Interviewer: It's Wednesday, June 9, 2010. So for the record I would like you to tell me your name. I would like to go back a little bit and tell me where you went to school, why you chose nursing and then tell me a little bit about your basic experiences and your basic nursing program.

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I was the product of Holyoke Catholic High School back in the late 60's and at that time there were not many options for women. We could be a secretary, we could be a mother, we could be a teacher or we could be a nurse. Anything else was discouraged. I actually was planning on going to the Providence Hospital School of Nursing, had gone through the entire process and was accepted. In late Spring of 1969 we received, a handful of us from the high school, received a letter in the mail that the Bishop had decided at that point not to reopen the Providence Hospital School of Nursing, so that didn't leave us very many options and we were scrambling around a little bit. So in the front office of Holyoke Catholic High School was Dr. Mary O'Leary[i]'s mother. She was the secretary and the glue that held the high school together, so she said to my friend Maryellen and I, you need to go see my daughter, Mary. So off we went and we came to see her daughter Mary who was at STCC for one year of prepping to open the first Associate's Degree program in the area and Mary, her daughter, had also been an educator and a faculty at the Providence Hospital School of Nursing. So here Mary found herself to Springfield…um…we had to do one year of what I now call a pre-nursing program because this program wasn't ready until the Fall of '70 and we were needing something in the Fall of '69, so we came onboard and we took many of the courses that we needed to support nursing. We took English and the social sciences. We took our anatomy and physiology. We took microbiology. We really cleared away everything that we could possibly clear away other than nursing. Mary actually hired the two of us. She call us her two Mary's…she hired the two of us as work study students and she had us on our hands and knees with mops and pails over in the original building, which was quarters five and six at the far, far, far corner of the campus which no longer is being used. Half of the building was for nursing and the other half was for another society on campus. So in that building which was an old commander's home…it was almost a duplex, it was a

double building so one side had a full house, the other side had a full house, but we had the unit to the left, quarters five, and in there we had faculty offices, we had the classrooms, we had the nursing lab, we had everything that we needed at the time to do nursing. Any other courses needless to say were held out of quarters five. So there we stayed for our two years and we spent two years in quarters five. Needless to say, the program was much smaller. I believe…if I count back, we graduated in the low 40's, 41, 42. We were pinned in the cafeteria on a plywood platform. It was quite…we were a very good bonded group. We all did well. We had…most of us that I even remember had excellent career starts and that's how we began our education here. Some of the faculty that Mary originally hired was still here…I'm going to say when I finished my degrees and I was working part time, some of the faculty was still here. Now we are talking…this was 1970. Mary pulled me out of…I wasn't even finished with my Bachelor's program in '78 and she pulled me out and she said I need you to teach. So I was teaching for her without even a Bachelor's Degree being finished. At the time I do believe she was doing something that the Board of Registration said you could do because I doubt with Mary, the attorney, that you could not do that. So she was putting me on a waiver and that's when I began teaching is 1978 and I had my own career path after that but I continually intermittently taught for Mary. I taught for her in the School of Nursing as a clinical instructor and I also taught for her in the School of Health when she was the Dean of Health in Nursing. So I did health science courses for her, I taught some health courses to physical therapy and occupational therapy and we had other programs at the time. They were…I believe they were called mental health technicians, something that I think we could use again but that program no longer exists. So then I ended up…Mary desperately tried to talk me into coming back to working as a clinical chair of medical assisting and the timing was never right. I had babies and I kept saying no to her but I continued to work as a clinical faculty for her and then Joan Millet, who was one of the original faculty, convinced me that I needed to start teaching something other than med surg and she roped me into teaching. She had nobody to go to Gerontology with her and she said you are going to come with me. So off I went to Gerontology with her and we spent many happy years with freshman nursing students at

Heritage Hall in Agawam. Then she decided that I needed to start teaching OB and at the time, my career had me as the Director of a prenatal center in Holyoke so I said okay, this is the golden opportunity and the time for me to do it and then I just continued and I finished my Master's Degree and the first opportunity to be hired after I finished the Master's Degree I was offered a position, although Mary was no longer Dean of Nursing, she was Dean of Health and Nursing and there was another individual, Aileen Neville, who was at the helm of nursing at the time and that's when I was hired back in 1994, progressed from 1994 from faculty to…um…then the college decided…or Aileen decided that she was going to open an evening program based on I believe collaboration with the local hospitals. So I ended up taking chair of the evening program and we did that for four years but we found that the evening program was more of a challenge than we expected it to be because in the evening program, most of the students were working full time and the faculty that you were hiring from 4 PM on, also thought that they were going to be part-time faculty. So the combination of the students working full time, coming to school full time, the faculty working during the day and taking another full time assignment, the mesh just didn't work. So what we did at that point was…it was never really called an evening program. It was called an afternoon option to the day program and that's based on regulations. So we started at 4:00, which gave us legal ground to call it an afternoon option of a day program, and we meshed all those students into the day program. So we continued to keep the numbers but we changed the time but we also do have evening clinicals and weekend clinicals so we still give some of the students that really have to get out of that 9 to 5 an opportunity to be able to complete their program requirements in an easier fashion for them. That is…there is a lot of meat in between there and I am going to ask you to ask me questions so you can get more information that you need.

Interviewer: Okay. Let's go back in time to the first program in the officer's quarters.

: Okay.

Interviewer: Recall if you will those…

It was a very cohesive group 'cause we were there in that…we were like prisoners. We were confined to the same quarters for everything that we did. All of our lectures were there, all of the faculty was always there. The students really weren't supposed to be in the kitchen with the faculty when the faculty was eating but needless to say, the students were whittling in and out of the kitchen when the faculty was in there eating and I do clearly remember Mary O'Leary in the kitchen of Quarters Five and every day, and I said this at her retirement dinner, every day she ate the same thing…cottage cheese, tuna fish and green peppers all mixed up and I thought it was the food of wisdom. So I decided I was going to try cottage cheese, tuna fish and green peppers and frankly it didn't work. But we were always together, we learned a lot from being such a small group together. We learned about each other, we learned our likes and dislikes about each other, but we supported each other and we did everything humanly possible to get us through to the end. One day we found the building vandalized and we came in and we still to this day…I think I know what happened but I won't put it on tape…um…all of our equipment, our sphygmomanometers and our stethoscopes everything was out on the campus green when we came in the morning. So that was quickly rectified and that did not happen again but that again put a little, you know, strength into our group. The other thing that we needed to do was…of course back at the time, people were so interested in the nursing cap but needless to say, it was a new school so we did not have a nursing cap. So a group of us, and one of them was Shirley L. she was an older woman in the class. Unfortunately she died not too many years after she graduated, but she spearheaded this group of us that wanted to design a cap and, of course, we were back and forth to Mary O'Leary about the cap and she looked at us one day and she said, listen to me, it's not what is on the head, it's what in the head. If you want to get a cap, then go ahead and do it. Well we did design this cupcake like cap. It was sheer, it was…in fact there is one up there, it's a little bit different design, this cupcake like cap, and we wore it as students with great pride. We handmade them at the time until Mary found a manufacturer to make it, but we had…as students we had burgundy and gold ribbon on it and then, of

course, when we graduated we had black. The uniforms we had were quite interesting. They were your straight A-line dress with a big burgundy bib in the front and we didn't really love the burgundy bib, but one thing we did get to do was take that bib off to graduate, so we all had that as a graduation uniform. There are still schools out there that I see in catalogs that wear similar attire but that was…great pride in what we did. We were very happy with our caps and very happy and we were also surprised at the time because we had a handful of men in the program and we thought, wow, we actually had one couple, Peggy and Michael. They ended up getting married, neither one of them are practicing as a nurse. They moved to either Vermont or New Hampshire and…maybe one of them is practicing as a nurse but they just changed and they went to the simpler life and did simpler things when they got up there. A lot of people in my class went far and beyond, but it's really pleasing to me that I graduated from the first class and now I'm only the third Dean of this nursing program in 38 years, so…

Interviewer: Where did you go for clinical?

When I was here, I clearly remember going to Mercy Hospital. Most of my clinicals were Mercy Hospital. I also went to Northampton State Hospital.

Interviewer: How was that?

: Well…I was just speaking about this to someone the other day. Ironically, my friend Maryellen and I…we were always together and we had our patient assignment and, of course, at Northampton State Hospital if you were in the Holyoke unit or the Chicopee unit or the Springfield unit, that meant that's where you lived so there was really no discretion. So if you went up to visit somebody and you were visiting somebody in the Springfield unit, everybody in there was from Springfield. But we had one of our patient assignments this day and I remember her as being a young girl, very wiry and she was probably in her early 20's and she had lost all of her teeth and I remember that about it, and she was always laughing about the fact she didn't have any teeth and she bolted on

the two of us. She is running through the greens and the hills of Northampton State Hospital and the two of us were chasing her and she had us by a mile with her length and her wiriness and finally we got her to come back. We were never so scared in our entire life, thinking we lost a patient but we found our patient and we brought our patient back and she giggled all the way. I didn't enjoy it. I thought there were some intimidating situations when I was up there. One of my assigned patients was someone who was up there for forensic psych and she actually murdered her significant other and she propositioned me in the greenhouse and that as a young kid of 19, I was petrified. I was positively petrified and I was very glad when that rotation ended. Although to this day, I know the building still exists in part, I would love to go into that building but we also had the opportunity to go to all of the other wards and it's a different time, it's a different type of nursing, it's a different type of healthcare and I'm glad that it's gone. I'm glad that it's gone. People should not…but we didn't know any better but that's how we put people that were a threat. But, of course, now we have got medications, we have got better ways to treat people, better ways for people to be out there and live healthy lives in the community other than what was happening back prior to the 70's.

Interviewer: And when you were at Mercy, those…

Mercy was…it was the old Mercy, not the new Mercy, the old Mercy and I remember being in the Memorial House which was the old Mercy now and not all the rooms had running water, so if you needed water for hygienic care, what you needed to do was you need to go cart it from some utility room that had hot running water. So complicating that was the fact that you also didn't have disposal of water if you were in an isolation room, so what people don't realize today is you can be locked in that isolation room for hours and what you would have to do is take your dirty water and pour it at the doorway into a clean bucket that somebody else was holding, so they could walk back down the hall to get rid of your dirty water and then come back and give you some clean water so you can continue to do what you were doing. I'm sitting here and I'm realizing I'm really not that old, but that's how archaic some of these things were and I remember one

very very big room that was saved for the Bishop, or if the Bishop wasn't going to be sick it was saved for the special…special patients that were coming in. It had a big huge arch in the front and it was amazing. And, of course, all the Sisters of Providence…and I ended up working for the Sisters of Providence for years but the Sisters of Providence walking around in their starched whites and…the history of the Sisters of Providence which I used to do because I was part of the Mission Committee and chair the mission at Sisters of Providence in my mid-years of my career and its fascinating to see what those nuns did in order to deliver healthcare to this community. I think I mentioned to you on our first visit that part of their video shows the nuns who lived in South Hadley, minus the South Hadley bridge, so they would get in their little boats everyday and they would row clean linens across and take dirty linens back to launder them and then back and forth with the clean linens to get to the original Providence Hospital which was in downtown Holyoke, which the Bishop recently closed, which was Holyoke Catholic High School and that building still stands. It was right behind it so it was right behind…Holyoke Catholic was the…I was born in the old Providence Hospital. I remember it before they tore it down. I would have to walk to school behind the back of it. I was a walker. But yeah, it was different, healthcare was completely, completely different. Nursing was different.

Interviewer: How so?

Nursing back then…there really still was the handmaiden to the physician and not that all of that is wrong, but you did…when the physicians came in, you stood up and gave them your chair. When the physicians came in, it was yes doctor, no doctor, yes doctor and that respect still needs to be there but it was different. There was no collaboration. It was the doctor told you what to do, you didn't participate in the care of your patient, you didn't participate in the decision making. You monitored, you treated, you medicated, you did your post-op care. Hopefully we were all critically thinking, I do believe that we were because needless to say the physicians were not there all the time and then slowly the change began that nurses, especially when ICU's came in to being which we didn't

really have. ICU's are a new concept and people don't really understand what a new concept they are. Actually what I tell the students all the time, is the patients that are in ICU today, are the patients that we had on the units and most people that…let's say that the patients that come in for one-day surgery are the patients that we had on the units for five and six days. The patients in ICU's today would not have survived, they would be…we would have no way to keep them alive, but the patients that we had in ICU are patients we may be discharging in 48 hours now because of the increase and the perfection…not the perfection, we are not where we need to be yet, but the dramatic changes in technology and how we can care for people is just so much better, so much better. We would admit people for a gallbladder, we would admit them 48 hours before their gallbladder was going to come out, we would do all pre-op care, we would prep them, we would enema them, we would, you know, hallucinate them. We would send them off to surgery, we would bring them back, we would do so many things. Now you come in at 8:00 in the morning and you are home at 8:00 at night and you had your gallbladder out. Although back then it was…the surgery was much more complicated than it is now. We are doing a lot of laparoscopic surgery which we did not do then. But people that are in ICU today are truly sick. We could not have kept them alive back then, we just couldn't, it would have been impossible, impossible. We didn't have the technology, we didn't have the knowledge, we didn't have the medicine and I…also a product of the evolution, I took off shortly into my career to Yale – New Haven for 2 ½ years to work in medical ICU and it was there that my eyes opened up to some of the technology that we really didn't have in Western Massachusetts and then when I came back to Western Massachusetts, back to where I left, Providence Hospital, but I went into an intensive care unit, technology that we had…I had worked with for 2 ½ years at Yale, was just coming into Holyoke. But, of course, you can't bring technology in until you have the physicians and the equipment and the staff that knows how to do it. So I remember many a call in the middle of the night that this wasn't working or that wasn't working and can you come in and see what you can do to fix it, because there were very few of us that actually knew what to do. But also what nurses could get caught up in, and I hope it's not happening today but I'm sure it is…and I also tell the students this, you

have to be mindful of your patient. You can't be the keeper of the tubes, you have to take care of the total patient and not just take care of the equipment because then you are missing a key piece to patient care. You have to be able to take…and I miss it, I desperately miss taking care of people and my hands on the unit.

Interviewer: Given that, let's go into your present. You are now the Dean…very good. But you have a perspective on the Associate Degree Program and what you experienced as the first students in this program and what you have at this point. What I would like to hear is your opinion as far as the changes that you have seen, how the Associate Degree Program has changed to meet the needs.

: Well we [*ADN*] were never really accepted in the beginning because I clearly remember the anxiety of the staff that I was going to work with saying, we have never had somebody with a degree like yours, we don't know what to do with you. And I will tell you I was put under the microscope by that first head nurse and I do thank that first head nurse, and her name was Jeannette B., and she is still working a couple of days a week. I will get back to that evolution in a minute, but she was absolutely instrumental in my success rate, as was the other ladies that I worked with, Pat S. and Katy M. and Yvonne K. They were extremely instrumental in developing my career, but I will tell you Jeannette did not let me do one thing without breathing down my neck and watching that I knew how to do it. She would watch everything that you did and when she was satisfied that you knew what you were doing, she let you fly but I think what they all found out that year…because there were about six of us that went to Providence Hospital for our first job…I think they found out that the Associate Degree nurse really was a capable, sound nurse when they graduated but, of course, with Mary O'Leary and the faculty that we had at the helm, it wouldn't have been otherwise because they would not have graduated us unless we knew what we were doing and we were the group that proved ourselves. So as time went on and the diploma schools were going, going, gone, Mercy was closed within two years of Providence closing, Worcester was closed within a few years of that, and Holyoke Hospital closed. Baystate Medical Center was one of the

last ones to hold on, but they didn't hold on very tightly because they started collaborating with colleges for a lot of the sciences so they knew that this was the way it was going to be and there were very few Bachelor programs around. So in order to have nurses, they were hiring at an Associate Degree. History is still repeating itself on a daily basis, what are we doing to do with the Associate Degree nurse? We know that we have to have as much education as we can. The National League for Nursing just came out with levels. I mean we have been fooling around with this for years, but the NLN did come up with levels and the levels are all based on what each degree should do and they have got LPN and then Associate's and then Bachelor's and then, of course, up through Master's, Nurse Practitioner, DNP and Doctorate. The future they hope is Doctorate's at the bedside. The reality of that, that's not going to happen for a very long period of time because your community college students or graduates are filling the needs of the community. We are the front line people out there. Most of your nursing homes are Associate Degree nurses. Most of your…many of your hospitals are Associate Degree nurses. The ones that are going magnet are looking for more Bachelor's level and up but they are hiring Associate Degree graduates with the commitment that they will finish a Bachelor's Degree within a reasonable period of time. There is always going to be a need for an Associate Degree nurse as far as I can see in the community, in the home, in the long-term care facilities and in many of the smaller hospitals that are not going magnet. You learn, you continue to grow. Not everybody is going to get a higher degree but what we are seeing in the community college are people with existing Bachelor's, existing Master's and in some case, Doctorates, that are seeking an Associate Degree to compliment their existing degree. What they are finding though is, they still need to advance with nursing degrees. It is not going to be, I have a Bachelor's Degree in Fine Arts so I'm going to get an Associate's Degree in Nursing so I have a Bachelor's Degree but no, that's not it. They are not going to be looked at…they won't be looked at any better than an Associate Degree nurse without another degree.

Interviewer: You know you are mentioning…basically, what I'm interested to hear are some of your opinions as far as entry into practice and the four year degree and the

relationship of that which has been an old long-standing issue in nursing and the different levels that we have is very confusing to some people. You can have three different levels, an ADN, a Diploma and a Baccalaureate and you all take the same exam so it is a confusing issue. So I would like to have your thoughts on that and your thoughts on the Associate Degree nurse and some of the factors that you found that they go to get a further education.

: The Associate Degree students are here for a reason. They are choosing community colleges for affordability, they are choosing community colleges for convenience and they are choosing community colleges because they live in the community. So those individuals that are seeking an education in a community college are here for a reason. They may be parents, they may be full time employees doing something else and they are trying to better themselves. A large percentage of those will not seek advanced degrees but there will always be a place for them. We do know, and I have been working on a project with the State of Massachusetts…we call it the Nurse of the Future Committee. We have been doing this for four years and we have developed competencies that we expect any nurse to have. LPN's straight up through. They are all going…we are not using the word 'level' as the NLN did, we are just expecting that they have these eleven competencies and I can share them with you if you would like to see them. We are also encouraging all of our graduates to enter a Bachelor's level program as soon as possible after graduation. I have just finished work on a grant. Part of that grant was to develop a seamless transition for the Associate Degree graduate to go into the University of Massachusetts Amherst and finish a Bachelor's Degree within a year. The motivated student can do that. Starting in the Fall of '11, we are going to be looking for a signed commitment from those students that are willing to come in and do this fast-pace through Associate's to get their Bachelor's Degree. So in reality, a high school grad, which usually doesn't have the opportunity to get right into an Associate Degree nursing program…if they can stay on task and have support, they can finish an Associate's Degree and a Bachelor's Degree all within four years. So they can exit at three years with their RN, work part time as an RN and finish that Bachelor's Degree and have a

Bachelor's Degree the following June. So we are strongly encouraging this. Also any student that talks to me that has another degree, I give them their other options. I do not…I embrace them but I don't tell them this is the only thing that they can do. I share with them other levels that they can go into and still earn, they can get a second Bachelor's Degree and there is a handful of programs in the area that they can go and get an RN and a Master's Degree within three years. University of Massachusetts Worcester, University of Connecticut and some in Boston, you can go and do a fast track and get your Bachelor's Degree with an existing Bachelor's in another discipline. You can get your Bachelor's Degree in a year…excuse me, you can get your…ability to take your RN license in a year, then in two more years you have got your Master's Degree. It's rigorous, I did counsel a student to do that, she came back to do some observation here. She was a graduate of Middlebury College in Vermont so that alone will tell you that she is a high academic. She finished at UMass Worcester in a year, took her RN license and had it and she was fast finishing her Master's Degree. So for someone like that who has the ability, but not everybody has the ability because of finances and family responsibilities. But those that can do it, that can still live off mom and dad or live off a partner or live off a spouse and can do it, it's possible because not every student has the ability to enter a four year college and get an RN. 'Cause what we need to remember is most people that are admitted to a four year college, do not even come close to starting any nursing courses until the second semester of their second year or the first semester of their third year. So for them, they are doing essentially what many community college students do, is take all of their supporting coursework and then go in and finish their nursing degree in two years. People look at it as levels of degrees that are different but what I see on paper for the students that are coming in here, there are very few and far between that have just the basics of what they need to be successful in nursing done. They have many other courses done and many of them are just so fragmented because they did this, they did that, they did the other thing, that they don't have enough to put together in the right place to get a degree and many of them could have another degree based on what they have on paper.

Interviewer: You have been here as a student and now you're the Dean. Can you in go through and look at the changes that have been made as far as the curriculum and the focus as the increasing acuity rate of the patients and basically healthcare has changed. What has been done with this curriculum?

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It's not just the curriculum and what is taught in the classroom, it's the clinical, it's how are we addressing the clinical needs and there is a lot of controversy at this moment in time about clinical. One of the issues is that we really are being encouraged both nationally, statewide and locally to increase and add more care of the elder adult into the curriculum, but as time progressed here, we also are…we know that what the students need to do. They need to be able to take care of the sicker patient as a med surg patient. We used to years ago…let's go in and observe in ICU. I see no benefit at all of observation in ICU. Every now and then you know that the faculty will put students in to observe. They really need to do as much of the hands on as they can. Some of the newer thoughts that are out there are actually taking the student, letting the student chart review, talk to the other disciplines, sit down and talk to the patient for a day or two days and then go in and take care of the patient because it can be completely overwhelming to a student because we have shorter day-stays now. Patients aren't there. Years ago, and not too many years ago, you could plan on…okay, you knew that you were going to have three post-op gallbladders, two post-op hernias, maybe a couple of…let's just say a couple orthopedics depending on what unit you're on. You knew you could plan on that so you knew your week was all set because you had those patients. You don't have those patients anymore. When you go in there, it's going to be a new adventure every day. It's like all the years that I did do maternity with the students, we never knew what was going on. I would go in there two hours before the students were to meet me because I was clueless. Because when you leave maternity on Thursday and you are coming back on Friday, it's another whole new game. It's a new mom, it's a new baby, you may have nothing going on, you may have three caesareans going on, you don't know, and that's where a lot of the medical surgical is right now because patients come and patients go. As we said earlier, they could be admitted in the morning for a gallbladder and you are

taking care of them all day and five years ago, you would have your patient back the next day so you could finish, get them discharged. Now there is no way you see the patient from admission to discharge because they are gone before you come back again. So we need to be able to address that and keep the students up to date with that. They are seeing the sickest of the sick on the med surg units. One new concept that we have begun with Baystate Medical Center as part of the grant that we were working on and as part of some trends that are out there, are called Dedicated Education Units. And these Dedicated Education Units, the hospital actually contracts with us, we pay their nurse manager to be our clinical instructor and they have specially trained staff nurses that want to be there and want to teach. So our students are assigned to a staff nurse. The nurse manager is their educator and one of our faculty is their…I don't want to use the word evaluator, but she is the person to contact and to call if something goes awry and we are starting our second dedicated education unit in the Fall and we will be having one…if it continues to go well, we will have one in the Fall and one in the Spring with seniors only at Baystate Medical Center. It's not widespread and was started, I believe, in The Netherlands, was the first Dedicated Education Unit. It sprung into this country. Oregon who is very, very,, very proactive and ahead of the game in nursing education, brought the first Dedicated Education Unit to the surface…I want to say about five or six years ago. I have actually had the opportunity to go out to Oregon twice to go collaborate, especially with Tanner, and to work with them and see how their Dedicated Education Unit began and how the staff is so exuberant and that is part of the reason why Baystate started it, because we did go with Baystate. I went with some people from the Regional Employment Board and we went out with the State…I went out with a group from the State of Massachusetts on a second visit. Oregon is extremely…they are doing fantastic things with nursing education. They actually put in a part of their program where they did a transition that was LPN to ADN to BSN and what they found was they lost their pool of LPN's. So they went and are revisiting that situation because we do know that there is always going to be a place for LPN's. There is always going to be a place out there in some of the institutions, be it a hospital, be it a long-term care, be it a school, for

LPN's. So that's what Oregon did but I did…I digress a little bit. So we recognize that too many pull-outs for an Associate Degree program is not a great idea.

Interviewer: What do you mean pull-out?

: By a pull-out I mean, you have got a semester of medical surgical but you will pull the student out for three weeks to go to maternity or you will pull the student out for three weeks to go to community. We are in the process…active phase right now of trying to perfect that and trying to make that piece better. We are trying to blend it a little bit better and we are very early in the process so I really don't have a lot to report, but it is something that we are actively working on and I'm expecting if we have this conversation again in two years, that I'll have a lot more to tell you because we are putting a curriculum change into place for Fall of '11. We are actively working on it and what we have done, is we have taken the eleven Nurse of the Future competencies and we have put them into all parts of the curriculum, into the clinical piece, into the lecture piece. We are looking to see where we might be redundant and lectures can end up being redundant so…

Interviewer: Can you explain that?

: Yeah. Where are we teaching death and dying? Are we teaching it in five different places or are we just teaching it in the place where death and dying is identified? I do believe that we are teaching it in multiple places because it's going to come up in Oncology, it's going to come up in pieces of Gerontology, so we are trying to identify where we are teaching and we are trying to match it to have it in the best place without any redundancy because that can happen in any curriculum because of faculty autonomy. They can do whatever they need to do and throw things into a lecture. We don't control faculty lecture, we are trying to orchestrate the contents so it's delivered in the best way with the maximum amount of education but also making the students do a lot of the thinking. We know now that a traditional lecture with a lot of the students, especially this

generation, isn't the best way to go. We are applying case studies and critical thinking exercises and patient simulation is doing a lot to help and apply critical thinking and critical thinking can't stop. We make them think from the second they walk in the door and hopefully they are still thinking when they leave because it's so important in how successful they can be.

Interviewer: How do you start handling that?

:Critical thinking? Well very early on…let's just take…one example would be the very beginning freshman. Let's just do a simulation and…um…one of our very creative faculty, Donna W. (sounds like), when she worked with me in the evening program, she went ahead and she did a hysterical…I don't want to call it hysterical but it was a simulation based on a well elder. I told her she needed to make the elder a little bit older than she had it for what she was doing, but she had the lady sitting up in the chair with her pocketbook and her pearls and her whole entire outfit and her younger daughter is trying to tell her that she needed to have more wellness, that she needed to exercise more and watch her diet more and it was a family simulation. Now don't forget we have the simulator in the chair dressed up and it was absolutely, completely fascinating because we would give the students a list of things that they needed to do. Let's just say we were having them do a basic nutritional assessment. So on the nutritional assessment, it would be a diet intake, what you usually eat, do you take vitamins, do you take supplements and a typical freshman student without a lot of experience would go in and they would say…okay, what did you eat for breakfast? And so the person would say it. And what did you eat for lunch? And they would do a narrative on that and then they would say, do you take any vitamins? And the simulator would say, yes I take a vitamin a day and I take…let's say for an example, I take Glucosamine and the student would go on to the next question and then the next question. So you are videoing this and then you go back and you sit down and you look and you really sit there and let them evaluate what else could you have done? Okay, you take the vitamin. Why are you taking it? You are taking Glucosamine but you went to the next question. Why are you taking

Glucosamine, how long have you been taking Glucosamine? Does have it any effect on your? Is it helping your joint pain? So in that case we are very early in the beginning doing critical thinking. We also do it with case studies and we are now on a clicker system. I had the opportunity to purchase clickers for the classroom and with the clickers, the faculty can…students all hold the clicker in their hand and the faculty will bring up a slide and they can ask the student the question and you have the automatic response from the entire group. The next slide will automatically bring in the responses so that you can sit there and say, you know, only 30% of you thought that this was the right answer. Let's talk about it. So you can digress with that for four, five or six minutes so we can get everybody on the same page. So we are doing a lot with technology, with simulation, with clicker systems and that's some of the ways that we are trying to bring critical thinking in. We also have them do wellness fairs as a freshman. We will send them out to do nutritional assessments, physical assessments, we will send them out to do blood pressure clinics. So instead of just taking the blood pressure and writing it on a piece of paper and sending somebody home, they have the opportunity to sit there facilitated by their instructor. If they find some blood pressures that need attention, to sit down and talk. Did you take your medication today? No. Are you on a medication? Yes. Well why didn't you take it? 'Cause I ran out of money. So that alone can help the student to understand…okay there is really something other here than just having a high blood pressure. Why is their blood pressure high? Are they being treated? And we will send the students…the students will send the patients right back to their doctor that very day. Something that you do very early on in the community, not just in the hospital. So we do as much as we can with application of critical thinking and we move it straight up through the curriculum and the case studies and the scenarios with simulation become extremely complicated as they go through and the feedback is really quite good with simulation. We also had the opportunity in the past to have sick children. Mary Elizabeth…my Sister Mary Elizabeth would annihilate us all if we said sick kids, so I try to this day to say sick children. They are not goats she would say…sick children. So we are developing…we have developed and we use acute asthma scenarios for the students because we look at the common morbidities in greater Western Massachusetts

and we try to address the common morbidities and asthma is a problem, diabetes is a problem, heart disease is a problem. So in the curriculum we are also trying to address what is the most common themes because when they graduate, they need to be able to jumpstart and go out there and take care of their community because asthma in this community is a problem, but in another community it may not be as big a problem. So then they may need to address something else. So we have teen pregnancy, we have low birth weight, we have…although low birth weight across the nation is better than it has ever been. We have asthma, we have diabetes, we have heart disease and we have to address this. So we are making the students very aware of what the most common themes are that they are going to expect to see when they get out there and we have got sick kids…sick children…in the school system. It's amazing to believe what is in the school system that never…and when I was being educated or you were being educated, these children were not seen never mind in the school system. They were hidden somewhere, they were in their parents' houses or they were in an institution and they were never seen. These children are in the community, they are an active part of their cohort and they are in the classroom and they are in there learning to the best of their ability. So we have to have them ready to get out there and we have to have them ready to do this so we are trying to expose them to as much as we can about what is the reality of your community.

Interviewer: Okay, so far this has been just excellent. I would like just to hear what in summary you would like to say for the record as far as where STCC is at this point?

: Okay, STCC is in a very, very strong place in the community. I think that based on the number of admissions for the number of seats, and I know that is a trend across the country, but we have several hundred requests for admission based on our inability to take more than…we would like to fill 96 seats. Of course we over-admit by a few just because we know that we need that buffer because people change their mind at the last minute, people find out this isn't for them, people don't want to touch somebody. You never know what the reason is going to be why people don't stay with nursing. But

STCC is in a very strong place in the community, it is respected in the community and it has been respected in the community for a very long time. Actually it was the first Associate Degree program in the community to the best of my ability. Holyoke came in after as did Berkshire and Greenfield. They were after STCC. Mary O'Leary, I have to give her a tremendous amount of credit. She put her foot down and she made Associate Degree nursing in this area what it is. There are…actually the National League for Nursing…most of the schools that they accredit are Associate Degree schools. Over 75% are Associate Degree schools and we have to follow their standards. One thing I didn't mention is we are starting to add technology to the curriculum. By that we are working on a small cell phone grant that three of the faculty put together and they are bringing that technology to the students and every student starting with the freshman class of 2009 through 2011 will be issued a cell phone via the grant and we are putting textbooks on their phones, we are doing instant information searching on their phones and we are teaching them how to use it, not as a telephone but as a tool. So they have IPhones, Blackberry Storms and a few of them have IPods that don't have the internet service. We are adding web-based learning. We are slowly putting web-based learning on. We had to prove to our national accrediting body that we had the ability and the college's support to do it. We also have now our own Blackboard license and we were sharing the one that the college had, but now we have our own. Our accrediting body thought that that was absolutely wonderful and that allows us a lot more autonomy to deliver as much as we can via the internet for learning. We will never…I shouldn't use the word never…the plan is not to be a web-based program. The plan is to adjunct our learning with web-based learning, to still see the students, to still bring them in. We are actually adding a three credit pharmacology course to the curriculum in January which will be two parts web-based and one part hybrid, but we still will be seeing the students and still will be meeting with the students. So we are progressing at the rate that…with great speed, but we want to just keep abreast with everything and get our students ready for what the future is and the future of nursing is, they need to be more competent, more technology competent, and they need to understand that stopping with an Associate's Degree is going

to be an option for some, but for the whole we need to encourage them to continue to grow with higher degrees because that is where their career is going to bring them.

Interviewer: I have thought another question. How is the job market at this point? I hear about a nursing shortage and yet I'm hearing from Associate Degree people…students that are current, that they are having a hard time.

The projections were a little bit off, let's say. They expected my age group, which are the nurses in their mid/high 50's to leave and go part time or to retire, but the economy and the service of the United States is not allowing that to happen. Nurses that are there have a stable job. Many of them are carrying the benefits and many of their husbands, wives, partners, have lost their jobs. College tuition for their children has gone up and nurses are not leaving their jobs, so many of them instead of decreasing hours, actually increased hours. So we cannot put new graduates in positions that are not there. I do see with this year's graduating group, in the class of 2009, it was much worse than it is this year. This year I am going to tell you that at least 15 of them walked out of here by the pinning ceremony having jobs.

Interviewer: And what area are they getting positions?

:Some of them are acute care, some of them are long-term care and some of them are current employees as nurse's aides or care technicians where they were, but the point is they are leaving here with positions. What is going to allow them, and I told them this, which his maybe why they are pushing…the minute they have that license in their hand, hospitals and employers do not want to hire anymore until the license is in hand. In the past they would hire, wait until your license was done, and then bring you on. They would put you through your orientation period and then make you official. Now they don't like to do that anymore. When you have that license, you are much more marketable. So I do believe the class of 2009 is essentially 100% employed as of now

and the class of 2010 is well on their way. I do think they will all find jobs. Last year actually, about a dozen were employed in the school systems.

Interviewer: Have you as part of…administratively…do you follow through at all on…when one of your graduates or any of your graduates get in a position? Are you in a position to follow through and find out how they are doing as far…

We do a six-month follow up survey. We try to get the information from the student and then we…in the past we would just send letters out to all the area employers and have them fill out a form. We found that that wasn't as successful as finding out where the student is and then sending a follow-up survey to the employers to have them fill it out that way. We do our best but the students are…the graduates I should say are more responsive to the follow-up surveys than the employers but last year the rate was a little bit better.

Interviewer: How is the pass rate on the…

Excellent. We had a period of time there…when I came on board I was concerned about the admission process. I had some really deep concerns about it and I made my case and we really upped the ante on the admission process. We increased the grade point average, we increased the grade across the board in sciences and in all the supportive coursework as well as the coursework for nursing and we put minimum admission requirements. We made them…I got rid of the SAT's because SAT's, other than coming right out of high school, mean nothing…mean nothing and we were losing some strong candidates based on the fact that as a 30 year old woman or man, they didn't want to take the SAT's or their outcomes weren't as great. So we made everything a minimum of a C+, every course. You can't repeat your science courses more than twice, there is research out there that will tell you that a student with a strong base in Algebra II and a student with a strong base in the sciences with a minimum of a C+…I would like to see it B- but that I doubt I will push for. But students with a minimum of a C+ in math and

science have a much better chance at successfully completing a nursing program than any grades that are lower. The research also tells you that students that have repeated their science courses more than twice, each course, which would mean more than two shots at A&P I, A&P II or microbiology, also don't succeed and our research tells us the same thing. So there is a reason why we put these rigid requirements in. We also are doing a pre-admission test which just gives us a snapshot of their ability to use the English language, basic math and basic sciences because we also know there is a complete direct relationship to use of the English language and success in a nursing program and those people that don't have a good use of the English language, both written and verbal, are unable to complete a program without challenges or complete it at all.

Interviewer: You upped the ante. What was the ante that was there before you upped it?

It was a C in all supporting coursework and not too many years ago, it was upped. It was in my tenure as a faculty, so probably within the last 15 years we upped just nursing to C+ but in the last seven years…six years, we upped all coursework to a minimum of C+. So if somebody comes into us that wants to get into the program and they have a C in English, they have to repeat it. If they don't have a minimum of a C+ in Algebra, they have to prove to us that they can do it before they are admitted. Sciences, everything has to be a minimum of a C+ and I will tell you that the population of students here with C+'s is very small, that the bulk of the students are solid 3.7 students and that grade point average, unfortunately in all nursing programs, does drop. So what students need to understand is when they come in with a 3.6,5,4,8, whatever they are coming in with, that their chances of graduating with that are…they are probably going to graduate with 3.2, 3.3, 3.4.

END OF TRANSCRIPTION

[i] Permission granted by Dr. O'Leary ,who developed the associate degree nursing program and was the first Dean of nursing at STCC, to use name, titles and positions held.(9/9/2010): Education: Sacred Heart High School 1949; Providence Hospital School of Nursing 1952; Boston College:;BSN 1954;MSN 1958 (First RN to receive the MSN @ BC) (along with a basic st.) (2 degrees awarded in 1958);JD 1966;D.Ed 1979