



# NURSING IN ACTION

STORIES FROM RUSH NURSING STUDENTS,  
EDUCATORS, CLINICIANS & RESEARCHERS

## A NURSE, NALOXONE AND A NEIGHBORHOOD STROLL

HOW FATE STEPPED IN FOR LIZ BARRETT  
TO SAVE A STRANGER'S LIFE

EFFECTIVE PARENTING  
THERE'S AN  
APP FOR THAT

NP HELPS  
CHICAGO TEENS  
REJECT VIOLENCE

MAN ON  
A MISSION  
IMPROVING LGBTQ  
PATIENT CARE

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MORE ANXIOUS  
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MILLENNIAL  
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# MEET SOME OF OUR CHANGE-MAKERS

“Through these stories, you will discover how Rush nurses are actively tackling some of the most difficult issues facing our country: poverty, opioid addiction, violence, mental health, chronic disease, discrimination and disparities in care.”

Every day, nurses know that what they do matters — to a patient they care for face-to-face or to a family who will benefit from their research. That’s because nursing has such a meaningful impact across every sector of health care. Today, nurses’ influence spans from direct patient care to innovations in technology that improve care. Nurses direct organizational strategy to enhance care quality and advocate for public policy to expand access for those who need it most.

We want you to meet some of these change-makers. In this publication, we aim to share personal stories from Rush students, faculty and alumni who have leveraged their nursing education and remarkable ingenuity to find new ways of addressing society’s toughest problems. Through these stories, you will discover how Rush nurses are actively tackling some of the most difficult issues facing our country: poverty, opioid addiction, violence, mental health, chronic disease, discrimination and disparities in care.

All our featured nurses are motivated by their drive toward better options and outcomes for the populations they serve directly or indirectly. This is what we mean by our magazine’s name: Nursing in Action. Here nurses follow the path to empowerment through graduate education, learning and collaborating with some of the most respected faculty in the country.

At Rush, we have a long legacy of preparing nurses to confidently pursue answers to some of our communities’ most vexing health and social concerns. Through our nationally ranked master’s and doctoral level programs, we challenge nurses to assume an array of leadership roles in nursing education, research and practice.

I find it gratifying that, more than ever before, organizations recognize the value of bringing nurses to the table for creative, real-world problem-solving. Because let’s face it — practical, proven solutions are not easy to deliver, no matter where we work.

I hope you enjoy these stories of how nurses have applied their passion and know-how to achieve greater personal and professional fulfillment while vastly improving the care in our communities.

**If you would like to join us in our commitment to solving some of our greatest health challenges — or if you have ideas to help us along the way — please contact me via Twitter, @RushNursingDean. Your actions can make a world of difference.**

**Marquis D. Foreman, PhD, RN, FAAN**  
John L. and Helen Kellogg Dean of Nursing  
 @RushNursingDean

## MAN ON A MISSION

Improving LGBTQ patient care

As a nurse practitioner and gay man, Erik McIntosh is passionately leading a movement to improve health care for LGBTQ patients.

BY AMY LYNCH





# LET'S TALK ABOUT SEX

As a gay man and a nurse practitioner at Rush University Medical Center, Erik McIntosh, MSN, RN, ACNP-BC, was surprised when his own primary-care physician neglected to inquire about his current and past sexual experiences during an appointment. But when another medical colleague told him that as a minority he'd have to advocate for himself, he knew something had to change.

"It was striking to me that sexual behavior was not a standard discussion," McIntosh says. "A patient goes to their provider for assistance in living the best, healthiest life they can. The mentality that patients should initiate conversations specific to their health is just backwards."

### MAKE NO ASSUMPTIONS

All patients deserve welcoming, caring and equitable health care, regardless of their sexual orientation, gender identity or expression. Even the most experienced and well-intentioned medical staff can succumb to cultural, religious or implicit personal bias. Therefore, the lesbian, gay, bisexual, transgender, queer/questioning medical community is leading an effort to strive for enhanced sensitivity and better treatment for LGBTQ patients.

"Health care providers should realize that when working with LGBTQ individuals, like any individual, their identity can be complex and comes from a myriad of experiences that have shaped who they are at this moment," McIntosh explains. "Providers should allow LGBTQ patients to share who they are, what they experience, what they do and what they believe without putting a label or an assumption on it."

As part of his doctor of nursing practice training through Rush University's College of Nursing, McIntosh chose to initiate an LGBTQ Healthcare Competency Program to study the lack of provider knowledge in this area and its subsequent effects on patient outcomes.

He also works in conjunction with an in-house committee at Rush to conduct LGBTQ-focused educational sessions for the organization's health care staff that touch on terminology and concepts, barriers and ways to more openly discuss patients' sexuality and gender identity. The goal is to address the need for more specialized knowledge, greater preparedness, better behavior and improved attitudes regarding LGBTQ health at the provider level.

### EDUCATION IS KEY

"I've encountered patients who ask me if I'm gay, I think because it's a way for them to connect and feel safe in a system that hasn't always treated them or a loved one justly," McIntosh says. "Through this project, I'm hoping to create an environment to reflect, discuss and explore this topic."

**"It was striking to me that sexual behavior was not a standard discussion."**

Nationally, LGBTQ patients have reported discrimination in the form of health care providers who refuse to touch them, use abusive language, blame them for their health status or are physically rough during examinations.

"There are still nurses who harbor anti-LGBTQ attitudes, which certainly affects the health and well-being of LGBTQ patients," says Cecilia Hardacker, RN, MSN, CNL, director of education at Howard Brown Health. "When I talk to them, they quickly understand that there's so much more they need to know. We let them off the hook for a minute, because you can't expect someone to know something they've never received any education about. But, to really be patient-centered, you need to know as much as you can about your patients. Gaining their trust is the key to helping them."

Current data from the U.S. Department of Health and Human Services shows that the LGBTQ population is more likely to experience higher rates of physical violence, heart disease, certain cancers, obesity, anxiety, depression, suicide and sexually transmitted infections.

### UNIQUE HEALTH ISSUES

"There are health issues for every letter of the acronym, unique to each group," Hardacker says. "Also, young people are especially vulnerable to bullying and lack of acceptance from their families; in health care, they're dependent on parents or others for guidance."

Older LGBTQ adults experience hardship as well.

"When they're in need of help or professional care, perhaps in a nursing home, they many times choose to go back into the closet rather than remain out and vulnerable," Hardacker says.

While some LGBTQ patients may feel more comfortable with a nurse or physician who is also LGBTQ, McIntosh says the provider's own sexual orientation or gender identity shouldn't matter.

"What does matter is that the health care provider understands and acknowledges their bias and attitudes toward the LGBTQ community, and how that could

potentially facilitate or hinder a meaningful dialogue and patient-provider relationship," he says.

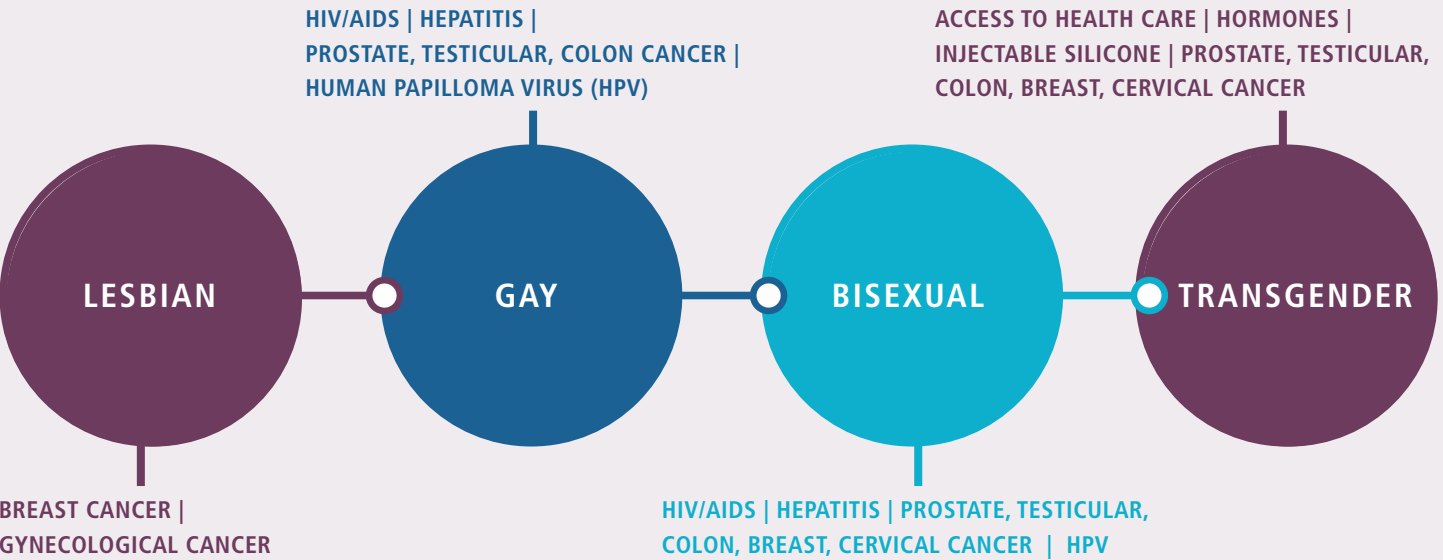
"Just because a nurse is part of the community doesn't make them more capable," Hardacker says. "They may have personal experiences that make them more aware, but they cannot be expected to solely carry the burden of caring for LGBTQ patients."



## LGBTQ PATIENTS HAVE UNIQUE NEEDS

Everyone deserves equal and humane access to quality health care. Providers should take a thorough health history as well as discuss safer sex; heart health; diet; exercise; tobacco, alcohol and drug use; coming out; sexually transmitted infections; and depression and anxiety.

Though each patient's needs are unique, here are some additional health concerns to address.






QUALITY CARE FOR ALL PATIENTS

Hardacker says all health care professionals have an obligation to educate themselves about LGBTQ issues if their own experience hasn't provided the knowledge they need. She offers opportunities to learn by facilitating sessions and workshops for health organizations throughout the country (including the Midwest LGBTQ Health Symposium) and teaching LGBTQ-based curriculum to nursing students.

Going forward, Hardacker would like to see accredited

LGBTQ health best practices education adopted into all pre-licensure nursing programs.

"LGBTQ content is being slowly infused into curriculums; right now it's not required, so not many schools are doing it," she says.

"The health and well-being of the LGBTQ individual needs to be taught at every level of education," McIntosh agrees. "My advice to providers is to be curious and open, make no assumptions and be honest with your patients. Then, LGBTQ-competent care will follow." 

NEW PILL HELPS PREVENT HIV

Primary care providers can now play a key role in preventing new HIV infections.

Pre-exposure prophylaxis (PrEP) is a medicine taken daily that can be used to prevent HIV. After providers take a sexual history, the hope is very high risk patients will be identified early enough to benefit from taking PrEP. Very high risk includes anyone with an HIV infected

partner, anyone who doesn't consistently use a condom with partners of unknown HIV status, and anyone who shares injection drug or hormone equipment.


When taken as prescribed, PrEP blocks the virus from making copies of itself and spreading throughout the body.

According to the Centers for Disease Control and Prevention,

HIV and AIDS remain a problem in the U.S. In 2014, there were nearly 40,000 new cases of HIV, 70 percent of which occurred among those who had male-to-male sexual contact. In addition, transgender women as well as women who have sex with bisexual men are also susceptible to contracting HIV, according to the journal The Lancet Infectious Diseases.

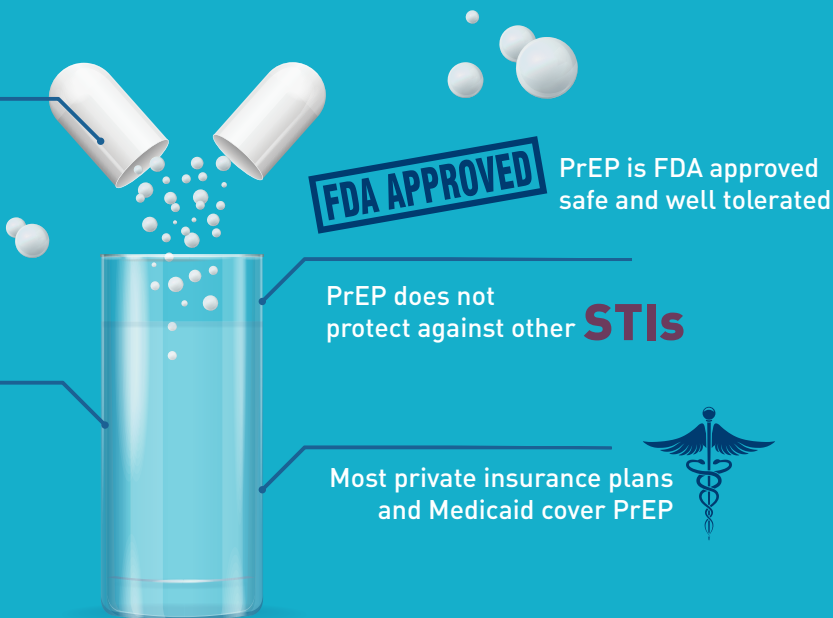
HERE ARE SOME KEY FACTS, ACCORDING TO THE CDC

1 IN 3 primary care providers haven't heard about PrEP

 All licensed health care providers can prescribe PrEP

Overall, daily PrEP can reduce HIV infection by more than **90%**

Daily PrEP can reduce HIV infection among intravenous drug users by **70%**



politics  
crime  
terrorism  
college debt  
unemployment  
retirement  
economy  
24-hour news cycle  
social media  
police violence

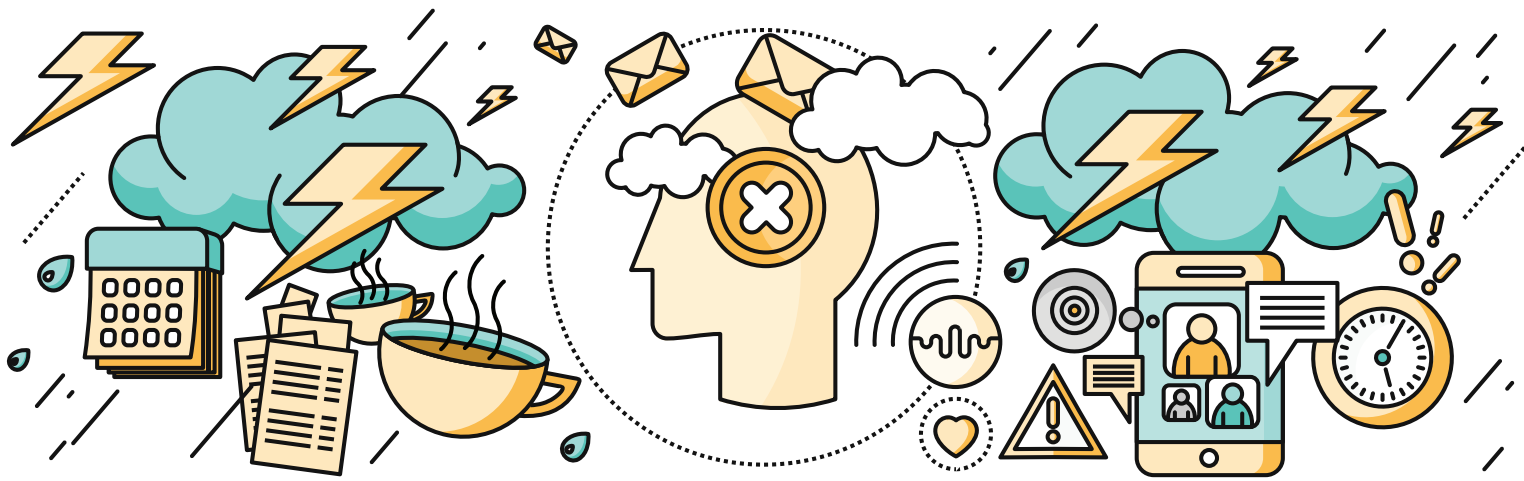


ANXIETY

Anxiety disorders are the most common mental disorder in the U.S. In fact, they afflict an estimated 40 million American adults, or 18 percent of the population, according to the National Institute of Mental Health.

With numbers like this, you may think Americans must be more anxious than ever before. But are they? The answer may lie in a better understanding of what anxiety disorders are and aren't.





# ARE AMERICANS MORE ANXIOUS THAN EVER?

BY LINDSEY MALKUS

## ANXIETY VS. ANXIETY DISORDER

Anxiety is a normal reaction to stress. Being nervous or sad or scared about an event that would make others feel likewise is reasonable if the feeling fades. Anxiety disorder goes further: The reaction is intense and doesn't resolve easily. It's irrational, causes significant distress and preoccupation, and interferes with daily life, including sleep.

"Anxiety is a normal part of life," explains Kathy Delaney, PhD, PMH-NP, FAAN, a psychiatric nurse and director of the Psychiatric Mental Health Nurse Practitioner program at Rush University College of Nursing. "We are all anxious from time to time. But what marks anxiety for some individuals is that the worry, concern, fears become persistent and overwhelming."

As a practicing psychiatric nurse practitioner and assistant professor at Rush, Michelle Heyland, DNP, APN, PMHNP-BC, adds, "It is only considered to be diagnosable anxiety if these symptoms interfere sufficiently with the person's life."

According to the Anxiety and Depression Association of America (ADAA), anxiety disorders include generalized anxiety disorder, panic disorder and panic attacks, agoraphobia, social anxiety disorder, selective mutism, separation anxiety, post-traumatic stress disorder, obsessive-compulsive disorder and specific phobias.

## FIGHTING MISCONCEPTIONS

As is the case with many mental illnesses, anxiety disorders are often misunderstood. The biggest fallacy, according to Heyland, who has worked with anxiety disorders in outpatient and inpatient settings, is that individuals with these disorders can "control" their symptoms.

In fact, control comes into play in most myths and stigmas surrounding anxiety. From avoiding stressful situations to maintaining a healthy lifestyle, the internet and well-meaning individuals have plenty of ideas about how anxiety sufferers should control their disorder. Delaney points out that while this way of thinking may come from a good place, it's ineffective. "Once an anxious person's brain is focused on a fear, it is very difficult for them to stop focusing on the issue."

Delaney, whose work with anxiety focuses on children, says another common misconception she's witnessed is the notion that children will "grow out" of their anxiety. "Children do mature out of some childhood fears. For instance, a 7-year-old's fear of ghosts and monsters," says Delaney. "But say, social anxiety — children do not grow out of that without help."

## LEARNING TO MANAGE

"We have a highly effective program developed by nurses," Delaney says. "COPE (Creating Opportunities for Personal Empowerment) teaches teens to recognize and stop automatic negative thoughts and replace them with positive thoughts instead."

For example, students are taught to deep breathe and repeat positive statements to block negative ones. This and other strategies help them self-regulate: Though they may not be able to avoid triggers, they learn how to reduce and control their response. And every success builds confidence and pride in their healthier responses. These tactics work with adults as well.

In addition to techniques like COPE, nurses help patients by guiding them as they confront their fears. "In the outpatient setting and as part of a treatment team, nurses may accompany patients to situations that cause significant anxiety," Heyland says.

For example, "The treatment team may accompany the patient to the grocery store to not only help them make healthy choices but to also provide support for someone who experiences significant anxiety in a crowded setting." The hope of this exercise, Heyland adds, is "a decrease in anxiety symptoms over time."

According to the ADAA, cognitive behavioral therapy can be just as or more effective than medication (or a combination of CBT and medication) for most people over the long run. In instances where medication is needed, several exist to treat anxiety disorders, including selective serotonin reuptake inhibitors (SSRIs).

## A COMPLICATED QUESTION

So, are Americans more anxious than ever? Well, yes and no. For Delaney, there's no easy answer. Citing data from author Jean Twenge, PhD, a professor of psychology at San Diego State University, Delaney says one could argue "that anxiety has climbed since the 1930s until the 1990s,

and now has somewhat leveled off, but remains very high." She also cites another report synthesizing 48 articles on the prevalence of anxiety that show anxiety levels differ dramatically throughout the United States. Delaney's conclusion: "The answer depends on the source."

Heyland thinks anxiety might seem to be more prevalent due to greater awareness. "I believe that anxiety [disorders are] more widely recognized as an actual condition," she says. "In addition, the pressures that have increased as society evolves have also caused people to experience more anxieties."

It may be unclear whether we're suffering more anxiety than ever, but there is some good news. Nurses and other medical professionals are working to better understand this disorder and provide patients with tools to control and live with their anxiety.

"Anxiety is highly treatable," Delaney stresses. "We should be focused on early intervention." ☎

# SURVIVING THE STRESS

With the advent of 24-hour TV news and smartphone apps that push notifications as events happen, we can feel like we're in constant high alert.

Divisive politics, terrorism, war, human rights violations — these and other factors are part of daily life for anyone tapped into the news. Because it can be hard to escape what's happening in the world, the best strategy is to fine-tune your coping mechanisms to maintain perspective and rebalance.

Here are a few tips:

## SET BOUNDARIES ON NEWS

**CONSUMPTION** Turn off app notifications for a week and see if you feel better. Read a trusted daily newspaper and avoid TV news and its dramatic voices and visuals.

**TAKE CHARGE OF SOCIAL MEDIA** You don't have to necessarily unfriend someone whose opinions stoke your rage, but you can hide them. Their posts will not show up in your feed, and they'll never know.

**PULL YOUR FRIENDS AND FAMILY CLOSER** Scheduling get-togethers with friends and family each week will help you feel centered and give you events to look forward to.

**TAKE A WALK** Even a little fresh air and exercise can do wonders for stress reduction. Pay attention to the sights, sounds and smells. Notice the ordinary and look for the extraordinary.

**PRACTICE MINDFULNESS** This takes some practice but try to regulate your breath by taking deep inhalations, which increases oxygen to your brain. Then imagine you are exhaling out your worries. *For more mindfulness tips, see page 38.*

**GET HELP** If anxiety affects your daily life, such as eating, sleeping, socializing and general happiness, please get help. You're not alone, and a professional can help equip you with the skills you need to thrive in a stressful world.





# ANXIETY AND TODAY'S KIDS

A DNP project designed to help them cope

BY LAURA LAMBERT



It's normal for kids to worry about everything from natural disasters to stranger-danger to report cards to relationships — and to be wary of anything unusual, scary or new. But sometimes worry tilts into full-blown, diagnosable anxiety disorder, and up to 80 percent of kids with anxiety aren't getting the treatment they need.

"We all have some degree of anxiety," explains LeeAnn Hoodjer, MSN, ARNP, a family nurse practitioner and doctoral student at Rush. "Anxiety, or worry, is meant to keep us safe and from harm. It's a natural response to anything that could potentially hurt us. Unfortunately, that response can become uncontrollable and start to affect people's daily lives — that's when it's an anxiety disorder."

But in today's always-on, high-stress culture, those safety mechanisms can be overwhelmed. Today, 1 in 8 children may suffer from some type of anxiety disorder.

"It's the No. 1 mental health disorder in children," says Hoodjer.

Statistics such as these led Hoodjer to her doctoral project: helping children with anxiety. And she started in a place she knew well — St. Paul's Lutheran Church and School in Waverly, Iowa — the small parochial school where her three kids, ages 9, 7 and 4, were enrolled.

## A MATTER OF SECONDARY PREVENTION

As a working nurse practitioner, Hoodjer knew intuitively that mental health is an important component of all patient care settings, whether in family practice or emergency medicine, and it's why she decided to pursue a doctor of nursing practice (DNP) in psychiatric-mental health in the first place.

But while the prevalence and importance of mental health issues weren't new to her, the notion of secondary prevention was. The goal of secondary prevention is to reduce the impact of anxiety by recognizing it early and teaching coping strategies to prevent long-term problems.

"In family practice, everything we do is based on prevention," explains Hoodjer. In one of her first courses at Rush, she learned how that point of view could be extended to mental health. "I didn't know you could prevent mental health issues."



## IT TAKES FRIENDS

The project Hoodjer plans to undertake, starting in fall 2017, is based on a curriculum out of Australia called the FRIENDS programs. FRIENDS is a collection of evidenced-based, cognitive behavioral programs that promotes emotional resilience and — of particular interest to Hoodjer — aims to prevent anxiety (and depression) in childhood. It's the only program of its kind endorsed by the World Health Organization.

While data is central to Hoodjer's project — anxiety scales are taken before the program at one-, three- and six-month intervals to measure effects — the idea is that learning anxiety management skills as children will reap a lifetime of benefits, potentially heading off future battles with substance abuse and difficulties in work, school or relationships.

## STARTING YOUNG

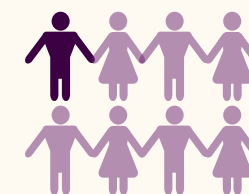
"It has to start at the root when they're kids," says Hoodjer.

Which is exactly where she plans to start — with second- and fifth-graders. The principal and a kindergarten teacher at St. Paul's have also taken the FRIENDS training and will be implementing it with the school's youngest children.

Hoodjer has found a strong partner in Kris Meyer, PhD, principal at St. Paul's. Meyer is especially passionate — resilience was the topic of her doctoral dissertation, though with a different student population: college students.



OF KIDS WITH ANXIETY AREN'T GETTING THE TREATMENT THEY NEED



1 in 8 CHILDREN

MAY SUFFER FROM SOME TYPE OF ANXIETY DISORDER



MENTAL HEALTH DISORDER IN CHILDREN



**HOODJER’S PROJECT A NATURAL FIT**

“It reinforced my research, and what the research said about resilience is that it can be taught,” explains Meyer.

Part of that early education is simply learning to put words to feelings. Unlike attention deficit hyperactivity disorder, for example, with its more obvious and observable symptoms, anxiety can remain unnamed and unnoticed, locked inside a child’s thoughts and feelings.

“For children, it’s teaching them this is what worry feels like. When you feel it, this is anxiety,” explains Hoodjer. The program helps kids identify negative thoughts and manage negative thinking. The hope is that these techniques help prevent anxiety from progressing to a disorder.

“It’s about coping skills,” says Hoodjer — whether you’re 5 or 50.”

Parents are an important part of the program. “If the airplane is going down, they say to put the mask on the adult first,” says Hoodjer. And it’s the same with anxiety. “We teach the parents how to identify and change their behavior and help them so they can help their children.”

**HIGH HOPES**

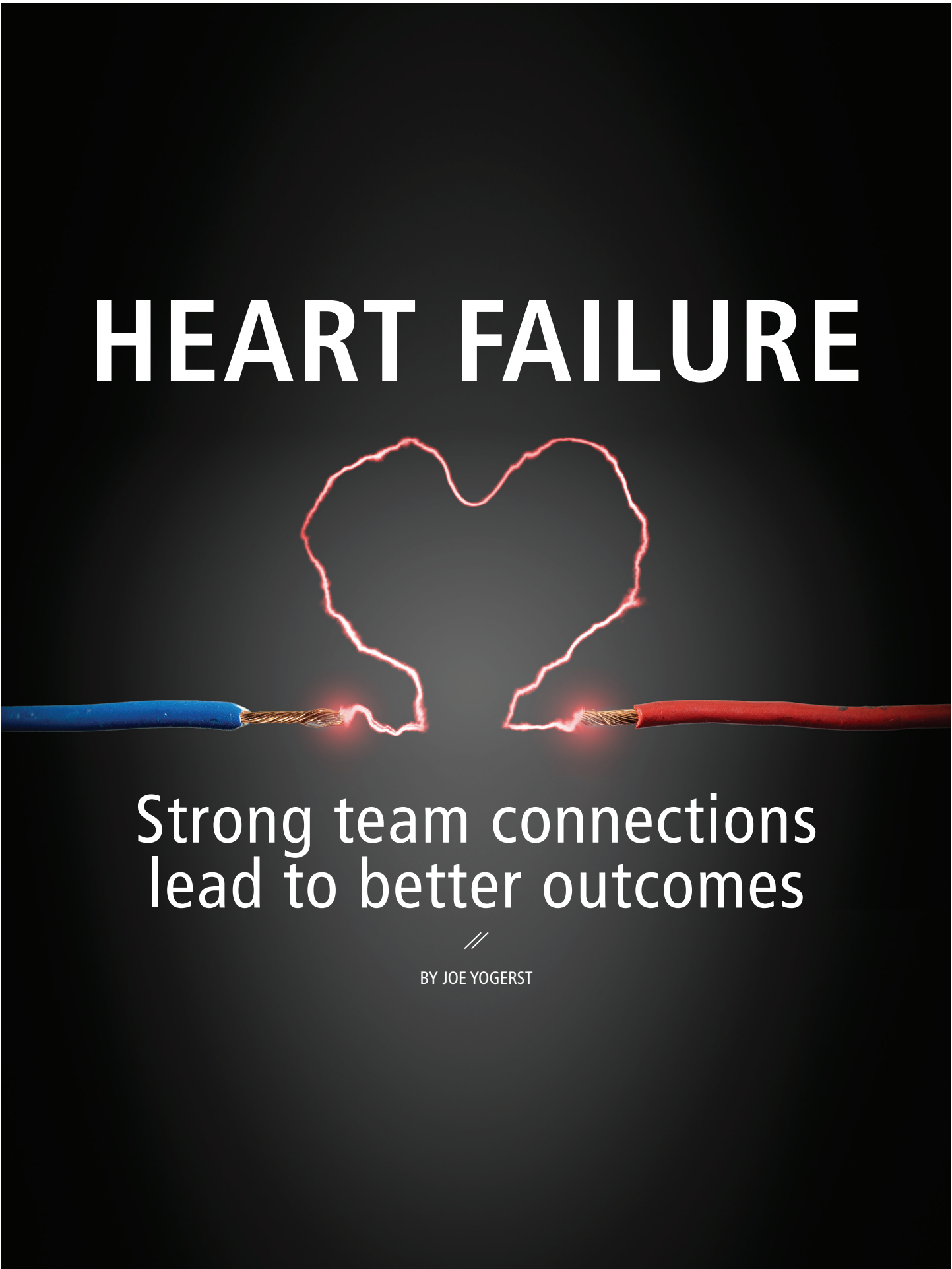
Meyer is eager to see how the program plays out for the entire school community — parents, children and the teachers themselves. As is Ruth Fiedler, EdD, RN, PMHCNS-BC, CNE, Hoodjer’s DNP advisor at Rush.

“I hope that when all is said and done, everybody involved will come away saying, ‘Wow, we see these kids had a problem, we were able to do something to help improve it, and we can see that there are techniques that do make a difference,’” says Fiedler. “How wonderful to have this group of young people walk away and have (these techniques) with them for their whole lifetime.”



**“The program helps kids identify negative thoughts and manage negative thinking.”**

*– LeeAnn Hoodjer, MSN, ARNP, doctoral student*





Innovation has often originated in Chicago. And the same is true at Rush University Medical Center, where the heart failure (HF) transition team is revolutionizing the way patients are treated.

“With our Heart Failure Transition Program (HFTP), what we’re really focusing on is connecting the inpatient team to the outpatient health care team and resources in the community,” says program director Barbara K. Hinch, DNP, ACNP, assistant professor, who heads an interdisciplinary team of nurses, physicians and social workers, as well as case managers and pharmacists.

And they are offering these transitional services without additional costs to patients.

CONTINUITY OF CARE

“Health care for many people is very fragmented,” Hinch says. “They come to the hospital, they get inpatient treatments, they get discharged and their primary health care provider may or may not be connected to the institution they were just discharged from. Their follow-up appointment may be 20 to 30 days after they left the hospital, and there may be things that have gone on during that time. It’s just very fragmented.”

Chronic heart failure is a condition that cannot be cured, but its progression can be slowed with medication and treatment. Even under the best of health care and home care circumstances, many patients experience reoccurrences and ongoing issues after leaving the hospital. A patient’s welfare can be further compromised by psychosocial concerns often magnified in big cities like Chicago.

“It’s a population of patients that could really use some additional support,” says Hinch. Which is exactly what the

HFTP attempts to accomplish — ease the transition from hospital to home life as seamlessly as possible to reduce the number of readmissions and help patients segue into healthier habits and lifestyle choices.

BUILDING A BRIDGE

“Heart failure transition teams are extremely important,” says cardiologist Burhan Mohamedali, MD, medical director of Rush’s Advanced Heart Failure Program. “They provide a necessary service as a bridge for the patients between the hospital, where all care of the patients is met in a uniform setting, to the outpatient environment, where patients have to navigate the complex medical world on their own.”

The program kicks in from the moment a heart failure patient is admitted. An RN case manager takes overall charge of the patient’s pathway through the hospital and beyond, while an inpatient social worker gives the patient a comprehensive psychosocial assessment to make sure everyone on the team is aware of any home life issues that may arise. This connection to the community continues as the Rush outpatient Bridge social work team uses this information to ensure that all identified barriers are addressed.


“We normally look at all components — financial, living arrangements, any issues that might be of concern, or any barriers,” Hinch explains. “This initial assessment is so important because it sets the stage for what we are going to do with this patient when they’re ready to go home.”

FORGING A RELATIONSHIP

Another key member of the team is the nurse practitioner in the HF clinic, who often develops a close and trusting relationship with patients and their families.

**“This initial assessment is so important because it sets the stage for what we are going to do with this patient when they’re ready to go home.”**

— Barbara K. Hinch, DNP, ACNP, assistant professor



**“We took the time to erase our preconceived ideas about who we thought our patients were and what they needed. Instead, the team listens and responds to what is happening in patients’ lives.”**

“This care not only includes the necessary medical management,” says Monique Colbert, NP, an acute care nurse practitioner on the HF transition team, “but encompasses recognition of when to refer the patient to social, nutritional, behavioral health and/or financial resources.” For some, spiritual care is very important as well, she adds.

During the patient’s hospital stay, the team also provides information on access to care, nutrition, medication, exercise, insurance, makes follow-up appointments and arranges transportation to appointments if needed. The team also identifies patients who may need home health care, which can be provided through home health agencies with expertise in caring for heart failure patients.

COMMUNICATION IS KEY

Another benefit of the transition team is communication. Following discharge, patients can expect phone calls from their case manager within 24 to 48 hours and a Bridge social worker within the first week to answer questions and ensure they are taking their medications properly, have transportation to follow-up appointments and are monitoring their blood pressure, weight, and so on.

**“The results have paid off with increased compliance and decreased readmissions.”**

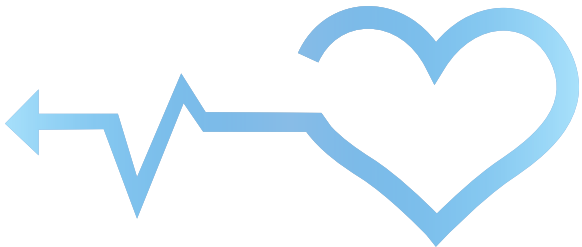
— Kathleen Egan, director of social work at Rush University Medical Center

“As you can see, this is truly a Herculean effort to assist heart failure patients,” says Mohamedali. “The patients do not receive a bill for the services received from the Heart Failure Transition Team. This is purely a hospital supported initiative with all the cost of the team borne by Rush.”

A HOLISTIC APPROACH

“The idea of ‘It Takes a Village’ is what many programs at Rush — including the HF program — are based on,” says Kathleen Egan, director of social work at Rush University Medical Center. “We have spent time studying our community, its resources, and worked at creating valuable partnerships/relationships. We took the time to erase our preconceived ideas about who we thought our patients were and what they needed.” Instead, the team listens and responds to what is happening in patients’ lives, she adds.

This holistic approach allows the HF transition team to identify barriers, better assess risks and create care plans that address the individual medical, social and spiritual needs of its patients. “This is a work in progress,” Egan adds. “But the results have paid off with increased compliance and decreased readmissions.”





# CHICAGO'S MOST VULNERABLE YOUTH

## NP helps teens reject violence

Through the Adolescent Empowerment Program she created at her nurse-managed faculty practice clinic, Terry Gallagher and her students are inspiring at-risk teens to think bigger about their future.

BY BETH JANES

**The group of teens walked into the large room, saw the rows of heavy black body bags and gasped.**

Growing up on Chicago's West Side near an intersection known for violence — a dividing line between not only police precincts but also gang territories — these kids have seen their share of body bags. But they weren't expecting them here, and it freaked them out.

After gentle reassurance, a few of the bags were opened. Once the teens saw the mostly elderly bodies and learned most died of natural causes, they began to relax and view the specimens as educational tools. Their fear gave way to intense curiosity — and an amazing experience for the young students, says Terry Gallagher, DNP, APRN, FNP-BC, CNL, an assistant professor in the department of women, children and family nursing at Rush University College of Nursing.

**“Many of these kids haven't learned the coping skills other kids their age have, so small, inconsequential arguments can devolve into life-altering and life-ending interactions.”**

This visit to the Rush anatomy lab — where the teens got to hold a human heart and see what muscles look like under the skin — was part of a field trip for the Adolescent Empowerment Program (AEP), which Gallagher runs along with a team of Rush nursing students out of the Sue Gin Health Center at Oakley Square, a mixed-income housing development in one of Chicago's roughest neighborhoods. The AEP's focus is prevention of violence, substance abuse, dropping out of school, teen pregnancy and more, all through the lens of improving decision-making.

### THE DANGERS OF IDLENESS AND BOREDOM

Gallagher, a nurse practitioner who also manages the Sue Gin clinic, one of Rush College of Nursing's faculty practice sites, created the AEP in the summer of 2016 based largely on what the adolescent residents of Oakley Square told her they needed.

“They weren't coming into the clinic on their own, so we went to them; we walked around and started talking to kids,” says Gallagher, whom the teens recognized because of her work at the clinic. “They told us they didn't feel safe outside and they aren't allowed to loiter around the development. They actually said: ‘There's nothing for us to do.’”

Boredom, fear, feeling ignored and powerless, plus a lack of support, educational resources and a lawless environment can all contribute to teen violence and crime. The statistics in Chicago are especially grim. People ages 20 and under commit more than 33 percent of Chicago's murders and manslaughters, according to the Chicago Police Department. Meanwhile, the Chicago Tribune reports that in 2016 alone, 324 children ages 16 and younger were shooting victims.

“Many of these kids haven't learned the coping skills other kids their age have, so small, inconsequential arguments can devolve into life-altering and life-ending interactions,” Gallagher says. She remembers an a-ha moment while listening to a talk by a teen violence expert. “He said, ‘We treat this like an adult problem, when actually it's a pediatric problem,’” she says. “It made sense. All the strategies seem to be aimed at adult minds, but that's not who we need to reach.”



Terry Gallagher, DNP, APRN, FNP-BC, CNL (back left) and members of the Adolescent Empowerment Team.



**A PROGRAM MIX OF HEALTH ISSUES, LIFE SKILLS AND FUN**  
The AEP meets once a week at the clinic for two-hour sessions. Recruiting is done mostly by word of mouth. “When we started, I hoped we’d get five teens, but that first session there were tons of kids,” Gallagher says. Typically 10 to 15 show up each week, but they’ve had as many as 50.

Gallagher wanted teens to feel comfortable coming to the clinic to discuss health issues, but also to gain life skills. So she and the nursing students strive to make sessions fun, not feel like a class or lecture.

Each session begins with a group dinner and socializing, followed by a presentation, movie or other programming meant to spur discussion around a topic. The last half hour is spent debriefing and playing games. One session, for example, involved projecting male and female anatomy on the wall and asking teens to label the different parts. “They were completely befuddled,” Gallagher says.

Another game Gallagher says the teens like is called Four Corners. “We’ll read out a scenario or question — for example, ‘It’s OK for women to hit men’ — and they’ll have to go to a corner designated with their answer, whether it’s ‘I strongly disagree,’ ‘I disagree,’ ‘I agree’ or ‘I strongly agree’ then we’ll talk about why they choose that corner,” she says.

Bullying is a popular subject — and an area where AEP has already made a difference. After watching a clip from a documentary, one teen admitted she herself was a bully.

“She said she was going to go to school the next day and apologize, and that she didn’t realize how much she could hurt someone,” says Sirene Helwani, a recent Rush College of Nursing graduate who worked closely with the AEP as part of a fellowship. “For her to acknowledge that in front of the group was powerful and moving.”

**“When we started, I hoped we’d get five teens, but that first session there were tons of kids.”**

**TEENS IMPACT THE TOPICS AND ACTIVITIES**  
As the participants have evolved, so too has the program. For example, when one of the complex’s residents had a heart attack and died near the mailboxes, the teens were shaken. “What I heard was that people felt really helpless and powerless and didn’t know what to do, so they asked us to teach them CPR,” she says. “Within a week or two, we had five mannequins here.”

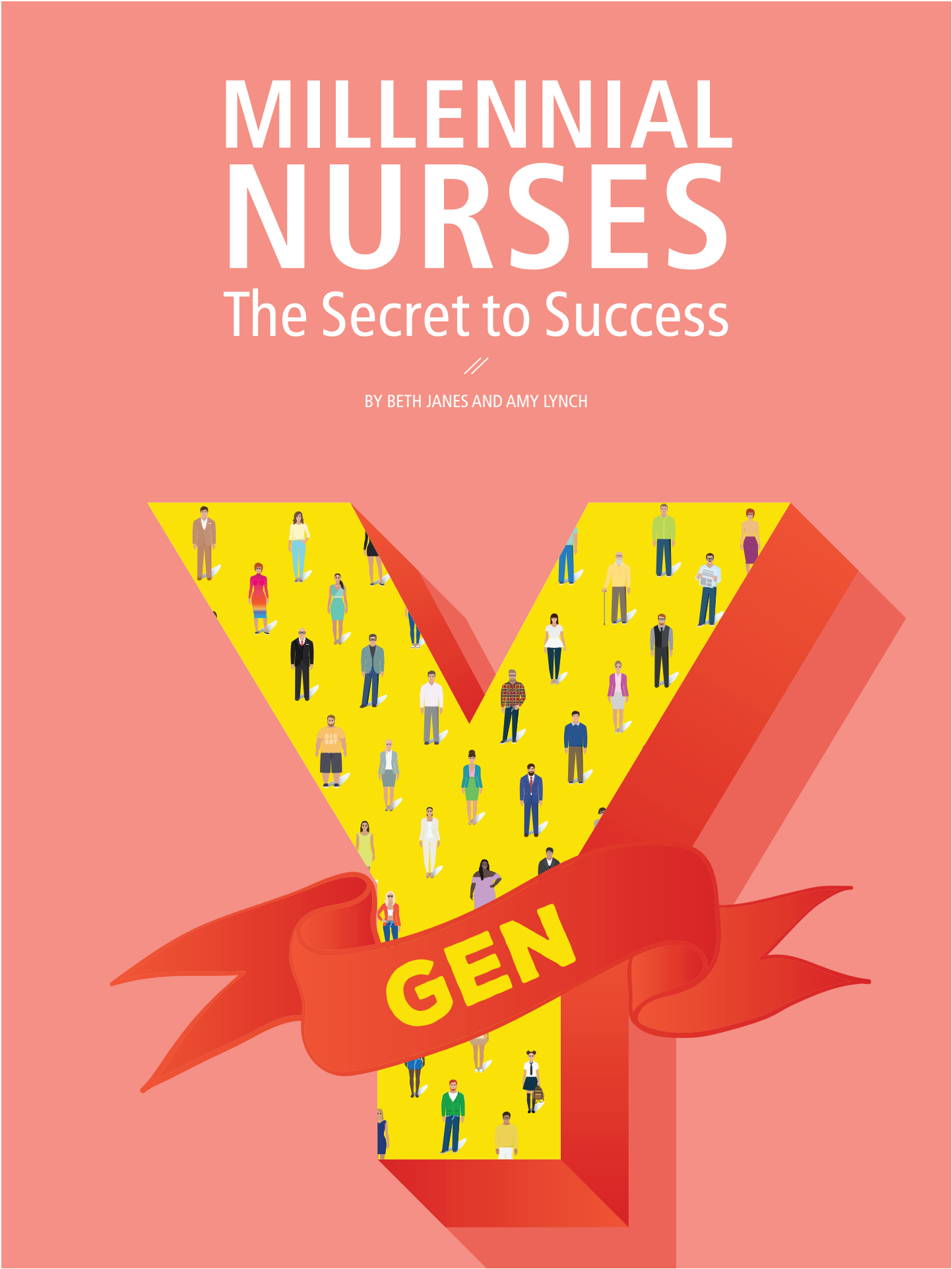
Campus visits and college fairs are another feature of the program. At one college fair, Helwani helped a participant, a high school sophomore and aspiring veterinarian, overcome her shyness and fear and talk to college recruiters. “After that, I saw her confidence go up, she looked happier and was excited to go over all the info she got,” she says.

**“They told us they didn’t feel safe outside and they aren’t allowed to loiter around the development. They actually said: ‘There’s nothing for us to do.’”**

**NURSING STUDENTS BENEFIT TOO**  
The AEP makes as much of an impact on the nursing students who help run it as it does the teens. “They’re all students so they can connect on a similar level and it allows a trust to be forged,” Gallagher says.

The program also helped Helwani realize that nursing, and her education at Rush, could go well beyond learning to draw blood and read charts.

“It’s really taught me to think of health more holistically — socially, emotionally, environmentally — all these things play a role in how you prioritize your health,” she says. “The experience has made me more humble and passionate about social justice, too. It’s unfair that some kids don’t have the same support as those in affluent communities. So it’s been a reminder to keep working toward health equity in my professional career and personal life.”





Much has been written about Millennials, also known as Generation Y, but whatever you believe about people born between 1980 and 2000, they're a force to be reckoned with. By 2020, Millennials will be the largest generation in the workforce. By 2025, they could make up 75 percent. And many are likely to find their way to health care, and nursing specifically, as demand and opportunities rise.

According to the U.S. Bureau of Labor Statistics, health care occupations are expected to see the fastest employment growth. By 2022, the number of employed nurses is forecast to hit 3.24 million, a 20 percent jump from 2012. What's more, by 2025, the nurse shortage is projected to be 260,000.

Training enough Millennials to fill those positions is only one problem. The other big one: Keeping them. Turnover is high among this demographic, notes Jason M. Purcell, a DNP student at Rush University College of Nursing who has studied the topic. His research identified one medical center in the Midwest where approximately 75 percent of RN turnover was from Millennials. Another survey found that a third of RNs leave their first nursing job within two years.

Compounding the problem is that Millennial nurses, like their peers in general, see job-hopping as a given. Research shows that up to 61 percent expect to stay in their first position no longer than year; less than 20 percent anticipate working for only one employer long-term, Purcell's research found.

**WHY CURBING TURNOVER IS CRUCIAL**  
Because it's easy for nurses to jump to new jobs, organizations must work to retain them. Purcell points to a report in Policy, Politics & Nursing Practice stating turnover is one of the most "disruptive and expensive

problems facing the U.S. health system." It not only costs up to \$80,000 to fill one vacant registered nurse position, turnover contributes to nurse burnout for remaining staff, he reports.

Curbing turnover yields monetary savings, of course, but also improvement in patient care and employee satisfaction. What's more, nursing schools and hospital nurse residency programs can start sowing the seeds of longevity early. The key for both: Addressing the unique needs, desires and attitudes of Millennial nurses.

To that end, Purcell states, "The strategies Millennial nurses best respond to are mentoring, frequent feedback, opportunities for advancement, professional development, and reward and recognition."

**HOW MENTORSHIP RETAINS NURSES**  
Rush University College of Nursing and its Medical Center, for example, recognize there's a silver lining to an aging nurse workforce — a talented pool of clinicians and faculty who can support and guide the new generation of nurses.

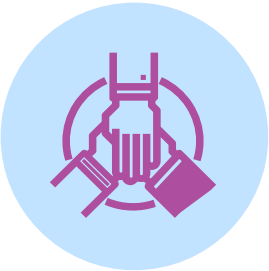
While in school, supportive relationships with faculty advisors and mentors set the tone. Students in their last term are immersed in a typical nurse schedule and work with a preceptor. New graduate hires at Rush University Medical Center also work with a preceptor during an eight-week orientation, plus complete a residency. Often the preceptor turns into a long-term mentor.

In fact, that was the experience for Maura Waldron, MSN, RN, a 2015 graduate who works on a RUMC general medicine floor, and her preceptor, Katie Wood, MSN, RN, a graduate and 10-year veteran of Rush who recently moved out of state.



**“Nursing is always evolving, and with that so should the nurse.”**  
– Maura Waldron, MSN, RN

# MILLENNIAL NURSES



ARE EXCEPTIONAL COLLABORATORS



WANT FREQUENT FEEDBACK TO ENSURE THEY ARE DOING A GOOD JOB



APPROACH TASKS IN INNOVATIVE WAYS



VALUE EDUCATION AND PROFESSIONAL DEVELOPMENT OPPORTUNITIES



ENGAGE WITH CAUSES THAT HELP PEOPLE, NOT INSTITUTIONS



WANT A COACH, NOT A MICROMANAGER

“With each new experience, Katie walked me through the process,” Waldron says. She recalled one, in which Wood once stood behind her while she made a suggestion to a resident physician. “After I finished, the resident agreed (with me),” she says. “As we walked out of the room, Katie said, ‘Good job. That’s how you advocate.’ It was supportive moments like that which fostered my confidence.”

Wood’s simple “good job” is an example of the kind of feedback many Millennials thrive on.

Ample networking, volunteer and development opportunities are other ways Rush encourages mentorship and addresses Millennials’ needs.

**CREATING THE RIGHT ENVIRONMENT FOR MILLENNIALS**  
“I cannot express how welcoming Rush is to new graduates,” Waldron says. “The residency program helps them integrate smoothly. Skills workshops in state-of-the-art labs help hone nursing skills. Clinical nurse specialists throughout the institution are there to provide (continuing) education. ... Most new graduates want to stay for that environment.”

Woods helped foster that environment by encouraging openness, teamwork and humility — traits Millennials

often are thought to be lacking. Her best lesson, which she learned as a Rush student: “Look, listen and learn,” Woods says. “Don’t presume you know everything. Ask questions.”

That advice hit home for Waldron, who says new grads should find mentors or buddies they can talk to and learn from. “Nurses are caring by nature, so most want to provide that compassion to a new nurse,” she says. “Nursing is always evolving, and with that so should the nurse.”

Rush takes that seriously, offering professional development, plus the leadership and advancement opportunities many Millennials crave. Waldron, for example, in her two years as an RN, has completed training in end-of-life care, cardiac support and mindfulness. She’s joined floor-based committees, trained as a charge nurse, and advanced to an “RN 2.” She’s also now a preceptor herself — and is happily building her career at Rush.

“I stayed because it fit,” Waldron says. “I enjoy taking additional courses and being held to a high standard of care and expected to always improve my skills. ... The nurses I work with are (also) a major reason I stayed. They are a compassionate, intelligent, ambitious, caring, thoughtful cohesive group of exceptional nurses, and I knew staying on this floor would make me a better nurse.”





# A SHOT AT LIFE: A NURSE AT THE RIGHT PLACE, RIGHT TIME

/// BY LINDSEY MALKUS

**IN LATE SEPTEMBER 2016, THE AREA AROUND WRIGLEY FIELD IN CHICAGO BUSTLED WITH EXCITED CUBS FANS, WHILE ONLY BLOCKS AWAY A MAN WAS LYING ON THE SIDEWALK, FIGHTING FOR HIS LIFE.**

Elisabeth Barrett, MSN, RN, and her husband were out for a walk in Wrigleyville with their dog and 2-week-old son. The area near their home was busy with game day activity, and nothing seemed out of the ordinary, at first. That all changed when a few blocks away, they noticed a couple of people staring at someone on the ground.



**SMALL PUPILS, SHALLOW BREATHING, UNRESPONSIVE...**  
At first, “I thought it was probably just some drunken people from the game,” Barrett recollects. However, on approach, after seeing the man was unresponsive, she jumped into action and performed a quick physical assessment including sternal rub and breath rate check. She determined the man had more than likely overdosed on opioids and directed a bystander to call 911.

This class of legal and illegal substances, which includes morphine and heroin, affects pain receptors, and in large enough doses can short-circuit the part of the brain that controls breathing.

Knowing that every second counts in reversing an overdose, Barrett sent her husband running back home to their medicine cabinet, where months before she’d stored a naloxone kit, a lifesaving tool that she never thought she would use.

**FORTUITOUS TRAINING**  
This specific dose of naloxone, a fast-acting medication that can block or even reverse the effects of opioids, found its way into Barrett’s medicine cabinet thanks to a training session she attended the previous May. As a family nurse practitioner doctoral student and instructor in the master’s program at Rush, she takes advantage of campus events and encourages her students to do the same. This event, in particular, caught her attention.

“As an ICU nurse, I have certainly used naloxone before, but always in a controlled setting. I often feel helpless outside the hospital walls because I don’t have the tools to do what I know how to do. Considering the increase in opioid deaths in Illinois, I knew this opportunity was unique,” she noted in an email to the event organizer, Julie Worley, PhD, FNP-BC, PMHNP-BC, CARN-AP.

According to the Centers for Disease Control and Prevention (CDC), overdose deaths involving prescription opioids have quadrupled since 1999, and so have sales of these prescription drugs. In Illinois, death by opioid overdose increased to 1,835 in 2015. Compare that to 998 deaths in Illinois due to traffic accidents in the same year.

Worley, an assistant professor at the college, is very familiar with the opioid epidemic. As a researcher and psychiatric, mental health, and family nurse practitioner, she’s witnessed the effects of substance use disorders firsthand, which is why she decided to become better equipped to deal with overdoses.

Her work includes conducting research on the disorders and spearheading efforts to increase education for nursing students and faculty at Rush. The goal is to empower nurses beyond the curriculum, so they are better equipped to combat the epidemic of opioid misuse and addiction.

“When naloxone first became available to the public without a prescription (in Illinois), I found out that Chicago Recovery Alliance provides the required training to administer it,” Worley recalls. She reached out to the Alliance’s director, Dan Biggs, and became certified as a trainer. Shortly after, with some help from Biggs, she and the Chicago Recovery Alliance brought the program to Rush and provided naloxone kits to about 100 nurses and students.

**“Within 10 seconds, he opened his eyes,” she remembers. “He was still in a daze, but awake and breathing normally.”**

**“When the EMTs finally arrived, they were shocked and impressed to find out that an off-duty nurse had the lifesaving naloxone to administer.”**



**A POWERFUL MOMENT (A POWERFUL OUTCOME)**  
Months later, thanks to this group endeavor, Barrett found herself with the tools she needed to save a man’s life while game-day traffic delayed the ambulance. Thankfully, the naloxone injection she administered in his thigh worked almost immediately.

“Within 10 seconds, he opened his eyes,” she remembers. “He was still in a daze, but awake and breathing normally.” When the EMTs finally arrived, they were shocked and impressed to find out that an off-duty nurse had the lifesaving naloxone to administer.

Barrett downplays her efforts: “I think this was a right place, right time kind of thing.”

But for Worley, hearing a success story like this is thrilling. “It really is tangible evidence of the impact that you can have.”

In fact, Worley adds that the CDC recommends everyone, not only nurses, be prepared for this type of emergency, especially households with people who take prescription opioids for pain. Consider requesting a naloxone kit at your neighborhood pharmacy at the same time you pick up your prescription opioid medication.

**STARTLING STATISTICS FROM THE CDC**



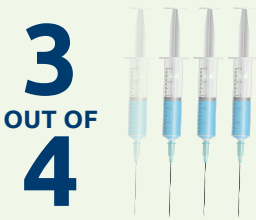
**91 AMERICANS DIE EVERY DAY FROM AN OPIOID OVERDOSE.**



**MORE THAN 6 OUT OF 10 DRUG OVERDOSE DEATHS INVOLVE AN OPIOID.**



**MORE THAN 12,989 PEOPLE DIED IN 2015 FROM HEROIN-RELATED OVERDOSES.**



**AMONG NEW HEROIN USERS, ABOUT 3 OUT OF 4 REPORT ABUSING PRESCRIPTION OPIOIDS BEFORE USING HEROIN.**



**FORGET THE STEREOTYPE**

One detail that has stuck with Barrett is how ordinary the victim appeared. “This guy, you could have picked his outfit out of my husband’s closet,” she remembers. “He was well-dressed, well-kempt, clean.”

“I think people like to think that they’re in this sector of life where it doesn’t affect them,” says Barrett, though she and other nurses are very aware of the pervasive nature of opioid addiction.

Worley echoes Barrett’s sentiments. “People have that attitude of ‘This wouldn’t happen to anyone I know,’ and ‘I don’t live in a place where someone is going to be on the street.’”

Though Barrett doesn’t know what happened to the young man after he got into the ambulance, one thing is clear: Thanks to preparedness and quick thinking, he and others like him can have a fighting chance. 🕒

# HOW TO SAVE A LIFE WITH NALOXONE

FAQ with Julie Worley, PhD,  
FNP-BC, PMHNP-BC, CARN-AP

**Q: WHAT IS NALOXONE (ALSO KNOWN BY THE BRAND NAME NARCAN)?**

**A:** A medication designed to reverse opioid overdose.

**Q: WHAT DRUGS ARE CONSIDERED OPIOIDS?**

**A:** Opioids include the illegal drug heroin, and pain relievers available legally by prescription, such as oxycodone (OxyContin), hydrocodone (Vicodin, Norco), methadone, codeine, morphine, and tramadol.

**Q: WHO SHOULD HAVE A NALOXONE KIT IN THEIR HOME MEDICINE CABINET?**

**A:** Along with medical professionals, the family and friends of individuals who are taking illegal opioids, suspected of taking them, or have taken them in the past. Some experts also recommend family and friends of anyone taking high doses of opioids for chronic pain have naloxone available for accidental overdose.

**Q: CAN ANYONE ADMINISTER A NALOXONE SHOT?**

**A:** Anyone with naloxone on hand should be trained in its safe usage as well as how to manage an opiate/heroin overdose situation.

**Q: IS IT HARD TO GET NALOXONE?**

**A:** Depends on your state. Anyone can get naloxone in Illinois without a prescription after receiving training from a pharmacist. However, it can be hard to find a pharmacist who provides training. If you can’t find one, contact the Chicago Recovery Alliance ([anypositivechange.org](http://anypositivechange.org)).

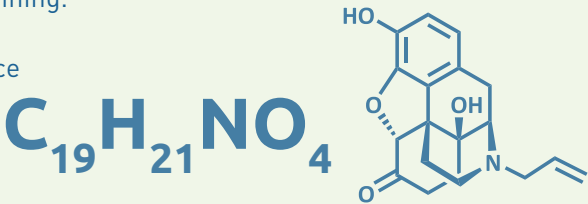


**Q: DO I NEED MORE THAN ONE DOSE ON HAND?**

**A:** More than one dose in rare cases may be needed to reverse an overdose.

**Q: SHOULD PEOPLE WITH SEVERE CHRONIC PAIN AVOID OR STOP TAKING OPIOIDS?**

**A:** People with severe chronic pain should consult with their health care professional about whether to take opioids. Medical professionals should follow the most recent recommendations and take precautions whenever prescribing opioids, such as a shorter course (three days), consulting the Prescription Drug Monitoring Programs (PDMP) database, and following the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain.



# TWO NURSES, ONE SENATOR, A chance encounter and five minutes to influence

BY LAURA LAMBERT





**What happens when a Rush nursing faculty member and her doctoral student show up in Springfield and press for face time with a senator?** In this case the senator ends up co-sponsoring Senate Bill 0642, keeping hope alive for Illinois APRNs who are passionate about primary care and the health of underserved communities.

Although legislative bills like this one failed twice before, this time a team of determined leaders were intent on nursing it along its path into law.

**THE PRIMARY CARE PROBLEM**

In Illinois — and across the country — there’s a growing shortage of primary care providers. Some estimates put the national shortage as high as 96,000 in the next 10 years. Today, Illinois alone needs 454 more primary care providers.

But advanced practice registered nurses (APRNs) can solve the problem — if lawmakers let them.

“We need the providers right now,” explains Melissa Kalensky, assistant professor at Rush University College of Nursing and a family nurse practitioner at Oak Street Health, a network of primary care clinics targeting underserved, Medicare-based populations across Chicago. “It’s unfortunate and shortsighted that practicing APRNs who are trained and qualified to do this work are prevented from doing so,” she adds.

At the end of 2016, the Department of Veterans Affairs (VA), the nation’s largest employer of nurses, made a sweeping decision to allow APRNs to practice to the full extent of their scope and licensure without mandated physician collaboration, regardless of state restrictions. It represents a slow but steady shift toward empowering highly trained and experienced nurses to help solve this nationwide problem.

In Illinois, however, there remains a reduced practice regulatory structure — which is where Senate Bill 0642 comes in. It would amend the Nurse Practice Act to allow APRNs to practice without having a collaborative agreement in place with a physician. SB0642 would simply allow more APRNs to reach communities without primary care options.

**CHANGE IS INEVITABLE**

Forty years of research points to the positive patient outcomes with APRNs – providing safe and high quality patient care that matches their physician counterparts. In 2010, the Institute of Medicine (IOM) called for the removal of barriers to advanced practice nursing to address the changing pressures on the health care system.

Twenty-three states have already lifted restrictions.

To Kalensky, the argument is straightforward. “The data is there to support it. The IOM wants it to happen. And it

is a solution for patients whose lives would be improved with access to primary care.” The delay from some Illinois lawmakers is prolonging the inevitable, while the health of communities continues to deteriorate, she says.

**In those few minutes, Bauer and Kalensky persuaded Van Pelt not just to vote for the bill, but also to co-sponsor it.**

**OPPORTUNITY FAVORS THE PREPARED MIND**

In March, Kalensky and several Rush students and staff traveled to Springfield to make that very point to Illinois lawmakers. The Illinois Society for Advanced Practice Nursing briefed them beforehand, providing talking points to help them make the most of their limited time.

Alongside Kalensky, Katherine Bauer, a doctoral student in the Rush family nurse practitioner program, had the opportunity to speak for several minutes with Illinois State Sen. Patricia Van Pelt.

Kalensky explained, “I’ve always spoken to staff, so this was my first experience speaking to a senator directly. We made multiple stops at her office and persisted until we caught her between meetings.”

“We were able to tell the stories of our patients in Chicago who have access-to-health-care issues,” says Bauer. The personal touch mattered — and, she says, it helped that both she and her patients were constituents on the city’s West Side.

“We did a high-five, and had to control our excitement about what just happened,” Kalensky said.

Later in the day, Kalensky ran into a Rush alumna, Marie Lindsey, PhD, FNP-BC, who is an influential nurse advocate and current professor at the University of St. Francis. Lindsey said the encounter was “meant to be” as Sen. Van Pelt, in particular, has a schedule almost impossible to penetrate without an appointment.

The success lay not just in finding an additional sponsor, but also in the inherent lesson about an APRN’s role — and responsibility— to help shape health policy. ☪

**“ We were able to tell the stories of our patients in Chicago who have access-to-health-care issues.”**

- Katherine Bauer, doctoral student



Family nurse practitioner faculty and students regroup to discuss their progress during lobby-day at the Illinois State Capitol. Left to right: Lucy Amaro, Raechel Ferry-Rooney, Kathy Swartwout, Melissa Kalensky and Katherine Bauer.



**VICTORY FOR PATIENTS & PROVIDERS**

The hard work of nurses, professors and others in health care has paid off. On June 25, 2017, the Illinois House and Senate approved Senate Bill 0642/House Bill 0313 with amendments, granting full practice authority (FPA) to Illinois licensed Advanced Practice Registered Nurses (APRNs) certified as a nurse practitioner, nurse midwife or clinical nurse specialist.

FPA means nurse practitioners no longer must have a collaborative agreement with a physician, and they now can prescribe medication without a physician’s signature. Each APRN must meet education, clinical experience and licensure requirements before being granted FPA.

**“It will be up to all of the APRNs to positively impact the culture in their organizations. These changes do not diminish the need for collaboration, which all health care professionals must do for optimal patient care.”**

- Lynne T. Braun, PhD, CNP, professor and nurse practitioner, department of adult and gerontological nursing & department of internal medicine



Gov. Bruce Rauner signed the revised Illinois Nurse Practice Act into law on September 19, 2017.

- No written collaborative agreements needed in any practice setting.
- Authority to prescribe legend and Schedule II-V controlled substances.
- When prescribing benzodiazepines and opioids, some special requirements are set forth.
- The physician’s name is not required on any prescription for an APRN with full practice authority.
- \* The title APN will no longer be used and is replaced by APRN.



# SOCIAL CONVERSATIONS

ARE YOU PART OF THE NURSING COMMUNITY ON TWITTER?

Join us for important conversations as together we strive to create healthier communities and positive change for our patients and profession.

“ If you say things of consequence there may be consequences – the alternative is to be inconsequential. ”

— @TheOpEdProject  
@RushUNursing

“

The more I think about it,  
#PhD #DNP & other  
terminal degrees  
MUST fully reclaim "Dr."  
PhDs were called Dr.  
before MDs were.



@MonaShattell

“

Unfortunately we live in a country  
where gun rights are more  
important than human rights.



@RushNursingDean

“

#FacultyPractice & nurse-managed  
clinics bring teaching, research &  
service together to benefit students,  
the public & our profession.



@AngelaMossRN

“

When I think about soda  
companies targeting  
minority communities  
with more advertisements  
than other communities,  
I get angry.



@fruitNveggie  
(Monique Reed)

“

‘Early stress affects the  
brain’ — This is why we  
must support families  
& take special care of  
our children starting in  
the womb. @anamfp



@WrenethaJulion

“

‘Research amplifies nursing’s  
impact’ but only 1% of nurses  
have PhDs ... let’s change this!  
#nursingresearch @RWJF



@ShannonHalloway

“

All providers need to practice to  
the full extent of their license and  
skill. #APRNs need full practice  
authority nationwide.



@EACarlson22

“

Got miles  
from @United  
for medically assisting  
an ill passenger.  
#TherelsaDoctorOnBoard  
#DNP



@MichelleHeyland



# EFFECTIVE PARENTING THERE'S AN APP FOR THAT

BY BETH JANES



**M**eltdowns at mealtimes, temper tantrums in the supermarket, acting out for attention one minute, ignoring your directions the next — struggles like these are as much a part of parenting as snuggles and story time. Ever wish there were an app for all that?

Well, now there is thanks to Susan Breitenstein, PhD, RN, associate professor of community, systems and mental health nursing at Rush University College of Nursing.

Called ezPARENT, the Android tablet-based app is a self-administered adaptation of the Chicago Parenting Program (CPP), a 12-session group workshop developed by three other Rush nurses. The CPP and the app use videos and exercises to teach parents simple strategies proven to create positive behavior change in kids.

A very useful feature of the app: It lets parents go through the training whenever and wherever it's most convenient.

That's huge given parents' often hectic and unpredictable schedules, and considering childcare and transportation challenges, Breitenstein says. So it's no surprise that early research shows completion rates for the app hit 85 percent compared to 50 percent for the traditional CPP.

## EARLY INTERVENTION IS KEY

While all parents can benefit from the app — Breitenstein herself is grateful for the parenting support she received while raising her own children during the CPP research — for some it can be life-changing. Up to 20 percent of children show behavior problems that interfere with relationship development and school achievement, and kids in low-income families are more at risk, according to research. What's more, problems that start early can lead to persistent and long-term issues.

That's something Breitenstein saw firsthand, early in her career as a child and adolescent psychiatric nurse. "We'd see kids 8 or 9 years old with behavior problems that were well-entrenched and difficult to change," she says. "By that point, too, parents were really frustrated."

The CPP and now ezPARENT target families of 2- to 5-year-olds — starting early to prevent the problems that can snowball when a child starts lagging behind, Breitenstein says. It focuses on small things that make a big difference, like the importance of child-focused time, setting limits and giving praise and feedback, plus strategies for handling misbehavior.

The app progresses in a series of six modules that each take an average of 45 minutes to complete. Video vignettes show diverse families interacting in real-world, relatable and relevant situations — like a tantrum at the supermarket — and include accompanying exercises, such as spending 15 minutes a day fully attuned to your child.

"These days, we have our phones with us all the time

and aren't always fully present for our kids," Breitenstein says. "I remember one mom talking about how her child would constantly interrupt her while she was on the phone, and she realized that if she disconnected for 15 minutes and focused fully on her child, she could then make the call without getting interrupted."



**"That mother made changes and saw changes in her daughter. It's not that she was doing something bad, but she recognized that there was a different way of interacting."**

## STRATEGIES THAT WORK

The app has been shown to improve kids' behavior and parent-child relationships, plus help parents feel more confident — same as the group-based CPP.

"The videos especially help parents recognize and reinforce positive things they do already and see things they want to change," Breitenstein says. Recognizing behaviors in yourself and adjusting accordingly is a powerful and effective teaching method, she adds. "It's not us saying, 'Do this,' or 'Don't do that.'"

For example, the app never tells parents not to spank; rather it presents alternatives and eight keys for effective discipline. "It's powerful when parents start paying closer attention to how they discipline," Breitenstein says. "And what we find is that spanking usually goes away."

She recalls another parent who told her about an epiphany after watching a video depicting a parent-dominated playtime.

"She said, 'That was me! I thought I was helping my child, but now I see I wasn't letting her control (her own play),'"

"That mother made changes and saw changes in her daughter. It's not that she was doing something bad, but she recognized that there was a different way of interacting."



**A PRESCRIPTION FOR PARENTS**  
Though ezPARENT isn't available to the public yet, that's something the team is looking into. In the meantime, it's being tested in a research study, funded through the Agency for Healthcare Research and Quality, in pediatric primary care sites in the city of Chicago.

"Parents trust primary care providers, so it's almost like a prescription they can give, like a vaccine," Breitenstein says. "The provider can say, 'Here's something we suggest for all parents.'" The app is truly for everyone and there should be no stigma around its use, she adds.

Laura Pabalan, MD, a pediatrician with Rush Pediatric Primary Care, is participating in Breitenstein's research by offering the app during checkups. Although providers already have a lot to do at that time, Pabalan says the app will save time and aid both providers and parents.

"Behavioral issues are often the first things parents bring up," she says. "But the topics are so complicated and time-consuming that we feel at a loss — we don't have time to go in depth, plus resident physicians don't get a lot of training on parenting and behavioral issues. The app bridges the gap and is a simple resource we can recommend parents explore on their own."

Pabalan says the majority of parents she's talked to seem interested, and of her patient families who have used it, feedback is positive. "They like that they can do it at home and find it really helpful," she says.

Breitenstein also sees the app as a potential money saver for parents and providers once it rolls out. As part of the digital study, parents are given the \$100 tablets, but group-based programs that parents attend in-person can cost much more, she says. "It can be \$1,000 a person when you factor in things like training group leaders, finding space, getting food," she says. Pediatric practices could purchase tablets to lend out, and bill insurance companies if parents don't own a device.

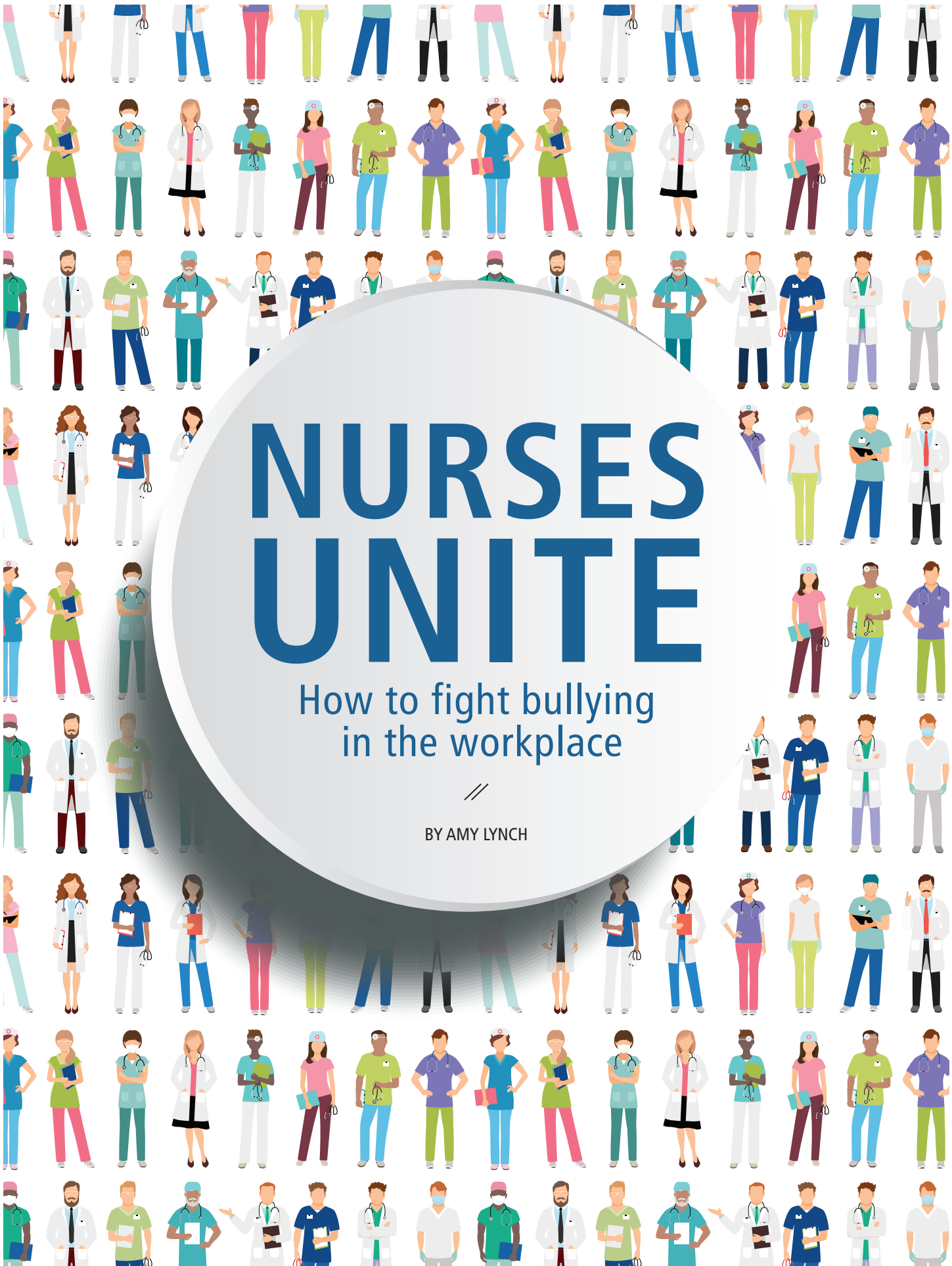
Logistics aside, Breitenstein says support tools like ezPARENT are important.

"Kids want approval and attention. If parents mostly point out what their kids do wrong, their kids will keep repeating that because that's how they get attention," she says. "(Parents) want their child to be successful, confident and kind. The app shows parents how to start paying attention and identifying those behaviors they want to see again."



**“The videos especially help parents recognize and reinforce positive things they do already and see things they want to change.”**

- Susan Breitenstein, PhD, RN, demonstrates the new ezPARENT app.





If you think bullying only happens on school playgrounds, think again. It also affects far too many adults in the workplace. In fact, according to the American Nurses Association, incivility, bullying and workplace violence are serious issues in nursing. Before nursing can win the war against bullying, employers must teach practical strategies for dealing with bullies and promote safe reporting.

“Workplace incivility/bullying is any negative behavior that demonstrates a lack of regard for others,” explains Beth Bolick, DNP, PPCNP-BC, CPNP-AC, FAAN, professor and director of the Acute Care Pediatric Nurse Practitioner Program at Rush University College of Nursing, and a Robert Wood Johnson Foundation (RWJF) executive nurse fellow. “This can include teasing, gossiping, purposely withholding business information, overruling decisions without rationale, passive-aggressive behavior, verbal intimidation, eye rolling and demeaning others.” Jennifer Grenier, DNP, RN-BC, director of Rehab Services at Rush University Medical Center, draws from her own personal experiences to educate colleagues and help reverse the doctor/nurse and senior nurse/new nurse stereotypes of bullying.

“Bullying and incivility is an issue that’s been near to my heart since I was a kid,” she says. “I was bullied as a child and in high school. As an adult, I’ve been surprised to see how much it still goes on in health care.” Grenier points out that because bullying is situational, it can be harder to define than more obvious types of harassment, but is still every bit as important to address.

THE STATISTICS

The numbers are shocking: A 2015 study published in the Journal of Nursing Administration indicated that 82 percent of nurses reported being the receiver of or a bystander to bullying on a daily or weekly basis. A 2009 Johnson & Reed study found nearly 21 percent of nursing staff turnover could be attributed to bullying, and 60 percent of all new nurses who quit their first jobs within six months did so because of it.

Bullying not only exacts a price on the victim’s mental, emotional and even physical well-being, it costs employers as much as \$88,000 to replace one nurse, according to an article in the Journal of Nursing Administration. And the toxic work environment bullying creates will ultimately worsen patient outcomes.

THE SOLUTION

However, the good news is that with the right tools, employers can promote a nurturing, safe and respectful environment and successfully reduce and even stop bullying. The first thing nurse leaders must do is educate their staff on how to identify and respond to bullying.

“Millennials are now receiving training in school about how to address bullying,” Grenier says. “Even kids are more educated these days and know this behavior isn’t supposed to be happening, but many adults didn’t get those tools as they were growing up.”

The next step is to involve nurses in workplace policymaking around bullying and empower them to report violations. According to Bolick, if you experience or witness bullying at work, the first thing to do is speak up immediately. If a behavior is making you uncomfortable, it needs to be addressed.

“ Millennials are now receiving training in school about how to address bullying.”

– Jennifer Grenier, DNP, RN-BC

NO MORE EXCUSES

Grenier agrees and adds that many times, bullies do not fully realize the effect of their behavior.

Unfortunately, many nurses don’t report bullying, either fearing repercussions or because they reluctantly accept it as part of the job. For older nurses and senior staff, bullying may be downplayed as simply a rite of passage.

“New nurses are trained by senior nurses who are skilled, but may not necessarily be good with the social aspects of the job,” Grenier explains. “So, people might write a bully off as someone who just has a ‘strong personality.’ We need to stop beating around the bush and excusing it by calling it other things.”

The consequences of workplace bullying include isolation, anger, depression, job dissatisfaction, fear, decreased self-esteem, stress-related illness, marital problems and even suicide. Witnesses to bullying also suffer.

All nurses should familiarize themselves with the policies of their organization. Most address bullying within their codes of conduct, and health care systems often provide a toll-free number or online system for employees to report bullying anonymously. Some organizations have also developed a universal code word that employees can say, or even flash via a badge, when they feel bullied to diffuse the situation before it gets any further out of hand.

STOP BULLYING TOOLKIT

As part of her work as an RWJF Fellow, Bolick created a series of online videos and a toolkit to teach health care professionals what constitutes bullying, and how to deal with it. She encourages health professionals to visit StopBullyingToolkit.org to access Civility Tool-Kit resources that empower leaders to identify, intervene and prevent workplace bullying.

“On any given day, we each can be in the position of perpetrator, receiver or bystander of negative, pervasive behaviors that most of us learned over many years and now must unlearn,” Bolick says. “Building a culture of respect takes a gracious space, forgiveness and time.”



Jennifer Grenier, DNP, RN-BC, and Beth Bolick, DNP, PPCNP-BC, CPNP-AC, FAAN, at Rush University Medical Center.

“Workplace incivility/bullying is any negative behavior that demonstrates a lack of regard for others.”

– Beth Bolick, DNP, PPCNP-BC, CPNP-AC, FAAN

RESPECTFUL CONVERSATIONS FOR DIFFICULT SITUATIONS

TIPS FROM STOPBULLYINGTOOLKIT.ORG

1PLAN FOR THE CONVERSATION

- Validate the facts
- Determine the focus of the conversation
- Create an environment conducive to effective communication
- Allot adequate time/prevent interruptions
- Determine who should participate in the discussion

2CHECK PERCEPTION

- Start the conversation with the reason for the meeting – be brief – then stop
- Ask the other person to describe his/her perception of the event

3DELIVER THE MESSAGE

- Situation: Repeat the situation and provide more detail
- Background: Provide background to the situation that puts the situation into perspective
- Impact: Describe the impact of the situation on building & sustaining human capital and impairing patient outcomes

4EMPATHIZE

- Provide a gracious space with good intentions and respect throughout the conversation
- Be comfortable with pauses/silence and truly listen
- Be sensitive and straightforward
- Put yourself in the other person's shoes

5SUMMARIZE & FOLLOW-UP

- Review the highlights of the conversation
- Check for understanding
- Determine what is to follow before the meeting and review the plan
  - Restorative justice
  - Administrative action
- Arrange for follow-up



# JUST BREATHE

## Mindfulness training easing stress for nurses

BY LAURA STROM

- Buzzers and ringing phones
- Perpetual electronic recordkeeping
- Complex, sicker patients
- Ethical dilemmas
- Communication with multiple providers and family members
- Rapid patient turnover
- Life-and-death implications

**This is the life of a registered nurse in a hospital setting. Not surprisingly, it can also be a recipe for burnout if not for a technique that is receiving high praise.**



**A**ll jobs come with some degree of stress, but nursing is considered one of the most stressful professions, according to the National Institute for Occupational Safety and Health at the Centers for Disease Control and Prevention. In fact, some experts call nurse burnout a public health crisis.

### THE STAGGERING STATS

The statistics for burnout are staggering, and they have been for some time. A 2014 study in Policy, Politics & Nursing Practice reveals that an estimated 17.5 percent of newly licensed RNs leave within one year of starting their first nursing job, and 33.5 percent leave within two years. A 2016 study in the American Journal of Critical Care found that about 25 to 33 percent of critical care nurses manifest symptoms of severe burnout syndrome (BOS), and up to 86 percent have at least one of the three classic symptoms.

**“So how can I change, since the situation isn’t going to change?”**

### A CROSSROADS

Yet some determined nurses are experiencing a bright ray of hope.

After enduring her own struggle with burnout, Julia Sarazine, DNP, APN, FNP-BC, adjunct professor at Rush University College of Nursing, found renewal by first learning and now teaching and propagating the benefits of mindfulness — a popular topic in the media as workers in many industries seek to disengage from autopilot and better cope with daily stress.



Julia Sarazine, DNP, APN, FNP-BC, adjunct professor, leads a class in stress reduction through mindfulness.

Burnout and the resulting BOS occur when there is a discrepancy between expectations and ideals of an employee and the actual requirements of a person’s position, Sarazine explains. BOS can lead to emotional and physical exhaustion, indifference and a diminished sense of personal accomplishment.

Fighting BOS arose as a personal quest for Sarazine, who suffered from it as a young nurse.

“I developed burnout,” she says. “I would wake up in the morning and I would have to have two cups of coffee to get to the office ... the hospital. I wasn’t connecting with my patients like I normally would. I’d come home, and I would want to just put on pajamas and watch TV and go to bed.” Sarazine said she withdrew socially, had feelings of inadequacy permeating her home and work life, and decided to leave nursing. Several years later she was offered a hospital position again.

“I thought, ‘How am I going to go back there? It’s still going to be a very demanding position. So how can I change, since the situation isn’t going to change?’” It was then she discovered meditation and the practice of mindfulness and went on to become a credentialed instructor.

Her success with her own mindfulness practice, as well as conversations with like-minded colleague Samantha Sarris, BA, MBA, manager of staff engagement at Rush, led Sarazine to become a mindfulness trainer there.

**“Mindfulness is an intentional method of paying attention, on purpose, in the present moment, nonjudgmentally.”**

### WHAT IS MINDFULNESS?

Mindfulness is an intentional method of “paying attention, on purpose, in the present moment, nonjudgmentally,” according to Jon Kabat-Zin, PhD, a leading mindfulness expert. A successful practice allows one to step back from a situation, reduce the bombardment of self-judgment and more clearly and calmly analyze and take control of situations.

“Now I meditate most days,” Sarazine says. “I have a formal meditation practice. I sit down and focus on the sensation of my breath — that is, strengthening my muscle of attention.” She pays attention to the self-criticisms or other thoughts that come to her, acknowledges them, but brings her mind back to the sensations of her breath and starts her day more grounded.



HOW TO START PRACTICING

Sarazine practices and advocates informal mindfulness sprinkled throughout her busy day.

“That means I try to be as present as possible with what I’m doing,” she says. “For example, when I’m driving to work, if a car cuts in front of me, I may have a stress reaction of wanting to honk my horn. If I’m grounded, I can feel the stress in my body but then choose: ‘I’m not going to honk my horn. I’m just going to let this go.’ So I am able to not react to everything that happens.”

Another example: “When you’re washing your hands, which happens many times a day, use that as an opportunity to drop in and be mindful. Focus completely on the sensations of washing your hands: feel your hands, connect with your body, use your sense of smell.”

She recommends apps such as Calm, Headspace and Mindfulness.

THE ROAD TO RESULTS

Two years ago an annual survey of Rush’s nursing staff revealed lower than benchmark scores in responding to the statement: “My organization helps me to deal with stress and burnout,” Sarris says. This and her own training and research on mindfulness informed her desire to work with Sarazine to fully incorporate mindfulness into the staff engagement curricula.

After one year of focusing on stress reduction interventions like mindfulness, the annual survey showed “tremendous improvement” to the stress and burnout question, says Sarris, increasing by 9 percent. And she anticipates the next score will climb higher

Additionally, Sarris and Sarazine recently began work on a pilot study, collecting more data on the effectiveness of the mindfulness program. In the meantime, anecdotal evidence is compelling. Though mindfulness was at first a 20-minute training session, it has expanded to four-hour workshops for nurses and nurse leaders, with spots filling up within 24 hours of announcement. Trainees report improved job satisfaction and increased productivity, as well as a “ripple effect” at home among family and friends.

“We’re seeing a positive effect in all areas of their lives,” Sarazine says.

A nurse participant praised the training by saying, “I learned that I can practice mindfulness as a way to be present in my feelings of stress and not let those feelings overtake me.”

“I’m really, really proud of what Julia has done,” Sarris says, “and of what we’ve been able to accomplish together. Seeing our survey results increase in that way — that people are feeling that the organization is here to support them — is a huge win.”

UNPLUG TO RECHARGE IN 60 SECONDS

With Angela Johnson, MPH, MSTOM, Dipl OM, LAc

If you’re wondering how to employ mindfulness techniques in your own life, fortunately there is one powerful method that relies on something you already do at least 17,000 to 23,000 times per day — breathing. Yes, with a little practice, you can learn to focus that breath and breathe a little relaxation into your day. **HERE’S HOW TO GIVE IT A TRY.**

1

Sit in a comfortable chair with your feet flat on the floor.

2

Adjust your posture so your spine is straight, but not too tight or tense.

3

As you breathe, begin to pay attention to the sensations of breathing.

4

As your mind wanders, silently acknowledge the thought and say to yourself, “wandering.”

5

Without judgment, refocus your attention on the sensations of your breath.

6

Repeat steps 4 and 5 as needed. The more you practice, the less your mind will wander.

CONGRATULATIONS! YOU’VE JUST PRACTICED MINDFULNESS. NOW, CHECK IN WITH YOURSELF: DO YOU FEEL MORE RELAXED?

If you are interested in “The Art & Science of Being More Fully Present,” visit [rebalanceworks.com](http://rebalanceworks.com) for more mindfulness practices.

ANESTHESIA  
Is it safe for children?

BY BETH JANES





**Imagine being told your young son or daughter needed surgery. Anesthesia is probably one of the last things you'd worry about. After all, it's safer than ever and complications are rare, right?**

Yes — with a relatively recent, minor caution. Although an estimated 6 million children are put under general anesthesia every year with a mortality rate close to zero, research is raising new questions about how the procedure may affect the rapidly developing brains of kids under 3 years old. Specifically, whether there's a link to learning and behavior problems as children get older, says Audrey Rosenblatt, CRNA, who is studying the topic as a PhD candidate at Rush University College of Nursing.

**SUPPORTIVE HEALTH CARE PROVIDERS CAN HELP**  
“It's sometimes a surprise for families to hear, and it's a lot to process as they are thinking closely about the (medical) problem in front of them,” says Rosenblatt, who's also the certified registered nurse anesthetist (CRNA) manager at Ann & Robert H. Lurie Children's Hospital of Chicago. “So that's my job — I worry about it for them.”

Indeed, nurse anesthetists work collaboratively with surgeons, anesthesiologists, dentists and podiatrists, providing more than 60 percent of the anesthesia administered in the U.S., says Michael J. Kremer, PhD, CRNA, director of the nurse anesthesia program at Rush. Rosenblatt and other CRNAs also counsel parents prior to surgery on what to expect.

**“The current understanding is that the younger the child and the longer and more times he or she is exposed to anesthesia, the greater the potential risk for cognitive effects later.”**



**“I want to make sure what I'm providing them (children) is safe at every stage, including as they grow and develop.”**  
— Audrey Rosenblatt, CRNA, PhD candidate

“Anything we can do to study clinical issues and be involved in research that improves the safety and quality of care is important,” Kremer says.

A passion for safety drives Rosenblatt's research. “I want to make sure what I'm providing them (children) is safe at every stage, including as they grow and develop,” she says.

So, while there are plenty of unanswered questions, Rosenblatt says that at this stage, parents shouldn't worry too much. Here's why:

**NO DIRECT EVIDENCE SHOWS ANESTHESIA CAUSES LEARNING OR BEHAVIOR PROBLEMS**  
For her first paper, Rosenblatt reviewed more than two dozen studies that explored whether kids who had anesthesia were more likely to develop cognitive problems in the years that followed. The results: “About half the studies show there's no issue, and for the other half that does suggest a risk, it was slight,” she says.

**FACTORS OTHER THAN ANESTHESIA COULD PLAY A ROLE**  
Countless variables impact how a child's brain and cognitive difficulties may develop, and researchers haven't fully untangled whether anesthesia has a part in it. For example, children with medical conditions requiring multiple surgeries likely won't have the same experiences, including those that contribute to their learning and behavior, as kids who have always been healthy, Rosenblatt says.

**A CHILD'S AGE AND ANESTHESIA EXPOSURE MATTERS**  
The already low potential risk drops even further for kids as they near age 4 and for a single, short, routine procedure. “The current understanding is that the younger the child and the longer and more times he or she is exposed to anesthesia, the greater the potential risk for cognitive effects later,” Rosenblatt says.

**PUTTING OFF SURGERY USUALLY ISN'T THE ANSWER**  
If surgery can be postponed, that can be considered. But “children don't usually have elective procedures,” Rosenblatt says. And, unlike any potential cognitive effects of anesthesia, experts often know with certainty the negative consequences of delaying a necessary surgery or test. Some procedures also have better outcomes if done early, Rosenblatt says. So those factors tend to far outweigh unknown, unproven risks. Still, she adds, parents should discuss timing with their health care provider.

Rosenblatt's latest study, which tracks school performance and other markers in children who've been under anesthesia at Lurie Children's, will add to the current body of research. And, while it's smart to know all potential risks, it's also wise to weigh the benefits of anesthesia: It provides kids vital protection against pain and stress during procedures — which experts know can in fact affect brain development. 📖



# IT'S ALL ABOUT THE BABIES

## Life as a neonatal nurse

BY LAURA LAMBERT

For preemies and micropreemies — high-tech environments attempt to replicate everything that would normally happen in the womb

**S**hift change is at 7 a.m. Jarrett Austin, RN, BSN, a neonatal nurse on the night shift at Rush University Medical Center, is briefing the daytime team. He'll have drawn all the necessary blood tests for his tiny charges an hour earlier. These neonatal intensive care unit (NICU) patients are the smallest, the sickest and the most vulnerable. Most cannot breathe, eat or regulate body temperature on their own.

For those born early — the preemies and micropreemies — high-tech environments attempt to replicate everything that would normally happen in the womb, where lungs and other complex physiological systems develop.

Says Austin, "It's not just changing diapers and feeding babies."

### CHICAGO'S HIGHEST-RISK BABIES

For NICU babies, a typical stay is measured in weeks and months, not days — and since nurses care for a maximum of three babies during a 12-hour shift, they know them well — in some cases, better than the babies' families. This prolonged one-on-one time leads to an intimate knowledge of each baby's breathing pattern, color, temperature, budding personality, energy level — even for those "24-weekers," as they're called, who barely weigh a pound.

As a Tier III facility, Rush's NICU sees many of the highest-risk babies from the Chicago area. While most are preemies, there might also be full-term babies born with cardiac defects or congenital disorders or who are enduring drug withdrawal. These children are born to mothers who range from young to experienced, from well-to-do families to those living in poverty. The sheer diversity of the population served is striking, says Christie Lawrence, DNP, RNC-NIC, APN/CNS, the clinical nurse specialist (CNS) on the unit.

Lawrence no longer works bedside, though she did for the first 10 years of her now 18-year career at Rush. As the NICU's CNS, she educates the staff on new therapies and disseminates the latest in evidence-based practice. As an instructor, she mentors Rush University students interested in neonatal care.

### A DEMANDING, REWARDING JOB

Many students underestimate just how difficult and demanding NICU can be, even though they're working with 1-pound babies.

"It's not the size of the patient," Lawrence says. "It's physical work. It's a lot of brain work. And it's a lot of heart work."

The job requires keen assessment skills and a relentless focus on even the subtlest changes. And because time is critical, NICU nurses must not just notice, but act.

"Our kids don't have a long reserve," she says. If they get sick, their condition deteriorates quickly.

Austin, who has been at Rush just over a year, already had one such case — a 26-week-old preemie who developed a blood infection.

"In an hour, they can go from doing great to passing away," he says. "That's what ended up happening."



### LITTLE MIRACLES

Amid such tragedy and heartbreak, though, there are far more happy endings.

One 24-week-old baby Austin cared for was struggling. He needed surgery and was having trouble breathing, even on a ventilator. The team prepared the family for the worst.

"I'm leaving at the end of the day, wondering if this infant's going to make it," says Austin. "Then fast-forward a couple months down the road: You come into the unit and you realize the baby has gone home!"

The lengthy stays in the NICU make the work both difficult and incredibly rewarding. Relationships bloom over those long and intense weeks and months.

### FAMILIES ARE PART OF THE CARE TEAM

"It's the one place where you can't separate the patient from the family," Lawrence says.

**"We encourage family to be at the bedside, to be part of our care and part of our plan. We need them and they need us."**

Indeed, families are critically important, says Punitha Jonadoss, RNC-NIC, a neonatal ICU RN on the unit. "My favorite thing in the NICU is being able to take care of a 24-weeker, following them through their hospitalization, being there for every milestone. During that time we really get to know the families."

After being discharged, many families bring the babies back to visit. Rush even hosts an annual "preemie picnic" to honor those connections.

"That's the most rewarding thing, seeing these infants grow and thrive," Jonadoss says. 🕒



# TRAVELING THE GLOBE FOR THE FUTURE OF NURSING

BY LISA JEVENS



**Improving global health care is daunting, especially given the ever-increasing complexities and challenges facing providers worldwide.** The need has never been greater for health professionals from every discipline to collectively identify and prioritize common issues, and work to address them.

According to Cathy Catrambone, PhD, RN, FAAN, associate professor at Rush University College of Nursing, the world's 19.3 million nurses and midwives are uniquely positioned to spearhead such efforts, and the organization she leads is in the midst of an initiative giving nurses and midwives a unified voice and vision for the future.



Cathy Catrambone, PhD, RN, FAAN, associate professor, president of Sigma Theta Tau International

## NURSES, NURSE LEADERS AND MIDWIVES

Catrambone is the 2015-2017 president of the 135,000-member Honor Society of Nursing, Sigma Theta Tau International (STTI), a global organization dedicated to advancing world health and celebrating nursing excellence. In 2014, STTI convened the Global Advisory Panel on the Future of Nursing & Midwifery, or GAPFON, to gather thoughts and record concerns on the state of health care as seen through the eyes of nurses or midwives, wherever they may practice.

During the past two years, Catrambone and her GAPFON colleagues have held high-level meetings on every continent except Antarctica, bringing together nurse leaders, government officials, and corporate stakeholders in health care from Asia and the Pacific Rim, the Caribbean, Latin and Central America, North America, the Middle East, Europe, and Africa.

## TOP ISSUES

Martha N. Hill, PhD, RN, FAAN, dean emerita and professor at Johns Hopkins School of Nursing, is the chair of GAPFON. Hill says the top issues raised in the meetings were not surprises, and there were some commonalities: maternal and child health, disaster preparedness and response, chronic disease management including AIDS and communicable disease outbreaks, the needs of aging populations, and nursing shortages.

"How do you ensure that the people who need care have access and it is sustainable?" Hill asks. "We heard that everywhere we went."

Other issues were more region-specific. For example, in the Pacific Rim participants brought up natural disasters like tsunamis and earthquakes. In Central and South America participants shared about drug-related violence. In the Middle East, Africa, and Europe there were distressing concerns about displaced people and the effects of conflict.

Catrambone says the nurses and midwives she and Hill met around the world exceeded her expectations for their willingness to work together. "It was an amazing experience to witness the amount of consensus around the issues, and the shared determination and goodwill to move these agendas forward," she says.

**"How do you ensure that the people who need care have access and it is sustainable?"**

## INTERNATIONAL COOPERATION

The heavy travel for the GAPFON initiative was a new experience for Catrambone, who has logged nearly 400,000 airline miles during her presidential term. Working with the highest caliber global leaders was no less impactful. Catrambone's most memorable visit was to the royal residence of Princess Muna al-Hussein of Jordan, who has worked with the World Health Organization and other groups to address health issues. British by birth, Princess Muna is known for her support of nursing and nursing education in Jordan.

In the summer of 2017, the team released a report of its findings, along with global and regional recommendations, at STTI's 29th International Nursing Research Congress in Dublin, Ireland.

The goal of the report is nothing less than a paradigm shift — to elevate the perception and role of nurses and midwives, Hill says. "It is designed to demonstrate why nurses and midwives should have a voice in policymaking and a seat at the table when decisions are made, from the local to global level."

## MAKING A DIFFERENCE

Through this visionary work, Catrambone and Hill are both examples of how nurse leaders can make change in the world.

"Nurses and midwives spend more time with patients at the point of care than any other health discipline," Catrambone adds. "We are uniquely positioned to exert our influence at the highest levels to improve the health of populations globally." 🌐



NURSING  
IN ACTION

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