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ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

April 2024

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

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PRESIDENT'S MESSAGE

Marilyn Dollinger, DNS, FNP, RN

Spring is almost here and with that comes increased advocacy activity as the New York State legislature gets close to the April 1 budget deadline and work focuses on other priorities.

As members were notified over the last few months, the ANA-NY Lobby Day in Albany is Tuesday, May 7, 2024. All ANA-NY members and two non-ANA-NY members from each of our Organizational Affiliates had the option to register by the April 5, 2024 deadline. The deadline is necessary so the appointments with the attendees' legislators can be made in advance. The first week in May will be busy—ANA-NY, NYONL, NYSANA and other nursing groups are scheduled to be in Albany that day.

I had the opportunity to present the "Top 10 Tips for Legislator Visits" to a few groups across the state and I will share that information in this column. Even if you did not register for the ANA-NY Lobby Day, you or your group may be attending a "Hill Day" in Washington or making visits to state or federal legislators in their district offices about specific issues or bills.

1. **Know who your elected officials are:**
   - N.Y.S. Assembly https://nyassembly.gov/mem/search/
   - N.Y.S. Senate https://www.nysenate.gov/find-my-senator
   - U.S. House of Representatives
   - U.S. Senate https://www.congress.gov/members/find-your-member

2. **Look up the state or federal legislators that you have appointments with:**
   - Name, district number and background.
   - Do you live in this legislator's district?
   - What committees does the legislator chair or sit on as a member?

3. **Based on the Lobby Day Prep with your professional association—what bill(s)/issue(s) are the focus for this visit?**
   - Make sure you have the correct bill # for the legislator(s) you are meeting with.
   - State:
     - o N.Y.S. Assembly bills start with "A" https://nyassembly.gov/leg/
     - o N.Y.S. Senate bills start with "S" https://www.nysenate.gov/legislation
   - Federal:
     - o House of Representatives bills start with "HR" https://www.congress.gov/
     - o U.S. Senate bills start with "S" https://www.congress.gov/

4. **Look up who the sponsor and co-sponsors of the bill are.**
   - Is the legislator you are visiting a sponsor or co-sponsor already?
     - o If so, thank the legislator.
   - What is the committee of jurisdiction for the bill (usually the first committee it is assigned to after being introduced; may be more than one)
     - o Is the legislator you are visiting, chair or a member of this committee?

5. **What is the "ask" for this legislator? This is usually determined by your association, and it may include:**
   - Ask the legislator to sign on as a co-sponsor of the bill.
   - If the legislator is on the committee of jurisdiction—advocate for the bill in committee.
   - Ask the legislator to share with your organization any issues that the committee considers important for the bill or new issues that you may not be aware of.
   - Ask for the legislator's support when the bill comes to the floor for a vote.

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FROM THE DESK OF THE EXECUTIVE DIRECTOR

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

I have two very important items for you to make note of:

1 New York State changed the requirements for the Mandated Child Abuse Training that we all received before our initial licensure. It now includes a section on implicit bias and adverse events. **Every mandated reporter, licensed in NYS, is required to receive the updated training by April 1, 2025.** If you missed the live webinar that was held in February, never fear, the webinar is now available as an enduring offering. Visit our website for more information. Once you complete the evaluation form you will receive two different certificates. One will be for continuing education and will be attached to the evaluation submission confirmation email. The other will be for NYSED and will be sent under separate email once your posttest has been scored. You will need to complete the top of the NYSED certificate and then you can submit it as an email attachment to OPONLINE@nysed.gov

2 We are super excited to announce an upgraded format for our newsletter beginning with the next issue. We are going back to an in-print format for our members (with an opt-out option for those wishing to stay green) and continuing the electronic version available on our website. Additionally, our print version will not be in a newspaper format. Instead, we have contracted with the same publisher, Health Com Media, that publishes *American Nurse,* the official journal of ANA. Our "newsletter" will be in a glossy magazine format beginning with the July issue!

ANA-NY IS 8,911 MEMBERS STRONG

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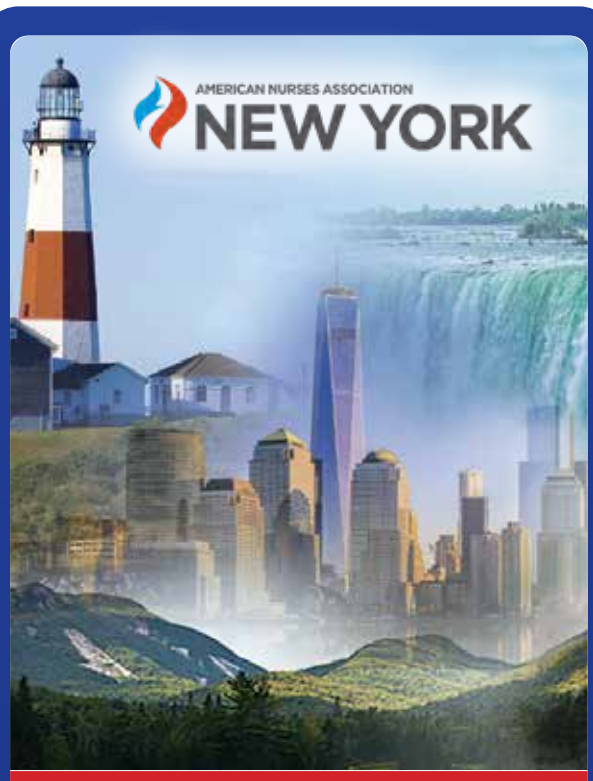

Article Submission

- Subject to editing by the ANA-NY Executive Director & Editorial Committee
- Electronic submissions ONLY as an attachment (word document preferred)
- Email: membership@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: membership@anany.org

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President's Message continued from page 1

6. **During the visit, *stick to the priority bills that the group has agreed to in advance.*** This is not the time to discuss individual laundry lists of issues or bills that the legislator and/or their staff are not prepared for, and your group may not have positions on.
   - The bill # for the focus of the visit is often sent to the legislator/staff when the appointment is scheduled so the staff can prepare.
   - If there are other issues you feel strongly about—ask to make a follow-up appointment with the legislator or staff as you leave.
     - o You will be doing this separate visit as a RN and not speaking for the professional association or your employer.

7. **Have talking points for the bills or issues on the agenda that support your association's positions and *stick to these*.**
   - Agree before the visit, who will lead the discussion.
   - Everyone should be prepared to give a brief self-introduction including role and specialty, how long you have been a nurse but usually--not your employer.
   - **Networking is valuable but review the issues first—expect only 20 minutes of legislator/staff time for the appointment.**
   - **If you are a constituent (live in their district) — say so!**
   - Briefly share experiences about how this bill/issue has an impact on the patients /families or students/faculty you work with (with all relevant HIPAA guardrails).

8. **Be prepared to respond to concerns that other stakeholders have, who do not support your group's position on the bill/issue.**
   - This is most effective when advocates use data to support the group's position or refute the other stakeholder's position.

9. **Leave a one-page summary of key talking points for the legislator/staff to refer to later.**
   - Leave business cards with the legislator/staff and ask for their business cards.
   - Offer the professional association as a resource for any nursing or healthcare issues for the legislator in the future.

10. **Follow-up with an email thank you to the legislator and staff (one of the reasons you want their cards!)**
    - Provide any information you offered to follow-up on during the appointment.
    - Ask for updates on the bill(s)/issue(s) that you discussed as it moves through the policy process.

I hope this helps give you some understanding of the process and confidence as you participate in advocacy for your patients, families, and professional nursing issues.

LEGISLATIVE UPDATE

By Amy Kellogg and Caiti Anderson

The 2024 legislative session began on January 3, 2024 when both houses convened for their first day of session. Normally, this day would also be marked with the Governor's State of the State address, but Governor Kathy Hochul gave her formal address one week later on January 9. The State of the State address is where the Governor outlines her legislative priorities for the upcoming session.

Her State of the State address was followed one week later, on January 16, with her proposed 2024 – 2025 Fiscal Year budget. The Governor proposed a $233 billion state budget, a 1.7% increase over the prior year's budget. In the healthcare space, the proposed budget will seek to implement New York's recently approved Medicaid Section 1115 Waiver Amendment. Under the 1115 Waiver Amendment, the State will receive $6 billion in federal funds, which will be used in part to establish "Social Care Networks" that will seek to integrate health, behavioral, and social care services that connect high-need members to nutritional and housing support services. Additionally, 1115 Waiver Amendment will address the health care worker shortage in New York by offering loan repayment programs and career pathways training programs for front-line health and social care professionals.

Included in Governor Hochul's proposed budget are several proposals that would directly impact the nursing profession in New York. The first proposal would add New York to the Interstate Nurse Licensure Compact (NLC). The NLC proposal allows nurses from other Compact-Member states to practice nursing in New York. We support the NLC and are currently working with others on educating the Legislature on the importance of the NLC and seeking to have New York become the 42nd state to join the compact. Another proposal that we have been monitoring relates to expanding EMS care for at-home care. We are monitoring this proposal to ensure that nurses are properly incorporated into the model that is being contemplated. The proposal this year would look at embracing a community paramedicine model and would authorize up to 200 new or expanded community paramedicine programs.

The Governor's budget also contains a proposal that would strengthen the enforcement authority of the Office of Cannabis Management to expedite the closure of unlicensed businesses selling cannabis illegally. As we have mentioned in the past, ANA-NY is part of Tobacco Free New York, a coalition advocacy group dedicated to fighting against tobacco use in the state. The coalition strongly supports this proposal and is advocating for this legislation to either be included in the final budget proposal or passed as standalone legislation. The proposal would prohibit the storage of flavored vape products where vapes and tobacco products are sold at retail or wholesale. This bill, S8531, sponsored by Senator Hoylman, and A9110, sponsored by Assemblymember Rosenthal, would expand enforcement against entities that are selling flavored vapor products, which are illegal to sell in New York.

An issue that we are strongly supporting is the Nurse Practitioner Modernization Act changes. In the Governor's proposed budget, she is proposing to extend the current Act for an additional two years. However, the Nurse Practitioners are working on passing legislation that would make the Act permanent in New York. We are working with the Nurse Practitioners to support their push to make the Act permanent. In addition to extending the Act, the Governor's budget proposal would also make permanent authorization for physicians and nurse practitioners to issue non-patient specific orders to RNs for tests to determine the presence of COVID-19, its antibodies, or the influenza virus. Another budget proposal would permit nurses to facilitate Hepatitis B testing through a non-patient specific standing order.

The budget will be all-consuming until the budget deadline on April 1. Once the one-house budget bills are released, negotiations will begin in earnest between the Assembly, Senate and Governor with the goal of completing the negotiations by April 1. However, the legislative calendar this year will likely make the April 1 deadline difficult to reach. Easter and Passover are at different times, meaning that the usually two-week legislative break that occurs once a budget agreement has been reached won't occur until the end of April in alignment with Passover. However, Easter is Sunday, March 31, meaning that a break will be taken to observe the holiday for at least a few days around the April 1 budget deadline.

We are also focusing on non-budgetary legislative issues. A potential piece of legislation that we are working on would require hospitals to add a seat to their governing board for a registered professional nurse who is clinically active. We are working on securing sponsors for this legislation and building a coalition of support.

On the regulatory front, we drafted and submitted comment to the New York State Education Department regarding their proposed regulations for patient non-specific orders. This proposed regulation is in response to legislation that was passed and signed into law last year, which supported by ANA-NY. ANA-NY submitted comments in favor of the proposed regulation, which would implement the underlying law.

Once the budget is complete, we will exclusively focus on non-budget issues until the conclusion of the legislative session on June 6, 2024. We will continue to work with the Legislative Committee and the Board to weigh in on issues impacting the profession throughout the course of this legislative session. ANA-NY's lobby day will be taking place on Tuesday, May 7, 2024 during National Nurses Week. We hope that many of you can join us in Albany that day. Please check the ANA-NY website for registration information.

Finally, we would like to remind you that ANA-NY has a Political Action Committee (PAC). The ANA-NY PAC will be supporting candidates that support the profession and issues of importance to our members. We urge you to visit the ANA-NY PAC web site and donate.

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.

FROM THE DESK OF THE HISTORIAN

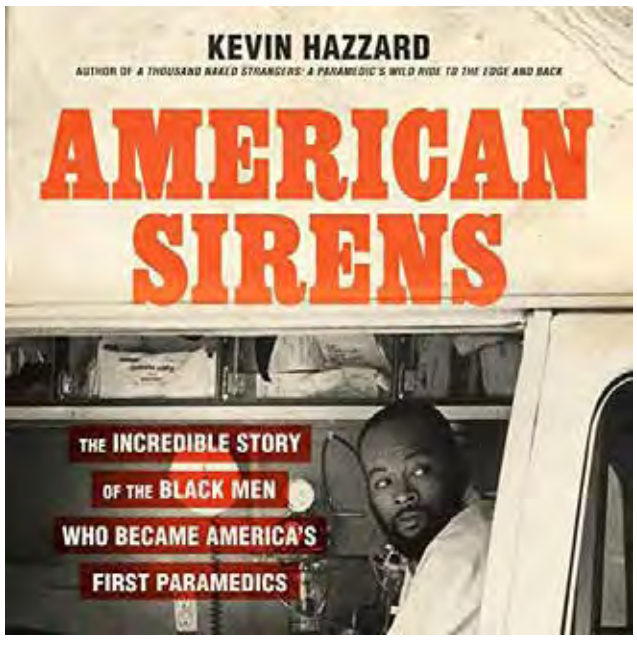
It's SPRING … I think.

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

April has arrived and hopefully, as the saying goes, will bring May flowers. Before we have our visual senses awakened with the colors of daffodils, crocuses, and tulips, it's time to share several aspects of history that spanned both Black History and Women's History months.

Throughout the years of this column, many well-known nurses of color have graced its page. This year, thanks to one of my nursing students, another nurse of color entered my horizon --- Jessie Sleet Scales.

As with many nurses of renown to American nurses, Nurse Sleet Scales hailed from Canada. Doors for admission to nursing schools in her home country were closed to her. So, as the late John Lewis frequently said, "Make a way out of no way" and that she did. She emigrated to the U. S. and graduated from Provident Hospital SON in Chicago. Again, employment doors were closed to her, so she traveled to New York. Illinois' loss was New York State's gain. She was the 1st African-American nurse to become a Public Health nurse. She spent her career working with the Charity Society in New York City caring for people suffering with TB. As I read about her intense, meaningful, and caring work with this marginalized population, my thoughts harkened back to another African-American nurse who also worked with tubercular patients in Harlem – Mrs. Mabel Keaton Staupers. Maybe at meetings of other nurses caring for other TB-affected population, or maybe through NACGN? I will have to do more research to discover if or where their paths crossed. (Sources: https://pubmed.ncbi.nlm.nih.gov/8161813/ https://aaregistry.org/story/jesse-sleet-scales-black-nursing-pioneer-born/)



As regular readers of this column know, reading is one of my passions. One of the books I read recently is American Sirens authored by Kevin Hazzard and published in 2022. While in Pittsburgh late last year, I saw a documentary on WQED entitled "Freedom House Ambulance: The FIRST Responders." Watching this stirred memories and I wanted to re-visit my memories and learn more. I was surprised to learn that Dr. Peter Safer, a name familiar to many in healthcare as the "Father of CPR," was the physician who recruited men of color in the Hill District, an African-American community area in Pittsburgh. As I read Hazzard's book, the more I learned about the culture of the Hill District, the fortitude and commitment to provide health care to a health care access desert. Another important fact I learned is that the Freedom House Ambulance model served as the template for communities nationwide wanting to start EMS community programs. I'm proud to be a native of Pennsylvania learning the impact that meeting a need had on our whole nation. Included here is the link to the documentary if you want to watch it. The book is a good read too! (https://www.youtube.com/watch?v=1pGFo0OmfwY) (Source of cover image is Amazon.com and my bookshelf).

The next book I want to share with you is a novel called "The Women," authored by Kristin Hannah in 2024. A family member sent me this book with the note: "I think you'll like this" and indeed she was right. After reading this book, I learned that Diane Carlson Evans, a veteran of the ANC who served and Vietnam and founder of the Vietnam Women's Memorial (VWM)was a consultant to Kristin Hannah. Hannah's main character is a young woman who wanted to uphold her family's tradition of serving her country, and like so many nurses and service personnel who went to Vietnam, she had no idea what she was getting herself into. Within the first few pages, I thought back to the late Maj. Helen Vartigian (a NYS nurse, Russell Sage alum, and an activist with Evans for the VWM) as I read about the 12th Evac Hospital based in Chu Chi. That was Helen's hospital. Many nurses lent their voices and stories to this book. For many, it may be difficult to read this book, for others it may bring

From the Desk of the Historian…continued on page 4

COMMITTEE SPOTLIGHT

Bylaws Committee

The Bylaws Committee is charged by the Board of Directors to periodically review the association Bylaws, maintain the Bylaws in harmony with ANA, vet any proposed amendments submitted by the ANA-NY membership, and bring any recommended changes to the Board of Directors and then on to the membership for final approval. In 2023, the current ANA-NY Bylaws were submitted to ANA for the scheduled (every three years) review and they were found to be harmonious, thanks to the good work and careful scrutiny of this committee. No Bylaws amendments were submitted by our members for the 2024 review cycle.

Meet the Committee Members:

Ann Tahaney – Bylaws Committee Chair - is a Charter Member of ANA-NY and was a member of the first Board of Directors, also serving as interim secretary when Karen Ballard became the Executive Director. She is a member of the Professional Nurses Association since 1993, serving in every position on their Board and, presently, secretary, membership chair, Communications committee co-chair, and co-editor of The Suffolk Nurse. She is a NYSNA Pension Fund Trustee and Investment Committee Member and President of NYSNA local bargaining at Syosset Hospital since 1991. Most of her experience as a Registered Professional Nurse has been in the Emergency Department and Intensive Care Unit. She was the Assistant Head Nurse of the ED from 1993 to 2011 and served as AHN of both departments between 2001 to 2005. From 2011 she has worked in Interventional Radiology full time until 2020 when she "retired" and now works per diem. She has 2 daughters, 1 granddaughter and 1 grandson.

Tiana Arroyo – no information submitted

Melissa Davis – no information submitted

Tanya Drake is a Founding and Charter Member of ANA-NY and a self-confessed bylaws geek. She believes that the written bylaws of an organization provide an instrument that identifies how the organization will conform to its charter and fulfill its functions. They identify who has the power to govern the organization, and outline its structure, leadership and responsibilities, and how each part relates to the others. The bylaws form a set of rules that the membership considers so vital to the organization that they cannot be changed without advance notice to the membership plus a super-majority vote in favor of the change. Bylaws are more powerful and important than any one individual or group within the organization. A strong bylaws committee, along with astute members in the organization, is important. Together they serve as a watchdog to guarantee that the organization does not stray from its purpose and functions as set forth in its charter.

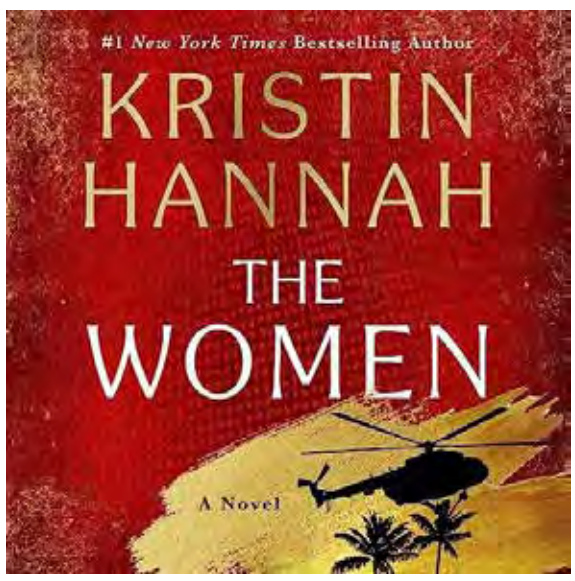
Tanya is passionate about nursing, patient advocacy and community service. She has been active in local, state and national professional organizations throughout her career, served in numerous leadership positions, and has been recognized for her contributions to nursing education and clinical excellence. She earned an MSN from Hunter College-CUNY and a BSN from Long Island University-Brooklyn Campus. A published author, Tanya retired after a 40-year career in nursing education and was honored to be named Professor Emerita of SUNY Rockland Community College. In addition to liaison to the Bylaws Committee, she is Vice President of ANA-NY, a member of the Board of Trustees of Montefiore Nyack Hospital, and a Community Educator for the Hudson Valley Chapter of the Alzheimer's Association. Tanya also builds houses with Habitat for Humanity in Rockland County and travels as often as her budget allows.

Tanya J. Finch – no information submitted

Meghan Scanlon, BSN, RN, is from Smithtown, NY and has had the pleasure of serving on the ANA-NY Bylaws Committee for the past three years. Meghan graduated with her BSN from Villanova University in 2019 and is on track to graduate with her MSN in Healthcare Organizational Leadership and MBA from Johns Hopkins University this fall. Upon graduating with her BSN, Meghan worked as a Surgical Intensive Care Unit Registered Nurse at Long Island Jewish Medical Center in New Hyde Park, NY. She is now the Manager of Finance and Operations at North Shore University Hospital in Manhasset, NY, where she oversees day-to-day and strategic operations for the 756-bed facility. She leads the Management Associate Program, a prestigious, full-time healthcare administration training program, for both NSUH and Northwell Health. Meghan is excited to continue her work with the ANA-NY and to promote the continued development of the nursing profession.

Faye Wang – no information submitted

From the Desk of the Historian...continued from page 3



comfort, and for others, I hope it will open you eyes, your hearts, and your minds. (Source of cover image is Amazon.com and my bookshelf).

Those are some of the highlights of two important months in the profession of nursing. To close out this column, let's take a look at some important historical April dates from the American Association for the History of Nursing's webpage

Dates	Who/What/Event	Source https://www.aahn.org
April 7, 1939	Jane Hitchcock died – PHN worked at Henry Street Settlement w/ Lillian Wald	https://www.aahn.org/hitchcock
April 9, 1860	Nightingale Fund Council & St Thomas Hosp Board establish school	https://www.aahn.org
April 11, 1905	Colorado nurse licensure law passes – 2 years after NYS approved licensure for RNs in 1903	https://leg.colorado.gov/sites/default/files/images/olls/2000a_sl_134.pdf
April 12, 1912	Clara Barton – teacher, American Civil War nurse, founder of the American Red Cross – died	https://www.aahn.org; this columnist's personal research

If you have any topics or nurses you'd like to know more about, please let me know via email at hutchg@sage.edu.

Hope you enjoyed this column.

Until next time,

Trudy.

BOARD BUZZ

This quarter, on behalf of our members, the Board of Directors:

- Joined President Dollinger in thanking Secretary Hutchinson and Director –at-Large Susan Chin for their service to the organization and welcomed Seon Lewis-Holman and Theodora Levine to the board.
- Accepted the Nightingale Award on behalf of the members at the Center for Nursing Nightingale Gala on September 30, 2023.
- Thanked President Dollinger for representing ANA-NY as a moderator for Cracking the Code on Healthcare event in Rochester, NY on October 5, 2023. Speakers included Dr. Pam Cipriano, President of the International Council of Nurses (ICN) and Dr. Kedar Mate, President and CEO at the Institute for Healthcare Improvement (IHI).
- Approved the Treasurer's Report which showed: Total income is above budgeted and total expenses are below budget for the 2024 First Quarter.
- Supported President Dollinger continuing to meet with our organizational affiliates (OAs) to strengthen our connections and learn how ANA-NY can best serve them.
- Finalized the 2024 Committee Rosters and are attending the committee meetings.
- Voted to support the following initiatives:
  - Northwell Health in their Northwell Health Advancing Nursing Careers Experience (NHANCE) Program, which will provide career pathways into nursing roles
- Continued to participate in virtual and in-person leadership activities with ANA and other professional organizations. Our numbers of programs for ANA-NY, ANA, and OAs have proliferated greatly. Schedule for the year are listed on ANA-NY website.
- Affirmed the change to our newsletter and journal publisher, Health e-Careers (HeC) which notified us that our contract was being terminated effective July 2024. The staff have secured a new publisher, Health Com Media and are beginning the transition logistics.
- Are pleased to announce that two ANA-NY members were selected for ANA awards: William Rosa and Josephine Agyei
- Voted to sponsor the following: NACLI Annual Awards Brunch -$200.00 and HIMSS Annual Symposium - $500.00

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

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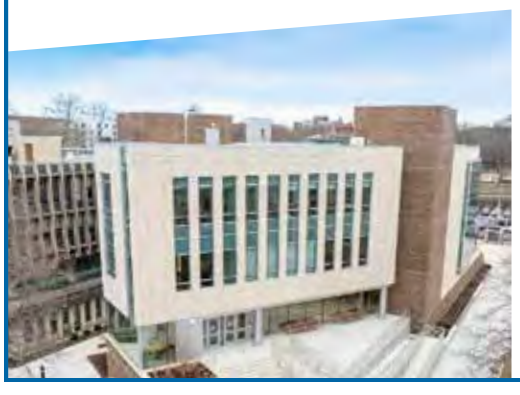

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Genesee Valley Nurses Association (GVNA)

Mohawk Valley Nurses Association (MVNA)

New York League for Nursing (NYLN)

New York State Association of Nurse Anesthetists (NYSANA)

New York State Association of School Nurses (NYSASN)

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

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

Philippine Nurses Association of New York (PNANY)

Professional Nurses Association of Dutchess/Putnam, Inc. (PNADP)

Professional Nurses Association of Rockland County (PNARC)

Professional Nurses Association of Suffolk County (PNASC)

Professional Nurses Association of South Central New York (PNASCNY)

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

Are you a member of a nursing group that should become an Organizational Affiliate (OA)?

Here are some benefits: 1. A discount on exhibiting at ANA-NY's annual conference; 2. Attendance at ANA-NY's annual conference at a member registration rate for the OA's representatives; 3. The right of OA's RN liaison to attend and speak at ANA-NY's governing assembly, without vote; 4. A link with your logo on ANA-NY's website with recognition of OA status; 5. Access to professional development opportunities for OA's members and staff; 6. Access to experts in a variety of nursing specialties; 7. Opportunities to network with ANA-NY members across New York State; 8. Access to speakers from the membership on a variety of nursing topics; 9. Preferred sponsorship opportunities at special events and other programs; 10. A complimentary subscription to ANA-NY's quarterly newsletter for your members.

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

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

NO KIDDING

What Did the Photographer Say to the Psychiatric Patient? Posey

Connie J. Perkins, PhD, RN, CNE

Restraints are part of medical past and present taking various forms in several nursing specialties. Restraints, either physical or chemical, are a controversial subject that have some nurses missing the "good old days", others disgusted thinking about what was once common practice, and some pre-dreading the documentation just by hearing the word. Restraints are used to control unwanted behavior and should be motivated by safety rather than control. One of the oldest manufacturers of medical restraints is Posey. The J.T. Posey Company was founded in 1937 by John Posey in San Francisco with foot cradles as their first item for sale (Vitality Medical, Inc., 2024). Posey grew to what most of us know them as today: vest restraints, bed alarms, gait belts, safety rails, wrist restraints, and mitts. Let's take a look at the history of psychiatric care by era to see how we got where we are today regarding psychiatric treatment and use of restraints.

The 1800s was considered the era of asylums. The idea of asylums came from Europe and focused less on physically restraining people, but rather confining them to a building and subjecting them to techniques to control their behaviors such as ice baths and electric shock (study.com, 2003-2024). These facilities first started in the Northeast of the United States and "By the 1870s virtually all states had one or more such asylums funded by state tax dollars" (D'Antonio, n.d.). As part of the moral treatment movement, asylums were made to look like homes and provided on-site recreation, but quickly became overcrowded and understaffed leading to an increase in the use of restraints (study.com, 2003-2024). The concept of institutionalization had its merits: establishing a routine set by the facility, having centralized access to healthcare, peer-to-peer support, and learning how to contribute to a community while being supervised. However, behind the locked doors incomprehensive things were happening that led to the downfall of institutionalization. The somatic treatment of the early 1900s is called the psychosurgery era. Psychosurgery, coined by a Portuguese neurologist in 1936, is a term that covers not a single procedure, but works to capture the invasive surgical procedures used to treat mental disorders (Lichterman, et al., 2022). While partial or complete lobotomies were common during this time, it became apparent that these procedures were sometimes performed without consent, without anesthesia, outside of sterile areas, and not by trained neurosurgeons (Staudt, et. al., 2019).

I had the pleasure of attending an art exhibit and panel discussion called Willard Suitcases. When the Willard Psychiatric Center in Willard, NY closed, over 400 patient suitcases were left behind in the attic. Jon Crispin, a photographer, was permitted to open and photograph the contents (see figure 1). For me, it was emotional to see what could have been their entire lives in one photo, wondering who these individuals were beyond their diagnosis and how their belongings were just left behind untouched for years.

Figure 1
Jon Crispin Photo from Willard Asylum Suitcase #2

Note. To see more photos from this exhibit, visit https://joncrispinposts.com/2011/07/24/willard-asylum-suitcase-2/

With asylums in the rear-view mirror and psychosurgery being understandably scrutinized, "by the 1950s…chlorpromazine offered hopes of curing the most persistent and severe psychiatric symptoms" (Rojas-Velasquez, 2017, p. 52). The pills era took over and lives on with the intent of returning mental illness suffers back to their families and communities by controlling their symptoms. While I am thankful that more regulation is occurring and rights are being provided to all patients, I have seen first-hand issues with deinstitutionalization. Medications do not eliminate severe symptoms and many patients are left to figure out how to "adult": find a job that they can safely and effectively perform while managing their symptoms, get themselves to all medical appointments, manage their medications, maintain a household, and navigate the everchanging waters of social life. I struggle with all of these things and as far as I know my frontal lobe is fully functional. We have all witnessed inside and outside our hospital walls the effects of patients who cannot access care and cannot support themselves. With the wave of more agencies not taking Medicare/Medicaid patients, the increasing need for psychiatric-focused emergency rooms, and the rising cost of prescription drugs, maybe it's time to revisit institutionalization…while learning from our past mistakes. Maybe, just maybe, it's time for a new era: institutionalization 2.0.

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EVIDENCE YOU CAN USE

Evaluating Orientation Processes in the Operating Room

Emery Briggs, EdD, RN, CCRN; Kathryn Colabufo BSN, RN, CNOR, CST; Judith Markee, RN; Lia Fischi MSN, RN, ONC; Sandra Hathaway BSN, RN, CPN; Theresa Ott-Hayes BSN, RN, CNOR; Carrie Edinger BSN, RN, CGRN

In the everchanging healthcare landscape, some facets of nursing remain unchanged. Historically, nursing turnover within the first year of practice has been most prominent compared to turnover later in a nurse's career. Currently, the trends are the same and the cost of turnover is up to $64,500 per nurse (Nursing Solutions Issues, 2022). The financial implications place hospitals in challenging positions, forcing evaluation of onboarding and, precepting strategies. In addition to financial concerns, recruitment, retention, and job satisfaction have been brought to light as important factors in process improvements. Orientation process for nurses is priority given the first-year turnover rates. Nurses across the country are seeking improvement in existing processes to better understand and improve workflows, including the onboarding and orientation of new to practice nurses. With a continuously evolving system of healthcare, it is imperative to align orientation processes to match today's world of nursing. Today's nurse has different life experiences, learning needs, and expectations from a job and requires an orientation process that meets these needs. Hospitals are now focusing on how orientation processes can be improved to help decrease the amount of first year turnover being faced. Training and retention of new to practice nurses has also gained attention in healthcare as an essential element to provide quality care (La & Yun, 2019). In effort to properly orient staff, encourage retention, and ensure safe patient care, orientation processes with nurse preceptors are an emerging study topic.

At Upstate University Hospital (UUH) in Syracuse, NY, the same challenges are being faced with turnover and retention. Paying specific focus to the first-year nurse, orientation style is now a focus for improvement. UUH has a shared governance structure which supports these process improvements. Shared governance councils can and are recommended to be used as an avenue for clinical nurses to develop ideas, process improvements, and innovation, with the guidance of coaches and sponsors. This gives clinical nurses the support and autonomy to improve practice within their own areas, and potentially beyond. Overall, shared governance is an area where clinical inquiry is encouraged, and sacred cows are questioned. Nursing shared governance groups at UUH have voted in adopting a new orientation model that better aligns and structures orientation for both new to practice nurses, and nurse preceptors. Knowing nurse preceptors play an instrumental role in orientation, UUH placed focus on searching for a model that will support and guide nurses during this process. Nurses, across the country have made a plea for help, specific to the orientation and precepting processes in the acute care setting (House, 2023). With nurses entering practice at a variety of stages in life, as well as nurse preceptors becoming preceptors at earlier stages in their career, the need for understanding processes through structured programs has increased.

Mayo Clinic experts developed the Tiered Skill Acquisition Model (TSAM) which is an orientation process focusing on increasing exposure and experience to new to practice nurses, while providing guidelines for nurse preceptors on how to advance their orientee through tiers (Joswiak, 2018). Implementation of a model that meets today's needs is instrumental to keeping up with the evolving state of hospital healthcare. Nurses across the UUH organization voted in this change with excitement to change the orientation/precepting style to better meet current state of healthcare needs, and with an overwhelming response from units to pilot this new process. Selecting a process that provides clarity in a multi-step process was attractive to UUH nurses, as the current process of orientation has nurses feeling unprepared and uneasy. Preceptors weren't aligned in their practices and were unsure when to end an orientation for new to practice nurses. TSAM outlines an orientation process that can be modified to any inpatient setting to help standardize understanding, appropriate advancement times, and appropriate milestones for orienting nurses which ultimately mitigates much of the gray area with which nurses currently report struggling. UUH Nurses who took specific interest in TSAM were those working in the operating room. This group of nurses quickly adopted and adapted TSAM from a model geared toward floor or unit-based nursing to meet their unit needs in the intraoperative arena. They then reviewed the orientation timeline, taking a deeper dive as to how a new orientation model may impact their overall process. As many of the operating room nurses participate in the Research and Innovation shared governance council, this idea was brought to council and a study was developed.

Currently at UUH, the orientation for a new to practice nurse in the operating room is a one-year process. Historically, new to practice nurses were not hired in the operating room, restricting the labor pool from which to draw. Nursing shortages have necessitated hiring from all levels of nursing experience into this specialized area. Nurses from the operating room felt that they would be able to revise the one-year plan into a ten-month process with the guidance of TSAM. Joswiak (2018) had that exact goal in mind that using a structured tiers model could increase new to practice nurse exposure to experiences earlier in their orientation process, thus allowing for confidence and competence earlier in practice, with potential for decreasing length needed for orientation. Clinical trainers from the operating room were key stakeholders in the development of tiers for the operating room and creating the ten-month vision while still incorporating all required aspects of the orientation process. UUH nurses, in the shared governance council, then developed the research question "How will TSAM in the intraoperative setting of a level 1 Trauma Center impact length of orientation for new to practice Registered Nurses"?

Based on Patricia Benner (1984) novice to expert model, the phases of learning will transition, over time and experience, to build nurses competence and confidence. TSAM is designed to help new to practice nurses' step away from the novice phase and towards higher levels of thinking, at a faster pace (Joswiak, 2018). TSAM can be modified to any specific specialty or unit to allow increased exposure to experiences earlier on in a nurse's career. UUH nurses, in the intraoperative setting, felt they could specifically apply TSAM in their work environment to meet new to practice nurse's learning needs, increase confidence and competence earlier on, save the hospital up to two months of additional orientation time and any associated financial impacts. Additionally, the TSAM orientation process which has been favorable across the country, can contribute to orientee satisfaction and ultimately retention if the nurse is feeling thoroughly supported through their orientation process. This study topic is particularly significant as UUH, like many hospitals across the country, is attempting to recover from nursing shortages and are very focused on retention efforts of any newly hired staff. Additionally, the nurses within the shared governance council highlighted the need for focusing on orientation processes in that job descriptions for operative nurses are expanding, new to practice nurses are coming in with a variety of learning styles, and a more recent uptick has been noted of hiring graduate nurses right into the operative settings. The days of expert nurses being the only preceptor for novice nurses are long gone, and it is time to meet the needs of today's learner in a new way. Structuring and standardizing the orientation process benefits both the new to practice nurse as well as the nurse preceptor, especially considering nurse preceptors have fewer years' experience than their preceptor predecessors (House, 2023). Conducting a study on the impact of changing to a structured preceptor model will help UUH track effectiveness of both the orientation process and the length of orientation needed.

Utilizing the shared governance council for Nursing Research and Innovation, the team of both clinical and non-clinical nurses designed their study with support and guidance from the council coach. The shared governance council has decided to learn more about nursing research by going through the process together, and on a universal topic of interest. These emerging nurse researchers are looking to begin data collection in February 2024. A quantitative approach will be used to track orientation length for new to practice nurses in the operating room. Data collectors will be clinical trainers from the intraoperative settings allowing for access to accurate, real time data collection. This data will be tracked, analyzed, and reported within the UUH system. Results are intended to be shared to a national audience to help contribute to new knowledge on orientation processes, specific to the understudied operative settings.

The goals for this study are multifaceted. Nurses within the organization are learning how to complete a research study through actively designing and participating in it. Nurses will have developed the skillset of understanding the scientific process of research and can, in turn, mentor the next emerging researchers. Nurses recognize their autonomy in clinical practice and have a seat at decision making tables, backed by evidence. Ultimately, this group hopes that results of the study will be to benefit the UUH orientation processes, in the operating room and beyond, as well as assist other hospitals to better understand and improve orientation processes for both orienting nurses and nurse preceptors. For any questions about this study, please feel free to reach out to Nursing research - request assistance (upstate.edu) for more information.

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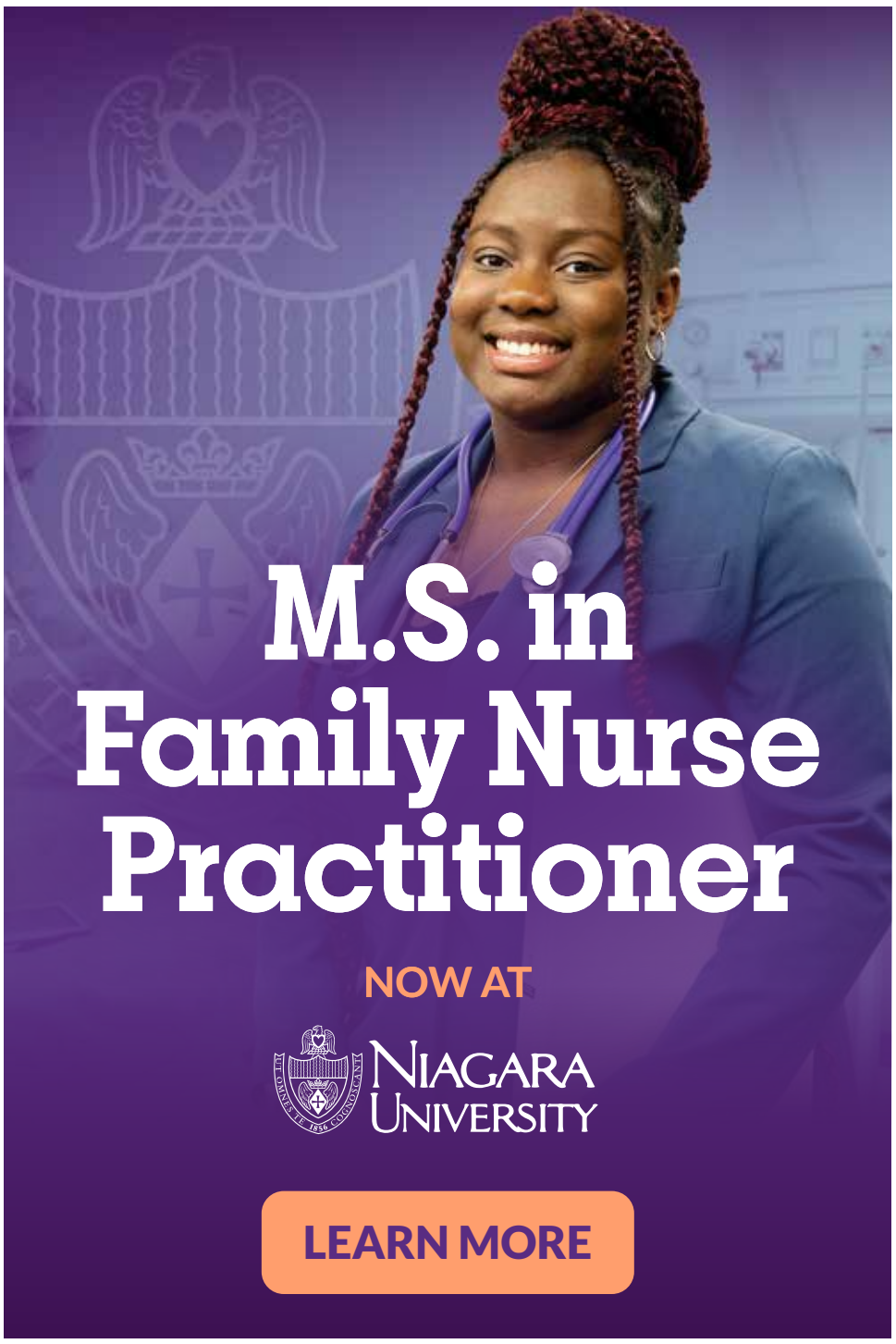

Delegating vs. Assigning: What You Need to Know

Registered nurses (RNs) often delegate to other RNs, licensed practical nurses/vocational nurses (LPN/LVNs), and assistive personnel (AP). (In some states or jurisdictions, LPN/LVNs may be allowed to delegate, so "licensed nurses" will be used in this article.) Delegating appropriately protects patients and reduces the risk of legal liability, yet the parameters of delegation often are not fully understood.

One common area of misunderstanding is delegation vs. assignment. Knowing the differences between the two is essential to ensure you delegate appropriately. The primary difference relates to scope of practice and where the clinician learned the activities to be carried out.

Assignment

According to national guidelines for nursing delegation from the National Council of State Boards of Nursing (NCSBN) and American Nurses Association (ANA), an assignment refers to the "routine care, activities, and procedures that are within the authorized scope of practice of the RN or LPN/VN or part of the routine functions of the AP." This definition covers fundamental skills that the assignee would have learned in a basic education program. A licensed nurse is still responsible for ensuring the assignment is carried out correctly.

Delegation

According to the NCSBN/ANA guideline, delegation applies when the delegatee is performing a "specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed." As opposed to work that is part of an assignment, the work associated with delegation was not learned in a basic education program. Therefore, the delegatee must have obtained additional education and have verified competence in the delegated area for which they will be responsible. The licensed nurse maintains overall accountability for the patient, but the delegatee is responsible for the delegated activity, skill, or procedure.

Licensed nurses can't delegate activities that involve clinical reasoning, nursing judgment, or critical decision making, and the delegated responsibility has to be within the delegator's scope of practice under the state's or jurisdiction's nurse practice act (NPA).

Responsibilities

Organizational administrators, the delegator, and the delegatee each have responsibilities when an activity, skill, or procedure is delegated.

Professionals who work at the administrative or managerial level of the organization set the cultural tone for the nursing work environment and are responsible for managing the delegation processes. Those at the administrative level within an organization define what nursing responsibilities may be delegated, to whom, and under what set(s) of circumstances. They are also responsible for developing and maintaining policies and procedures associated with delegation, periodically evaluating the efficacy and safety of delegation processes, and training and educating staff.

The *delegator* is responsible for determining the needs of the patient, when delegation is appropriate, and if the delegatee is competent to complete the delegated task. Delegators must follow delegation guidelines in the NPA and relevant organizational policies and procedures. Clear communication is key, and the delegator must be available as a resource to the delegatee. Delegators also need to evaluate outcomes as they maintain overall accountability for the patient. Delegators must be prepared to step in at any point if it appears the delegatee is not handling the assignment appropriately. Any problems should be reported to nursing leadership.

The *delegatee* is responsible for only accepting activities that fall within their competence and that they feel comfortable completing safely. Delegatees must communicate with the delegator, particularly if the patient's condition changes, and complete the activity correctly, including fulfilling any documentation requirements. Delegatees maintain accountability for the delegated activity and need to notify the delegator immediately if they have difficulty completing the task.

One special case

NCSBN notes that in some cases, APs are taught how to perform skills that were previously thought to be exclusively RN and LPN/LVN responsibilities, such as certified medical assistants administering injections. In these cases, it's best to consider such tasks as being delegated and, therefore, validate competency.

Keeping patients safe

Knowing the differences between assigning and delegating helps protect patients and avoid legal action should an error occur. Assignments involve routine tasks learned in basic education and that fall under designated scope of practice, while delegation involves tasks that were learned through additional education and for which competency has been determined.

Good communication and an understanding of the responsibilities of delegators and delegatees is essential to avoid misunderstanding. Remember, the licensed nurse remains accountable for the patient, but the delegatee is responsible for the delegated task.

Five rights of delegation

The NCSBN outlines five rights of delegation. In the case of a lawsuit, a key component would be whether you adhered to these rights:

- **Right task.** The task needs to fall within the delegatee's job description or is part of organizational policies and procedures.
- **Right circumstance.** The patient must be stable.
- **Right person.** The delegatee must have the appropriate skills and knowledge to perform the task.
- **Right directions and communication.** Clear directions need to be given, with the delegator verifying understanding by the delegatee. Communication must be two-way, with the delegatee asking questions as needed.
- **Right supervision and evaluation.** The delegator needs to monitor the delegated activity, including evaluating patient outcomes.

Article by: Cynthia Saver, MS, RN, President of CLS Development, Inc., in Columbia, Md and
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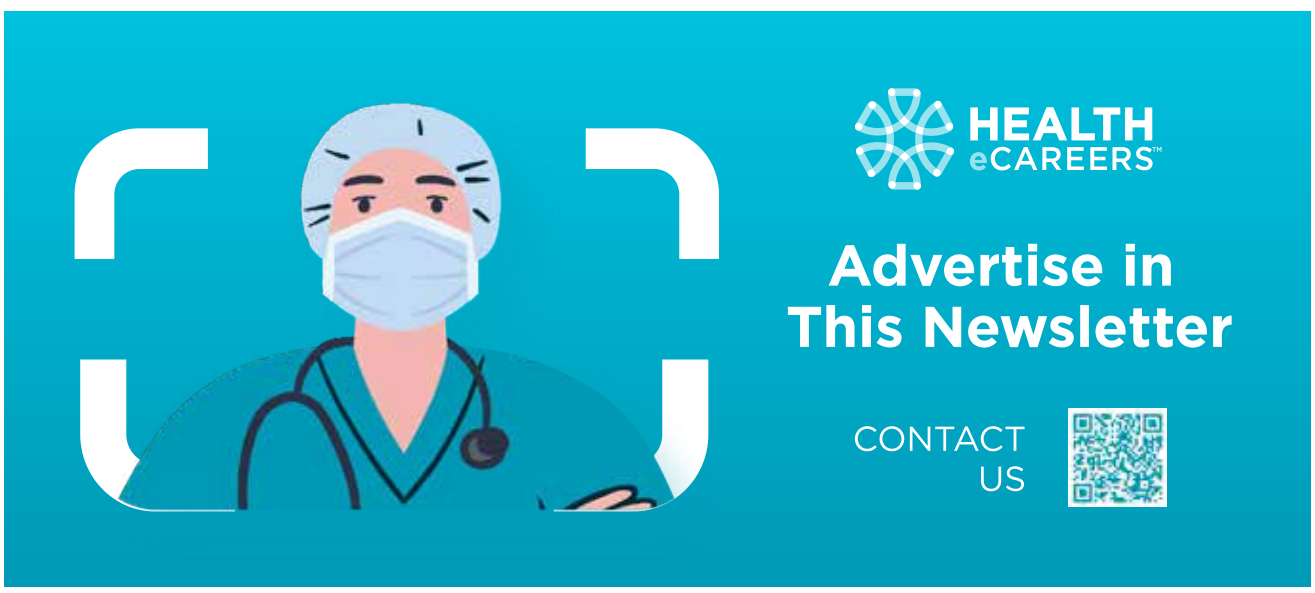

Questions You Should Ask Before Volunteering

Volunteering is a great way for nursing professionals, including registered nurses (RNs) and advanced practice nurses (APRNs), to get involved in their communities and to support causes that are important to them. However, there are some operational and legal considerations that nurses should investigate before agreeing to take on a volunteer position. This article will review some questions nurses should ask prior to taking on a volunteer position. It will also review some of the legal protections for nurses who are volunteering, and when those legal protections generally do and don't apply.

Usual venues that request medical volunteers include community fairs, concerts, sporting competitions, water sports, and foot races such as 5Ks, marathons, triathlons, and adventure races. However, a measure of caution is necessary: Know the expectations of medical volunteers in advance. There can be a mismatch or even a misunderstanding in what the organizers may expect of you, their level of support, and the realities of your scope of practice, skill set and capabilities. It's crucial to ask questions up front to clarify their expectations and yours so that you can make an informed decision regarding your participation, as well as consider any personal risks and professional liability risks. Several questions can be helpful to you as you evaluate opportunities to serve as a medical volunteer.

What are the organizer's overall expectations of the volunteer(s) providing on-site medical coverage?

When considering becoming a medical volunteer for an event, it's a good idea to contact the organizer in advance to ask clarifying questions. Will you work by yourself, or will you be part of a medical team? Is there any pre-event training available? Do they expect you to hand out ice packs, take vital signs, and provide basic first aid? Will you have to respond to people in need anywhere within the event venue, or will other event staff bring ill or injured persons to you? Do they assume that you, an RN, will administer medications to participants without pre-existing orders or independent practice authority? When you speak to the organizer directly, you have the opportunity to be clear about your scope of practice and the applicable limits of your licensure and capabilities.

Is the type of event aligned with your nursing license, experience, and knowledge?

Are you practicing in a state for which you hold a valid nursing license at the level you intend to practice (such as RN, APRN, or licensed practical/licensed vocational nurse)? Do you have any type of first aid, emergency care, or wilderness medicine training? Are you up to date on CPR and automated external defibrillator (AED) certification? These events are often held in outdoor locations as well as large, indoor event venues. The care you are being asked to provide is based on prehospital care principles. If other nurses and care providers who have experience in this venue will be available to mentor you onsite, there can be a much greater comfort level with volunteering. However, if you will be the lone nurse without backup except by calling the local EMS squad, then it's important to take stock of your own knowledge and skills before signing up.

Is the team composition appropriate to the anticipated medical needs at the event as well as the number of participants?

Events such as large-scale marathons with 5,000 or more runners, adventure races, or big concerts typically call for larger medical teams with numerous physicians, advanced practice clinicians (APCs) such as APRNs and physician assistants, nurses, and EMS personnel. These types of events tend to be very well planned and organized. If the event will require personnel with specialized rescue skills such as those of a lifeguard, a rock climber, or ski patrol, ensure that people with these competencies and credentials are part of the team and positioned in areas where their skills are most likely to be used. You should never be expected to perform rescue skills for which you have no experience or training.

What internal and external resources will be available at the event?

Internal resources include medical station structures such as tents, water stations, gators for transporting participants to the medical team, police or security, roving bike patrols, food, bathroom facilities, water, and electricity. Communication devices such as portable radios for contact with both race organizers and other medical team members are often essential, as cell phones may have limited connectivity in some venues. External resources generally encompass local EMS responders in ambulances, helicopters, watercraft, rescue apparatus, and divers. Local and regional healthcare facilities also are considered external resources as well as their capacity so the team can make well-reasoned decisions.

What types of equipment and supplies will be on hand?

Will the event organizer provide the medical supplies and equipment, or do they expect the medical team to bring whatever they determine is necessary? If provided by the organizer, is the equipment fully functional? Are the supplies usable (not damaged or expired) and in sufficient quantity? Are AEDs available? The team needs to carefully decide whether a basic life support level of care will be provided or an advanced life support level. If physicians and APCs are available, then consideration of an advanced life support level might be reasonable. This decision will dictate supply and equipment needs as well as team competency and skill needs.

Are there well-coordinated plans, including an orientation?

Have the organizers held an event such as this in the past? Do they work closely with those on the medical team to ensure that planning is well coordinated and that the medical team has the necessary access to resources and decision-making? Do they offer an orientation to the event, including the layout and location of key resources, areas of greatest injury risk, points of entry and egress for emergency vehicles, and criteria for cancelling or ending the event before it's scheduled to be over (for example, lightning storm, excessive heat or cold)? Who is the lead medical volunteer and does this individual offer an orientation to being part of the medical team?

What are documentation and quality management expectations?

How will medical encounters be documented? Is there a patient contact log or a formal care record? In the event of a complex or serious case involving the medical team, is there any type of post-event follow-up with the team or quality management plan to inform future event coverage? What type of follow-up does the event organizer expect after serious medical encounters and what can the medical volunteer legally provide without violating patient confidentiality? How are media inquiries handled?

Is this coverage volunteer or is there compensation?

Consider the implications of Good Samaritan laws. Good Samaritan laws vary from state to state and are intended to cover healthcare professionals who volunteer to help people experiencing a medical emergency. Sometimes even receiving a t-shirt, food voucher, or swag from the event can be viewed as compensation. Being compensated with monetary payment and, potentially, giveaway items can nullify Good Samaritan protections. Review the Good Samaritan Law in the state where you plan to volunteer, especially if you intend to rely on Good Samaritan protections.

What liability coverage exists?

Seek clarification from the event organizer regarding whether they have liability insurance coverage for their event. If so, does it provide any liability coverage for medical volunteers? What are the provisions of that liability coverage if medical volunteers are covered? If there is no liability coverage as part of the event organizer's policy, do you have your own professional liability policy that offers the appropriate coverage? Knowing that you are protected provides essential peace of mind. It also is a good idea to know if the organizer's policy covers you for any injuries you may sustain as part of your duties as a medical volunteer.

A rewarding opportunity

Being an event medical volunteer is personally and professionally rewarding. It expands your healthcare horizons and offers the opportunity to learn new skills. As in any type of practice setting, always ensure your decision-making and actions are based on a solid foundation of knowledge, skills, and abilities. Never hesitate to ask questions, seek clarification, learn as much as possible with capable teachers and mentors, and enjoy the journey.

Article By: Linda Laskowski-Jones, MS, APRN, ACNS-BC, CEN, NEA-BC, NREMT, FAWM, FAAN, is editor-in-chief for Nursing 2023.

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10 Healthy Habits for Your Brain

Two-thirds of Americans have at least one major potential risk factor for dementia. The need for effective risk reduction strategies to help all communities grows larger by the day. Without any change, the number of Americans with Alzheimer's could nearly double by mid-century and become unsustainable for our health system.

While some brain changes are inevitable as we age, there is a growing body of research to suggest that adopting healthy behaviors may reduce the risk of cognitive decline and help reduce the risk of dementia. For example, one study found that eating a large amount of ultra-processed food can significantly accelerate cognitive decline. Another study suggests that regular physical activity, even modest or low exertion activity such as stretching, may protect brain cells against damage.

"It is imperative that we encourage Americans of all ages to protect themselves from Alzheimer's and dementia through positive, everyday actions," said Erica Salamida, Director of Community Outreach of the NYS Coalition of Alzheimer's Association Chapters. "There are steps we can take now to help reduce the risk of cognitive decline later."

A recent poll reported that retired Americans fear developing dementia more than any other condition. Luckily, science is at the point where we know the habits that will help keep our brains healthy. Prevention is the best medicine for any disease and nurses are trusted messengers who can encourage people to take action. By following as many of these 10 tips as possible, individuals will achieve maximum benefits for the brain and body. This is true even for people who have a history of dementia in their families.

We encourage you to weave in these easy-to-understand brain health strategies into your daily interactions.

1. Challenge your mind. Be curious. Put your brain to work and do something that is new for you. Learn a new skill. Try something artistic. Challenging your mind may have short- and long-term benefits for your brain.
2. Stay in school. Education reduces your risk of cognitive decline and dementia. Encourage youth to stay in school and pursue the highest level of training possible. Continue your own education by taking a class at a local library, college, or online.
3. Get moving. Engage in regular exercise. This includes activities that raise your heart rate and increase blood flow to the brain and body. Find ways to build more movement into your day — walking, dancing, gardening — whatever works for you!
4. Protect your head. Help prevent an injury to your head. Wear a helmet for activities like biking, and wear a seatbelt. Do what you can to prevent falls, especially for older adults.
5. Be smoke-free. Quitting smoking can lower the risk of cognitive decline back to levels similar to those who have not smoked. It's never too late to stop.
6. Control your blood pressure. Medications can help lower high blood pressure. And healthy habits like eating right and physical activity can help too. Work with a health care provider to control your blood pressure.
7. Manage diabetes. Type 2 diabetes can be prevented or controlled by healthier eating, increasing physical activity, and medication, if necessary.
8. Eat right. Eating healthier foods can help reduce your risk of cognitive decline. This includes more vegetables and leaner meats/proteins, along with foods that are less processed and lower in fat. Choose healthier meals and snacks that you enjoy and are available to you. Make eating right a habit!
9. Maintain a healthy weight. Talk to your health care provider about the weight that is healthy for you. Other healthy habits on this list — eating right, physical activity and sleep — can help with maintaining a healthy weight.
10. Sleep well. Good quality sleep is important for brain health. Stay off screens before bed and make your sleep space as comfortable as possible. Do all you can to minimize disruptions. If you have any sleep-related problems, such as sleep apnea, talk to a health care provider.

"Research confirms what we have suspected for some time – people can lower their chances of cognitive decline with healthy habits," said Salamida. "If nurses can remind everyone that these 10 Healthy Habits can make a difference, we can turn the tide against the common factors that increase the risk for dementia. It's never too late or too early to take charge of your brain health."

To learn more, visit alz.org/healthyhabits

The Alzheimer's Association is available with information and support for families as they navigate the disease and related research. For more information, visit alz.org or call the 24/7 Helpline at 800.272.3900.

Caring for Older Adults with Obesity

Jennifer L. Pettis, MS, RN, CNE, director of strategic alliances, the Gerontological Society of America

Obesity is a chronic disease requiring interprofessional management that aligns with standards of care and clinical guidelines for all individuals, including older adults. Several years ago, the Gerontological Society of America (GSA) made a commitment to enhance the understanding among healthcare professionals, such as physicians, physician associates, nurses, nurse practitioners; policy makers; and consumers, including older adults and their care partners, of obesity and overweight and vital need for a person-centered, multipronged approach to effective care. GSA makes available a variety of obesity-related materials via geron.org/obesity including a flagship activity supporting primary care teams who seek to implement a comprehensive approach to help older adults with overweight and obesity recognize and care for their condition, *The Gerontological Society of America KAER Toolkit for the Management of Obesity in Older Adults*.[1] Additionally, we have an Obesity and Aging Interest Group that is expertly led by GSA members, Dr. John A. Batsis, a geriatrician and an associate professor in the Division of Geriatric Medicine in the School of Medicine and the Department of Nutrition in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill and Dr. Kathryn Porter Starr, a registered dietician and an associate professor at Duke University School of Medicine and a research health scientist at the Durham VA Medical Center. During the GSA Annual Scientific Meeting in November 2023, I had the opportunity to sit down and talk with these two colleagues about caring for older adults with obesity, and I am delighted to share excerpts of our conversation with you in this column.

Jen Pettis: Let's start by examining perceptions around obesity. Dr. Batsis, how well is obesity understood as a chronic disease by different audiences?

Dr. John Batsis: *I think this is a great introduction to the topic of obesity and weight in older adults. Obesity was designated as a chronic disease by the American Medical Association several years ago. The challenge is whether it has been implemented and accepted that obesity is a chronic disease by healthcare practitioners. That's the big question that we need to ask ourselves. Obesity needs to be viewed along the lines of hypertension, diabetes, high cholesterol, and other comorbidities. We need to consider obesity as a chronic disease, not as a failure of behavioral management among patients across the entire lifespan. It's about biology. Everybody is an individual, and, with each chronic disease, it's a biological basis of what triggers the onset of the disease.*

There is also a challenge in that different healthcare practitioners and physicians have different degrees of education in what obesity is, its causes, and how to treat it. In the past when I went through training, we didn't receive a lot of nutrition-related education. Thankfully, things are changing, and a first good step is obesity being recognized as a chronic disease.

We also have negative stigma and a lot of biases towards persons with obesity in our society. People with obesity are not lazy, in a position where they failed, or are unable to change their diet or exercise. A lot of people with obesity try to lose weight. We really need to think about how we target everyone individually. Everybody is different, and a one-size-fits-all strategy doesn't address this major epidemic. Individual strategies are critically needed.

Lastly, we know there are many racial and ethnic disparities in obesity care. A major component of this is access to care. Social determinants of care and recognizing that everybody has different backgrounds and areas of privilege compared to areas of non-privileged rural or urban areas. These are just some small examples, but these all impact the differences in the heterogeneity that we see in older adults' obesity. It's complex, and I think that's really a major take home point. There isn't one solution. It's really a multifactorial based solution.

Jen Pettis: Dr. Starr, how is obesity linked to other chronic health conditions and risks for functional decline and decreased independence in older adults?

Dr. Kathryn Starr: *As we're thinking about obesity as a disease, it's important for us to think about the biological components of obesity and other chronic health conditions and inflammation. Chronic low-grade inflammation is a major contributor to those associations with obesity, cardiovascular disease, insulin resistance, type 2 diabetes, and numerous other chronic health conditions. Considering the quality of the muscle as we're aging, coupled with the physiological changes that come with age, anabolic resistance is a concern. We know that we are going to see a decline in muscle mass, muscle quality, and function as we get older. It's naturally occurring.*

However, when we have an inflammatory component mixed in with the natural aging process, we know that it's going to contribute to a decline in function. Add to that excess adiposity and consider muscle quality and how it impacts the ability for the body and the muscles to function. There is going to be an impairment in us being able to do the activities of daily living and things that we love to do. As we consider the correlations with obesity and other chronic health conditions and functional decline, I think it is important to come back to the physiology that's happening in the body when there is excess adiposity. We're moving into this conversation about treating obesity as a disease, I think that really helps paint the picture that it's not about willpower. It's not about someone's just not trying hard enough or they're not willing to put in the effort or time. Let's think about it as a disease state. Let's think about how we can treat that with multiple modalities and understand that yes, there is a behavioral component to this, but that's one component that we must include in that conversation. I think multiple chronic conditions are another great area where we can home in as we continue this conversation around obesity as a disease state.

Dr. John Batsis: *I really want to hit home what Dr. Starr just shared. It's about biology, and, only in the last 10 to 15 years, have really gotten a great understanding of the biological basis of obesity itself as a disease. Once we understand that, then we can target biology. Some of the newer medications, some of the strategies are really affecting underlying biology. Clinicians can address the underlying biology with adjunctive types of therapies.*

Jen Pettis: Dr. Batsis, you mentioned earlier about different racial and ethnic groups, and I wonder if you can tell us a bit about prevalence of obesity in older adults between some different groups. There is a significant issue in health disparities between urban and rural populations. Could you comment on that as well as ethnic and racial differences?

Dr. John Batsis: *First and foremost, we need to think about how we define obesity. Particularly in older adults, that is a major challenge. In clinical care, we frequently use body mass index (BMI). We know that as one ages their height and body composition changes, and we lose muscle mass and muscle strength with age. This really changes the ratio of weight over height in meters squared. Body mass index is not a great indicator for adiposity in older adults. We know that its diagnostic accuracy diminishes as people age. Waist circumference is probably a better indicator. Using both is probably even better as an indicator.*

I just want to mention a couple of caveats. Our healthcare system is not able to measure body fat in everybody, at least at this stage. Most estimates use body mass index for good or for bad. It's just the way it is from a population-based standpoint. Depending on the survey that's used, for instance the National Health and Nutrition Examination Survey, both in males and females using body mass index of over 30 kilograms per meter squared, the prevalence of obesity in the United States is approximately 42% to 43%. Seventy percent of our population over the age of 18 are classified as having obesity or overweight. This is a true public health epidemic. Irrespective of the challenges that we've had over the last couple of years with COVID-19, some of the long-term estimates have shown that our life expectancy is starting to be affected.

When you do a deeper dive into different populations at risk, a lot of developing countries are now assuming a lot of industrialization. We see a lot of their rates increasing in urban versus rural settings, which is where we see disparities. Much of that is about healthcare access challenges. Disadvantaged communities include tribal communities. They have poor access to care and fewer resources than others, and their rates of obesity are much higher alongside other chronic conditions. Every population has different targets in terms of potential causative reasons. Someone in rural North Carolina versus in rural Florida; one rural is one rural is one rural. You can adapt that according to every type of demographic. There are a lot of similarities, but there are a lot of differences, and we really need to be understanding some of these health equity issues.

Jen Pettis: Dr. Starr, this seems like it might be a simple question, but I suspect it's not. Why is it so important to intently address obesity in older adults?

Dr. Kathryn Starr: *We know that our older adults are very heterogeneous. When we are working with our older adult patient population, we have the saying, "when you've seen one older adult, you've seen one older adult." It's not just the physiological changes, it's the social determinants of health that are included in the factors that promote obesity. It's the education, it's the racial differences, it's the ethnic differences, it's the trauma potentially from childhood that's not been dealt with. There's just so many components included in how we're thinking about obesity and how we're thinking about the treatment of obesity. Consider how society views food. Food is social, food is love, food is gathering, food is celebration, and food can be sadness. There's also this other relationship that we have when we're thinking about the relationship we have with food, and that is the individual. We must put that into the model.*

When we're thinking about the biology of aging, the social determinants of health, giving education about proper intake and what your energy needs are, how we're treating this with another chronic health condition, and then how we're dealing with some of the psychological components, this cannot be tackled by one person. The primary care provider cannot be the one person who's helping to treat and manage and work on this obesity treatment management while maintaining our patient-centered approach with the individual. I think that our healthcare system is not necessarily built for that interprofessional approach to care for obesity. We have seen this interprofessional approach work in bariatric surgery models, and we've seen it work in cancer models. We've seen it work in other chronic health condition models. I know that we can make this work.

We must tackle this; this is an epidemic. We're talking 70% of the population is in that overweight category. It's just going to continue to become a problem that we must address. It's not just a quick fix. We really do have to tackle this from all these angles, which is why it must be with intent. The other major component is meeting our older adults where they are and bringing them into this conversation. We need to be their partner alongside them in this process rather than imposing a treatment plan on them. We need to discuss what is the plan that we're going to be working on together? What is the interprofessional plan and how do we continue that continuity of care? It's not a 15-minute visit; it can't be. I think we're trying to treat it as a 15-minute visit, and that's why we're not really seeing a lot of movement here in obesity management and treatment.

Dr. John Batsis: *I think that's exactly the fundamental issue, Dr. Starr. You can't do this in 15 minutes. Older adults come to the primary care clinician with their list of six or seven items during a 15, 20, even a 30-minute visit. They're not going to get to number six or seven, which is often where weight and weight-related health promtion is on their list. They are more worried about their knee pain, they're more worried about their shortness of breath, their waking up and being exhausted, which may all fundamentally be part of the obesity itself, but it's lower on their list and it's lower on the provider's priority list.*

From a patient standpoint, we need to meet the patient where they are, and, from a primary care standpoint, there is an infrastructure challenge. I think a huge infrastructure challenge, which regrettably or not comes full circle to reimbursement, because that's what our system is all about. We predominantly have a fee-for-service rather than value-based care. We haven't even

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touched upon the surface of community-based resources here. It's like a hub and spoke model where the PCP can potentially be the coordinator, but they really need a team. That is a key point – obesity care requires a team approach.

Jen Pettis: The assessment piece is so important. Older adults themselves need to be included as part of that interprofessional team as the team begins to support the older adult on their weight loss journey. What are some key tenets of that assessment that PCPs and others need to consider, Dr. Starr?

Dr. Kathryn Starr: *The geriatricians and gerontologists in the room are always going to come back to what matters most to the older adult. That's fundamental in what we're taught and in how we work with older adults. However, that is not fundamental across the board with all clinicians. The older adult must be at the forefront, as we said, and the interprofessional team needs to always think about what matters most to them. What about mobility? What are the 4Ms? In addition to what matters most and mobility, it is medications and mentation. And, we can add the 5th M: multicomplexity. We need to consider how all the 5Ms impact the older adult and how they also cross over into obesity treatment and management. There is a component for each of those. Obesity treatment may significantly improve mobility. We know there is a connection between obesity and cognition – research shows us that obesity is a risk factor for dementia. We also know that so many chronic diseases are inextricably linked to obesity. From an assessment standpoint, we need to put the older adult first and make sure that we're all on the same page and that our goals make sense. We need to meet the older adult where they are.*

We also need to think about sarcopenia and how we measure the loss of muscle function and loss of muscle strength. We might evaluate speed, hand grip strength, or chair stands. We need some form of a functional component in there so we can truly capture their functional status. One of the other things that I think is also paramount to this is making sure that we know where the person's at in this process. This is not just a quick fix. This is going to take time, and this is going to take some work, but it takes work from the entire team.

I love what Dr. Batsis said about creating this hub system where we have these resources, such as community-based organizations, out there available for an older adult if we identify they have a need such as food insecurity. There needs to be cross-communication between the PCP, the registered dietician, the community-based organization, and the social worker. It's important to know when a social work consultation is put in because we see that there's food insecurity, then we can confirm that they received the meal.

From an assessment standpoint, what is the patient's functional status? How are they moving? How does that quality muscle mass look? As we're thinking about treatment options, are there some community-based organization resources that we can refer people to? Are we identifying those social determinants of health that we need address? From the treatment component, if we're prescribing diet and exercise, do they have the resources to do this? If they do not, where are those resources? How do we get those resources and how do we have those conversations? Assessment is crucial. I think when we're thinking about assessment, we often have those blinders on and we're just thinking BMI, body composition, waist circumference, and it's so much more than that. We've already covered all those things. My thoughts around this idea are about having this comprehensive assessment, which can't be done in 15 minutes. It's going to have to be across disciplines, across professions, and coordination of that care and communication of care.

Dr. John Batsis: *This comprehensive assessment really needs to incorporate core geriatric principles. That includes thinking about geriatric syndromes as well as the social behavioral components. A comprehensive geriatric assessment can't be done in 15 minutes. How are you going to be able to do all this all at once? Our annual wellness visit is a great chance to incorporate some of the core geriatric assessments and functional assessments important in managing persons with obesity.*

Jen Pettis: I'd like to spend our remaining time together talking about treatment plans and the full continuum of obesity care options that are available. Dr. Starr, would you address dietary and physical activity interventions? One thing that comes to mind here – and I'd love to hear your thoughts on what we need to do differently – is when an older adult has pain in their knees and needs that knee replacement and the orthopedist tells them that they must first lose 20 pounds. How does someone like you help them meet that goal safely and effectively with these interventions?

Dr. Kathryn Starr: *It's such a great question, and we see this all the time. We see an individual who is really in a lot of pain; however, they're an individual with obesity, and the surgeon is not willing to take them to the operating room until they've lost weight. What I see happening in my clinical setting is the individual who has then really reduced their dietary intake and really focused on trying to get to a specific BMI level because they want their surgery so they can move without pain. We are seeing this loss of weight, but it's loss of muscle mass and function. By the time I'm getting them in there, they're often not even able to get up out of a chair. We need to improve the communication part of this. We must make sure if we're telling someone that they must lose weight to get a treatment, they are given the resources along guidance and consulting so that they can lose weight safely.*

One of the key things that I do in my clinic, and what I have done with my orthopedic surgeons is really talk to them about, "Hey, I understand that this is the requirement that we have for surgery. How can we work together?" If we have somebody, they're now putting in a consultation for a registered dietician so that we can see the patient and help them with that weight loss safely. We help them with that weight loss in a way in which we make sure that they're getting adequate protein, they're getting enough micro and macronutrients, and that we're doing that in a safe environment so that when they do lose that weight, they're going to be able to go into the operating room and they're going to be able to get back to that functional baseline status more quickly.

One of the key concerns is making sure that we're not just telling people they need to lose weight or move more. We must be more purposeful with our comments because older adults are listening to what is being told to them, especially if pain is on the line. They're going to do something to get out of pain. From a lifestyle intervention perspective, there are several things that we must think about. I constantly focus on muscle physiology because it just helps me really capture that ability to think about what's happening to the muscle. We need to focus on what we need to do so that they can have that movement and keep that mobility so they can keep that functional status and their independence.

I want to make sure that we're thinking about muscle with weight loss and one of our focuses is not to just promote movement, but to promote purposeful movement. It's about doing strength training so that we can truly help keep that muscle mass as strong as possible, especially when we're thinking about weight loss. Regardless of weight loss, we really do need to be thinking about strength training. Unfortunately, only around 20% of older adults are doing any form of strength training exercises. From a nutritional and dietary standpoint, we're really thinking about making sure that they're meeting micro and macronutrient intake, but also making sure they're getting in that protein intake and doing anabolic resistance to building muscle mass. Resistance training is important for stimulating muscle protein synthesis, and that is something that we consider when we're thinking about older adults and protein intake, especially when we're thinking about weight loss. Finally, we do need aerobic exercise. It's a combination of all three of these making sure that we have a purposeful diet that includes high quality protein and making sure that we're thinking about not only aerobic exercise, but also resistance training so we can really maximize muscle health and help these individuals lose weight in a way that they can keep that muscle mass as much as they possibly can.

Jen Pettis: You mentioned earlier about potential trauma someone might have experienced in the past and other things that might be contributing to their obesity or their overweight. Can you comment a bit on psychological and behavioral services for an older adult when they're on this journey?

Dr. Kathryn Starr: *Absolutely. When we consider substance abuse disorders, and we go to the literature around addiction and substance abuse, the psychologist is one of the key players in that, because this is something that we should find the root cause of to start the healing process. A lot of times the psychologist is not a part of the weight loss journey or the weight management journey, and it should be because we have ties to food.*

If we've had some trauma or if we're using food to fill something inside of ourselves, we really have to work on that regardless of what treatment we do. If we're not fixing that internally, there's going to be another void that must be filled and it's going to be filled with something else.

Having the psychiatrist on board is such a crucial component. I think they're frequently missing on the team when we're putting together who is on the team for obesity treatment and management. They really do need to be a part of that conversation so that we can really help. One of the great models is the VA Move Program. It includes an exercise physiologist, a registered dietician, and a psychologist. All three of those working together to really help change behavior, educate, and work through some of the components that might be dealing with trauma or psychological connections that we're utilizing food to fill a gap.

Jen Pettis: Dr. Batsis, the last question is for you. What are the roles of pharmacological and surgical interventions in care for older adults?

Dr. John Batsis: *I was waiting for that question, Jen, and it's not a short answer unfortunately, but I'll try to summarize it. We have all been exposed to a plethora of new anti-obesity medications, particularly the GLP-1 agonists. Another one was approved just earlier this week. I think there's a lot of promise with these medications. The clinical trials have really demonstrated significant amount of weight loss in these populations. As with any clinical trials though, you really want to dissect the studies. You want to see what, where, and with whom were these clinical trials done, in terms of what was the patient population and what were the characteristics of those patients. Very few trials have had a significant number of older adults in their cohorts. There are some older adults included, but most participants are not older adults.*

That's first and foremost. Why is that important? Circling back to our earlier conversation, the biology of an older adult is very different than the biology of a 20, 30, 40 or 50-year-old. We need to be very mindful of that. That's not to say not to use these medications, but that's not to say we should completely use them in everybody. They should be considered as adjunctive therapies to lifestyle therapies of improving dietary quality and aerobic and resistance exercise. The reason for that is the weight loss that is observed with these GLP-1s is particularly high. It's almost on par with what you see with bariatric surgery. We know from the bariatric surgery literature, when you lose weight, you're losing both fat and muscle. This comes back to the issue of weight loss induced sarcopenia. We haven't even talked about the effect on bone, but that's a discussion for another day.

How do we mitigate that and who are the appropriate candidates? I would love to say I have good evidence for you, Jen. But there are minimal studies of looking at body composition changes in older adults because of these medications. We know that weight loss on its own without aerobic and resistant exercises leads to a disproportionate reduction in muscle mass. Individuals who are on these medications should probably be well positioned to undergo a structured exercise routine, whether they should be initiating that at the time of the medication or not is unknown. The hope is that they have been engaging in changes in their diet and exercise. They have that foundation, and then you're adding on top of that the GLP-1, so you're not starting an exercise routine de novo. I think that's what I'm afraid of in this population.

From a surgical standpoint, there's been more literature on older adults but with a lot of methodological challenges in the literature. How do you define older adults? Is it age? Is it functional status? The type of surgery is important. Is it open versus laparoscopic? Cognition and social support are also factors. You're hearing a lot of the same themes, comprehensive geriatric assessment in the evaluation of our patients.

Jen Pettis: I think that is a great place to end our discussion: Quality obesity care for older adults starts with comprehensive geriatric assessment. Thank you, Dr. Starr and Dr. Batsis, for joining me today and for all your contributions to our obesity work at GSA.

During our conversation, Drs. Batsis and Starr highlighted so many important points about quality obesity care for older adults. Unfortunately, barriers to older adults accessing this care remain. In fact, in June 2023, GSA convened 15 multidisciplinary leaders in a roundtable discussion to examine these barriers and propose solutions. With a presentation at the GSA 2023 Annual Scientific Meeting, Drs. Batsis and Starr along with

their colleagues, identified seven strategies, listed in Box 1, to address barriers to quality obesity care for older adults.[2,3]

As nurses, we are well positioned to implement steps that address these barriers. For example, nurses can assess healthcare environments and lead changes that will ensure that the environment is welcoming for and accommodating to people of all body sizes. Similarly, they can lead the way in using person-first language when referring to all people in their care. For example, rather than referring to an obese person or a diabetic, they refer to a person with obesity or a person with diabetes. These are but two examples. However, I challenge readers to review the action steps in Box 1 and consider them a call to action to ensure that all individuals with obesity, including older adults, receive evidence-based quality care delivered with respect.

If you have any questions about what you learned in this column or wish to share your thoughts about it, please reach out to me jpettis@geron.org. Please find all the freely available obesity resources from the Gerontological Society of America at geron.org/obesity.

GSA receives support from Novo Nordisk for The Gerontological Society of America KAER Toolkit for the Management of Obesity in Older Adults. Novo Nordisk also supported the round table discussion.

References
1 Gerontological Society of America. The Gerontological Society of America KAER toolkit for the management of obesity in older adults. 2022. geron.org/obesity.
2 Batsis JA, Lofton J, Pendrey A, et al. Addressing barriers to a full range of evidence-based obesity care for older adults: a GSA roundtable discussion. *Innov Aging.* 2023;7(Supp 1): 984. https://doi.org/10.1093/geroni/igad104.3162
3 Batsis JA, Lofton J, Pendrey A, et al. Addressing barriers to a full range of evidence-based obesity care for older adults. Poster presented at GSA 2023 Annual Scientific Meeting November 8 – 12, 2023; Tampa, FL.

Box 1: Addressing Barriers to Accessing a Full Range of Evidence-Based Obesity Care Options by Older Adults

- Inform and educate about obesity as a chronic disease requiring care across the life span.
- Address weight bias and stigma among health providers and the public.
- Use person-first language when referring to someone who has obesity.
- Engineer environments of care to accommodate people of all body sizes.
- Respect and honor cultural considerations about body size.
- Ensure access to the full range of care for older adults with obesity: diet, exercise, behavioral modification, and medical and surgical interventions.
- Incorporate an interprofessional, evidence-based approach to caring for older adults who have obesity.

Meet Dr. Candy Campbell, one of our featured speakers at the 2024 Annual Conference at The Sagamore Resort in Bolton Landing, NY.

Candy is an award winning actor, author, filmmaker and motivational speaker. Initially, she earned a BA in Theatre/Acting, then transitioned into nursing, where she adopted the persona of Florence Nightingale. Florence Nightingale is the founder of modern nursing and became an icon of "The Lady with the Lamp." Continuing Florence's social reforms to improve healthcare, one of Candy's books is Improve to Improve Healthcare: A System for Creative Problem-Solving.

Join us to hear her invigorating speech about The Nurse Innovator - Florence Nightingale at our 12th Annual ANA-NY Conference for this unique opportunity!

Meet Mark Nelson, one of our featured speakers at the 2024 Annual Conference at The Sagamore Resort in Bolton Landing, NY.

Mark is currently the Executive Director at Association of Payment Professionals. Mark is an enthusiast about AI and the innovative, emerging trends being implemented.

Enjoy an uplifting presentation about AI Applications in Healthcare at our 12th Annual ANA-NY Conference for this unique opportunity!

MEMBERS ON THE MOVE

Anita Nirenberg, PhD, RN, AOCNP (ret), FAAN, WR Hearst Professor of Clinical Nursing Emerita, Hunter College and Graduate Center, City University of New York, received the **Founders Award from the Children's Brain Tumor Foundation** for 35 years of membership on the Board of Directors.

Dr. Nirenberg was inducted into the Academy in 2013. She is a member of the Bioethics and Genomic Nursing and Health Care Expert Panels.

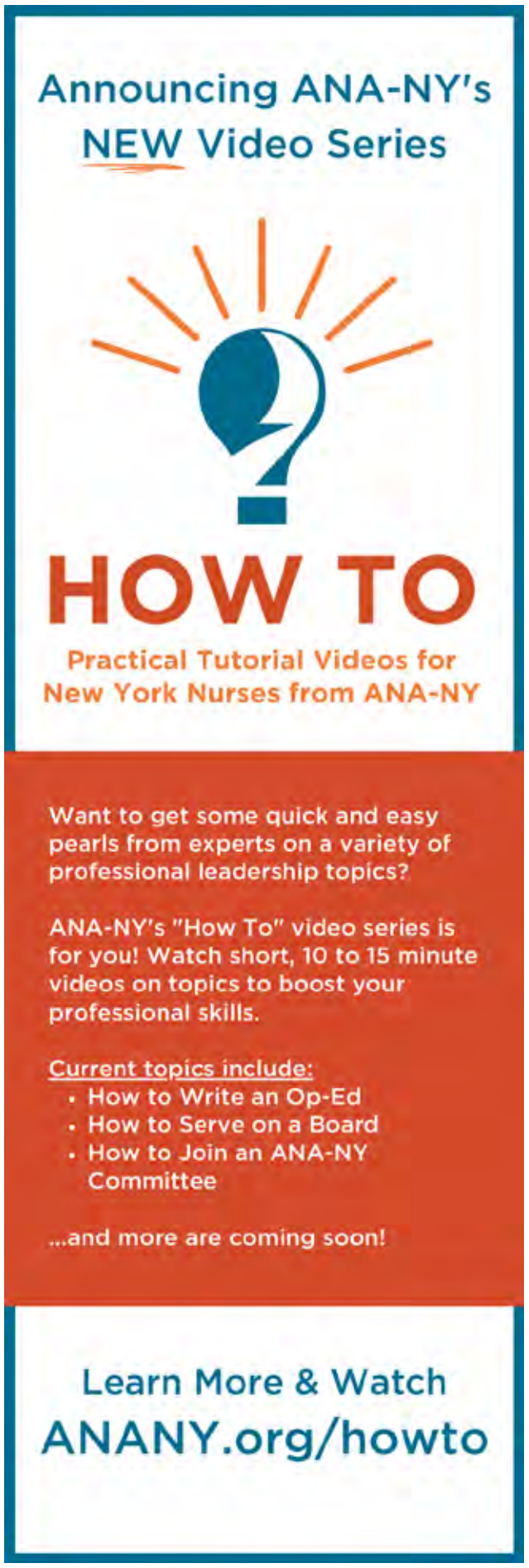
Billy Rosa, PhD, MBE, APRN, FAANP, FPCN, FAAN, Assistant Attending Behavioral Scientist, Memorial Sloan Kettering Cancer Center, has been appointed **Editor-in-Chief** of ***Psycho-Oncology***, the official journal of the American and British Psychosocial Oncology Societies.

Dr. Rosa was inducted into the Academy in 2018 and has been a CANS member since 2022. He currently serves on the Global Nursing and Health, LGTBQ Health, and Palliative and End-of-Life Care Expert Panels.

Read the recently published Op-Ed piece by Dr. Toby Bressler:

https://www.statnews.com/2024/01/12/nurse-manager-staffing-crisis-hospitals/

Our Executive Director, Dr. Jeanine Santelli was recently appointed to the Commission on Collegiate Nursing Education Accreditation Review Committee.



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Tjada Garvin Wheatley Heights
Bryan Keane New York
Nicholas Picard Amityville
Sarah Waldman Brooklyn
Matthew Murphy Fishkill
Oluneye Oladapo Baldwin
Christine Aiken Glens Falls
Norma Donohue Lindenhurst
Sabrine Laue New York
Michelle McNair Bronx
Andrea Smith Yorktown Heights
Jacquelyn Kreason Rochester
Adriana Omeroglu Glendale
Amanda Johnson Fairport
James Peabody Farmingville
Michelle Gilbert Conesus
Emily Ross Skaneateles
Igor Beytelman Brooklyn
Anne Kim Forest Hills
Jody Beaudoin Beaver Dams
Katrina McMahon Rockaway Park
Erin Lynch Sag Harbor
Danielle Curry Bay Shore
Nicole Wallace Manorville
Marianne Jaffa Rockville Centre
Jacklyn Kelly Sea Cliff
Jalisa Saud Jamaica
Amanda D'Amato Staten Island
Denise Harris Rochester
William Vaughn East Berne
Solitaire Branch Port Jefferson Station
Lisa Santiago Yonkers
Sarah Hughes Richmond Hill
Lynn Segerivas Babylon
Jill Bernhardt Fairport
Ifeoma Awaka Pleasant Valley
Denise Daly Waccabuc
Miyaseki Paragas Fresh Meadows
Tiffany McAuliffe Scarsdale
Mariela Mata Lopez Forest Hills
Aman Asous Staten Island
Precious Ekeh North Babylon
McKenzie Sheldon Rochester
Nicholas Spak Rome
Gail Donovan Kew Gardens
Aaron Sylvester Brooklyn
Catherine Michels Patchogue
Susan Iuliano Lackawanna
Amy Jones Addison
Loredana Delventhal Lagrangeville
Rickell Gordon Rochester
Alasia Amos Newburgh
Lofton Crooks Florida
Bernadette Jean Brooklyn
Christine Deritis Honeoye
Kameca James Fleetwood
Okwuchukwu Udemba Saint Albans
Ugo Oji Pomona
Mary Godineaux Brooklyn
Sheree Hall Auburn
Claudelle Raymond Hempstead
Kelly McGarrigle Staten Island
Kathleen Malizia Scotia
Kristen Martin East Rockaway
Rosanne Hilliker Albany
Chante Post Hilton
Leah Avino West Seneca
Jennifer Garib Brooklyn
Tameka Hall Lee Yonkers
Cindy Nabeejat South Ozone Park
Marsha Sinanan Vasishta Irvington
Marlena Hanington Albany
Helen Bedua Bronx
Iliana Quinones Bronx
Ray Sukhu Ozone Park
Michele Guayara Peekskill
Mia-Knoll Santos Hollis
Ismeric St Hilaire Brooklyn
Waseem Sheikh Syosset
Deborah Louis Queens Village
Susan Vallach-Trossello White Plains
Annmarie Spinella Holbrook
Emily DePrimo Yorktown Heights
Anna Sanders Brooklyn
Nwamaka Eze Arlington
Evelyn Fidman Staten Island
Lisa Waddington Howard Beach
Carol Dunson Hempstead
Allison Murphy Valley Stream
Anna Conte Lancaster
Christina Larocchia Bellmore
Sarah Swenson Williamsville
Caroline Goldstein Staten Island
Candida Saagber Westbury
Ellen Powers Syracuse
Sangeetha Madhu Deer Park
Joanna Brock Bloomingburg
Erin Springer Remsen
Jessy John Albany
Nikolaos Kontogiannis Endicott
May Tong Brooklyn
Yuri Pashchuk Syracuse
Isabelle Lombardi Webster
Mackenzie Hollister Huntington
Yehuda Shoob Brooklyn
Jeff Owens Brooklyn
Melissa Prechtl Clifton Park
Kathleen Tanney West Winfield
Karen Rosier Williston Park
Megan Tebo Hilton
Brittany McClain New York
Alyssa Politoski Manhasset
Lauren Hanamy Floral Park
Michelle Diaz College Point
Cinzia Sacchetti Mamaroneck
Kevin Johnston South Setauket
Erica St Pierre Long Island City
Alana Aissa Gem Barias Putnam Valley
Hannah Weinstein Coxsackie
Darien Raggobeer Staten Island
Trinita Yegnon Washingtonville
Geoffrey Mei Bayside
Veronica Franklin Simon Jamaica
Amber Mori New York
Meredith Casey Catskill
Catherine Lauerman New York
Kathia Duverne-Douyon Farmingdale
Colette Alvarado Ronkonkoma
Annmarie Martinez Yonkers
Andrea Reyes Barragan Congers
Nabeeha Shihadeh Yonkers
Kailee Reiss Patchogue
Casey Gallagher-Licitra Lansing
Carine Desrouleaux Cambria Heights
Lilian King East Islip
Joanna Fritze-Jeremie Schenectady
Julie Ann Tagarao Astoria
Mary Truesdel Middletown
Ashley Reynolds Miller Place
Jenifer De Leon Island Park
Alexandra Barlatier Valley Stream
Jannes Suson Woodside
Talis Sherriffe-Higgins Rensselaer
Denise Valiente Astoria
Mave Tzall Brooklyn
Natasha Wynter Spring Valley
Thyais Clerge Jamaica
Jesus Rey Arboleda Valley Stream
Christina Yusko Port Chester
Tyler Gadway Malone
Dee Dee Rutigliano Geneseo
Ashley Hunter Central Square
Doris Billingham Troy
Rose Voyard Wheatley Hts
Diana Morgan-Almonte White Plains
Shannon Higgins New York
Anne Quinn Rockville Centre
Desrene Roberts Mount Vernon
Andrew Tallon Eastport
Dr. Yolonda Lee North Tonawanda
MARIE Dabel Brooklyn
Inessa Goldshteyn Brooklyn
Anne Barry New York
Steven Zhu Brooklyn
Melissa McCarthy Greenlawn
Melvin George Amityville
Mahuwa Mukherjee Schenectady
Samantha Grillo Setauket
Helen Prestage Pearl River
Julia Segretto Bethpage
Dajah Plummer Cambria Heights
Irene Auteri Brightwaters
Damaris Monsalve North Baldwin
Johanna Martinez Brooklyn
Gabrini Leblanc Centereach
Alana Stillman Auburn
Elvia Sandiford Brooklyn
Nili Shuah Greenvale
Marlen Abramova Forest Hills
Maryann Ku Woodside
Heidi Schrader Holbrook
Jennifer Pagano Hawthorne
Christine Orana Mount Vernon
Mariam Belem Bronx
Ashley Cuoccio East Northport
Catherine Petitti Eastchester
Maria Valcarcel Shirley
Sophia Valdez East Elmhurst
Anne Lamora Rensselaer
Ivy Joy Balocating Cooperstown
Eve Zrihen Woodmere
Karen Almonte Bronx
Shanice Mann Brooklyn
Andrew Assli Brooklyn
Rihua Xie New York
Mary Lorally Palarpalar Yonkers
Francesca Valenti Oceanside
Jeanette Garcia Otisville
Michelle Rojas Wappingers Falls
Devonia Edwards Amityville
Shalu Thomas White Plains
Oluwafisayo Benson Spring Valley
Tara Clement Brooklyn
Lesley Deoliveira Brooklyn
Carol Ortega Mahopac
SHANIQUA Buntley ROCHESTER
Joyce Jazmines Centereach
Erden Mernica Bronx
Paula Guimaraes De Sa New York
Priscilla Garcia New Rochelle
Alyssa Coffey Batavia
Samantha Fernandez New York
Cayla Fendick Binghamton
Crystal Zamora Ozone Park
Sharon Curtis Valley Stream
Kelly Logan Galway
Rebecca Clarkin Gloversville
Lisa Maneggio North Bellmore
Alyssa Germaine Massapequa Park
Danielle Massaro Wantagh
Atifa Alieva Brooklyn
Kate Huang Oakland Gardens
Grace Chang Oakland Gardens
AMANDA R Luiso Ardsley
Judene Colthirst Albany
Judy Liu New York
Guo Hua Zhang Elmhurst
Alyssa Tygh New York
Karan Tohaan Glen Oaks
Amy Armstrong Lancaster
Emily Cotter New Hyde Park
Rayniel Martinez Pichardo Bronx
Uzair Qazi Astoria
NANCY Rizzuto Brooklyn
Susan Anello Maryknoll
Gianila Desir Brooklyn
Starlyn Fabian Caceres Bronx
Jessica Cropo Rochester
Holly Shaw Glenwood Landing
Genny Nunez North Baldwin
Lindsey Wind Olean
Jasmyn Moore Bronx
Dawn Pickett Jamestown
Denise Chevalier Brooklyn
Darlene Parham Brooklyn
LEONA Brophy New York

WELCOME NEW MEMBERS

Ryan Martin Lockport
Tonya Blackburn Winthrop
Keith O'Connor Valley Stream
Sherelle Mullings-Liverpool Brooklyn
Mercy Kollek Briarwood
Victoria Walters New York
Stephen Marcotte Syracuse
Sherley Fils-Aime Elmont
Elizabeth Sierra Elmont
Nicole De Vries Brooklyn
Ashley Rogers Cadyville
Heather Miller Liverpool
Verona Henningham Rosedale
Shannon David Rockaway Park
Jennifer Ryan Merrick
Christine Dawson Smithtown
Catherine Bell West Islip
Brenda Uraga Richmond Hill
Stephanie Fiore Yorktown
Sheila Lopez Highland Mills
Carmen Hope Islip
Denise Smorto New York
Afifa France Gansevoort
Ka Hogan New York
Stacey Dabel New York
Tracy Finke Liverpool
Alex Varenko Yonkers
Claire Clark Astoria
Alexandra Alexander Brooklyn
Angela Stormo Rochester
Nicole Kirchhoffer Staten Island
Katie Smith Allegany
Debra Harry Brooklyn
Alyson Marazzo Katonah
Raquel Griffith Brooklyn
Justine Geisler Walden
Melissa Chau Jericho
Teresa Klapak Levittown
Paige Hammond Bemus Point
Chioma Goodluck Bronx
Bilal Haroon Ossining
Courtney O'Brien Bronx
Natalie Coburn Brooklyn
Latasha Hanley Mount Vernon
Jennifer Quednau Saugerties
Kyle Owens Brooklyn
Sandy Ye College Point
Genya Spektor Brooklyn
Kelly Grande Nanuet
Kathleen Hetsel Kings Park
Mary Blaize-Williams Valley Stream
Antonella Oberst Bellmore
Maryellen Thierfelder Oakdale
Rachelle Pierre-Louis Hollis
Emily Kingston Plainview
Maureen Cline Buffalo
Jennifer Udoff Airmont
Supaporn Pathumanon Bronx

Kellie Mickel West Seneca
Mary-Elizabeth Cass New City
Karin Rodriguez Rockville Centre
Cassandra Wolniewicz Amherst
Joanna Saporito Hicksville
Katie Morgan New York
Tara McCarthy Lynbrook
Meghan McGuigan New York
Julian Cuesta Port Jefferson Station
Anne Marie Channer New York
Trudy Kelly Cohoes
Janeth Daley Brooklyn
Darcel Reyes Yonkers
Kaylin Cottone Rochester
Paige Simpson Center Moriches
Zoraida Sebastien New York
Ruth Sagesse Brooklyn
TASHA Peebles Bay Shore
Nicole Luisi Staten Island
Mary Angel Madriaga Middle Village
David Johnson II Geneva
Bella Nisimova West Nyack
Thalia Mendes Mineola
Kim Chelsea Palomares Mineola
Brooke O'Neill New York
Erin Bartran Waterloo
Veronica Bisson Stanfordville
Jessica Ruta Great Neck
Nichole Michelle Riehm Mohegan Lake
Rachel Glennon Wappingers Fl
Kayla Ford North Baldwin
Ryan Erickson Long Beach
Lijia Zhang Westbury
Melissa Berrios Oceanside
Vanessa Cole Bronx
Raegan Ferro Brooklyn
Kaleena Soorma Brooklyn
Helen Mayhew Schenectady
Jennifer Corbin Brooklyn
Morenikeji Adetula Brooklyn
Benizia Bastidas Middletown
Margaret McCarthy Tuckahoe
Kristen Jaenicke Staten Island
Deslyn Erhabor Brooklyn
Jolie Zimmerman Oceanside
Kelsey Baffour-Addo Elmont
Joy Evoh Yonkers
Linda Stahura Westbury
Mojisola Obaweya Brooklyn
Bevin Cohen Bronx
Itztla Gutierrez-Hamilton Brooklyn
Margaret Divens Fairport
Omesh Khemai South Richmond Hill
Ashlee Houser Poestenkill
Amanda Beard Buffalo
Tashana Fowler Brooklyn
John McKeever Coram

Loida McKeever Coram
Deborah Lugo Port Jefferson Station
Rafaela Herrera Uniondale
Annmarie Osbourne Mastic
Brunette Guervil Queens Village
Sarah Ortiz Woodhaven
Mary Roese Schoharie
Nicole Zweck Whitney Point
Sarah Rusher Merrick
Irina Kondrateva Brooklyn
Courtney Thompson Brooklyn
Emily Shkreli New York
Jessie Mascho Sprakers
Evens Pierre Elmont
Rocio Kalina Port Chester
Cherrie Bridgeman Deer Park
Michele Scally Hudson Falls
Courtney Escalera Hilton
Michelina Halpern Deer Park
Joseph Barachina Bronx
Nicholas Cona Brooklyn
Lisa Gaughan Suffern
Kwana Valdes New York
Kerry Hulihan Prospect
Jenna Yager Little Falls
Euvin Weeber Greenwood Lake
Christine McNally Huntington Station
Sabrina Wheatley Elmhurst
Kimberly Zoulas Schenectady
Nataliia Miranda Staten Island
Priya Mathews Hopewell Junction
Rosemary Reyes Massapequa
Marissa Smith North Bangor
Jennifer Lopez-Mazariegos Auburn
Ana Cruz Jara Yonkers
Nicola Kennedy Hempstead
Carla Ferraccioli Binghamton
Felicity Fernandez Brooklyn
Lydia Saint-Louis Brooklyn
Lucas Spencer Cooperstown
Julia Pilat Rochester
Maritza Clerine-Hung Baldwin
Anna Marin Bronx
Phillip Fiorello Tonawanda
Faydine Richards Bronx
Maria Grand New York
Susan Asabor Elmont
ELINORE Ioan Merrick
Michael Lively Levittown
Lori Buschofsky Albany
Jane Mcgrath Garnerville
Buenaventura Mora Glen Cove
Joel Overton Bronx
Robin Vines Hempstead
Hasmin Sinchioco Glen Cove
Magdala Howard Brooklyn
Rosa Murria Bay Shore
Alycia Costanzo Hemlock

Randy Yhap Staten Island
Jennifer Valletutti Staten Island
Brittany Toth Corinth
Jo-Anne Williams Inwood
Laura Fusco Carmel
Janelle Post Buffalo
Jennifer Gecaj Cortlandt Manor
Julia Mazurak Bedford
Angelica Demarco Greene
Tara Cortes New York
Nicole Albanese Deer Park
Olivia Cisneros Port Washington
Sheree St. Ivey Medford
Robi Zarex Baisas Bronx
Christina Schwenker Holtsville
Cynthia Knudsen East Setauket
Nicoletta Capizzuto Yonkers
Chaneisse Reaves Rochester
Marlene Brynes Hartford
Saein Lee Long Island City
Ericka Fernandez Staten Island
Debra Kelly Wurtsboro
Evette McDonald Bronx
Alexandria Burns Buffalo
Melba Abatayo Albany
Emmanuella Gbeneku Cambria Heights
Leah Pierre-Louis Brooklyn
Catherine Parvel Marcellus
LINDA Fox Saratoga Springs
Moira McGinn Brooklyn
Cynthia Pascaretti Ulster Park
Christine Cox East Aurora
Kathleen Boyle Warwick
Susan Wyman Glens Falls
Robin Allen New City
Jill Ryan Massapequa
Edwidge Thomas Cortlandt Manor
Alycia Jarvis New Rochelle
Deborah Walker Huntington
Diane Carlson Port Jefferson Station
Sonia Thomas West Nyack
Rachael Stacom New York
Flora Antwi-Miller Chestnut Ridge
Pamela Douglin Harris Springfield Gardens
Ashlyn Arthur Springfield Gardens
Leslie Worona Staten Island
Magdalena Zavala Woodhaven
Marva Frederick Cambria Heights
Jennifer Santoro Plainview
Robitha Panamdanam Cortlandt Manor
Chefei Tam New York
Chefei Tam New York
Tina Sadarangani Larchmont
Caroline Doe Rotterdam
Jennifer Moses New York
Galina Bukhgalter Brooklyn

S. Raquel Ramos New York
Wanda Mayo-Robinson Rye Brook
Doris Fernandez East Meadow
Sandra Waugh Baldwin
Nicole Paraisy New City
Reeja Mathew East Meadow
Carlene Waller Yonkers
Annette Pepe Warwick
Dorothy LaCombe Ballston Lake
Dorothy LaCombe Ballston Lake
Ruth-Ann Harrison Bronx
Rebecca Raab North Syracuse
Ashley Harris Lake Luzerne
Jason Mahler Binghamton
Carline Charles Baldwin
Nancy Chandler Burlington Flats
Charlene Clarke Fleetwood
Alicia Brown Saint Albans
Catherine Boccanfuso Staten Island
Jeaninne Ottman Rochester
Kathleen O'Connor Malverne
Abiola Daramola Bronx
Annette Pineiro Brewster
Kirsten Konsevitch Port Jefferson Station
Chinyere Nebo Valley Stream
Sung Hee Choe Staten Island
Dr Rebecca Owens, DNP, MBA, MSN, RN, PMH-RN New York
Kristine Arcadi Amherst
Nicole Morris Bronx
Philippe Bah Bronx
Stacy Antwi Brooklyn
Louisa Matthew-Cooper Oakdale
Jane Locke Binghamton
Noel Carty Laurelton
Jasmin Waterman Brooklyn
Christine Nunes Shoreham
Yelena Zelenyak Staten Island
Caitlin Roberts New York
Ashley Graham-Perel Jamaica
Joseph Brindisi Amherst
Leronda Decamp Brooklyn
Deon Noble Brooklyn
Shernette Suer Elmsford
Rod Amazan Bronx
Martine Marsan Mineola
Laura Lau Brooklyn
Marilyn Ramdeen Brooklyn
Veronica Campos Ridgewood
Mary Rose Orleans New York
Ingrid Guyah Bronx
Edward Clarke Bronx
Christine Evanchuk Ballston Spa
Christina Curcio Middleburgh
Corinne Harvey New York
Amelia Cataldo New York
Erika Helmer Glens Falls

Nurse Honor Guard

ABOUT US:

The **Central New York Syracuse Nurses Honor Guard** is comprised of a group of Volunteer Nurses (RN,LPN,NP,Nurse Midwives,SN) who choose to serve and honor deceased Nurses at the time of their death by attending their funeral or memorial service. We invite all CNY Nurses to join us; whether you are active, retired or a Student Nurse, women or men. You will be welcomed with open arms, in what might well be, one of the toughest jobs you may ever love. We serve the families of fallen Nurses in CNY and beyond. We go wherever the call is needed.

HISTORY OF THE NIGHTINGALE TRIBUTE:

FIRST NHG: The Nurses Honor Guard was started in 2003 by the Kansas Nurses Association and brought to the Hospital CNO and Professional Practice Council to see if there would be any interest in supporting them. (They approached the Hospital Foundation and Nurses Union (OPEIU) for funding) and they all were happy to help.

NATIONAL NHG COALITION: Julie Murray heard about it in 2011 she was so inspired and knew she had to bring this to the rest of the nation. Gradually, with the help of social media they have grown from150 4/22 to over 250 groups nationwide including Alaska and Hawaii! Julie has made this her mission to have enough groups so any nurse can have this when they need it. It is my mission in NYS, too. It's a way to bring back the dignity and respect to our profession which has taken quite a beating lately. It helps restore our souls for nursing. We want to remember NO NURSE IS FORGOTTEN.

There will be a **National Nurses Honor Guard Coalition Conference** May 17-18 in Kentucky with 250+ attendees. (400 is max we can accommodate!) There are many sessions planned and networking to be done as we gather, share, grow, and celebrate our USA Nurses Honor Guards! There will be establishment and recognition of all of the USA State NHG chapters who are organizing, and Presidents will be installed for each state. I am proud to say that I have been asked to be NYS NHG President. This is a massive honor, and I am SO proud of all of our NYS Chapters who have pulled together. Thank you for your support! My dream came true.

CNYSYRNHG: I heard about it in February 2021 when I watched a video on Facebook of a Memorial Service being presented. I was hooked, her heart was touched, and knew we had to have this in CNY-Syracuse. Covid delayed starting, but plans started in November, '21 and our first tribute was 4/10/22 and started with 4 members. This is the first group in CNY; there was one in Plattsburg, NY. We now have 45 members and have done over 150 tributes since 4/22. This is a total over 1000 years of nursing careers within our chapter alone! We have marched in parades, presented at nursing conferences and CON's, TV/Radio, visited funeral homes to share information, and more. All 4 Syracuse Hospitals are supporting us by publicizing our NHG.

My Dream was to have NHG chapters across NYS, and we now have over 20 chapters: Syracuse, Utica, Albany, Batavia, Rochester, Bath (Southern Tier), Hudson Valley, Buffalo, Cooperstown, NYC, Long Island, Binghamton, Plattsburgh, Cattaraugus, and Finger Lakes, Soon we will unite as NYS NHG.

LOGO: NYS with a flame over Western NY. The Core city has a red cross over it, depicting each chapter. Designed by my niece, graphic designer. Each Chapter in NY can use the logo representing their chapter.

TRADITIONAL UNIFORM AND SYMBOLS

Nurse's Uniform:

- Florence Nightingale designed a **nurses uniform and cap** when she went to work with the wounded in the Crimean War in 1860's **Capes:** Dates back to WWI, with military nurses in battlefield who wore navy capes with scarlet lining. 1 side is tossed over the shoulder because it made them more visible and signaled to others when they were treating a soldier. We wear white nurse's dresses or scrubs, white stockings and shoes, cap and cape. Men wear white scrubs and white nurse's shoes. The traditional Nurse's uniform is a symbol of our profession.

White rose: symbolizes a nurse's devotion to her profession.

Nightingale lamp: The Lamp of Knowledge is the official symbol of the Nursing Profession. This was received at our capping ceremony. How many still have theirs?

The illumination of the light is a portrayal of the Sanctity of Life and represents all of what Florence Nightingale, the Lady with the Lamp", stood for: courage, compassion, gentleness, kindness and an unwavering devotion to duty and higher education. ~ Nursing is the light that never waivers! We also acknowledge the loved one's who made a difference, and the sacrifices they and the supportive family made as well, when they are given a lamp.

HONOR THE LIVING CEREMONY:

We go to hospice and end of life facilities and perform a ceremony for nurses whole they are still alive. They receive a red rose, miniature lamp, Certificate of achievement and Nurse's Quilt, a 'comfort blanket', which are made and donated as a gift from the Nurses Honor Guard.

NIGHTINGALE TRIBUTE:

The Nightingale Tribute is performed, a white rose is placed on the casket or beside the urn, a final call to duty is announced, with the Nurse being called three times (bell rings out with each call) after the third call, the Nurse is then released from their Nursing duties, as their work is done. The Nightingale lamp being forever extinguished and presented to the family (much like a flag presentation at a Military Funeral). This is followed by a recitation of the Nurses Prayer and we process out.

We move forward to minister to the bereaved family members, who are now grieving the loss of their loved one. This ceremony is very healing for the family and is such a great way to honor our profession with dignity.

"The Nurses Honor Guard attends the funerals of nurses who have died. We are a volunteer organization, and the service is free to the nurse's family. This is the first chapter in CNY. We wear the traditional all white uniform, with cap and cape. I will post in our email group and on our Facebook Page when we have a service to attend, and we'll meet at the service. We meet at the funeral home or church where the memorial service will be held and perform a short presentation of the Nightingale Tribute, Last Roll Call, and Nurse's Prayer. A Nightingale lamp is carried that is lit as we process into the service, and after the Roll Call, the flame is extinguished, signifying the end of the nurse's career, and the lamp is given to the family. A white rose is placed at the casket or urn or given to a family member, and after the prayer we process out. I am contacting the regional funeral homes, hospice and regional hospitals. We all take part presenting sections of the tribute and representing the honor we are giving to our nurse colleague. Someone carries the lamp, another carries the rose, and another carries the triangle, which is rung at the Roll Call. There are about 4-6 of the group who attend each memorial service or funeral. We are now able to accept donations to help defray the costs of flowers, Nightingale lamps, printing and other supplies.

We have 45 nurse members in our chapter and have presented the Nightingale Tribute at over150 nurse's funerals since April '22. Crouse hospital invited us to perform a Memorial Ceremony honoring 19 of our nurses who have died the past few years. Our Honor Guard has been well received and the families are so grateful we come to honor their family member's nursing career. There are about 250 Nurses Honor Guard chapters across the USA. We are so thankful to be part of this organization. Below are pictures of our nurses who have attended some of the Nightingale Tributes.

Attached is the **flyer** with information for the nurses on the Honor Guard. Nurses are responsible for getting the uniform together. The caps, shoes and uniforms are available at the Bayberry Uniform Shop in Liverpool. The owner is giving us the caps and lamps at his cost. Any nurse in the Honor Guard will get a 20% discount on her uniform; just tell them you are joining us. They supply all uniforms, lamps, and caps to the NYS NHG chapters, as well.

I also have attached the brochure that is going to the funeral homes and families. It has contact information and what we do, and the presentation we do is on the inside of the **brochure**. It is a very moving presentation, and the families greatly appreciate that we are honoring their loved one's professional nursing career.

Please join us as we honor our fallen nurses for their professional career. You will be blessed beyond measure. Our goal is that **No Nurse is Forgotten.**

Submit Names for the Annual Nightingale Tribute

The Nightingale Tribute honors late nurses and recognizes their commitment and dedication to science and the practice of nursing.

Please help us to honor our deceased colleagues in this year's Nightingale Tribute by submitting names and years lost using the online form linked here by Friday, May 17, 2024.

Vampires are Real: Stay Away from the Energy Vampires

Phyllis S. Quinlan, PhD, RN-BC

When you are thinking about crafting your personal Self-Care Program please remember, you cannot lead a positive life if you keep company with negative people. It is just impossible to sustain a positive attitude or mindset, or your energy under the relentless influence of chronically negative individuals.

I have no explanation for why negative people need to sow doubt where there is faith, need to complain when there is hope, or need to laugh at acts of kindness. I just know that they need to do all these things and more in order to make themselves noticed and relieve the stress that is triggered by being around those who have faith, embrace hope, and know the kindness matters.

You could be having a better than average day when you get to sit down for a break to enjoy a cup of coffee. However, if you take your break in the company of an energy vampire you will most likely notice that in about 15 minutes that vampire drained the positive energy from your day. They are experts at covertly and overtly sucking the joy out of most things. Yes, vampires are real! We all know an energy vampire and the challenge of working with them. I encourage you to make the choice to only limit our exposure to when it is necessary to actually work with them or be in their company.

I would rather eat lunch in my car than sit in a lounge or cafeteria with an energy vampire. I'm suggesting that you make a better choice for yourself too. Limit your expose to these people. Find an alternative spot to take a break or eat your meal. Resist getting drawn into conversations you don't want to have. Stop sharing your personal life with these folks because they'll find a way to contaminate that joy too. They are compelled and relentless in their mission to suck out all the good of any situation or relationship.

Make sure the company you keep is a real part of your Self-Care Program. Positive vibes only. That doesn't mean you cannot acknowledge something that needs improving. It just acknowledges that to really make a change for the better, you need a clear, positive mindset to construct a clear, positive strategy. Remember joy is your birthright!

SPAN (Statewide Peer Assistance for Nurses)

SPAN (Statewide Peer Assistance for Nurses) is offering free wellness webinars and workshops. Find your topic(s) of interest below and use the link to sign up!
https://wellableservices.as.me/SPAN

4/17/24	7:00 pm	Sleep Tight Tonight
5/15/24	12:00 pm	Realizing Resilience
6/12/24	9:00 am	Tai Chi
7/17/24	12:00 pm	Social Wellness
8/21/24	7:00 pm	Beating Burnout
9/18/24	12:00 pm	Guided Meditation
10/16/24	7:00 pm	Mindfulness and Your
11/20/24	12:00 pm	Gratitude –A How To Guide
12/18/24	9:00 am	Health Holiday Guide

Playing Games with Quality Improvement

Christina Bierling-Norris, PhD, RN, NPD-BC
Lori Healy-Brown, MSN-Ed, RN

Nursing professional development (NPD) in the acute care setting is a vital component of quality care and patient safety. NPD practitioners provide bedside staff with the knowledge and skills that are necessary to care for patients safely and effectively. However, NPD practitioners can face significant challenges in developing and presenting educational initiatives that lead to quality improvement. These challenges include time, budgetary restrictions, and lack of access to staff nurses for educational activities (Seymour et al., 2023). NPD practitioners must create and present innovative and engaging learning activities that can be operationalized with limited time and resources.

Gamification can be an effective strategy to meet the competency and continuing education needs of bedside nurses (Seymour et al., 2023). Rutledge et al. (2018) define gamification as the application of game design elements (conceptual building blocks integral to building successful games) to traditionally non-game contexts (Rutledge et al., 2018, p. 1014). Gamification has been shown to increase learner engagement and allow for learning in a "reflective, safe, and nonthreatening environment" (Bonn et al., 2022, p. E149). Game-based learning can also incorporate multiple learning modalities, increase critical thinking, and improve the retention of information (Woolwine et al., 2019).

Blood Culture Contamination

According to the Centers for Disease Control (CDC), contamination rates for blood culture specimens should not exceed 3% of the total specimens collected (Centers for Disease Control and Prevention, 2023), and a goal of less than 1% is achievable. Contamination of blood culture specimens can lead to the administration of unnecessary or inappropriate antibiotics and can increase patient length of stay (Centers for Disease Control and Prevention, 2023). In January 2023, a community hospital in the Northeast United States noted that the contamination rates for the hospital emergency department were greater than 6%.

Nursing professional development and the quality team were engaged to determine if the gap in practice was related to a knowledge and/or a skill gap. The NPD team observed breaks in technique during the collection of specimens and determined that there was a knowledge and a skill gap in the practice. The NPD team had consistently taught blood specimen collection during nursing orientation and the skill was reviewed with the bedside nurses as part of annual education. The education that was being provided was primarily lecture-based, and although the information was being reviewed, there was a significant gap in the process.

The Educational Initiative

Based on the evidence in the literature that gamification can improve the retention of information and learner engagement, the NPD team created an educational initiative using a game to teach the skill of blood culture collection. The educators observed that the nurses were not scrubbing the collection site for the recommended thirty seconds. The team designed an activity where the learners were given an orange and an alcohol wipe. Each learner was asked to scrub the orange to music for what they perceived to be thirty seconds. Learners who came close to the thirty-second time were given small prizes. The learners were highly engaged in the activity and many expressed surprise at the length of time needed to meet the thirty-second goal. A brief discussion was held regarding key points of blood culture collection, including the timing of serial draws, appropriate equipment, and access sites. The learners were allowed to ask questions after the game. The educational activity took less than five minutes.

The Results

Rates of contamination of blood cultures drawn by the emergency department (ED) nurses were tracked. Blood cultures in the emergency department were drawn by both the nursing staff and the phlebotomy staff. Data was collected to track the rate of contamination of blood cultures drawn by the nurses, who participated in the education and by the phlebotomists, who were not included in the education.

The rate of contamination attributed to specimens drawn by the ED nursing staff decreased from 70% in January to 30% in September. The overall rates of contamination decreased from a high in January of 6.3% to 2.7% in September. However, the rates of contamination for the phlebotomy staff remained consistent.

Figure 1
Contamination Rates

Conclusions

Despite education to both new staff and existing nurses reviewing correct techniques and policies for blood culture draws, blood culture contamination rates were well above the national benchmark. The implementation of game-based education resulted in a measurable improvement in quality outcomes. The educational program was brief and could be provided while the nurses were working, with little interruption to their patient care. The initiative required minimal financial investment and could be presented by a single educator to multiple staff members.

A game-based approach to nursing professional development and quality improvement proved more effective than the traditional didactic methodology. Gamification "transforms teaching from the transmission of content to be memorized into learning through inquiry and peer interaction"(Pollio et al., 2021, p. 126). Gamification increased learner engagement and led to retention of the concepts being taught, as evidenced by a significant decrease in blood culture contamination rates.

Future Use

The response of both the bedside nurses and the NPD team to the use of gamification was overwhelmingly positive. The data demonstrated a measurable improvement in blood contamination rates. Based on these findings, the plan moving forward is to incorporate gamification into further educational initiatives and to track the effect that this educational strategy has on quality outcomes.

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Scholarships, Grants, and More...Oh My!

Looking for funding to support continuing your education, or support your research or EBP project? Looking for opportunities to collaborate with colleagues on issues that impact our profession? Well, look no further as the Center for Nursing has just what you need. See below for a description of the many opportunities available to nurses and nursing students.

Dr. Barbara Zittel Baccalaureate Degree in Nursing Scholarship

A $2,000 scholarship will be awarded to a qualified registered nurse advancing his/her education to complete a baccalaureate degree in nursing.

Eligibility Criteria:

- New York State residency
- Acceptance into a baccalaureate degree in a nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE)
- Full-time or part-time study
- If already enrolled in a New York based RN to BS degree program, minimum current GPA of 3.0
- Applicants who are denied are eligible to reapply for a subsequent year

Past Recipients:

- 2023 Leah Haslett
- 2022 Jack Huang
- 2020 Aleesha LaBounty
- 2019 Yvette Savaria
- 2018 Katie Swanson
- 2017 Catherine Barry
- 2016 Mandi Conroy

St. Luke's Hospital School of Nursing Alumnae Association Nurse Educator Scholarships

Two $4,000 scholarships will be awarded to qualified registered nurses advancing his/her education to complete academic credentials for a nurse educator position.

Eligibility Criteria:

- New York State residency
- Acceptance into a nursing education program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE)
- Full-time or part-time study as defined by the admitting education program
- If enrolled in a graduate education program, minimum current GPA of 3.5; if undergraduate, minimum GPA of 3.0
- Agreement to teach a minimum of one year in an accredited nursing education program in New York State after completion of degree
- Applicants who are denied are eligible to reapply

Past Recipients:

- 2022 Marlene Lofters-Dinham
- 2021 Antoinette Saponaro
- 2020 Ebony Samuel-Bakpessi
- 2019 Donna Cutting
- 2018 Francine Laterza
- 2017 Carrie Rewakowski
- 2016 Kattiria Gonzalez
- 2015 Linda Kelly
- 2014 Patricia Manocchi and Paige Synesael

The Noah Tubbs Family Trust Nursing Research Grant

A **$10,000 grant** will be awarded to a qualified registered nurse pursuing nursing research. Special consideration will be given to nurses pursuing research in the field of geriatrics.

Eligibility Criteria:

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

Past Recipients:

- 2022 Dillon Dzikowicz
- 2018 Natina Reed

The Mary J. Finnin Grant for Nursing Innovation in Oncology

A **$7,500** grant will be awarded to a qualified registered nurse who is currently pursuing or interested in pursuing nursing innovation in the field of oncology.

Eligibility Criteria:

- Reside in and/or practice professional nursing in New York State
- Have a baccalaureate or higher degree in nursing from a nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE)
- Licensed as a registered professional nurse in New York State

Nightingale Scholarship

A **$5,000 scholarship** will be awarded to a qualified high school senior who is enrolled full-time in a NYS accredited baccalaureate RN nursing program beginning in the fall semester post-high school graduation.

Eligibility Criteria:

- New York State residency
- Acceptance into a NYS generic 4-year BSN nursing program accredited by the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE)
- Full-time study
- Graduating from a NYS high school with a minimum GPA of 3.0 or equivalent
- Evidence of community service during their high school career
- Maintaining a minimum 3.0 GPA during 4 years of a generic BSN program

Past Recipients:

- 2023 Gavin Trezza
- 2022 Kaitlyn Lindsey

The Cathryne A. Welch Center for Nursing Research (CNR)

Join colleagues from across New York to advance excellence in health care through research and evidence-based practice (EBP). The CNR, in collaboration with ANA-NY, has numerous opportunities to conduct research, publish in reputable journals, prepare and conduct educational programs, find mentors for research and EBP, etc. For more information visit the website or contact Susan Seibold-Simpson at research@cfnny.org

The Future of Nursing NYS Action Coalition (NYSAC)

New York was one of the first states to be invited to create an Action Coalition in response to the inaugural Future of Nursing report in 2010. Housed at the Center for Nursing, NYSAC has been actively involved in advancing and diversifying the nursing profession. Volunteer nurses across New York serve on NYSAC's committees including Leadership/NOBC, Education, DEI (Diversity, Equity & Inclusion), Media, and Practice. NYSAC meets monthly and plans virtual Summits to showcase some of the splendid work being done. For more information visit the NYSAC website at New York State Action Coalition - Center for Nursing at the Foundation of New York State Nurses, Inc. (cfnny.org).

For more information about any of the information above visit the Center for Nursing website at www.cfnny.org or email Deb Elliott, Executive Director at delliott@cfnny.org

Disability Education: Leveraging the Expertise of Standardized Patients with Unique Lived Experiences

Elizabeth A Berro, PhD, RN, CHSE, CNE; Marie Lourdes Charles, EdD, RN-BC, FNYAM; & Sharon Stahl Wexler, PhD, RN, FNGNA

Advances in healthcare and medical technologies have improved the survival of children with congenital and critical illnesses, with almost one in five children in the US today living with chronic diseases or other special healthcare needs (Glinianaia et al., 2020; Health Resources & Services Administration [HRSA], 2022; Perry-Eaddy et al., 2023). In New York State, 484,147 received special education in 2022 for a variety of federal disability categories, including autism, intellectual disability, and orthopedic impairment (NYSED, 2023). Children with special healthcare needs (CSHCN) are over-represented in the healthcare system, with over 50% of pediatric intensive-care patients having complex chronic conditions (Gallegos & Cachillo, 2023). CSHCN are more likely to live in poverty and be non-Hispanic Black, facing burdens, barriers, and biases contributing to healthcare disparities (HRSA, 2022). However, traditional healthcare education remains primarily focused on acute care, which often leaves nurses ill-equipped to meet the needs of these patients (Sharkey, 2022). This seems especially problematic for new graduate nurses navigating complex medical situations with limited disability-specific education and experience (Song & McCreary, 2020). We, therefore, share an innovative education program developed to improve the nursing care provided in the context of CSHCN.

Research has demonstrated that parents of children with chronic illnesses feel unheard and disregarded by healthcare professionals (Gallegos & Cachillo, 2023). This lack of communication is a pervasive issue recognized by parents and healthcare providers (Sharkey, 2022). Nursing educators strive to provide opportunities for students to develop communication skills; however, traditional clinical nursing experiences are limited. While research has shown that simulation-based education with standardized patient (SP) feedback improves medical students' communication skills (Qureshi, 2020), there is a paucity of research on how simulations can be used to provide nursing education in the context of pediatric CSHCN. Neither a literature review by Ozkara (2022) nor our recent literature search found studies that employed an SP for the context of CSHCN. We, therefore, identified a need to develop and evaluate an SP-based simulation for this purpose.

A grant from the Hugoton Foundation enabled faculty at our northeast university to incorporate disability nursing care into our curricula. The nursing faculty in the traditional 4-year and accelerated second-degree program moved to embrace nursing care for individuals with visible and invisible disabilities and families living with CSHCN. As explained by the Alliance for Disability in Healthcare Education (ADHC, 2019), biases and stereotypes on the part of healthcare providers can contribute to disparities in care. The integration process began with hiring an international nurse expert on disability care who provided faculty education on disability, including personal reflection on biases and misconceptions. This was followed by a curriculum review that assessed disability content offered in didactic, traditional clinical, and simulation-based education. The review revealed several simulated clinical experiences incorporating the care of individuals with disabilities but failed to capture the family experience. While simulations addressed many of the core competencies outlined by the ADHC, the experience did not adequately acknowledge that parents of those with a disability best understand their condition and those of their children. Parents of children with disabilities are increasingly considered care experts, and their expertise should be utilized in all aspects of care (Gallegos & Cachillo, 2023).

The simulation educators recruited and trained SPs with personal experience as caregivers of individuals with disabilities to play the role of parents. This approach ensured that the simulation was grounded in the lived experiences of families in caring for children with disabilities, providing nursing students with a more authentic learning experience. The pediatric simulation focuses on the care of a 9-year-old child with severe spastic cerebral palsy, requiring a gastric tube (GT) and tracheostomy tube. The child is admitted to the hospital through the emergency department from home because of increased secretions and fever. Objectives of the simulation include:

- Communicate effectively with all participants in this child's care, including family members and other health care professionals.
- Identify relevant cues based on the focused assessment of a child admitted with difficulty breathing.
- Take appropriate actions for a child with a tracheostomy, increased secretions, and respiratory distress, including suctioning, chest physiotherapy, and oxygen delivery.
- Demonstrate safe GT and intravenous medication administration.

A simulation staff member with expertise in training SPs and a Certified Healthcare Simulation Educator (CHSE) nurse provided training to the individuals playing the role of the parent. Training included methods for maintaining fidelity and consistency and feedback techniques. The SPs and trainers reviewed the SP script that included the history and current condition of the pediatric patient and suggested challenge questions. The training included observation of the scenario, allowing the SPs to ask questions or clarify the objectives of the experience. One of the SPs with the most relevant caregiving experience initially expressed concern that the simulation would be too "close to home" and might be emotionally overwhelming. Training, therefore, also focuses on dealing with strong emotions that may be evoked by reenacting emotionally distressing situations.

The simulation was evaluated comprehensively, including the perspectives of educators, students, and SPs. Overall, the simulation was a positive and valuable learning experience for all involved. SPs praised the simulation's realism, and educators noted the opportunity to foster effective student communication skills. Students completed the SET-M (Simulation Evaluation Tool-Modified), which revealed that students particularly valued the opportunity to practice communication skills and gain a deeper understanding of the challenges faced by families of children with disabilities.

SPs also provided positive feedback in the simulation staff debriefing, noting that the simulation was highly realistic and allowed them to share their expertise and insights with future nurses. Simulation educators expressed initial concern for the emotional experience of the SPs, as the realism may evoke strong or negative feelings. However, this was not the case. The SP, who had expressed initial concerns, described feeling empowered with the chance to provide feedback. Another SP wrote," It also makes me happy to know that a small comment can benefit your students and, at some point, the patients."

The successful implementation of the Hugoton grant-supported simulation demonstrates the potential of utilizing SPs with personal experience in disability care to enhance nursing education. This innovative approach not only enhances the realism of the simulation but provides nurses-in-training with valuable insights into the perspectives and experiences of families directly affected by disability. Moving forward, the transition of these specialized SPs into the broader SP pool will ensure the continued availability of authentic experiences for future nursing students. Additionally, if SPs are unavailable, we are exploring using parent avatars during prebriefing sessions to expand the use of this innovative simulation model. We encourage other nursing educators to consider replicating this model to prepare their students better to interact compassionately and effectively with families of children with disabilities. Future research is warranted to systematically evaluate the impact of this simulation on students' communication skills, cultural sensitivity, and clinical competency, further solidifying its role as a valuable pedagogical tool in nursing education.

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New Charter Public High School Lead by Nurses Opens in New York State

The Nurses Middle College Capital Region Charter High School (Nurses MC CR) welcomed ninety-five freshmen students in September 2023. The high school, temporarily located in a private school in Rensselaer, is a free public school and a replica of the first model of its kind which began in 2011 called the Rhode Island Nurses Institute Middle College (RINI). Nurses MC CR is a 4 year college preparatory program of study beginning in the 9th grade which prepares students to be college ready for a career in health, preferably nursing. The impetus for bringing this model to New York began in 2019 when nursing colleagues were looking for innovative ways to help improve the nursing pipeline. With record nursing shortages experienced in many healthcare sectors across our state, Nurses MC CR is one way to engage interest in the nursing profession in middle school aged youth.

The mission of the Nurses Middle College Charter High School Capital Region is to prepare a diverse group of students to become the highly educated and professional nursing workforce of the future.

Background

In order to garner support for this concept, the Center for Nursing at the Foundation of NYS Nurses, Inc. in collaboration with a few other nursing colleagues, held three informational sessions in January, May, and June of 2020. Nursing, health care, education, charter school representatives, community folks, and others gathered to learn about the model, discuss the feasibility of this type of program being accepted in the Capital Region, and determine the necessary steps to move forward. In early 2021, further discussion, data gathering, and planning ensued, and with support and direction from the flagship school in Rhode Island the journey began. A Board of Trustees was formed and a charter was submitted and approved by the State University of New York (SUNY) Board of Trustees in October 2021.

Our vision is to create an innovative high school experience that is student-centric, structured to foster a supportive learning environment, and committed to developing the skills, knowledge, and passion necessary to excel in the nursing and allied health professions.

- *"We educate the next generation of nurses with a focus on academic rigor, leadership development, and workforce readiness."*

Unique Program

While Nurse MC CR operates under the same laws and regulations as a public high school, the nuances of the program are as follows:

- Smaller classroom size so students receive individualized instruction and support;
- Students wear scrubs, provided by the school, so they assume the role of healthcare professionals beginning in freshman year;
- All instructional courses, including the arts, are taught through a nursing lens;
- Support and guidance provided by the well trained staff is guided by the XX nursing tenets of ….
- Students take college level courses at area colleges and universities which saves students money when attending college after graduation;
- Students receive work-based learning experiences during the school year;
- Students become certified in First Aid and CPR, and can become a certified nursing assistant (CNA) or certified first responder (CFR) while in high school;
- Many opportunities for summer internships and work study programs.

School Environment

As a surprise to students over the winter holiday break, the Center for Nursing with the support of Davin Healthcare, transformed the school environment into a nursing wonderland of artifacts, posters, books, murals, among other items, that depicted the rich history, diversity, and future possibilities of the nursing profession. It is believed if the environment in which students are learning is enriched with reminders of where their careers may lead them, it provides incentive and encouragement to continue in the program.

Future Plans:

Nurses MC CR is a unique and specialized public charter high school. Adhering to all the necessary requirements by the Board of Regents and the NYS Education Department, Nurses MC CR offers students more than a traditional public school. Smaller class sizes, individualized mentoring by faculty and support staff, opportunities to explore health care settings and meet health care professionals all lead to a unique and enriched experience. In addition to finding a permanent home for Nurses MC CR, school leadership is actively recruiting students for the 2024-2025 freshman class from all areas of the Capital District. Plans include recruiting students into the sophomore class as well since capacity can accommodate a larger class. The first graduating class is planned for June 2027. Nurses MC CR has not only gained interest from students interested in becoming a nurse or other health care professional and their parents, and also from community leaders, health care providers, and business leaders. While the school has received tremendous interest and support, it also relies on donors to support the additional advantages of the program, such as the purchase of a synthetic human simulation model for learning about anatomy and physiology, or off campus experiences throughout the student's high school experience. Despite enormous efforts and due diligence, the school opened in 2023 at a temporary location. The Trustees continue to recognize the importance and value of a permanent location and is actively engaged with multiple partners to resolve this issue as the highest priority. To find out more and donate visit the website: Preparing the Professional Nursing Workforce of the Future - Nurses Middle College - Capital Region (nursescr.org)

*A STEM focused school that can improve math and science skills for a diverse student body will lead to well-educated and diverse health care workforce. For these reasons, ANA-NY **supports** the Nurses Middle College model in the Capital Region of New York.*

Jeanine Santelli, ANA-NY Executive Director

Article written by Deborah Elliott, MBA, BSN, RN, Nurses MC CR Treasurer, and Maxine Smalling MS, BS(N), Nurses MC CR Trustee

Other Nurses MC CR Board of Trustee members:
President: Susan Birkhead, DNS, MPH, CNE
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Updates from the Climate and Health SIG

On February 7, 2024, EPA released their final rule for particulate matter, otherwise known as "soot." Soot is a health-harming pollutant that is produced by power plants, tailpipes on cars and trucks, and other industrial sources. Soot poses elevated health risks for children, seniors, and people with chronic illness and an estimated 85,000-200,000 deaths are caused each year by this deadly pollution. With this update, EPA is strengthening the standard for soot pollution from a level of 12 micrograms per cubic meter to 9 micrograms per cubic meter.

In response to the announcement of the proposed rule, the Alliance of Nurses for Healthy Environments Executive Director Katie Huffling, DNP, RN, CNM, FAAN issued the following statement:

"Nurses welcome today's updated rule from EPA on particulate matter as an important public health safeguard against dangerous air pollution. EPA's proposed stronger soot standard, released today, will prevent 4,500 premature deaths and 2,000 emergency room visits and yield up to $46 billion in net health benefits in 2032.

"Studies show that people of color are disproportionately exposed to and harmed by soot pollution. Strengthening the standard is critical to protecting the health of those most impacted by particle pollution, especially for those near polluting sources and those disprotated exposed to increased levels of particulate matter. Asian, Hispanic, and Black individuals are at a higher risk of death from exposure to soot. Exposure to, and inhalation of, soot leads to increased mortality rates, hospitalizations, and visits to the ER. Soot is also linked to grave illnesses and health risks including diabetes, cancer, kidney disease, asthma attacks, heart attacks, stroke, heart disease, COPD, Parkinson's disease, dementia, low birth weight, greater risk of preterm birth, higher rates of overall mortality, and possibly adverse pregnancy outcomes.

"While we celebrate this proposal as a critical step forward, this final proposal leaves the soot 24-hour standard unchanged which will continue to limit the EPA's ability to address and limit spikes in soot pollution. Nurses and health advocates will continue to advocate for the strongest possible soot standards which are consistent with what the science calls for."