*(4), 491–504. https://doi.org/10.1111/inr.12425

Murray, M., Sundin, D., & Cope, V. (2018). New graduate registered nurses' knowledge of patient safety and practice: A literature review. *Journal of clinical nursing, 27*(1-2), 31–47. https://doi.org/10.1111/jocn.13785

Ortiz, J. (2016) New Graduate Nurses' Experiences about Lack of Professional Confidence. Nurse Education in Practice, 19, 19-24. https://doi.org/10.1016/j.nepr.2016.04.001

Padilha, J. M., Machado, P. P., Ribeiro, A., Ramos, J., & Costa, P. (2019). Clinical Virtual Simulation in Nursing Education: Randomized Controlled Trial. J*ournal of medical Internet research, 21*(3), e11529. https://doi.org/10.2196/11529

World Health Organization (2013). A universal truth: No health without a workforce. Retrieved from http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/

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Documenting nursing assessments in the age of EHRs

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

Nurses have grown accustomed to documenting assessment results in the electronic health record (EHR), rapidly clicking responses to assessment checklist questions. However, at times nurses complete these actions without giving enough thought to their documentation because they want to move on to their "real" work: caring for patients.

The danger of this approach is threefold. First, nurses might base their assessment on the checklist not the patient, which can lead to an incomplete assessment, especially if the nurse inadvertently clicks something as being done when it hasn't. Second, nurses might fail to adequately document a finding if it does not match up with the available options in the checklist. Third, nurses might fail to document assessments when a patient's condition changes or fail to document practitioner notification of the change.

All three scenarios can leave nurses open to legal action. For example, a harried nurse caring for a patient who had a total hysterectomy clicks "normal" as the result of abdominal auscultation even though she hasn't completed this assessment and misses the absence of bowel sounds. Soon, however, the patient develops vomiting and severe abdominal pain and is diagnosed with a bowel obstruction. This nurse could be held liable for the delay in treatment.

Dangers of improper documentation

Documentation is a vital nursing responsibility. It's important for planning patient care, communicating with providers, and demonstrating compliance with federal, state, third-party, and other regulations. But documentation issues can result in professional liability lawsuits or action against a nurse's license.

NSO and CNA's *Nurse Professional Liability Exposure Claim Report: 4th Edition* found that documentation deficiencies are contributing factors in many nurse professional liability claims, and that the average total incurred for claims involving allegations related to documentation was $238,761. The same report also noted that 9.7% of all license protection matters, which involved defending nurses during State Board of Nursing inquiries, were related to documentation. Of these, nearly half (49.6%) involved an allegation of fraudulent or falsified patient care or billing records. Failure to document treatment/care as required by regulatory agencies or facility policy comprised 28.6% of matters related to documentation, followed by documentation that didn't accurately reflect patient care and services (12.8%), failure to properly correct documentation errors according to facility policy (5.3%), and inadequate or untimely documentation (3.8%). These matters serve as reminders of how nurses need take time ensure they are completing documentation properly.

Benefits of EHRs

Too often nurses view EHRs negatively, feeling they're cumbersome and take nurses away from the patient. But a well-designed EHR has several benefits, including improved efficiency and quality patient care. For example:

- EHRs provide an excellent mechanism for communicating with a variety of healthcare providers in a timely fashion, thereby improving care coordination.
- EHRs can incorporate guidelines, reminders, and decision support tools that can help providers make better decisions and deliver better care.
- Electronic documentation eliminates the problem of misinterpretation of handwritten orders.
- EHRs facilitate immediate access to data by multiple people in multiple locations.

EHRs also can protect nurses against lawsuits and actions taken against their licenses. However, to gain the most benefit, nurses need to take full advantage of EHRs. For example, according to NSO and CNA's *Nurse Professional Liability Exposures: 2015 Claim Report Update*, 45% of nurses who experienced a liability claim did not use the available EHR, compared with 19.2% of those without a liability claim.

Proper EHR documentation

You can take several steps to ensure you're documenting assessments and other information correctly in the EHR.

- ***Follow basic documentation principles.*** Whether you're documenting on paper or in an EHR, the same basic principles apply. Document promptly, accurately, and without bias. Don't interject opinions about patients or providers. When making a correction to previously recorded information, include the reason for the change. Remember that the EHR provides a date and time for each entry, providing a clear documentation trail.
- ***Adhere to policies, procedures, regulations, and guidelines.*** In the event of a legal action, one of the first steps an attorney will take is to determine if you followed your organization's policies and procedures related to nursing assessments and documentation, as well as any relevant state, federal, or local guidelines, and guidelines from professional associations.
- ***Copy and paste cautiously.*** The copy and paste feature in EHRs can be a time saver, but errors, including errors of omission, can easily occur. For example, you copy your note for one patient with a myocardial infarction (MI) into another MI patient's record but forget to add that you notified the provider of the new S4 you heard on auscultation. If the patient later experiences severe heart failure, you will have no evidence that you notified the provider. Another problem with copy and paste is that errors can rapidly spread as others pick up the same erroneous information. For instance, a nurse copies an assessment for a patient with pneumonia several times, forgetting to update the temperature, which has returned the normal. The patient's physician reads the note, thinks the patient isn't responding to treatment, and changes the antibiotic. Subsequently, the patient experiences a significant adverse event from the new antibiotic, which leads to legal action against the hospital, the physician, and the nurse.
  A report from the Partnership for Health IT Patient Safety recommends providers "act with volition," thinking about what is appropriate for copying and pasting and reviewing notes carefully. Ideally, the EHR should have a mechanism for easy identification of material that has been copied and pasted (for example, a different color text), so that providers are reminded to carefully review.
- ***Beware of autofill and templates.*** Like copy and paste, the autofill feature can save time by avoiding repetitive entries, but you need to verify that the information automatically filled in is correct. Similarly, templates for regularly occurring events such as the first postoperative visit after a total knee arthroplasty can help save time and ensure needed information is collected, but you still need to be aware of individual patient needs and assessment findings.
- ***Use notes appropriately.*** Sometimes what you need to document as an assessment finding isn't in a checklist or pull-down menu. Don't choose the "next best" option; doing so can lead to miscommunication and clinical and billing errors. For example, if you select "pressure injury" because "skin tear" isn't available, legal action would be based on the more serious injury. A better approach is to add a note to the patient's record. Be sure your note provides vital information in a succinct matter to avoid "note bloat" (also a side effect of inappropriate copy and paste). If an option that you would use frequently isn't available, talk with your manager or informatics contact about adding it to the EHR.
- ***Protect patient privacy.*** Do not share your passwords and change them regularly, according to your facility's policy. In addition, don't enter information in view of other patients.
- ***Don't ignore alerts.*** Alerts are there to help you make better decisions when it comes to patient care. For example, when you enter your assessment data, you may receive an alert that a patient could be at risk for sepsis. Your prompt action could save the patient's life. On the other hand, too many alerts may lessen their efficacy, leading to "alert fatigue". Talk with your manager or informatics contact to discuss settings.
- Complete an effective assessment. You won't have the information you need for the EHR unless you perform a quality assessment. Don't simply consider what a computer checklist tells you to include. Use your critical thinking skills to match the assessment to the patient.
- Document changes in the patient's condition. Remember to enter changes to the patient's status into the computer and include if you notified the provider of the change.

Effective use of EHRs

These actions will help you gain the most benefit from the EHR:

- *Document promptly and thoroughly.* This not only helps protect you from liability but, more importantly, ensures that information is quickly available to other providers.
- *Document accurately.* Don't omit key information and don't try to cover up if you failed to document or take correct action.
- *Get involved in EHR selection.* Often, nurses don't use the EHR correctly or take full advantage of its capabilities because the design is poor. Ask to be included on committees tasked with selecting the EHR vendor. Consider which systems best reflect what providers need to document and assess for user interface by checking items such as the font size of screen text.
- *Identify opportunities for improvements in EHR function.* Instead of engaging in potentially dangerous workarounds, notify leadership where improvements are needed. In some cases, the format of the EHR can be tweaked to make it easier for the user.
- *Don't assume the EHR is always right.* The EHR isn't infallible. If, for example, results of a test don't seem to match the patient's symptoms, follow up with the provider – the test may need to be redone.
- *Provide education.* Consider helping your colleagues learn more about proper documentation in the EHR by providing an education program or suggesting such a program to your professional development department.
- *Be patient centered.* The ability to document at the patient's bedside can save time and improve accuracy, but only if you keep your focus on the patient instead of on the computer. Maintain eye contact and consider telling patients what you are entering into the computer, which can help ensure the information is accurate.

A partnership

Rather than having an adversarial relationship with the EHR, nurses should consider the EHR as a care partner. By serving as a repository of data, providing alerts as needed, and facilitating communication, the EHR can help ensure quality patient care—and reduce nurses' risk of legal action.

RESOURCES

Balestra ML. Electronic health records: Patient care and ethical and legal implications for nurse practitioners. J Nurs Pract. 2017;13(2):105-111.

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When the Student Becomes the Teacher: A Black Nurse's Experience in Maine

By Jenny Radsma, PhD, RN (Professor, University of Maine at Fort Kent)
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Reprinted with permission from ANA Maine Journal July 2021 issue

We will have to repent in this generation not merely for the hateful words and actions of the bad people but for the appalling silence of the good people.
Martin Luther King, 1963

A recent nursing graduate, Naomi (a pseudonym), recently shared her fears and apprehensions about being a new nurse with two white, middle-class nursing faculty. In that conversation, she also revealed the discomfitures she has encountered as one of the few black nurses on staff, the snubs from patients, the constant vigilance she maintains to determine someone's reception of her as a black woman and nurse, and, surprising to us, the unsettling curiosity people have about her hair. Like other new licensees, Naomi's confidence and skill will grow as she gains clinical nursing experience. But unlike her white counterparts who grapple with being new nurses, Naomi's experience is overshadowed by being a black nurse in a white healthcare setting. During our conversation, Naomi revealed a number of situations and behaviors to which she and other black nurses in the nation are routinely exposed. These experiences hinder their confidence and further challenge them on every front, including their learning, day-to-day clinical experiences, and their advancement in the profession.

We, the authors, are two well-educated faculty who teach or have taught topic areas such as transcultural nursing and determinants of health. Despite that we consider ourselves open-minded, Naomi's revelations left us reeling and humbled. We came to realize how well-intentioned white nurses like ourselves are often oblivious to the experience and needs of their black nursing colleagues. We became mindful of how little we knew about the experience of black nursing students in predominantly white schools situated in equally white communities, nor did we know about their experience in the clinical setting after they graduated. Thanks to our discussions with Naomi, who requested anonymity, we provide some of our key learnings with supplementation from related literature.

Historically, the nursing profession reflects the racist attitudes and discriminatory behaviors of the time. For example, in 1854, Mary Seacole, a well-travelled Jamaican nurse, offered to serve in the Crimean war. The War Office in London turned her down, and Ms. Seacole, who would have worked alongside Florence Nightingale had she been accepted, attributed this refusal to her skin color. In the U.S., similar prejudices delayed for decades the admission of black applicants to nursing schools. Mary Eliza Mahoney worked as a janitor, cook, washerwoman, and nurse's aide for 15 years at the New England Hospital for Women and Children before finally gaining acceptance into the nursing program of that same institution. Her persistence and determination paid off: in 1879, she became one of three graduates that year and the first black person ever to graduate from an American nursing school. Other black nurses followed, Adah Belle Thoms, Estelle Massey Osbourne, and Hazel Jonson-Brown, to name a few, each one taking on significant social and professional challenges to obtain their rightful role as nurses and leaders. Two contemporary examples include Beverly Malone, currently CEO of the National League of Nursing (NLN), who also served a two-term presidency for the American Nurses Association (ANA; 1996-2000). Ernest Grant, named Nurse of the Year for his work treating burn patients after the 9/11 attacks, became the first male president of the ANA (2018-2020).

In relating her own journey, Naomi indicated that successfully completing a BSN fulfilled her life-long dream of becoming a nurse. At the time we spoke, she had completed her orientation for the position she held on a medical-surgical unit at a Maine hospital. She then relayed some of her race-based experiences, beginning with the fascination white people—patients, visitors, and peers, alike — have about her naturally textured hair. On one occasion, while looking through some lab reports, she felt her hair being patted, then realized it was a colleague; another time, a visitor pulled on her hairdo and asked, "Is this real?" The violation of her personal space in this way, Naomi said, is not unique and many black women chemically straighten their hair to "fit in" to the expected Eurocentric image of a professional woman. Interestingly, of the 13 microaggressions listed in a HuffPost article, three of them refer to hair and correspond to Naomi's narrative. African Americans experience hair microaggressions when: (1) people ask to touch your hair—or just do it without your permission, (2) they say you have good hair because it's 'not nappy,' and (3) they tell you your hair isn't 'professional' (Borreson, 2020). For her part, Naomi typically styles her hair in a bun as a way to deflect unwanted attention from her natural hair.

Naomi conveyed that she feels respected by her colleagues and understands their curiosity about her, "which is kind of cool because I'm a very curious person, too. So, if you're different from me, I want to know how and why about you." However, despite that, she has dealt with racism all her life, the insults coming from patients are still a surprise. She has been called "Blackie," and one patient told Naomi she had never before seen a beautiful, smart black person, particularly in the role of a nurse. Another shocking account involved a patient being helped from a bedpan, who, presuming to mask his putdown in a joking manner, likened the color of his excrement to the color of Naomi's skin. When asked how she coped with such offensiveness, Naomi said that, in the latter case, she brushed it off "because what are you going to say to an 87-year old?" In other situations, such as when the visitor tugged at her hair, she freezes up. She struggles, not wanting to be perceived as "'the angry black girl' because I'm not that, it's not in me. I'm always going to try to educate someone first." Under the circumstances, Naomi's desire to educate others is commendable. Any nurse demeaned because of race or skin color warrants anger. Yet the literature is replete with black nurses who have been labeled as an angry black person, as if the nurse's anger in light of racism is problematic to their white colleagues. The white stereotype of the angry black person invalidates and dismisses the black nurse's experience and silences discussions of race (Frampton, 2020). Because of their skin color, black registered nurses have also reported patients refusing their care, assume they were an aide, or question their clinical judgement until verified by a white nurse. Additionally, black nurses describe their being assigned to black patients (Sanborn, 2020).

Racial microaggressions are verbal and non-verbal snubs, insults, condescensions, exclusions, and negations directed towards people of color that communicate, intentionally or unintentionally, a less-than status (Sue et al., 2007). Like carbon monoxide, Sue stated, micro-aggressions are invisible but potentially lethal. In addition to being hurtful, recipients experience a range of cumulative effects from such invalidations, including increased stress, decreased emotional well-being, and increased risk of depression. Additionally, learning and problem-solving become impeded and the targeted person is unable to perform at her or his best (Sue, 2021). White nurses, be that peers, faculty, or administrators, bear a professional obligation to be aware of what their black colleagues and students endure. Naomi relayed, "Imagine having to be hyper-cognizant of who you are, what you are, what your lineage means. Like when people look at me, they see this, but I have to show them I'm not that, I'm this. It's like preparing for battle. …What armor do I have to put on today?" New black nurses such as Naomi cope not only with clinical matters but they must also prepare for the poison of any insults and aggressions that may come their way in the course of a shift. For Naomi, "What do I have to prepare myself for in addition to knowing my meds, in addition to knowing what I have to prepare myself to do?"

Eradicating the discrimination and microaggressions targeting black nurses in the healthcare system is critical for a number of reasons. Certainly, it is the morally right thing to do. The health and wellbeing of nurses depends upon it and no nurse should be demeaned at the workplace because of one's difference from the dominant group. However, it is also necessary to stem the continuing shortage of nurses nation-wide. An estimated

17.5% of nurses leave their first job within a year and this figure almost doubles to 33.5% within two years (Kovner, Brewer, Fatehi, & Jun, 2014). Some may return to nursing but a number of nurses leave the profession for other careers. Contributing to nursing turnover are stress and job dissatisfaction, problems aggravated for black nurses by overt and oblique forms of workplace racism. Aside from the financial costs associated with the nursing shortage, patient care and outcomes are jeopardized when nurses are burned-out or insufficient in number to meet clinical needs.

Attracting black nurses and retaining them in the nursing profession is also necessary to meet the goal of diversity and inclusion (American Association of Colleges of Nursing, 2019; NLN, 2016). The COVID-19 pandemic of the past year has revealed grave racial disparities. African Americans are much less likely to receive the standard of healthcare typically administered to white people, for example, with pain management or asthma treatment, as well as maternal-child care. By promoting access to and improving the quality of healthcare experienced by people of color, a diverse nursing profession minimizes the systemic biases contributing to health disparities. Thus, the nursing workforce should ideally mirror the population it serves. However, the number of black nurses in the profession (7.8%) lags significantly behind that of black people in the general population (13.2%) (U.S. Department of Health and Human Services, 2019). In Maine, the whitest state in the nation, black people account for approximately 1.5% of the population, whereas black RN graduates account for less than one percent (0.9%) of all nursing grads in the state (Campaign for Action, 2020). Given their mistrust of healthcare and other government services, communities of color are more likely to rely on healthcare services and report greater satisfaction when health professionals look like them and can relate to them (Shirley, 2019).

So what can nurses do to counter, challenge, mitigate, and nullify the injustices experienced by their black colleagues? These matters will be presented in a subsequent article series.

The authors are profoundly grateful to Naomi for her candor in sharing and allowing us to document her experience in this way.

References

American Association of Colleges of Nursing. (2019). Enhancing diversity in the workforce. Retrieved from https://www.aacnnursing.org/Portals/42/News/Factsheets/Enhancing-Diversity-Factsheet.pdf

Borreson, K. (2020, 06/18). 13 microaggressions black people deal with all the time. HuffPost Retrieved from: https://www.huffpost.com/entry/microaggressions-black-people-deal-with_l_5ee8ffa9c5b6fe2600260ec8

Campaign for Action. (2020). How closely do Maine's RN graduates reflect the state's diversity? Retrieved from: https://campaignforaction.org/resource/closely-maines-rn-graduates-reflect-states-diversity/

Frampton. (2020). Back in scrubs: Nurses who must hush and suck it up! Retrieved from https://www.blackantidote.com/black-nurses-must-hush-and-suck-it-up/

King, M. L. (1963). Letter from Birmingham jail. Retrieved from: https://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html

Kovner, C. T., Brewer, C. S., Fatehi, F., & Jun, J. (2014). What does nurse turnover rate mean and what is the rate? *Policy, Politics, & Nursing Practice, 15*(3-4), 64-71.

National League for Nursing. (2016). Achieving diversity and meaningful inclusion in nursing education. Author. Retrieved from: http://www.nln.org/docs/default-source/about/vision-statement-achieving-diversity.pdf

Ng, W. (n.d.). "Death by a thousand cuts": The impact of microaggressions on the AAPI community. New York Presbyterian. Retrieved from: https://healthmatters.nyp.org/death-by-a-thousand-cuts-the-impact-of-microaggressions-on-the-aapi-community/

Shirley, K. (2019). Exploring the 10 percent: Why black nurses are imperative. Office of Community College Research and Leadership. Retrieved from: https://occrl.illinois.edu/our-products/voices-and-viewpoints-detail/current-topics/2019/10/10/exploring-the-10-percent-why-black-nurses-are-imperative

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. ., Holder, A.M., Nadal, K. L., & Esquilin, M. (2007). Racial microagressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271-286. doi: 10.1037/0003-066X.62.4.271

Sue, D. W. (2021). Death from a thousand cuts. *American Scientist*. Retrieved from: https://www.scientificamerican.com/article/microaggressions-death-by-a-thousand-cuts/

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2019). Brief Summary Results from the 2018 National Sample Survey of Registered Nurses. Rockville, MD. Retrieved from

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associated pneumonia in adults receiving mechanical ventilation and early enteral feedings. *Journal of the American Medical Association, 309*(3), 249-256. Retrieved from www.jama.com

VanBlarcom, A., & McCoy M. A. (2018). New nutrition guidelines: Promoting enteral nutrition via a nutrition bundle. *Critical Care Nurse, 38*(3), 46-53.

Wang, Z., Ding, W., Fang, Q., Zhang, L., Liu, X., & Tang, Z. (2018). Effects of not monitoring gastric residual volume in intensive care patients: A meta-analysis. *International Journal of Nursing Studies, 91*, 86-93. Retrieved from https://doi.org/10.1016/j.ijnurstu.2018.11.005

Wiese, A. N., Rogers, M. JM., Way, M., & Ballard, E. (2018). The impact of removing gastric residual volume monitoring and enteral nutrition rate titration in adults receiving mechanical ventilation. *Australian Critical Care*. Retrieved from https://doi.org/10.1016/j.aucc.2018.12.001

Silence in the Face of Inequity - Nurses' Time to Speak Up

By Elizabeth Weaver, BSN, RN

As nurses navigating a healthcare system strained by a pandemic, we must meet the challenges of the present and envision a better future for the nursing profession. To actualize that vision, it is essential to address the issue of racial and ethnic inequities. Vast and foundational inequalities are deeply woven into the fabric of our country and have persisted through centuries to bring us to where we are today - a society struggling to address the conflicts and divisions that have driven the disparate outcomes we witness daily among the people for whom we care. The global pandemic and the country's response have highlighted health disparities and have brought the discussion of race and racism to the forefront. Nursing, established on the tenets of empathy and justice, cannot exempt itself from this discussion, and must now endeavor to reform and address inequities that exist within the profession.

I am struck by the words of Kenya Beard, EdD, RN, AGACNP-BC, CNE, ANEF, FAAN, Associate Provost, Social Mission, Chamberlain University, a powerful and guiding voice in the discussion on diversity in nursing. In response to the question "how much diversity [in nursing] is enough?", she responded, "I would know there was enough diversity when racial and ethnic minorities felt safe to share their opinions about diversity in large settings - when diversity was such a normal occurrence that we would not have to ask how much diversity is enough" (Beard, 2014, p. 11).

It is well established that inequities exist in nursing. These inequities arise out of a long history of racism in the profession. It is eye-opening and disturbing to learn the facts.

https://www.blackpast.org/african-american- history/staupers-mabel-keaton-1890-1989

At the outset of World War II, Black nurses were not allowed to join the U.S. Army. Black nurse leaders, notably Mabel Staupers, the Executive Director of the National Association of Colored Graduate Nurses (NACGN), campaigned for equity, resulting in an initial cohort of 56 Black nurses being accepted into the army in 1941 (Hine, 1989). That number grew to 160 by 1943. However, because of a shortage of nurses during the war, in 1943 the Bolton Act was passed, which provided grants to nursing education programs. The Bolton Act forbade discrimination, thus more Black women and men entered nursing programs. By the end of World War II, the military accepted all qualified nurses, regardless of race. In 1942, the National League of Nursing Education (now the National League for Nursing) changed its bylaws, allowing for Black nurses to become members. The records of the NACGN reveal that Black nurses were banned from joining the American Nurses Association until 1950 (Schomburg Center for Research in Black Culture, Manuscripts, Archives and Rare Books Division, NYPL, retrieved 17 August 2021).

FNYSN Commemorative Pin

In the archives at the Bellevue Alumnae Center for Nursing History, there are seven oral histories provided by Black nurses. These nurses are Josephine Bolus, Harriett Brathwaite, Iris Brice-Gilmore, Mary Elizabeth Carnegie, Jane Elizabeth Godden, Hiricinth A. Griffith, and Etta M. Miller. Each account describes discriminatory treatment. The discrimination includes such phenomena as being offered less pay for private duty nursing than a white counterpart; patients refusing care from Black nurses; white nurses exiting dining rooms when Black nurses sat down; two separate education programs at one medical college; one for white students with white faculty and one for Black students with Black faculty; being housed in lesser accommodations; and being excluded from professional organizations. All describe being the "first" – the first Black nurse to work at Kings County Hospital, the first Black nurse to work in staff development at the Bronx VA, the first Black nurse to be elected to the state Board of Nursing in Florida, and so on. Dr. Cathryne Welch, distinguished nurse leader, recalls that when she was in her diploma program in , the school administration asked the student body whether they would find the admission of Black students acceptable. (The student body's response was a resounding yes and quickly prompted matriculation of Black students [C. Welch, personal communication, April 19, 2021]). 1957

In 2020, ethnic minorities made up 38% of the US population, but constituted only 19% of registered nurses (Smiley et al., 2018). The American Association of Colleges of Nursing estimates that only 16% of nurse educators are ethnic minorities, and a 2010 study by the Journal of Nursing Management estimated that of nurses who earn a salary of $120,000 or more, only 10% were ethnic minorities (as cited in Iheduru-Anderson & Wahi, 2021). In many regions of New York State, both Hispanic and Black nurse practitioners are underrepresented in the Hispanic and Black communities in which they practice, while White NPs make up 69% of the workforce, though they comprise only 55% of the state's population (Steigler et al., 2021).

These statistics reveal critical issues within our nursing education system and profession. There is a pervasive and pernicious aggregate of financial, social, educational, and cultural barriers preventing candidates from underrepresented minority communities from entering nursing education programs or completing their nursing degrees and progressing towards advanced degrees (Ackerman-Barger et al., 2015). It is well established that a workforce deficient in diversity may struggle to sufficiently care for and treat the diverse patient population it serves. Implicit bias, negative profiling and false assumptions linked to race, ethnicity, education level or socioeconomic status are risk factors for poor patient outcomes and are harmful to the nursing profession and the healthcare system in which we operate (Hall & Fields, 2013).

Discussion of racism and injustice is a source of anxiety and discomfort. Some may fear to admit that profiling and bias have impacted past decision making (Mee, 2021). Even the very language we use to describe our values as nurses can be detrimental to progress. Take the nursing tenants of empathy and equality, the notion that we should treat everyone the same, be "colorblind." This ingrained perception of what it means to be a nurse can discourage open conversation about very real injustices: since we profess to be equitable in our care, it implies that there is no discussion to be had about racial and ethnic health disparities. It gives the nurse a free pass to turn a blind eye and assume that all patients come from the same background and have had similar advantages in their lives (Iheduru-Anderson & Wahi, 2021). Even the way we teach nursing students encourages this narrative by attempting to discuss diversity, but in doing so creates "homogenous pools" that promote stereotypes and assumptions about large groups of people (Iheduru-Anderson & Wahi, 2021). Making blanket statements about the beliefs and behaviors of groups of people based on their race or ethnicity subtly implies to the student that it is okay to make assumptions of this nature, instead of truly appreciating the individuality of each patient and tailoring care accordingly.

Nurses need to be able to talk about these issues. Remaining silent in the face of inequality will not bring about change. In order to promote open and positive dialogue, the conversation about implicit biases and racial and ethnic disparities must be normalized. Working past the fear of having this conversation can be mitigated by using emotional intelligence and focusing strongly on empathy (Mee, 2021). For nurses, the discussion should start as soon as nursing education commences. Rather than a special course to address these ideas, frank examples with discussions about inequities should be woven into student experiences as they arise. The clinical setting is rich with diversity. Each patient is a unique individual and offers an opportunity to explore the complexities that shape our care. It's time for nurses to speak up and take action against inequality.

Dr. Kenya Beard's "6 R's" - a guide to discuss bias and reduce stereotype

- Recognize the opportunity to address race related bias
- Restate what was said and ask for clarification
- Recognize the society we inherited and the thoughts some have been conditioned to believe
- Reflect on potential biases
- Recover by giving voice to different perspectives
- Reframe by creating an ethos that delegitimizes stereotypes and affirms our professional values (Mee, 2021)

About the author: Elizabeth Weaver earned her associate degree at the Samaritan Hospital School of Nursing in 2017. She recently completed her bachelor's degree at Empire State College. This paper was developed as part of her capstone project, under the guidance of Deb Elliott at the Center for Nursing. Elizabeth also earned a BA in political science in 2008 from Vassar College. Elizabeth was named a Future Nurse Leader by ANA-NY in 2017. The author acknowledges the contributions from Susan Birkhead, DNS, MPH, RN, CNE, archival volunteer at the Foundation of NYS Nurses, Inc.

References

Ackerman-Barger, K., Bakerjian, D., & Latimore, D. (2015). How health professions educators can mitigate underrepresented students' experiences of marginalization: Stereotype, threat, internalized bias, and microaggressions. *Journal of Best Practices in Health Professions Diversity: Research, Education, and Policy, 8*(2), 1060 - 1070.

Beard, K. V. (2014). How much diversity in nursing is enough? *The American Journal of Nursing, 114*(9), 11. https://doi.org/10.1097/01.NAJ.0000453730.28229.4c

Hall, J. M., & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nursing Outlook, 61*(3), 164–173. https://doi.org/10.1016/j.outlook.2012.11.006

Hine, D.C. (1989). *Black women in white: Racial conflict and cooperation in the nursing profession 1890 – 1950.* Indiana University Press.

Iheduru-Anderson, K. C., & Wahi, M. M. (2021). Rejecting the myth of equal opportunity: an agenda to eliminate racism in nursing education in the United States. *BMC Nursing, 20*(1), 30. https://doi.org/10.1186/s12912-021-00548-9

Mee, C. L. (2021). Insights from Dr. Kenya Beard on health inequities and multicultural nursing education. *Teaching and Learning in Nursing, 16*(3), A1–A2. https://doi.org/10.1016/j.teln.2021.03.005

Schomburg Center for Research in Black Culture, Manuscripts, Archives and Rare Books Division, NYPL. "*National Association of Colored Graduate Nurses records 1908–1958*". Collection overview. Retrieved 17 August, 2021.

Smiley, R.A., Lauer, P., Bienemy, C., Berg, J.G., Shireman, E., Reneau, K.A., & Alexander, M. (2018). The 2017 National Nursing Workforce Survey. *Journal of Nursing Regulation, 9*(3), S1-S54.

Stiegler, K., Martiniano, R., Cleaves, M., Harun, N. (2021). *Nurse Practitioner Diversity in New York State*. Center for Health Workforce Studies, School of Public Health, SUNY Albany. www.chwsny.org/our-work/reports-briefs/nurse-practitioner-diversity-in-new-york-state/

Preventing Abuse by Integrating Sexual Health into Your Pediatric Practice

Article provided by the Trauma Response Program at Washington University School of Medicine-Child and Adolescent Psychiatry

Pediatricians have many health priorities to address with patients and families in every well-visit. While some pediatricians incorporate age-appropriate conversations about sexuality and development into their practice already, there is evidence that these conversations should be happening more, especially as these conversations have been linked to preventing childhood sexual abuse.

Prevalence and Impact Data

In a review of health maintenance visits, one of three adolescent patients did not receive any information on sexuality from their pediatrician, and if they did, the conversation lasted less than 40 seconds (Boekeloo, 2014). While we would like for sexual abuse to be a rare occurrence, one in five girls and one in 20 boys is a victim of child sexual abuse (Douglas & Finkelhor, 2005). Additionally, children are most vulnerable to child sexual abuse between the ages of 7 and 13 (Douglas & Finkelhor, 2005). That means that a high number of pediatric patients will experience child sexual abuse and waiting until adolescence to discuss sexual health or sexual abuse may be too late for many of our children.

After experiencing child sexual abuse, children may experience symptoms within three days of the events. These symptoms may include: increased arousal (difficulty falling asleep or staying asleep), re-living experiences (nightmares, intrusive thoughts, flashbacks), negative mood and cognitions ("I can't trust anyone,") and avoidance (of people, places, activities, as well as thoughts, feelings, and behaviors). Beyond these immediate impacts, children who had an experience of rape or attempted rape in their adolescent years were 13.7 times more likely to experience rape or attempted rape in their first year of college. Compared to those with no history of sexual abuse, young males who were sexually abused were five times more likely to cause teen pregnancy, three times more likely to have multiple sexual partners, and two times more likely to have unprotected sex (Homma, Wang, Saewyc, Kishor, 2012). The impact of child sexual abuse can lead to many difficulties throughout the lifespan including: increased rates of health issues (fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome); increased likelihood to report current and early age smoking, severe obesity, physical inactivity, alcohol or drug use, and sex with >50 partners; difficulties in interpersonal relationships; and increased mental health problems such as PTSD, depression, psychosis, and substance abuse problems.

Next Steps for Pediatricians

In order to effectively prevent child sexual abuse, children should hear safety messages from multiple adults, such as parents, grandparents, teachers, doctors, and nurses. Talking about sexual abuse prevention reduces the likelihood that it will happen and can even delay the early initiation of sexual activity.

When sexuality is discussed frequently and openly in a pediatrician's office, conversations about the topic can be easier and more comfortable for parents to initiate, pediatricians can explore parents' expectations for sexual development while offering factual information, and screening rates for STIs, pregnancy, and partner violence can improve as barriers to discussing sexuality diminish. Not only can pediatricians assist in identifying factors that place children at risk for maltreatment, pediatricians can assist in *integrating* sexuality education into the relationships they build with children, adolescents, and families.

While children and adolescents often receive sexuality education classes in school, pediatricians' efforts can complement their education in unique ways. With pediatricians, children and adolescents can ask questions, discuss embarrassing experiences, reveal personal information, and discuss their sexuality and sexual activity privately. To integrate this education, pediatricians can: 1) incorporate sexuality education into every visit beginning early in the child's life, 2) encourage parents to discuss developmentally appropriate sex-related issues with children and adolescents, and 3) utilize your relationship and your lifelong perspective of sexuality education to have conversations that may otherwise be difficult with children and teens.

Additional Resources

Visit the following links for additional resources to address sexual health with pediatric patients and their parents.

Bright Futures by the American Academy of Pediatrics

Healthy Sexual Development Flyer by Missouri Kids First

References:

Boekeloo BO. Will you ask? Will they tell you? Are you ready to hear and respond? Barriers to physician-adolescent discussion about sexuality. JAMA Pediatr. 2014;168(2):111–113pmid:24378601

Douglas, E. M., & Finkelhor, D. (2005, May). Child Sexual Abuse Fact Sheet. www.unh.edu. http://unh.edu/ccrc/factsheet/pdf/childhoodSexualAbuseFactSheet.pdf.

Homma Y, Wang N, Saewyc E, Kishor N. The relationship between sexual abuse and risky sexual behavior among adolescent boys: a meta-analysis. J Adolesc Health. 2012;51(1):18-24. doi:10.1016/j.jadohealth.2011.12.032

Providing Competent, Supportive Care for People Who are Transgender

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Sherry L Roper, PhD, RN

Reprinted with permission from Illinois The Nursing Voice, June 2021 issue

The idea that gender is binary (male or female) and determined at birth predominates Western cultures. However, research evidence and lived experiences suggest that gender exists on a spectrum with many options. Some people identify as a gender different from their gender determined at birth (Deutsch, 2016). Our traditional understanding of gender, based on chromosomes and primary (genitalia) and secondary sex characteristics, is often called biological sex or gender (or sex) assigned at birth. Gender identity, on the other hand, is the innermost concept of self as male, female, a blend of both, or neither (Lambda Legal, 2016.).

The majority of people are cisgender, which occurs when gender assigned at birth and gender identity are the same. However, the best available data suggest that approximately 1.4 million adults do not self-identify with their gender assignments (e.g., someone assigned female at birth but identifies as male) (Flores et al., 2016). Transgender is an umbrella term for this population. A visibly growing segment of the U.S. population does not identify with the binary notion of gender. Nonbinary is a collective term for this population, but individuals may use terms such as genderqueer, gender fluid, or gender non-conforming.

There is no standard or correct way to be (or be seen as) transgender. Some people who are transgender choose gender-affirming hormone therapy to achieve masculinizing or feminizing effects; others do not. Surgery that revises genitals to conform to gender identity is a critical part of the transition for many people who are transgender (Deutsch et al., 2019). Others do not feel that genital surgery is a necessary part of transition but may opt for non-genital surgeries to produce desired characteristics, including breast augmentation or removal and body contouring procedures. In other words, the importance of therapy related to the quality of life varies by individual. Also, some people who are transgender may want these services but do not have access to them because they are (a) unavailable in the community; (b) not covered by insurance (even if the individual has insurance, and many do not), and (c) too expensive.

Remember: there is no one way to "be" transgender or cisgender. People choose to express their gender identities in personally satisfying ways, which may or may not match social expectations of what it means to look and behave as a male or female. Some transgender women choose not to wear makeup or dresses, and some cisgender men choose to wear their hair long and earrings.

Health Disparities in People Who are Transgender

Negative attitudes and discrimination toward the transgender community create inequalities that prevent the delivery of competent healthcare and elevate the risk for various health problems (Grant et al., 2011). In comparison to their cisgender counterparts, people who are transgender experience higher incidences of cancer, mental health challenges, and other health problems (Department of Health & Human Services, n.d.). For instance, transgender women, compared to all other populations, are at the highest risk of injury from violence and death by homicide. People who are transgender are also more likely to smoke, drink alcohol, use drugs, and engage in risk behaviors (Institute of Medicine, 2011).

Furthermore, discrimination and social stigma increase poverty and homelessness in people who are transgender (Safer et al., 2017). The inability to afford basic living needs may lead to employment in underground economies, such as survival sex work or the illegal drug trade, which place the person who is transgender at an even higher risk for violence, drug use, and sexually transmitted infections (Deutsch, 2016).

People who are transgender are more likely to rely on public health insurance or be uninsured than the general population. Even those insured report coverage gaps caused by low-cost coverage that does not include standard services for preventative, behavioral health, or gender-affirming therapies, including hormones (Deutsch et al., 2019). Lack of access to comprehensive health care leads some people who are transgender to seek hormones from the community and social networks without clinical support and monitoring, putting them at additional risk for adverse reactions and complications.

Researchers suggest that healthcare providers' inability to deliver supportive and competent care serves as a powerful mechanism underlying health disparities (Fenway Institute, 2016). The experiences of people who are transgender are often not included in healthcare provider diversity and inclusiveness training. While transgender-related content in health professions basic education programs would effectively improve provider knowledge, skills, and attitudes, transgender health has not been prioritized in nursing education. The result is a nursing workforce inadequately prepared to care for people who are transgender (McDowell & Bower, 2016).

Nursing Care of People Who Are Transgender

Competent, supportive transgender care requires nurses to recognize potential biases and understand gender that may differ from their current beliefs and social norms. Honest reflection on these feelings is an essential step in providing competent transgender care. Using a lens of cultural humility, where cisgender nurses acknowledge that they do not adequately know about being transgender while also being open to learning, is helpful. In this spirit, open, transparent inquiry on the part of nurses when they do not know something (When I speak to your children, what name should I use to refer to you?) or how to proceed with care (I need to place a catheter into your bladder, and I know you have had gender-affirming surgery. Do you want to give me any special instructions?) can build trust.

While gender-affirming care such as hormones, androgen-blocking agents, and surgeries require specialist care management, nurses will encounter transgender patients in all healthcare areas. Assessing the history and current status of gender-affirming therapies is critical to inform safe care. For example, hormone-induced changes in muscle and bone mass, along with menstruation or amenorrhea, can alter gender-defined reference ranges for laboratory tests such as hemoglobin/hematocrit, alkaline phosphatase, and creatinine (Deutsch, 2016). Nurses should consider the gender assigned at birth (especially if it is the only gender information to which the lab has access) and gender-affirming therapy-induced physiological changes to make valid inferences about lab values. Nurses should also ensure that a complete history of the use of hormones and androgen blockers (including those obtained from non-licensed providers) is taken. Nurses should work with other providers to ensure that hormone therapy does not stop with hospitalization unless contraindicated by current pathology or prescribed

medications. Abrupt cessation of hormone therapy can have a significant and negative impact on emotional and physiological health.

Systems-Level Policies, Processes, and Advocacy

Professional nurses can play a crucial role by advocating for policies and processes that promote safe, effective, and supportive care for people who are transgender. Misgendering a patient (making an incorrect assumption about gender identity) can cause emotional distress and erode patient-provider trust. Unfortunately, electronic health records (EHR) often do not support competent care for people who are transgender. For instance, healthcare providers should use a 2-step gender identification process (Deutsch, 2016). However, many do not, and EHR systems rarely provide prompts for the processor space for easy documentation and access to information derived from the process. Asking about a patient's current gender identity can result in several responses. The EHR should make checkboxes for a reasonable number of those responses, including male, female, transgender male, transgender female, and nonbinary. A fill-in-the-blank is needed for other identifies. The gender assigned at birth also requires options beyond male or female; people born with external genitalia, gonads, or both that do not conform to what is typically male or female (intersex) may have been identified incorrectly at birth. The EHR should provide an intersex option to this question. Some people who are transgender are uncomfortable revealing gender assigned at birth, so decline-to-state should be another option. Note that this process should be the standard for all patients, not just those assumed to be transgender.

People who are transgender may use names other than their legal names (Lambda Legal, 2016). Navigating a legal name change is complicated and costly. Some people who are transgender do not have the resources for a legal name change; for others, it may not be safe, given current social or legal circumstances. Using a patient's chosen name and pronouns is critical to patient-centered care. The EHR should prominently document the patient's chosen name and pronouns, which should also be used outside the EHR, including for appointments and prescriptions. Patients should only have to provide the information once, decreasing the need to correct providers and improving patient-provider relationships. EHRs should also contain an organ inventory, perhaps as part of surgical history, as providers will need to know about the presence or absence of reproductive and gonadal organs to inform clinical decision-making. This information must be clear, unambiguous, and easily accessible in the EHR to inform care and prevent medical and surgical errors.

Nurses should work within governance processes to ensure that all institutional policies support transgender patients, staff, and visitors. Nondiscrimination statements should include gender identity. Policies about restrooms and staff changing rooms (usually labeled in gender-binary terms) should state that a person's gender identity rightly determines the room to be used and that that right should not require any proof (e.g., health provider confirmation) related to gender or gender identity. Finally, clear guidelines concerning non-private room assignments should include assigning roommates based on gender identity rather than gender assigned at birth.

Power to Make a Difference

The ANA Code of Ethics obligates nurses to practice "compassion and respect for the inherent dignity, worth, and unique attributes of every person" (ANA, 2015, para 1). While some nurses may intentionally discriminate against people who are transgender, it is more likely that a lack of knowledge and experience leads to nursing actions that result in suboptimal care. Nurses play critical roles in transgender care by (a) providing supportive, affirming care, (b) creating an inclusive environment, and (c) leading interprofessional teams toward gender-affirming care. Education and a commitment to understanding the lived experiences of people who are transgender is, therefore, essential for all nurses.

References

American Nurses Association. (2015). *What is the nursing code of ethics?* https://nurse.org/education/nursing-code-of-ethics/

Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Healthy people. Lesbian, gay, bisexual, and transgender health.* https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

Deutsch, M.B. (2016). *Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people* (2nd ed.). Center of Excellence for Transgender Health, University of California at San Francisco. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf

Deutsch, M.B, Bowers, M.L., Radix, A., & Carmel, T.C. (2019). Transgender medical care in the United States: A historical perspective. In J.S. Schneider, V.M.B. Silenzio, & Erikson-Schroth, L. (Eds.). *The GLMA Handbook on LGBT Health* (1, 83-131). Santa Barbara, CA: Praeger.

Fenway Institute, National LGBT Health Education Center. (2016). *Providing inclusive services and care for LGBT people.* https://www.lgbtqiahealtheducation.org/publication/learning-guide/

Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). *How many adults identify as transgender in the United States?* UCLA School of Law, William Institute. https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey.* https://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* http://www.nationalacademies.org/hmd/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-

Lambda Legal. (2016). *Transgender rights toolkit.* https://www.lambdalegal.org/issues/transgender-rights

McDowell, A. & Bower, K. (2016). Transgender health care for nurses: An innovative approach to diversifying nursing curricula to address health inequalities. *Journal of Nursing Education, 55*(8), 476-479. DOI 10.3928/01484834-20160715-11

Safer, J. D., Coleman, E., Feldman, J., Garofal, R., Hembree, W., Radix, A., & Sevelius, S. (2017). Barriers to health care for transgender individuals. *Current Opinion in Endocrinology, Diabetes, and Obesity, 23*(2), 168-171. DOI: 10.1097/MED.0000000000000227

Singh, S., & Durso, L. E. (2017). *Widespread discrimination continues to shape LGBT people's lives in both subtle and significant ways.* Center for American Progress. https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways/

ANA-NY Looks Toward the Future of the Nursing Field

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

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

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

ANA-NY Member Mixer

On August 25. 2021, ANA-NY hosted our first ANA-NY Member Mixer at Nitti's NYC. We wanted to know "How you doin?" and ANA-NY members let us know. It was clear this event was what our members wanted and needed. The humid summer air didn't stop ANA-New York members from coming and sharing time with no agenda, just the guarantee of a good time and the chance of winning some raffles. It was such a needed escape from all the hustle and bustle going on around us. It was nice to have a room where seasoned nurses could mingle pressure-free with new nurses just entering the workforce. We had some raffle item winners: Beverly Kara-Irwin won an ANA-NY Blazer, Candiace Roach won a Free Registration to this year's 9th Annual Conference, and there were other winners as well. Overall, it was a night that showed the caring community that attracts most to become a nurse. ANA-NY is proud to say that this event speaks on the diversity and representation of our nurses in the field.

Communication Coordinator Shakira Hernandez, Preconference Jose Perpignan and Jessica Sinclair

Preconference Speaker Jessica Sinclair, Member Daniel Lowe and Julie Elting

Preconference Speaker Jessica Sinclair and Member Daniel Lowe

Preconference Speaker Jose Perpignan and Conference Speaker Julie Elting

ANA-NY Raffle Winner Beverly Kara-Irwin

ANA-NY Raffle item winner Candiace Roach with Communication Coordinator, Shakira Hernandez

Mary Gallagher, Susan Chin, Beverly Kara-Irwins and Cameron Roblewsky

Patricia Roja, Beverly Karas-Irwin, Jose Perpignan and Mary Gallagher

ANA-NY registration table

Left AN-NY Members Chevaughn Graham, Rose Green and Alicia Sargent

Some of the raffle items given that night

ANA-NY Membership Activation Form

AMERICAN NURSES ASSOCIATION NEW YORK ANA AMERICAN NURSES ASSOCIATION

Essential Information

First Name/MI/Last Name

Mailing Address Line 1

Mailing Address Line 2

City/State/Zip

County

Professional Information

Employer

Type of Work Setting: (eg: hospital)

Practice Area: (eg: pediatrics)

Ways to Pay

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

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

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

☐ Credit Card

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

*Monthly Electronic Deduction | Payment Authorization Signature

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

Annual Payment $174.00

☐ Check ☐ Credit Card

Date of Birth Gender: Male/Female

Credentials

Phone Number *Check preference:* ☐ Home ☐ Work

Email address

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

Current Position Title: (eg: staff nurse)

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

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

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)

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CNA, NSO. Nurse Professional Liability Exposure Claim Report: 4th Edition. 2020. www.nso.com/Learning/Artifacts/Claim-Reports/Nurse-Practitioner-Claim-Report-4th-Edition-A-Guide-to-Identifying-and-Addressing-Professional-Liability-Exposures

CNA, NSO. Nurse Professional Liability Exposures: 2015 Claim Report Update. 2015. www.cna.com/web/wcm/connect/e05b5d91-cf38-444d-8727-ab65f25f8f6a/RC_Health_Nurses_Claim_Report_Update_101615.pdf?MOD=AJPERES&CACHEID=e05b5d91-cf38-444d-8727-ab65f25f8f6a

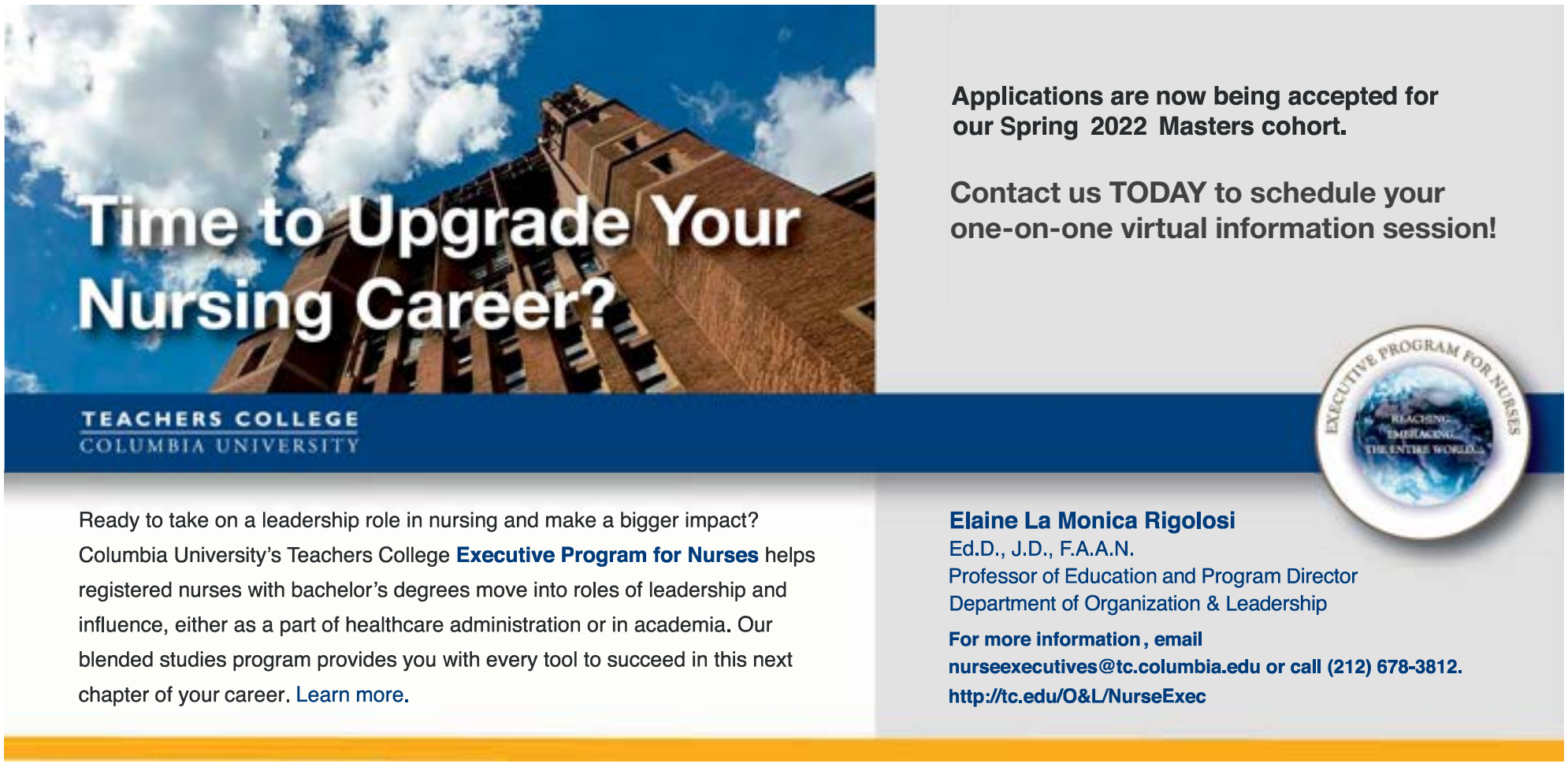
ECRI Institute. Copy/Paste: Prevalence, Problems, and Best Practices. Special Report. 2015. www.ecri.org/Resources/HIT/CP_Toolkit/CopyPaste_Literature_final.pdf.

Kelley T. Electronic Health Records for Quality Nursing and Health Care. Lancaster, PA: DEStech Publications; 2016.

Pagulayan J, Eltair S, Faber K. Nurse documentation and the electronic health record. Am Nurs Today. 2018;13(9):48-52, 54.

Partnership for Health IT Patient Safety. Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste. 2016. https://d84vr99712pyz.cloudfront.net/p/pdf/hit-partnership/copy-paste-toolkit.pdf.

Tsou AY, Lehmann CU, Michel J, et al. Safe practices for copy and paste in the EHR. Appl Clin Inform. 2017;8(1):12-34.



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