

Frontline  
Nurses



*I stand poised with my colleagues at the pier, reining in a river with a Dixie cup. And I have never been more proud to call myself a nurse.*

—Stacy N., Emergency Room Nurse, from the WikiWisdom Forum

Overview of the Situation

## Wisdom from Nurses So We **Never Again** Mishandle a National Healthcare Crisis

### FROM THE WIKI

*Overwhelmed and saddened by everything I'm witnessing and experiencing, I am surprised by a unique sense of inspiration—like maybe something good could come out of this? Perhaps nursing will get a chance to heal as a profession as the world sees our value once again? Perhaps this will be an opportunity to change how nursing approaches and cares for patients? Perhaps it will be a chance to address the nursing shortages, staffing ratios, and finally, look at changing the toxic cultures within nursing that causes burnout and compassion fatigue.*

—Juliano I.

This was supposed to be the Year of the Nurse and the Midwife. Instead, it has been the year of COVID-19.

Nurses across the U.S. were tested by COVID-19. Some broke down. Others found energy and pride in the struggle to care for COVID-19 patients without adequate protective equipment, staff, or support from hospital administration or the federal government.

The US already faces a shortage of nurses—the [Bureau of Labor Statistics](#) projects we will need 11 million more nurses by 2026. That is partly the result of demographic realities: an aging baby boom and an aging nursing population edging closer to retirement. Equally important are skyrocketing rates of burnout among nurses. Add the stresses of COVID-19 and a steady trickle of nurses turning away from the profession could turn into a stampede.

Nurses often put their patients' needs before their own. That didn't change during the pandemic. What did change is that nurses saw the level of sacrifice asked of them and denounced their working conditions under COVID-19 as both unfair and dangerous.

Through the recommendations in this report, nurses ask for three things: Listen to nurses. Protect nurses. Support nurses.

None of those is hard to do. However, they all require that policy makers and healthcare administrators who are unused to soliciting nurses' input learn to take nurses' ideas seriously. And they require elected leaders to ensure nurses have the supplies and supports they need to do their work safely and with integrity.

This WikiWisdom Forum report is the first step. It started with a unique online forum that asked nurses on the frontlines to share their stories, challenges, fears and joys from caring for COVID-19

## Overview of the Situation (cont...)

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patients. There are dramatic stories of nurses who risked their lives to help their patients despite a lack of adequate PPE. There are disgraceful stories of insufficient support from management, even retaliation for steps taken to protect patients and staff. And there are heartbreaking stories of nurses who didn't hug their children for weeks in an effort to keep them safe.

This report reflects the wisdom of the frontline nurses who added their ideas online on the Wiki. Some are new recruits, others veteran nurses. They work in hospitals, nursing homes, hospice care, schools, academia, public health, and nursing administration. Their ideas were honed by four nurse thought leaders—**Stacy Nigliazzo** and **Catherine Clark**, both emergency nurses; **Kayleigh Gattuso**, Director of Nursing Services in a long term care facility; and **Juliano Innocenti**, a psychiatric nurse—into the 14 recommendations in this report.

The recommendations, which were delivered to the sponsors on Sept. 8, 2020, provide a roadmap to protecting and supporting nurses and ensuring the next virus does not wreak havoc on America and the nursing profession.

The Year of COVID-19 has been terrible, but it presents an opportunity for meaningful positive change. If we as a nation listen to nurses, protect nurses and support nurses, 2020 could turn out to be the Year of the Nurse after all.

## Proposed Solutions

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### Local Healthcare Solutions

1. Adequately staff all departments.
2. Give nurses the protective equipment they need.
3. Give nurses emotional support on the job.
4. Ensure that employee benefits include mental health coverage.
5. Develop a comprehensive plan for crisis care that includes input from bedside nurses.
6. Expand the role of hospice care in hospitals.
7. Increase administrative transparency for patient safety.
8. Give bedside nurses a place at the table and commit to integrating their recommendations.
9. Require administrators and nurses to “Walk a Day in My Shoes.”

### National Level Solutions

10. Create a Pandemic Response Team empowered to plan for and oversee response to the next pandemic.
11. Ensure adequate PPE through domestic production and stockpiling.
12. Make quality healthcare available to and affordable for all Americans.
13. Expand access to and use of telehealth.
14. Support a coordinated and collaborative public health infrastructure.

## Local Healthcare Solutions

### Statement of the Problem:

Healthcare administrators face myriad challenges—they are squeezed by inadequate reimbursement rates, overwhelmed with the demands of an aging patient population and coping with nursing turnover that can cost an acute care hospital [\\$6.4 million per year](#).

A traditionally frugal and selfless group, many of whom consider their work “a calling,” nurses roll with the punches... until they can’t any more. [One study](#) shows that a stunning 49% of nurses considered leaving the profession in the last two years. Chances are that figure will be even higher post-COVID-19. Nurses who have been forced to confront moral and ethical challenges during this pandemic—How can I effectively support a dying patient who can’t be with her family? How can I reuse PPE when it’s against all of the rules of infectious disease prevention? How can I protect my own family from this virus?—are even more likely to question their career path.

Healthcare organizations cannot continue to treat nurses so cavalierly. Unless nurses are given the support they need and treated with the respect they deserve, they may not be there the next time a virus sends the county into a tailspin.

### FROM THE WIKI

*Many of us were already working in dangerous environments that included accepting risk of personal harm—like in the ER where we are routinely physically assaulted and verbally abused by our patients. But now that we see what we are expected to endure and the utter abysmal nature of the response of the federal government and hospital administrations to our circumstances, and as the public sees what we are expected to endure, I fear for the future of nursing.*

—Catherine C.

*I am taking some time off now for respite and that is one way I will be able to continue to care for my patients over time. I fear we will be overwhelmed and not resilient if our working conditions do not improve, however, and if we do not rest and restore ourselves. This is a pivotal time for nurses.*

—Elisabeth R.

## Proposed Solutions

### 1. Adequately Staff All Departments

Committed nurses will not take even a short break, much less a 30-minute lunch, if they are not assured their patients will be properly cared for while they are gone. Ideally, adequate staffing would mean hiring more nurses and certified nurse assistants. A sound policy of hiring traveling nurses to backstop staff nurses or float to all departments to provide breaks and respite for nurses would give nurses needed staffing support.

Hospitals should hire more nurses to cover anticipated staff turnover and staff beyond minimum needs in light of the time needed to properly train and integrate new staff.

### 2. Give nurses the protective equipment they need.

Stunningly, nurses from hospitals around the country continued to report inadequate PPE supplies into late July, when we began work on this report. The stories nurses told are unconscionable and cannot continue. Nurses reported being required to reuse PPE against every rule of infection control they had been taught. Others said they were reprimanded for asking about inadequate PPE or pointing out that physicians still had enough PPE to change masks for every patient reinforcing inequities in the healthcare system. Not surprisingly, nurses also reported endless worry about whether they were harming their patients, their families and themselves by caring for patients with COVID-19.

Whatever the ostensible reason—limited supplies, budget woes, etc.—the guideline must be: Give nurses the gear they need to protect themselves, their patients and their families. That is a nonnegotiable minimum requirement.

### FROM THE WIKI

*Police officers and firefighters get all the recognition they deserve for putting their life on the line in unsafe work conditions. But that is not what I thought I was signing up for. I've never considered myself a hero. It would be no different than any other day: I'm taking care of these people and haven't peed all day or had time for a sip of water. I'm there to do a job and sometimes if they need a little more of me that day, I care for them, which might result in a little less care of myself.*

—Emily A.

*Let the staff wear PPE if they feel they need to. We should never have to justify a situation in which we feel the need to protect ourselves. Ever. Especially with a disease that no one knew and still knows nothing about how to fight or protect against. If we are going to save lives, personally I don't need to be called a hero or be thanked. I want to feel protected and supported. And that was not the case from Day 1.*

—Ashley O.

*Challenges that we are facing in dealing with the pandemic of COVID-19 are the challenges that we face everyday multiplied and magnified. The broken system that has allowed multibillion-dollar for-profit health care systems to embrace productivity, reactivity and reimbursement over preparedness and an adequate resource supply is a daily struggle. When I say adequate resource supply, I mean PPE, ventilators, doctors, nurses and support staff of all kinds*

—Martha D.

## Proposed Solutions

### 3. Give nurses emotional support on the job.

COVID-19 caregivers continue to face untenable ethical and moral dilemmas. They need support, which can range from something as small as brief respites in the workday to process a patient's death, to something as large as ongoing professional counseling. It isn't up to managers to decide what nurses need; nurses themselves must be consulted. Their requests should dictate what specific emotional supports are provided to meet the individual needs of nurse employees working on the front lines.

### 4. Ensure that employee benefits include mental health coverage.

Nurses need to know they can access the professional mental health services they need and that the services will be covered by their health insurance plan. It is not enough to provide the phone number for an Employee Assistance Program (EAP). If we want to combat burnout, help nurses cope with moral and ethical challenges and, yes, even overcome PTSD brought on by COVID, they need access to mental health professionals, paid for by their employee health plan.

## FROM THE WIKI

*I am the lifeline between families and the hospital. The docs are overloaded. I am making these calls, and they are heartbreaking. There is no app that can help address the waterfall of grief I listen to all day. My co-workers have their own stress and we don't have time to talk and process. If you aren't in it, you can't imagine it. My hospital sent me a mental health app—offering me a 10-minute guided meditation of a forest walk. Seriously? This is a mental health emergency.*

—Julie S.

*I'm not one to cry and I had 2 breakdowns. Mostly because of the pressure I'm feeling. Worrying about my family and my friends and keeping my department at work afloat and positive. It's hard to be positive all the time, which I am mostly. But this isn't a positive time.*

—Lisa T.

*My holocaust survivor of a patient who lost everyone he loved in the death camps now must die alone. I am unable to get a priest to offer anointing and sacrament of the sick - instead it's completed over FaceTime. The wife of a patient who sobbed to me that she hasn't seen her husband in 6 weeks while he was hospitalized with COVID-19—and that's the longest they've been apart in 65 years of marriage. And now he's unresponsive. I hold myself together as I offer support, but later I fall apart: my head in my hands, sobbing. "I can't do this, how are we supposed to do this?"*

—Kris M.

## Proposed Solutions

### 5. Develop a comprehensive plan for crisis care that includes input from bedside nurses.

Many nurses on the Wiki related stories of being pulled from their regular job—labor and delivery, ortho, etc.—and thrown into the ICU without warning or support. Hospitals must have a plan, developed in conjunction with bedside nurses, for serving critical care patients when the ICU is overwhelmed. This would help ensure that a nurse feels competent and qualified to jump into a crisis situation. Two approaches mentioned on the Wiki and discussed by the thought leaders are:

- Cross training nurses regularly so a nurse feels competent and qualified to jump into a crisis situation.
- Developing a team approach to critical care that can be used in certain crisis situations to ensure all nurses work to their best and highest competencies to meet emergency needs of their patients.

### FROM THE WIKI

*We need to train all (or many) of the nurses in the hospitals to be ICU savvy. No matter where we are in the hospital, we need to be able to step up to ventilators and drips. I realize that this is a challenge as the skills won't be utilized regularly, but there must be a way to make critical care less foreign to the average staff nurse.*

—Victoria C.

### 6. Expand the role of hospice care in hospitals.

This recommendation, presented on the next page in its entirety, was posted on the Wiki during Phase 1 and universally embraced by nurses. Never again do they want to be thrust into the role of shepherding so many patients to and through the end of their lives. Hospice care is more than a way to ease a patient's final days; it's an effective way to relieve pressure on the nursing staff. Fully integrating hospice workers into hospital care settings should be a key part of future pandemic planning.



## Proposed Solutions

### FROM THE WIKI

*We are an inpatient hospice located in northern New Jersey and our highly trained staff provides care for patients at the end of life. When the COVID crisis began, the hospice team wanted to make a meaningful impact. A need arose when the burden of all the dying patients had reached its peak. Hospitalists were pronouncing patients at an alarming rate. The doctors and nurses were struggling with the losses. It was heart wrenching.*

- The hospice team became the pronouncement and post-mortem team. Our team took on one of the hardest jobs during the pandemic.*
- We worked with administration and medical affairs to get credentialing for all the nurses.*
- Information technology generated a beeper and paging system in our electronic medical record.*
- We collaborated with the nurse managers and nursing education to educate the staff.*
- Infectious disease and nursing set up an expiration checklist and postmortem procedure to meet the guidelines of the CDC and the department of health.*
- IT created pronouncement charting in the EHR and all of our nurses were able to access the electronic death registry.*

*Our nurses went to the bedside of every patient that died. They cared for each person in a dignified way. This alleviated the stress from the frontline doctors and nurses. It allowed them valuable time to spend with patients in need. We also collaborated with transport and the morgue team to track all of the patients. The hospice counselors provided emotional support and telephone counseling to the families of the deceased. Our staff assisted families with funeral plans and coordinated with funeral homes. After each pronouncement, patients were treated with the utmost reverence and respect. It was the last act of kindness that we could do for so many suffering with the virus. Hospice provided education and support to the nursing staff.*

*Our hospice nurses rounded on palliative patients. We assisted with interventions to alleviate distressing symptoms. iPads were used to FaceTime and connect families to patients in the most meaningful way. We were present for patients, helped alleviate their fears, made them comfortable, and feel safe.*

*The response from the nurses and doctors at the hospital was tremendous. They thanked us for providing each patient with the time and care that they deserved. The hospice staff are the finest professionals. We provided dignified postmortem care to over 100 patients. We facilitated over 117 FaceTime calls with patients and families. Our compassionate group provided bereavement support for all the families and assisted with all funeral arrangements.*

*It was difficult for everyone. This work gave us an enormous sense of purpose.*

*Thankfully, our pronouncement team is no longer necessary and COVID cases have decreased dramatically. We are now trying to regain our resilience and move forward.*

*—Lisa B.*

## Proposed Solutions

### 7. Increase administrative transparency for patient safety.

Many nurses suspect that the fiscal decisions of their hospitals do not reflect a commitment to patient safety and quality care. In some cases, the administration needs to rethink budget priorities; in other cases, it needs to be more transparent about fiscal realities. Financial decisions have real impacts on the workdays of bedside nurses who may lack needed supplies or appropriate staffing levels to provide the safe, quality care they know their patients deserve. Having a Chief Nursing Officer in the meeting is not enough. The voices of bedside nurses must be an integral part of humane budgeting, and transparency is needed to establish trust between nurses and healthcare institutions.

### 8. Give bedside nurses a place at the table and commit to integrating their recommendations.

During the COVID-19 pandemic, many nurses on the Wiki reported feeling as though they were expected to follow competing rules and regulations, work beyond their skill levels, and risk their own lives to do it—all while feeling like no one was listening to them or prioritizing their needs. That is why we believe a bedside nurse should have a place in management meetings. The Chief Nursing Officer (CNO) has many varied demands. That bedside nurse can be laser-focused on advocating for herself, her patients and her colleagues. But nurse advocacy only works if management is truly committed to listening to the bedside nurse and implementing changes that will serve nurses and their patients.

## FROM THE WIKI

*I am most concerned with the lack of communication between nurses and management as well as the economics of the hospital as a business. With hospitals generally run by administrators that have no frontline experience there is little respect and voice that nurses have. The nurses in administrative roles are faced with adhering to metrics and analysis of PPE equipment use and the like without advocating for the well-being of staff nurses. A previous hospital I used to work on punished nurses for using hospital-issued scrubs noting that these scrubs were only designated for doctors.*

—Maria G.

*If large national polls deem us trustworthy and ethical, then why are we not deemed good team members or reformers and change agents by those same individuals (Gallup, 2010)?*

—Bonnie T.

*This is where I would like to see the beginning of change, council meetings that allow projects to be determined 50/50. We are educated about compliance measures and understand metrics that must be addressed. We are capable of managing a crisis like COVID while maintaining SAFETY for our patients.*

—Donna D.

## Proposed Solutions

### 9. Require administrators and nurses to “Walk a Day in My Shoes.”

Nurses believe that administrators would make different, better decisions if only they could see for themselves the overwhelming challenges faced by nurses on the floor. But, they note, it is not enough for an administrator to show up once a year. Or even once a month. It must be regular and random to provide a full view of the workaday world of frontline nurses. (Regular visits to clinical units give the administrator an ongoing connection to daily nurse challenges. Random visits ensure they will get a fuller view by observing operations on different shifts, different times of the day and different days of the week.) It would be equally effective to have nurses “Walk a Day” in the shoes of hospital administrators. That would give bedside nurses a first-hand look at the difficult role administrators face in budgeting resources, managing operations, and handling litigation and complaints. The nurses, then, can bring that insight back to the floor and share it with colleagues who question administrative decisions.

#### FROM THE WIKI

*I appreciate that many people, including our hospital administrators, are terrified of contracting COVID, but all of them need to walk at least a few hours in our daily lives.*

*Perhaps they would see the awfulness of our daily lives better and offer more support and be better advocates.*

*I work in a facility where it feels like most leadership, especially senior leadership, are ghosts. We are short-staffed, we reuse PPE, and it's just generally asking too much of each nurse or CNA or other support staff member day after day after day.*

—Erica M.

*I am a Director of Nursing in a skilled nursing facility. I take pride in my team and take every opportunity to work right by their side. This usually allows me to see first-hand what our process issues may be. Where the room for improvement is going to come from.*

—Kayleigh G.

*Two weeks ago my organization was reprimanding nurses who felt the need to wear masks and sending out detailed emails outlining how if you could not prove you contracted COVID from work you would not be eligible for compensation for time missed from work. You would have to use your PTO. They have since changed the policy only after a huge outcry from nursing in the midst of a union campaign. The idea that a nurse had to fight that fight during all this...shameful.*

—Martha D.

## Proposed Solutions

### Why We Believe This Will Work

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While nurses at the frontlines appreciate 7pm claps and donated pizzas, they need more than accolades—they need work environments where they can use their competence, skills, and compassion to do what they are trained to do. They need the basic resources to do their jobs, such as PPE and support staff. And they need the infrastructure within their workplaces that consistently and meaningfully recognizes and values their contributions in visible and tangible ways. Providing guidance to nurses when they face ethical challenges and tending to their well-being and mental health also matter.

This requires listening to nurses, supporting nurses, and protecting nurses.

None of those requests is unreasonable or politically controversial. And they would go a long way toward keeping nurses working at the bedside and providing the quality, compassionate care patients expect.

## National Level Solutions

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### Statement of the Problem:

In the last two decades, the United States has faced five potential pandemics: SARS, Ebola, Zika, swine flu, and coronavirus. Only one turned into a full-fledged, worldwide pandemic. That means we know how to contain a virus. What we lacked in the COVID-19 pandemic was the political will and national leadership that could have contained this virus, lessened the strain on nurses, and saved lives.

The lack of a coordinated national response to COVID-19 shined an unflattering spotlight on so many of America's failings—the way it treats frontline nurses, the lack of quality healthcare and corresponding growth in chronic diseases, and the stark political split that makes a coordinated response seemingly impossible. The result: [more than 180,000 dead](#) in America by Sept. 1, 2020.

## Proposed Solutions

### FROM THE WIKI

*A pandemic shines a painful, sharp light on the limitations of both our nation's business-model of healthcare delivery, and our global supply chain. Preparation saves lives, but it's expensive. Yet scrambling to keep staff safe when supply chains have collapsed is more expensive. We have an ethical duty to plan as a nation for the next pandemic. I would hope this would involve cost analysis, better informed data on stockpiles of PPE, medications, durable medical equipment like ventilators, and human resources. Do we need to create a federal reserve medical corps similar to the national guard? I also hope we evaluate our supply chain model, in which items are sourced from a single or two origins. We cannot in the future be reactive in asking auto makers to assist in manufacturing medical equipment 8 weeks into a pandemic. We need to know how to mobilize before it's necessary.*

—Jen S.

### **10. Create a Pandemic Response Team empowered to plan for and oversee response to the next pandemic.**

After the Ebola crisis in 2014, President Obama created the Global Health Security and Biodefense unit of the National Security Council to develop a response to future pandemics. Rather than follow [the plan that group created](#), President Trump disbanded the unit.

We need a national reckoning on the mishandling of the coronavirus that results in a plan—ideally, a bipartisan plan since political affiliation is no protection against a virus—to elevate public health professionals, give them the keys to drive the next pandemic response, and ensure buy-in from the public.

This plan would be created by a Pandemic Response Team that would operate as a national agency empowered to run the pandemic response, with health as the first priority. It must be bipartisan, but able to operate independent of political pressure. Its first priority would be restoring faith in science and America's public health infrastructure. Then, when a virus hits, it would be in charge of everything from scientific studies to invoking the Defense Production Act to compel production of needed supplies.

## Proposed Solutions

### FROM THE WIKI

*I am scared. If I cannot get PPE I will still have to do my job. I feel nurses have been seen as disposable. A fireman would not be sent into a fire without his equipment. We are human beings, not machines. Employers need to start putting safety first and not just patient safety. Employees need to be protected. I feel that it has always been ok with employers to not provide adequate PPE and to turn a blind eye because it costs money. This has to change. Slips, trips, and falls and back injuries are not the only things to protect employees from. We need protection from exposure. Who would want to go into nursing now? After they have seen what the reality is? The dirty little secret that nurses know and have known for a long time, that we have to SAVE on PPE because there is never enough- well now the secret is out. It has to change.*

—Carol S.

### **11. Ensure adequate PPE through domestic production and stockpiling.**

We can **Never Again** rely on unstable supply chains for equipment nurses need to feel safe while they do their job and care for their patients. Stockpiling equipment and increasing capacity for domestic production are crucial to ensuring sufficient supply so the personal safety of nurses and their patients is Never Again compromised.

The idea of setting an ideal minimum level of stockpiled PPE was, perhaps, the most controversial recommendation among the thought leaders. A nurse in Phase 1 suggested a minimum of two months' supply was needed while several thought leaders suggested six months. One noted that six months is environmentally wasteful.

The bottom line: Hospital PPE supplies need to be sufficient for more than one day. Or five days. The PPE stockpile needs to be adequate for ALL employees who need protection—from physicians to janitors. The stockpile should be comprised of quality products that include manufacturer guidelines for appropriate use. The stockpile also needs to be replenished regularly and to reach bedside nurses when it is needed. It won't do anyone any good to have an untouched six-month stockpile of PPE that expires before it can be used, or a warehouse full of supplies that administrators do not release when needed.

Ultimately, stockpiles are not the answer. The real answer is for the country to develop the capacity to consistently manufacture sufficient PPE in the U.S. A reliable domestic supply chain will reduce the need to maintain enormous stockpiles.

## Proposed Solutions

### 12. Make quality healthcare available to and affordable for all Americans.

Fixing the country's healthcare disparities requires much more than offering free testing to everyone. Or even free healthcare to patients who contract the virus. It requires that all Americans have access to quality preventive care and quality ongoing management for chronic diseases such as obesity, diabetes, and heart and lung disease— all pre-existing conditions that lead to poorer outcomes for COVID patients. It's time for the richest country in the world to ensure all of its citizens have access to the health care they need, regardless of race, geography, or ability to pay.

#### FROM THE WIKI

*Our American health care system is completely broken. Our facility was lucky - we are in the heart of NYC, but we are a specialty center. Everyone we saw has some type of insurance or payment set up. However, every day on the news to hear about the death tolls, the uninsured who refused to go get help because they didn't have insurance. People who would show up to the ER because they don't have a primary care doctor. Health literacy suffers when people don't have primary care doctors. And people don't have PCP when they don't have insurance. Universally, people need health insurance.*

—Kelly Z.

*During the pandemic what we learned most as outpatient infusion nurses was how many unnecessary visits we had pre-pandemic. Patients would come to the city for a lab draw, hydration, perhaps just for a simple long term follow up visit. They came because they are connected to the facility, to the attending, to the staff. Maybe they came 5 years post BMT follow up because they are always worried. They would spend co-pays, time, energy and stress.*

*But during the pandemic, unnecessary appointments were put on hold. Visits that were just follow ups were pushed back. Most appointments were able to become tele-health appointments. Hydration 3x a week? Most likely not necessary, so it was canceled. Lab draw 3x a week to check platelet level, and then never needed platelet transfusion? Canceled.*

*To my organization's credit, they were able to transform outpatient care into a tele-health center. However, there weren't enough systems in place to make this work seamlessly.*

*Our hospital administrators should continue to have telehealth visits. The insurance systems should continue to allow for telehealth visits.*

—Kelly Z.



## Proposed Solutions

### 13. Expand access to and use of telehealth.

Insurers and American healthcare providers have been slow to embrace technology. If there is an upside to the pandemic, it is the fact that it has demonstrated the potential for telehealth. While we understand that it will not work for everyone—those without access to the internet, a computer, or smartphone, for example—if we expand it to those who can take advantage, it has the potential to relieve pressure on an overburdened system in addition to its power to keep patients socially distant.

### 14. Support a coordinated and collaborative public health infrastructure.

Watching the virus race around the world illustrates that we are globally connected. Isolationist policies cannot save us from a virus. We need to find ways to work together across county, state, and country lines—via the World Health Organization and other avenues— to keep one another safe. There must be congruency to promote and ensure national management of this and further pandemics. That means sharing resources, coordinating eradication efforts and, yes, telling the truth.

## FROM THE WIKI

*Yesterday, like every other day, I walked down the hall in our COVID unit (sweating in 15 pieces of PPE and exhausted because in 4 days I have already been away from home 62 hours). I am doing my morning rounds and going from one to the next. I am trying to encourage my nursing staff, reminding them that we are strong and we are a team and we will do the best we can. I am mopping, I am cleaning and stocking, preparing for the next transfer because we can't afford to use the extra PPE for another department to take care of it. I am calling families to provide updates, sometimes ones that encourage them to call and say goodbye. I am working with the county response teams and the 5 different counties that all want me to follow their specific protocol and call 3 different people once x,y,z happens with their one citizen who lived in their county 9 years ago. I am counting and recounting PPE, calling every paint store in a 50-mile radius looking for enough shoe covers to make it through the next 2 days.*

—Kayleigh G.

## Conclusion

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When we fail to contain a public health crisis, we end up with a national healthcare crisis, with nurses on the frontline. We can **Never Again** allow that to happen.

The first step to achieving that goal is to properly fund and empower public health agencies. They are the first line of defense against pathogens. Yet, [Kaiser Health News has reported](#) that after accounting for inflation, funding for the federal Centers for Disease Control and Prevention actually decreased over the past decade. And while the Affordable Care Act established a public health fund worth \$15 billion over 10 years—the Prevention and Public Health Fund—it has been [repeatedly raided by both parties in Congress](#) to pay for other, sometimes non-health priorities. Pair that with a new national questioning of science and the need to balance health and economic needs and we find public health dangerously depleted when it is most needed.

This novel coronavirus has taught us so many things, among them:

- Nurses are a critical national resource. They should be supported, respected, and empowered to ensure they will be here for us when the next pandemic hits.
- Where you live, the color of your skin, and how much money you make has a direct connection to whether you will die should the virus find you.
- Our world is more interconnected and, therefore, interdependent, than ever before.
- Shepherding a patient to the end of life requires a special skill set.
- There is a lot of waste in our healthcare system.

The question now becomes: What do we do with those lessons? If we simply allow them to fade away when the virus does, we will have wasted the opportunity this virus offers. And we will be doomed to repeat our mistakes.



Rebuilding trust in political leaders, hospital administrators, and public health officials is imperative. However, trust is a fragile thing. Once broken, it is difficult to mend. But, like the Japanese art of Kintsugi that puts broken pottery pieces back together with gold to create something that is stronger and even more beautiful, we believe that rebuilding the broken trust between nurses, their bosses and their political leaders can result in something that is stronger so the United States **Never Again** fails its people.

## The Thought Leaders



**Catherine Clark**, BSN, RN is an emergency nurse living in the Midwest. She is passionate about transforming nursing through education, leadership, and quality improvement to enhance patient care, amplify healing engagement,

and increase job satisfaction for nurses. She integrates a social justice lens into her clinical practice to tackle health disparities and address social determinants of health. Partnership, accountability, non-judgmental stewardship, and empathy are the values that guide her in providing care to patients as they pass through the emergency department on some of their worst days. She loves working in a team-based, fast-paced environment where she learns something new every day. Outside of work, she spends lots of time outside and in the kitchen, hiking, gardening, and trying new vegetarian recipes.



**Kayleigh Gattuso** is a Registered Nurse and has been practicing in the state of Ohio for 9 years. She comes from multi-generational nursing and found her niche as a Director of Nursing in a skilled nursing facility.

She is certified through the state for infection control and has managed and overcome a COVID-19 outbreak. She is well versed in state and federal regulation related to long-term care with experience as a clinical reimbursement specialist. Kayleigh practices nursing with honor, humility, and passion. She hopes to share her experiences in an effort to identify how the United States healthcare system can improve and better prepare for a healthier tomorrow.



**Juliano Innocenti** started his life as a professional ballet dancer, and then transitioned to working in HIV/AIDS research and philanthropy before returning to school to become a Registered Nurse in 2009. His specialties include cardiac telemetry,

infectious diseases, palliative care, and most currently psychiatry. He lives in San Francisco, CA where he works as a psychiatric nurse while he finishes his final coursework towards becoming a Psychiatric Mental Health Nurse Practitioner. He is a true believer in the power of prayer and meditation, open honesty, and the strength of mindfulness. Juliano attributes his compassionate nature and empathetic approach to the woes of humanity to his two dads, William and Michael, who have been the most understanding and loving people in his life; instilling in him an immense awareness of the injustices in our world, always remembering to speak up for those without a voice. Juliano is an avid volunteer as a first responder for the Red Cross disaster response efforts, and is proud of his past work in South Africa's Kwazulu-natal with AIDS orphans, as well as in Guatemala at a pediatric AIDS hospice.



**Stacy Nigliazzo** is a 21- year healthcare veteran who has served in the emergency department for the last fourteen years. In addition to nursing she also has a passion for the arts, considering both her life's work

in equal measure. She is co-poetry editor of [Pulse, Voices From the Heart of Medicine](#) (New York), and co-editor of the 2017 anthology *Red Sky: Poetry on the Global Epidemic of Violence Against Women* (Sable Books). She is the award-winning author of two books of poetry, [Scissored Moon and Sky the Oar](#) (Press 53).

Wisdom from Nurses so We Never Again Mishandle a National Healthcare Crisis

## About the Report

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WikiWisdom™ is a peer collaboration process used to amplify the voices of key stakeholders in critical policy matters. Facilitated by a professional moderator, the conversation is open to people who seek a safe, productive, and easily accessible avenue for solving problems and changing policies.

Each and every WikiWisdom report is created by the peers who choose to participate. This report, created in the midst of a pandemic, is unique in several ways. Like the dozens of forums we have run over the last 10 years, the Frontline Nurses WikiWisdom Forum drew thousands of nurses. Unlike the others, a much smaller percentage registered on the site and a lower than average number posted ideas or comments. In some instances, nurses who posted ideas came back and deleted them. Two reached out privately to tell us they took down their ideas for fear of retaliation from their bosses. We have never seen that in other forums, even those focused on nurses.

We are grateful to the 463 nurses from across the country who joined and shared their ideas and comments in Phase 1. And we are awed by the four nurse Thought Leaders who joined Phase 2 to craft the 14 recommendations in this report.

The project was sponsored by **New Voice Strategies**, the **John Hopkins School of Nursing** and the **American Journal of Nursing**. The online conversation was hosted by **Cynda Rushton**, Ph.D., RN, FAAN of the John Hopkins School of Nursing & Berman Institute of Bioethics, and **Theresa Brown**, BSN, RN, FAAN and author of the New York Times bestseller *The Shift: One Nurse, Twelve Hours, Four Patients' Lives*. The report was written by **Cindy Richards**, a professional journalist who moderated the online forum.

To learn more about WikiWisdom go to [wikiwisdom.net](http://wikiwisdom.net).

## Frontline Nurses



What have you learned from the frontlines of fighting the coronavirus that you most want policy makers, health care administrators and your bosses to know? If you were in charge, what is the first thing you would change to ensure we never go through this again?



### Submit a Response

You'll need to log in before submitting a response.

LOG IN

Responses

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**James B.** MODERATOR PICK

JULY 1ST, 2020

RN, MSN, Pt. Safety Specialist

Do not forget those who are vicariously traumatized.

Mandate de-stressing and debriefing sessions for all HCWs with a minimum number of contact hours per month as part of license renewal. Time in session should be compensated by employer. (OSHA has various requirements for similar situations that mandate employer responsibilities when employee is exposed to known hazards and this pandemic should be considered an known hazard)

[Read the Full Response](#)

Tags: COPING

👍 (1) | [Comments \(1\)](#)



**Lisa B.** MODERATOR PICK

JULY 1ST, 2020

Hospice team making an impact in an Acute Care hospital

We are an inpatient hospice located in northern New Jersey and our highly trained staff provides care for patients at end of life. When the Covid crisis began we worried about the health and well-being of our staff and residents. All of our nurses were deployed to assist in care for patients at the hospital . Our team was stressed but we all showed up. The nurses, home health aids, and team members worked MedSurg units, quickly getting up to speed on the procedures at the hospital and patient care protocols. The hospice team wanted to make a meaningful impact....

[Read the Full Response](#)

👍 (5) | [Comments \(2\)](#)



**Kayleigh G.** MODERATOR PICK

MAY 15TH, 2020

It will never be the same

I am a Director of Nursing in a skilled nursing facility. I take pride in my team and take every opportunity to work right by their side. This usually allows me to see first hand what our process issues may be. Where the room for improvement is going to come from.

Yesterday, like every other day, I walked down the hall in our Covid unit (sweating in 15 pieces of PPE and exhausted because in 4 days I have already been away from home 62 hours). I am doing my morning rounds and going from one to the...



Please Join Us

**Please note:** We are committed to protecting your privacy when participating in this forum. Only your first name and last initial will be show publicly and only nurses are welcome to join our conversation.

We know that nurses are the backbone of American health care, and often its heart and soul. The COVID-19 pandemic is testing all of us, but nurses are on the frontlines. This WikiWisdom Forum was created so nurses fighting the Covid-19 pandemic can share their experiences with each other.

This space will be available 24/7 until America exits this crisis. Join us. Share your knowledge, experience, and challenges about working on the frontlines of a pandemic.

We know you are overworked, understaffed, possibly heartbroken and anxious, but always courageous. Feeling part of a community, even a virtual one, can help.

When the COVID-19 pandemic has passed, we will select a group of leaders from this online conversation to work with our moderator to prepare a "Never Again" report which will be published by the American Journal of Nursing.

**Theresa Brown, BSN, RN, FAAN**

*Nurse and author, frequent contributor to the New York Times, author of the New York Times bestseller The Shift: One Nurse, Twelve Hours, Four Patients' Lives*

**Cynda Rushton PhD, RN, FAAN**

*John Hopkins School of Nursing & Berman Institute of Bioethics*

If you are not a nurse please share this forum with the nurses in your life and support our work. [Donate Here](#)

### Moderator Message



**Cindy Richards**  
Moderator

Welcome to the Frontline Nurses WikiWisdom Forum. I'm Cindy Richards and I will be your moderator.

How the WikiWisdom Forum Works:

#### Step One:

Nurses are invited to share their ideas in response to the questions posed on this platform. This crowdsourcing phase will last until we are through the Covid-19 pandemic crisis.

#### Step Two:

At the end of this crisis leaders that emerge in the online conversation and are identified by an algorithm are chosen to work with the moderator to shape the key ideas into a "Never Again" report.

#### Step Three:

The "Never Again" report will be published by the American Journal of Nursing and distributed widely by the



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F O R U M

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peer collaboration  
and networks.

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