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***Creative Nursing* Vol. 25 #1 – Professional Practice in a Changing World: Radical Advocacy**

**FROM THE EDITOR: Responding to Turbulent Times,** by *Marty Lewis-Hunstiger, BSN, RN, MA, retired pediatric nurse and preceptor, editor-in-chief of Creative Nursing, copy editor of the Interdisciplinary Journal of Partnership Studies, and affiliate faculty member in the School of Nursing at the University of Minnesota in Minneapolis, MN.*

For our overarching theme for 2019, our editorial board has chosen Professional Practice in a Changing World. In an era when health care has gone from a service, provided according to the high clinical and ethical standards of various health professions, to a business, with care decisions seemingly governed by market forces, how can we serve others in healthy ways, while honoring our ideals? Issue #1 is about advocacy – not just any advocacy, but radical. The title of this editorial comes from Guest Editor Barbara Stilwell, Global Campaign Executive Director of Nursing Now, who writes, "Nursing is key to shaping sustainable, effective, and affordable health services that are fit for the future and responsive to the challenges of turbulent times." Whom do present-day nurses and their interprofessional colleagues advocate for? Women in the grip of human trafficking. Patients with progressive pulmonary disease whose symptoms often place a heavy burden on activities of daily living. Children who lack the resources to meet health care requirements to enter public school. Patients whose needs and values have been pushed to the periphery, who are being talked over as if they weren't there, who need us to respect their knowledge. College students who need lifesaving information about breast health. Nursing students learning to provide mental health nursing care. Early-career nurses who need and deserve support for being innovators. These are the people who inspire our advocacy.

**FROM THE GUEST EDITOR: #Nursing Now**, *by Barbara Stilwell, PhD, MSc, RN, FRCN, Global Campaign Executive Director of Nursing Now.*

Nurses are the largest group in the global health workforce, but due to social, political, and gender inequality, their role has been undervalued. Nursing Now is a 3-year campaign to empower nurses worldwide by building grassroots support to demand better investment in nursing and midwifery to tackle 21st-century health challenges. Nursing is key to shaping sustainable, effective, and affordable health services that are fit for the future and responsive to the challenges of turbulent times. As diseases change and technology advances, empowering nurses will be key to a sustainable, high-quality, and caring health system. Whole-of-life care for chronic diseases and ageing populations requires a comprehensive view of health, which has always been a central part of the philosophy of our profession. Nurses work with patients throughout the span of their lives, helping them manage diseases and live healthy lives for as long as possible. In addition, nurses are more likely to be from the communities they serve, giving many of us an understanding of cultures and norms and making us well placed to work with local people on health promotion, disease prevention, increasing health literacy, and identifying barriers to health. The wider value brought to the health system by nurses has not on the whole been recognized by policy makers. Nurses in most countries face significant pressures at work, often in poor working conditions, with low pay, and unable to work at the level for which they are trained. Nursing Now aims to empower a whole new generation of advocates, particularly female activists pushing for equality inside and outside of health systems.

**ARTICLES AND ESSAYS**

**Advocating for Early-Career Nurse Innovators: Modeling the Institute of Medicine Report**, by *Linda Sue Hammonds, DNP, vice president; Nelda Godfrey, PhD, president; Terry Bryant, BSN, MBA, secretary; Margaret Mata, BSN, treasurer; Corinne Fessenden, PhD, member; Shirley Farrah, PhD, member; Amy Vogelsmeier, PhD, member; Kristine L'Ecuyer, PhD, member; Karen Johnson, BSN, member; Jill Kliethermes, MSN, CEO; Heidi Lucas, MPA, administrative staff member; and Karen Harris,*

*administrative staff member, all of the Missouri Nurses Foundation Executive Board in Poplar Bluff, MO.*

One of the purposes of the Missouri Nurses Foundation is to foster professional nursing in Missouri to promote and improve the quality of healthcare and healthcare outcomes for all Missourians. This article describes the Early Career Nurse Innovator Project, developed, implemented, and evaluated by the Missouri Nurses Foundation to honor the leadership of early career nurses whose level of expertise is between novice and expert (Benner, 1984). The program recognizes and encourages early career nurses who have designed and led innovations to improve and promote the health of Missourians. Theoretical underpinnings for the project included von Bertalanffy's Systems Theory, Benner's Novice to Expert Model of Professional Development, and Lewin's 3-Stage Model of Change. A total of 27 applications were received. Five early career nurse innovators and bedside nurses received awards of $500 to encourage further scholarship and innovation. The recognized initiatives were a neonatal intensive care unit (NICU) vaccination project; a postoperative ileus prevention initiative using chewing gum; a postoperative bowel regimen project; an early sepsis identification project; and delirium prevention through screening, early mobility, and passive range of motion. Members of the Missouri Nurses Foundation Executive Board traveled to each nurse's place of employment for a recognition ceremony to honor each award recipient and to facilitate recognition of the Missouri Nurses Foundation's impact. In addition, the five winners of the award presented their work at an evidence-based practice conference at the University of Missouri.

**The LOTUS: A Journey to Value-Based, Patient-Centered Care**, by *Liza Barbarello Andrews, PharmD, RPh, BCCCP, BCPS, critical care pharmacy specialist; Nina Roberts, MSN, RN, CCRN, NEA-BC, Director of Critical Care; Carol Ash, DO, MBA, MHCDS, former Medical Director of Critical Care and now CMO; Natalie Jones, MSN/ED, RN, CCRN, clinical nurse educator; Meghan Rolston, BSN, RN, CCRN, critical care RN in ICU; Melina Hughes, MSN, RN, CCRN, clinical nurse coordinator in ICU; Joanne Pelligrino, MSW, RN, case manager; and Ted Taylor, MDiv, BCCC, FHPC, DipPS, Director of the Department of Pastoral Care and Training, all at RWJ Barnabas Health System, RWJ Hamilton, in Hamilton, NJ. Dr. Andrews and Dr. Ash are also faculty members at Rutgers University in Piscataway, NJ.*

In response to the merger of a community hospital with a new health system, a multidisciplinary team began a journey of holistic transformation via a new rounding process called Leadership, Ownership, Transformation, Unity, and Sustainability (LOTUS) in the 20-bed ICU. Morphing from a hierarchical practice structure with limited engagement of multidisciplinary members, the LOTUS initiative (named for the blossom whose petals surround its core, the patient) afforded each discipline (petal) an equal voice and allowed a once-fragmented team to work cohesively, collaboratively, and at the highest level of the scope of practice for each discipline, thus affording expert guidance during care planning while providing a method to collect quality metrics. LOTUS allows staff members to view their patients in a new way, refocusing goal determination on patients and their families. The restructuring and evolution into a high-functioning team targeted the goal of enhancing quality care for patients, which, in the literature, correlates with improved patient safety and decreased mortality and ICU length of stay. Hospital systems focus on public reporting of patient opinions about their services, yet our process initially allowed what patients perceived as valuable in their care to drift from central focus to the periphery. The increasingly robust expert input of the various disciplines brought to light missed opportunities related to continuity of care, predominantly based on failing to connect care with social determinants of health. Refocusing our goal determination allowed us to evolve into citizen clinicians, aware of the need to address social determinants of health and to coordinate care beyond our walls.

**Operationalizing the Bridge Care Model – Advocating for At-Risk Students**, by *Rebecca E. Sutter-Barrett, DPN, APRN, BC-FNP, and Caroline J. Sutter-Dalrymple, DNP, APRN, BC-FNP, both associate professors in the School of Nursing at George Mason University and cofounders and co-directors of the*

*Mason and Partners Clinics in Fairfax, Virginia; and Lea Skurpski, MA, CCC-SLP, Director of Operations and Strategic Planning at Fairfax County Public Schools in Fairfax, VA.*
For at-risk, vulnerable school students and families, limited access to health care providers, funding, and transportation, as well as inflexible work schedules, can create barriers to their ability to access required health services in a timely manner, thus delaying enrollment. The gap in access to needed health services is occurring at the same time that health professions schools are challenged to find venues where their students can provide care for vulnerable, resource-poor populations. This article focuses on the implementation of the Bridge Care Model through an innovative partnership between an Academic Nurse-Managed Clinic Network and a local school system. Bridge Care is the "safety net to the safety net system" for patients, and has been highlighted by the National Organization of Nurse Practitioner Faculties as an exemplar of a successful academic practice/community partnership model that provides community impact. Through this mutually beneficial approach, direct health services were provided at an on-site, central student registration location through a cost-effective, sustainable partnership. School-based resources are not traditionally thought of as health care; with this Bridge Care clinic site, health care professions students are able to understand more fully the role of education and schools in the health of the most vulnerable children and families in the community. Our future workforce in acute care and public health settings needs stronger preparation in population health competencies, working in interprofessional teams, recognizing and responding to epidemiologic patterns, understanding care as value-based with a focus across the lifespan, and using ambulatory care delivery models.

**Advocating for Mental Health Nursing Education Using a Flipped Classroom**, by *Jill Jackson Van Der Like, DNP, MSN, RNC, clinical assistant professor of nursing and director of the Nursing Skills & Simulation Learning Center; Hillary Fox, MSLS, Health & Environmental Science Librarian; Angela Blackburn, PhD, ARNP, NNP-BC, associate professor and director of the MSN program; and Jessica Chisholm, BSN, RN, C-NPT, graduate student in the Master of Science in Nursing Education program and Graduate Assistant in the nursing program, all at the University of West Florida in Pensacola, FL.*
Educators are challenged to meet the needs of all student learning styles. Nursing educators care deeply about student perceptions, but understand the need for critical thinking in student learning outcomes. They are responsible for expertise in nursing content, educational transfer of knowledge, and teaching others to care for human life. The need for mental health nursing care touches every nursing specialty; the concepts are abstract and complex, with many unknowns concerning the mind. The flipped classroom (FC) provides an opportunity for students to explore concepts prior to classroom learning. This article describes an initiative to integrate an FC approach with a class of baccalaureate nursing students. This educational model has some barriers to acceptance: considering the workload outside of class, especially if clear guidance is lacking, students may feel they are having to teach themselves, resulting in an overall negative perception of the model. Despite student dissatisfaction, the nurse educator took risks to maintain and improve this innovative teaching method for this mental health nursing course because of the personalized student approach. The FC process is relationship-centered, and can be continuously adapted based on evolving student feedback. The students' improved assessment of instruction reaffirmed the belief in the power of student-centered learning to prepare students for the challenges of the mental health practice setting.

**Advocating for Breast Health Education for College-Age Students**, by *Jenny L. Monn, DNP, FNP-BC, assistant professor in the Department of Nursing at Millersville University in Millersville, PA.*
Though the incidence of breast cancer among young women is extremely low, the prognosis and the pathological issues surrounding cancer in younger women are considerably worse than for women older than 40. Early detection can play a key role in decreasing breast cancer mortality in young women, and improve the disease trajectory of young women diagnosed with breast cancer. The

modifiable lifestyle risk factors for breast cancer that are relevant to college-age individuals are also risk factors for other cancers and other chronic illnesses. Awareness of the risk factors can alleviate fear and anxiety, and can lead people to pursue prevention. This article describes a university's annual breast health education event focused on breast health awareness and breast cancer education. College-age individuals learn many health behaviors from their peers; these educational events provided students with an ideal setting to learn from each other as peer groups hosted activities in concert with medical practitioners and breast health experts. To draw attention to the event, a unique theme was selected each year; themes included Supporting Breasts of All Types, Know your Family History, and Treasure your Chest. Over the past 5 years this event has reached more than 2,000 students.

**Addressing Challenges of Patients with Chronic Pulmonary Disease using Makerspace Environments**, by *Tracy Fasolino, PhD, FNP-C, RN, ACHPN, associate professor in the School of Nursing at Clemson University in Salem, SC.*

Patients with chronic progressive pulmonary disease suffer from physiological and psychological consequences. Their ability to perform activities of daily living can be severely impaired. The disease typically has a prolonged phase of symptoms and needed support, and a short dying phase; medical teams concentrate on lung function and oxygenation, often overlooking the symptom burden or challenges of daily living. Direct patient care nurses are well suited to assist these patients and their caregivers, identifying challenges through interactions and active listening and assisting in the identification of solutions. Through interaction with the patient and caregivers, nurses actively listen for opportunities to reduce symptoms and improve quality of life, but do not always have the resources to create solutions. This article describes how direct patient care nurses can address the challenges these patients face, through an innovative environment known as a makerspace. Makerspaces are physical spaces where individuals with various backgrounds, education, and levels of experience can create items using tools and equipment such as 3-D printers and laser cutters, in an iterative sequence of drafting solutions, creating a product, reflecting, and revising. Health-care systems can collaborate with local academic institutions to share real-world challenges with innovative students, and work collectively to create prototypes for testing. Prototypes detailed in the article include reels to control oxygen tubing on the floor, methods for securing portable oxygen cylinders, a holder to store and differentiate daily and rescue inhalers, and a vest to stabilize tracheostomy tubing.

**From the Archive – I Am the Professor of Myself: How Our Patients and Their Loved Ones Become Our Teachers and Models,** by *Laurence A. Savett, MD, FACP, retired internist and retired clinical professor of medicine at the University of Minnesota Medical School in Minneapolis, MN.*

As health care professionals, we commit ourselves to lifelong learning. In that quest, wise professionals know that our patients and their loved ones become our most important teachers. This article originally published in *Creative Nursing* Vol. 18 #3 reminds us that our patients are the source not only of many of the clues to diagnosis but also of the information about the impact of the illness on themselves and their loved ones, their income, their emotional status, and the availability of support from friends and community. Patients should not be required to speak our language; rather, it's our obligation to keep the conversation open by avoiding jargon and speaking with clarity, putting ourselves in the patients' shoes, and asking the right questions in ways that invite honesty and reflection.

**THE VOICE OF PATIENTS AND FAMILIES**

***Tekichila Unpo* (Love One Another): Confronting Human Trafficking with the Guidance of Traditional Lakota Wisdom in Nursing Practice**, by *Whitney Fear, RN, BSN, RN Case Manager and Community Outreach Nurse at Family HealthCare, a Healthcare for the Homeless grantee clinic in Fargo, ND.*

Human trafficking emerged as a serious social issue in North Dakota during the Bakken oil field boom. The oil industry has seen a dramatic decrease in production in recent years; however, the presence of human trafficking continues to dominate the scene in the state. As RN Case Manager and Community Outreach Nurse for a Healthcare for the Homeless grantee clinic in Fargo, the author is the only nurse outside of a traditional environment who works with victims of trafficking in the largest metropolitan area of North Dakota. The majority of the current targets for this heinous industry are young Native American women. The author, a Lakota woman, employs an approach with trafficking victims that seeks to reestablish their view of themselves as beings with significant value and ability to contribute to the world in a way that no other beings can. "The word around town is that when you are ready to get out of the life, any service provider will do what it takes to get you to safety; if you aren't able to leave the life, we will do what we can to get you from one day to the next." In advocacy, she teaches professionals about the Lakota view of the Earth as a living being whose destruction may be correlated with the increased violence against women. Indigenous professionals struggle to integrate their ancestral wisdom into their professional lives; it is a difficult balance. She writes, "Colleagues, I ask this of you. Take a look around your practice. How would you spot a trafficking victim? Many trafficking victims are coerced by pimps through offerings of clothing, money, hotel rooms, and other luxuries they don't normally have access to. How would you offer them help? Would you extend rigidity and mind the boundaries you learned in textbooks? Or, could you see that woman as your sister?"

**Talked Over as if I Weren't There: Reflections from a Nurse and Educator**, by *Christina Purpora, PhD, RN, associate professor in the School of Nursing and Health Professions at the University of San Francisco in San Francisco, CA.*

Most nurses were taught in nursing school to avoid talking over a patient as if the patient were not there. This manuscript describes the author's experience of being talked over as a patient – what it meant to her as a nurse relating to the ethics of the situation and as an educator of future nurses. The American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements* (2015) addresses the responsibility of nurses at all levels within an organization to sustain a work environment that ensures quality, safe patient care. Nurses who embody this responsibility are knowledgeable, skilled, and mindful of what they say and how they act and interact around, with, and over patients and toward each other. Respectful interactions, civil exchanges, and the best resolution of conflict are some of the hallmarks of relationships that nurses have a duty to construct. Neither of the nurses involved in this incident knew that the author was a nurse and, "at the moment, I was not. I was a patient, and I felt vulnerable." The author didn't speak up to the nurse who acted unprofessionally, concerned that doing so might make the situation worse. Instead, she used a patient survey to describe the pressured environment she saw nurses endure as they tried to care for her in a system that is often unforgiving of any deviation from the schedule. In her role as a nurse educator she uses her story as a case study to spark discussion about how to practice with compassion and respect to build trust in relationships with patients, create ethical work environments, and engender civil relationships with colleagues.

**REFLECTING ON OUR HISTORY**

**The Nurses that Roared: Nurses from History Who Found their Voices and Challenged the Status Quo**, by *Julie Attenborough, PFHEA, Associate Dean and Director of Undergraduate Studies in the City, University of London School of Health Sciences; Lisa Reynolds, PhD, PFHEA, Lead of the Nursing Division in the City University of London School of Health Sciences and Strategic Project Director; and Peter Nolan, PhD, Professor of Mental Health Nursing (Emeritus) at Staffordshire University in Staffordshire, UK.*

Acknowledging the formative ideas of significant nurses from history is crucial if we are to be empowered through collective memory. There are gaps in the popular history of nursing, with the

influence of nurses whose images do not fit the mould being omitted from or adapted to fit populist discourse. This article explores how nurses from history challenged norms of nursing and society and considers how they can influence and inspire nurses today. It discusses the role of nurses in the fight for women's suffrage, campaigning for the vote, and caring for women who suffered in their fight to achieve it, and presents examples of outstanding bravery in the past and present day. Examples include some relatively unknown nurses in wartime, who also fought for equality and inclusion; nurses who challenged the care of marginalized groups, campaigning for improved treatment, sometimes at great personal cost; and the courage of present-day nurses. Drawing on the global campaign Nursing Now, the authors suggest that learning from these exceptional nurses and acknowledging and highlighting their contributions can inspire us to strengthen and promote nursing and to empower women globally.

**MEDIA REVIEW**

*An American Sickness: How Healthcare Became Big Business and How You Can Take It Back,* by Elizabeth Rosenthal. *Reviewed by Sarah Cascino, DNP, RN, MBA, Central Region Program Manager in the Performance Improvement Office at Northwestern Memorial HealthCare in Chicago, IL.*

Elizabeth Rosenthal's analysis, structured as a history and physical, explores diverse areas within health care, including the pharmaceutical industry, insurance and billing practices, creation of large health-care systems, and the recent regulatory environment. She states 10 economic rules of the dysfunctional health-care market, including, Economies of scale don’t translate to lower prices, “There are no standards for billing, and Prices will rise to whatever the market will bear. She also warns that in large health-care systems, economies of scale often are not passed on to patients. Her prescriptions for treatment address not only the needed system advocacy, but tangible tactics that can be used to stay informed and curb costs. She includes broad requests for system reform as well as very specific tips for patients about navigating care in the hospital, billing and insurance plans, and procuring medications and medical devices. What can health care professionals do? Rosenthal advocates for billing transparency, and urges professionals to work to decrease variations in care and to institute best practices in order to offer optimal care to patients. Systems can align to accelerate the use of evidence-based practices, address access issues, and provide the best care possible close to patients’ homes. Involvement at the legislative level is also needed, to help political leaders understand that there is much more at stake in health care than the bottom line.