Reflections on Serving in the Army Nurse Corps

Colonel (Ret.) Terris Kennedy, PhD, RN
VNF President

I spent 27 years on active duty in the Army Nurse Corps. It’s hard to believe that I retired 21 years ago, as it seems like yesterday. I applied for the Army Nurse Corps after graduating from my diploma nursing program and passing my boards in 1969. Although today you must have a BSN to apply for an ANC commission, I was able to receive my commission with a nursing diploma.

I chose to seek a commission in the Army Nurse Corps because the Vietnam War was raging and it seemed to me it would be an opportunity to learn and serve. It was not a popular war, but the draft was still in effect and there were young people serving who were subject to terrible injuries. At that time, because the need for nurses was so great, you could apply under a guaranteed assignment and declare to accept the commission if you didn’t get the assignment you requested. I requested to go to Japan, where there were five Army hospitals. I received an assignment to US Army Hospital Camp Zama, Japan, and so I accepted a commission as a second lieutenant. The hospitals in Japan were the first air evacuation stop for casualties from Vietnam, so it was truly an opportunity to learn how to care for patients with severe trauma without being shot at myself. I was on a unit of 120 orthopedic patients, where about 80% were traumatic injuries.

It was an opportunity to truly learn quickly and hone skills that I didn’t even know that I had. In a very short time, I learned the value of teamwork and the importance of working together. It was an environment where everyone trusted and supported. To this day, some of my dearest friends are those I served with in Japan; you really do make everlasting friendships and relationships when you share experiences like the ones we had in the Army. I am not sure that as a new graduate, I would have learned so much so quickly and be expected to lead in any other environment. I also learned the importance and value of all the military services, since we often worked closely with our colleagues in the other services (especially the Air Force). While I was in Japan, the Chief of the Army Nurse Corps said all Army nurses would have a degree, so decided to stay and serve with in Japan; you really do make everlasting friendships and relationships when you share experiences like the ones we had in the Army. I am not sure that as a new graduate, I would have learned so much so quickly and be expected to lead in any other environment. I also learned the importance and value of all the military services, since we often worked closely with our colleagues in the other services (especially the Air Force). While I was in Japan, the Chief of the Army Nurse Corps said all Army nurses would have a degree, so decided to stay in the ANC and was able to take extension courses to earn my BSN.

One thing that is very special about the ANC and its equivalent in other services is the assignment of a career counselor who can work with you to guide you in your career. This ensures that as you grow professionally, you’ll consider positions that continue to advance you in your skills, knowledge, and experiences. You are positioned for the right professional and military schooling at the right time, keeping your career on the right track.

Luckily for me, I had the opportunity to grow professionally by assignments that continued to enhance my skills, education, and experiences. I grew with each assignment. I also positioned myself favorably by taking the courses required to go to school and complete my BSN. Much later, I was able to go to school for a MSN in nursing administration. Once I completed my MSN in administration, my assignments allowed me to grow in nurse administrative practice. Probably the one of the most challenging, but most rewarding, was being assigned as the chief nursing officer for 18th Medical Services on the Korean Peninsula from the DMZ to the southernmost facilities. My last assignment was as the assistant chief of the ANC in the Army Surgeon General.

Reflections on Serving continued on page 14

Register now for The Business of Caring, VNA’s 2019 Spring Conference!

VNA will hold its 2019 spring conference, The Business of Caring, on Wednesday, April 17 at the Place at Innsbrook in Glen Allen, VA, just 20 minutes west of downtown Richmond. Additionally, we’ll be livestreaming the event to satellite locations throughout Southwest and Northern Virginia!

Join us as we examine the importance of value-based care, as well as how nursing can impact the quadruple aim. We will explore nursing’s role in improving the patient experience, cost containment, and impacting population health along with addressing engagement of the healthcare team with speakers from Press Ganey, the American Nurses Credentialing Center, and the American Nurses Association. Nurses of all practice levels will walk away with strategies they can implement in their practice environment to further the quadruple aim.

More details, including speakers and contact hour information, are available online. Registration is open at www.virginianurses.com. Agenda topics and times are subject to change.

Taking Care of the Caregivers: A Leader’s Guide to Resilience
Jeffery N. Doucette, DNP, RN, FACHE, NEA-BC, CENP
Vice President of Magnet Recognition Program and Pathway to Excellence, American Nurses Credentialing Center

Every Nurse is a Leader
Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN
President, American Nurses Association

Volunteer AMPs: More than Aids in the Office
Edmund Tori, DO, FACP, CH
Associate Director, MedStar Institute for Innovation (MI2), FACHE, NEA-BC, CENP
Director, The Influence Center at MI2

Best Practices for Improving Patient Experience
Mary Jo Assi, DNP, RN, FNP-BC, NEA BC, FAAN
Associate Chief Nursing Officer, Press Ganey

Keynote: Influencing Behaviors in a Changing Landscape
Jeffrey N. Doucette, DNP, RN, FACHE, NEA-BC, CENP
President's Message

I am very excited as I transition into the role of VNA President! I share this excitement with other new members of the VNA Board, as well as other leadership who will remain in place as well as those transitioning into new roles. I would like to take this opportunity to welcome our new board members while extending my gratitude to the VNF and VNA Boards for their support and mentorship over the past several years. I would also like to personally thank our past VNA President, Richard DeBenjamin, for her guidance and outstanding leadership during her time as our VNA President.

Looking back over the past year, the VNA, in partnership with the VNF, have accomplished much, but, we still have a long way to go. This upcoming year we will continue to focus on advancing healthcare delivery through patient advocacy; spearheading interprofessional collaboration to advance the quality of patient care provision through such avenues as nurse staffing and mitigation of the opioid crisis throughout the state; and promoting educational advancement along all lines. In addition, we will continue to work to elevate nursing practice, while strategically transforming the face of healthcare as we know it today within nursing practice, while strategically transforming the face of healthcare as we know it today within Virginia's youth are healthy, safe, and ready to learn; and support legislative solutions that create and sustain conditions that support the health and well-being of all Virginians.

As we continue to advance our support for the health of the people within the commonwealth, we will continue to strengthen our collaborations with other groups across the state. As we all know it to be true, "if you do not have a seat at the table, make sure to bring your own chair. And if you are not at the table, you may be on the menu." All we ask is that you join us at the table.

I look forward to what the year ahead holds for nursing across the state as well as within the healthcare arena. We will need to also champion change, Advancing Health, while promoting the highest standards of nursing practice as well as excellent patient outcomes. As part of nursing's public policy platform, we need to not only ensure that Virginia’s have access to sufficient numbers of highly qualified nurses, but, we will seek to assure that nurses are involved in the healthcare solution by practicing to their full scope of education and training; the improvement of students' access to school nurses to ensure Virginia's youth are healthy, safe, and ready to learn; and support legislative solutions that create and sustain conditions that support the health and well-being of all Virginians.

SYNC to Launch 5th Interprofessional Leadership Program in Spring 2019

The 5th offering of the program is slated to launch in spring 2019. Tuition reimbursement and program assistance are available for qualifying teams. Continuing education credits have been offered. Check www.syncva.org for more information or email Amy Szwarczweksi at aszwarcz@msv.org. SYNC is a partnership of the Virginia Nurses Association, Medical Society of Virginia Foundation, Virginia Hospital and Healthcare Association and the Virginia Department of Health.

From our past participants:

- "Really opened my eyes to who I am and who I want to be as a leader" - "SYNC will help you look and yourself and others on a deeper level; it will challenge your way of thinking and there will be growing pains. You will be thankful you took advantage of the opportunity to participate in SYNC with your team" - "Enlightening, challenging, satisfying, empowering"

Today’s healthcare teams face a growing need for interprofessional collaboration, creative problem solving, hands-on problem solving, and team training to drive organizational performance. SYNC is an innovative, team-based learning experience that teaches collaboration and leadership through hands-on problem solving.

The core of SYNC’s program is built around four hands-on workshops where teams learn about interprofessional collaboration and leadership from our nationally recognized faculty of field practitioners and our knowledgeable support staff. SYNC is an immersive learning experience for healthcare teams of 2-5 participants, ranging from national or local chapters. Far more than just a conference, SYNC is a partnership with the VNF, have accomplished much, but, we still have a long way to go. This upcoming year we will continue to focus on advancing healthcare delivery through patient advocacy; spearheading interprofessional collaboration to advance the quality of patient care provision through such avenues as nurse staffing and mitigation of the opioid crisis throughout the state; and promoting educational advancement along all lines. In addition, we will continue to work to elevate nursing practice, while strategically transforming the face of healthcare as we know it today within Virginia’s youth are healthy, safe, and ready to learn; and support legislative solutions that create and sustain conditions that support the health and well-being of all Virginians.

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Advocacy

As a professional membership organization, the Virginia Nurses Association hangs its hat on three key areas:

1. **Advocacy** in legislative and regulatory arenas that will serve to protect and advance nurses and nursing.
2. **Lifelong Learning Opportunities** to ensure that nurses have access to top-notch continuing education programs, tools, and resources, and virtual communities.
3. **Engagement**, both locally and commonwealth-wide, within and in conjunction with this association.

I'm excited to share with you everything we've been working on in these crucial areas, but I'd like to preface this with some exciting numbers:

Nearly 4,000 nurses will have joined VNA, their professional membership organization, by year’s end. This reflects a 9% growth in membership for the 2018 calendar year, at a time when the number of nurses in Virginia has grown by only 2%. More and more nurses have taken note of our track record in the past several years. They've witnessed our achievements, and they recognize VNA as the voice for all of nursing in Virginia and a leader in nursing. Nearly 4,000 nurses will have joined VNA, their professional membership organization, by year’s end. This reflects a 9% growth in membership for the 2018 calendar year, at a time when the number of nurses in Virginia has grown by only 2%. More and more nurses have taken note of our track record in the past several years. They've witnessed our achievements, and they recognize VNA as the voice for all of nursing in Virginia and a leader in nursing.

And together we succeeded! By the end of the year, we anticipate the governor will sign off on the promulgated regulations, and soon after, about 50% of NPs already practicing in Virginia will be able to complete the attestation process to practice without the restrictions imposed by physician supervision. Nearly 400 nurses participated, ensuring that those legislative committee meetings. And together we succeeded! By the end of the year, we anticipate the governor will sign off on the promulgated regulations, and soon after, about 50% of NPs already practicing in Virginia will be able to complete the attestation process to practice without the restrictions imposed by physician supervision.

In collaboration with the Virginia Hospital and Healthcare Association and other healthcare leaders, we also continue to address the requirements that will serve to protect and advance nurses in the workplace violence legislation passed two years ago. VHHA and the Virginia Association of Nurse Anesthetists, by testifying before legislative committees, and by attending – in mass – those legislative committee meetings.

Legislators sat up and took note.
- They trusted your portrayals of the situation,
- respected the collaborations between the Virginia Council of Nurse Practitioners, the hospital association, and VNA, and
- appreciated the role nurse practitioners could play in providing greater access and quality care to Virginia's residents.

In fact, VNA members broke organization records in legislative and regulatory arenas shared in meetings with individual legislators, by participating in one of nine legislative receptions held statewide in partnership with the Virginia Council of Nurse Practitioners, by testifying before legislative committees, and by attending – in mass – those legislative committee meetings. In fact, VNA members broke organization records in legislative and regulatory arenas shared in meetings with individual legislators, by participating in one of nine legislative receptions held statewide in partnership with the Virginia Council of Nurse Practitioners, by testifying before legislative committees, and by attending – in mass – those legislative committee meetings.

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Quality continuing nursing education. We also offer quarterly educational updates for our Nurse Peer Reviewers and Approved Providers, and held an educational design workshop in collaboration with the American Nurses Credentialing Center (ANCC) last May.

Our last fall and spring conferences focused on, respectively, nurse staffing and nursing’s role in addressing the opioid epidemic. We knew we hit the topics on the head when we had sold-out crowds! And of course, we held our first Innovations conference and annual Virginia Nurses Foundation Gala in late September. You can read more about these two events on pages 6-8. Next on our CE calendar is our annual Legislative Summit and our 2019 spring conference, The Business of Caring. Dr. Mary Jo Ams, associate chief nursing officer with Press Ganey, will be our keynote speaker. New for the spring conference, we’ve introduced an early-bird discounted rate. Stay tuned, check our website routinely, and be sure to read our emails for more information!

Engagement
On more than one occasion we have been told that if we don’t have a seat at the table, we bring our own chairs; and if we’re not at the table, we wish we were. So, in the past several years, in addition to participating chapter locations for this live-streamed event, these meetings are a great chance for you to connect with your colleagues.

In addition to providing quality education, VNA is an accredited approver of Individual Activity and Multiple Provider applications. In the past year we approved 23 individual activity applications and several provider applications. It’s one more way we can work to ensure the availability of quality continuing nursing education. We also offer quarterly educational updates for our Nurse Peer Reviewers and Approved Providers, and held an educational design workshop in collaboration with the American Nurses Credentialing Center (ANCC) last May.

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Join VNA for Upcoming Events!

Register now for VNA's final 2018 chapter education event, How You Can Address Nurse-to-Nurse Incivility in the Workplace! The event will be held on Wednesday, December 5 from 6:30 to 7:30 pm and presented by Dr. Deborah Kile, quality improvement coordinator at Sentara RMH Medical Center. Dr. Kile will share the history of nurse-to-nurse incivility, the top 10 forms of incivility, and cognitive behavioral techniques you can use to address these issues in your own practice. James Madison University will be hosting the event, and the program will be livestreamed to satellite locations across the state. Find the location nearest you and RSVP at https://tinyurl.com/VNADec18CE. NO COST TO MEMBERS! Bring a nonmember along for only $15!

VNA's annual Lobby Days kick off at the start of the 2019 General Assembly session. On January 29, January 31, February 5, and February 7, VNA will head to the Capitol to make sure the voice of nursing is heard loud and clear. Attendees will receive a legislative primer, a rundown of the bills VNA is supporting for this session, talking points, and tips on how to be an effective advocate for the nursing profession before meeting with their legislators. The day will conclude with a visit to the House or Senate chambers to see the legislature in action! All nurses are welcome to attend. For more information, including the day's agenda and contact hour information, visit https://tinyurl.com/VNALobbyDays19.

Inova Fair Oaks Hospital is proud to be a Magnet® Designated Hospital for the third time.

"Magnet designation reinforces the emphasis we place on safety, patient experience and teamwork every day. I am honored to be part of this passionate team of nurses."

- Regina O'Connor, RN, BSN, Inova Fair Oaks Hospital

VNF President’s Report: Year in Review

It’s been a busy year for the Virginia Nurses Foundation, made possible by an incredible group of volunteers and trustees, the latter of which includes three new members I’d like to recognize. We’re truly blessed to now have Dr. Patti McCue, Vivienne McDaniel, and VNA Immediate Past President Dr. Richardean Benjamin on our board!

I’d like to share some exciting foundation highlights from the past year.

Through the foundation’s Action Coalition, which is aligned with the Robert Wood Johnson Foundation's Culture of Health campaign as well as Virginia’s Well-Being Plan, we (along with our partners, the Virginia Nurses Association and AARP-Virginia) are making great strides toward our vision for the future: one in which EVERY Virginian has access to affordable, high quality care and lives with an optimal state of health, with nurses leading the way.

In addition to developing a chronic pain management program and another focused on diabetes management for presentation to community groups, the action coalition has also served as the launching pad for the development of a Mental Health Roundtable. The engagement we've had from nurses and behavioral health professionals in a broad array of settings including Community Service Boards, law enforcement, the Virginia affiliate of the National Alliance on Mental Illness, the Board of Nursing, the Virginia Department of Health, and the Virginia Department of Behavioral Health and Developmental Services has been phenomenal. We're now diving into three crucial issues:

1. Stigma
2. Integrated and interdisciplinary care, and
3. Access, availability, and appropriateness of care

We will also be working with VNA to develop next fall’s conference, which will focus on mental health. If this work strikes a chord with you, let our CEO Janet Wall know so that we can invite you to the table. She can be reached at jwall@virginianurses.com.

I’m also proud to share that we recently wrapped up the fourth cohort of SYNC – a year-long interprofessional leadership program we present in partnership with the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, and the Virginia Department of Health. We consistently receive rave reviews for the program and are excited about the innovative partnerships and work being completed in the capstone projects. (See more about SYNC in the sidebar article.)

There’s more: Earlier this year, we began convening a steering committee of nurse leaders from throughout the commonwealth to help us develop a new multi-month, multi-modal Nurse Leadership Academy for new and emerging nurse leaders across all healthcare settings. We anticipate launching the academy next year with a curriculum that includes everything from financial and human resources to change management culture and the development of an applied leadership project. Look for more information in the coming months!

And I’d be remiss if I didn’t mention the new “Nurses Change Lives” license plates that many of you have shared you’ve now seen on our roads! Not only does the license plate look great, it also provides needed revenue to grow our scholarships and education programs. Now for the shameless plug: These great license plates are available on the DMV’s website.

I’m excited about what the future holds and invite you to join our important work.

Inova Fair Oaks Hospital

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The Virginia Nurses Foundation (VNF) held its annual Gala on Saturday, September 22 at the Hilton Richmond Hotel and Spa – Short Pump. This year’s theme, Superheroes of Nursing, shined a spotlight on the commonwealth’s up-and-coming nurse leader as VNF awarded its 40 Under 40 Awards. Mary Dixon of UVA School of Nursing served as honorary chair, and co-emceed the event with VNF President Terris Kennedy.

Also on hand to celebrate were Dr. Jeffrey Doucette of the American Nurses Credentialing Center and Caryn Brown of the Virginia Magnet Consortium. Dr. Doucette and Ms. Brown presented newly-credentialed and redesignated facilities with their Magnet or Pathways to Excellence recognitions, as well as this year’s VMC Nursing Excellence Award winners.

This year’s winners included VNF Friend of Nursing award winners Senator Janet Howell (D-Fairfax) and Senator Emmett Hanger (R-Augusta), as well as the following VMC Nursing Excellence Award winners:

- **Nursing Education:** Elyssa Wood, Inova Loudoun Hospital
- **Clinical Nurse Research:** Susan Steck, UVA Health System
- **Advance Practice Nursing:** Barbara Runk, Sentara Williamsburg Regional Medical Center
- **Nursing Leadership:** Cathy Goad, Centra
- **Clinical Practice:** Gale Helmick, LewisGale Hospital Montgomery

Check out the full list of 40 Under 40 winners and honorable mention recipients in the August 2018 issue of Virginia Nurses Today and at virginianurses.com.
2018 VNF GALA HIGHLIGHTS

VNF Friend of Nursing Award winners Sen. Janet Howell (D-Fairfax) and Sen. Emmett Hanger (R-Augusta)

L to R: Dixon, VMC Nursing Excellence Award winner Gale Helmick, Brown

VNA President Linda Shepherd

VNF and VNA Chief Executive Officer Janet Wall

Honorary chair Mary Dixon, VNF President Terris Kennedy, VNF and VNA CEO Janet Wall

Honorary chair Mary Dixon

A few of the evening’s raffle baskets

L to R: Dixon, VMC Nursing Excellence Award winner Susan Steck, Brown

VNF President Terris Kennedy

THERE’S A PILL TO PREVENT HIV?

One pill. Once a day. Let’s talk about PrEP.

PrEP is a major advance in HIV prevention. For those who do not have HIV, this daily pill offers another powerful means of protection. When taken as prescribed, PrEP is highly effective in protecting against HIV.

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search “PrEP toolkit”

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**Nick Calvert**  
Program Director, VNA SMARTMOVE Real Estate Benefit Program

The SMARTMOVE program is a real estate financial benefit available to all nurses through Long and Foster in partnership with the Virginia Nurses Association! How does SMARTMOVE work? When you purchase a home, you receive a rebate and closing cost credit. When you sell a home, you get a listing fee discount. In all cases, you will receive one year of free VNA membership. As VNA's real estate affinity partner, we support your profession and understand your needs, and it is our pledge to treat you with the same quality care that you provide for your patients.

Virginia's real estate market is holding steady, with a small appreciation of some kind throughout most major markets, while the number of home sales has dropped. Current low inventory makes it a good time for sellers, and the slowdown in sales allows buyers to get in without a bidding war. If you have been considering a home purchase, now would be a good time to act while interest rates are still historically low. Unlike recent years, interest rates have begun to rise at a pace that could quickly change your future price point on a purchase.

With overall market conditions strong, now is a truly a good time to buy or sell and take advantage of the SMARTMOVE program! For more information Email NickCalvert@LongandFoster.com, visit https://vna.smartmove.com/, or call 877-645-6560. We look forward to helping you find a new home!

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**VNA Holds First Annual Innovations Conference**

Richmond, VA - Virginia Nurses Association held its first-ever Innovations conference on September 21 and 22 at the Hilton Richmond Hotel and Spa – Short Pump. Nearly 150 nurses from all parts of Virginia were in attendance. Ahead of the conference, the annual membership assembly brought members together to hear reports from the CEO, Virginia Nurses Foundation president, and VNF treasurer. The CEO and VNF president’s reports are available in this issue of Virginia Nurses Today on pages 2 and 3. Newly elected board members were sworn in, including new VNA President Linda Shepherd. Immediate past president Richard A. Benjamin shared her thoughts on her tenure as VNA president, and was given a token of the association’s appreciation for her terrific work.

Throughout the weekend, attendees had the opportunity to hear more about innovations in nursing from a lineup of exceptional guests. The conference’s speakers were drawn not only from nursing, but from the business and wider healthcare worlds. Friday keynote speaker Nancy Grden spoke about her experiences on the business side of healthcare and as a mentor for upcoming innovators. She stressed the importance of understanding one’s personal brand, or what makes one their “most authentic” self, and the power of networking to get others on board with new ideas. While she acknowledged that the laws and protocol involved can make healthcare innovation difficult, she also pointed out that the interdisciplinary model that is used in hospitals and other facilities can make it easier to solve problems through innovation. Friday’s session also included thoughts from Frankie Abralind, a design thinker from the Johns Hopkins Sidley Innovation Hub. Through games and exercises, attendees learned more about how to apply creative and imaginative thinking to their nursing practice.

Nurse innovator Rebecca Love was Saturday’s keynote speaker, and she shared her experience as the founder of HireNurses.com, including what led her to found the website, and what it’s like being the first-ever director of nurse innovation and entrepreneurship in America. She led attendees through a number of innovation exercises that generated new ideas and created an enthusiasm for innovation that is sure to impact positive change in hospitals and facilities across the commonwealth.

On Saturday afternoon, attendees took part in three rounds of concurrent sessions, with nine sessions being offered in total. New this year, concurrent sessions offered attendees the opportunity to customize their conference experience, including a very popular “hackathon” led by ANA Vice President of Innovation Dr. Bonnie Clipper. The hackathon built off of the ideas Rebecca Love shared in her Saturday keynote address, and encouraged participants to think outside the box about challenges they face in their practice.
Introduction

At nearly three million strong, registered nurses comprise the largest health care sector in the United States (Bureau of Labor Statistics, 2017). Data consistently illustrates that more RNs will be needed to meet the greater demands of an aging population, increased longevity, and increased access to health care, and that is often afflicted with co-morbid chronic illnesses (American Association of Colleges of Nursing, 2015). Furthermore, the largest segment of healthcare workers is the American Nurses Association (2015). This population that experiences greater longevity and retained across practice and academic settings (Bushen, 2017). The concept of caring has been identified as the foundation to nursing practice and a major contributing factor to the creation and sustainment of healthy work environments (American Nurses Association, 2015). Furthermore, research suggests that the current state of labor environments lead to cost-effective patient care delivery, effective interpersonal communication skills, improved patient education, and increased sense of professionalism and autonomy (Dyess, Boyking and Rigg, 2010). Studies also affirm that toxic work environments increase staff turnover and absenteeism rates, place an organization at risk for increased litigation, and can damage an organization’s reputation (Namee and Namee, 2011). Some antecedents associated with toxic work environments include oppressed group behavior as demonstrated by acts of subordination that enable inequitable relationships to exist and perpetuate (Duchschier and Myrick, 2008; Summer, 2010), as well as personality traits, coping skills, employment position, team dynamics, work communication, and an organization’s culture (Baillien, Neyens, DeWitte and DeCuypere, 2008). Since lateral incivility and workplace bullying are often associated with aggressive and disruptive behavior among nurses, this article will present the tenets associated with lateral incivility and workplace bullying among RNs, including its impact on colleague relationships, patients and health care organizations, and will illustrate the individual, collective and organizational responsibility to create a culture of respect.

Definitions

The National Institute of Occupational Safety and Health (2002) defined workplace violence from that of “offensive or threatening language to homicide,” and recommends that all workers be trained to “recognize and manage disruptive and abusive behavior”. Many have added to this awareness. Since professional nurses make up the largest segment of healthcare workers in the United States (American Nurses Association, 2015) developed a position statement calling for a workplace culture of respect and civility. In bringing awareness to this issue, all healthcare workers must first recognize what constitutes a disrespectful and uncivil workplace by clearly understanding the terminology.

Incivility

Incivility is the repeated, unwanted harmful actions intended to humiliate, offend, and cause distress. Incivility “is the repeated, unwanted harmful actions that are intended to cause distress. Bullying behaviors that cause distress. Bullying behaviors that harm, undermine, and degrade include hostile remarks, verbal attacks, threats, taunts, intimidation, and the withholding of support.

Impact of Nurse-on-Nurse Incivility

Acts of incivility and aggression toward nurses, affecting their performance, mental health and intention to remain with an organization or even the profession altogether (Nemeth LS, Stanley KM, Martin MM, Mueller M, Layne D and Wallston KA. (2017). Healthcare, 5(33): 1-12. Wilson et al., 2011). Failure to address uncivil behaviors can negatively affect the physical and mental health of nurses (Griffin and Clark, 2014). As a result, nurses may experience decreased job satisfaction, increased turnover, absenteeism, and work-related injuries (Lazarus, M. and Buchholtz, A. 2010). Organizations are also affected by incivility. It was estimated that in 2001 523.8 million was spent annually by employers to counteract the direct and indirect costs associated with uncivil behavior (Lasczinger, Cummings, Wong, and Grau, 2014). These costs include factors related to increased absenteeism, low productivity, halting production, workload and activity impairment (Levack and Buck, 2008). In 2011, lost productivity due to workplace incivility replaced $1.581 per year per nurse (Lewis and Malecha, 2011). It’s impact on patients is of particular concern. According to Nikstaitis and Simko (2014a), incivility has harmful effects on patient safety including increased medical errors, decreased quality of care and negative patient outcomes. Nurses who are dealing with the effects of negativity are less likely to respond fully to the needs of their patients and are less likely to speak up if there are safety concerns (Weinard, 2010). Examples of behavior that may compromise patient safety include using an unfamiliar piece of equipment without asking for help, lifting patients alone, failing to administer medications to patients alone, and attempting to complete an unclear procedure (Vessey, DeMarco and DiFazio, 2011). Nurses who are associated with higher nurse-to-nurse patient ratios and compromised patient care. In addition, nurse turnover has a negative effect on group cohesion and communication among healthcare providers, which in turn negatively affects patient safety (Wilson et al., 2011).

References


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The VNA Workforce Issues Commission’s Lateral Incivility Workgroup seeks to understand the current state of lateral incivility and violence among Virginia nurses. Please complete our “Lateral Violence in Nursing Survey!” (Nemeth LS, Stanley KM, Martin MM, Mueller M, Layne D and Wallston KA. (2017). Healthcare, 5(33): 1-12. Wilson et al., 2011). It’s impact on patients is of particular concern. According to Nikstaitis and Simko (2014a), incivility has harmful effects on patient safety including increased medical errors, decreased quality of care and negative patient outcomes. Nurses who are dealing with the effects of negativity are less likely to respond fully to the needs of their patients and are less likely to speak up if there are safety concerns (Weinard, 2010). Examples of behavior that may compromise patient safety include using an unfamiliar piece of equipment without asking for help, lifting patients alone, failing to administer medications to patients alone, and attempting to complete an unclear procedure (Vessey, DeMarco and DiFazio, 2011). Nurses who are associated with higher nurse-to-nurse patient ratios and compromised patient care. In addition, nurse turnover has a negative effect on group cohesion and communication among healthcare providers, which in turn negatively affects patient safety (Wilson et al., 2011).
Most nurses are familiar with the term evidence-based practice (EBP), but understanding of the concept and application into healthcare systems is inconsistent. Although it is fashionable to claim to have EBP, work remains for many organizations to establish an infrastructure that cultivates and supports true EBP integration (Brower & Nencie, 2017). As a result, systems continue to struggle with outcomes and efficiency, while spending disproportionately to provide the same care as other countries (WHO, 2000; Schneider et al., 2017). This paper will review EBP as it relates to nursing and strategies that support individuals and organizations to incorporate meaningful EBP to improve outcomes.

In previous centuries, healthcare was provided through tradition developed primarily by trial and error and personal experience (Schmidt & Brown, 2019). Florence Nightingale advanced modern nursing by modeling the use of inquiry and data to make practice changes that impacted patient outcomes (Mackey & Bassendowski, 2017). However, this model remained dormant until the 1970s when physician Archie Cochrane noted that many treatments used in healthcare were not supported by reliable, up-to-date evidence (Cochrane Consumer Network, n.d.). In 1993 the Cochrane Collaboration was established to summarize randomized trial evidence (Cochrane, n.d.).

Around this same time, nursing leaders promoted the integration of research into nursing practice through the use of exceptional research studies (research utilization) to change practice (Schmidt & Brown, 2019). The limitations of research utilization became apparent, and models for EBP emerged to address the real-world need for timely, state-of-the-art knowledge to promote patient safety and positive experiences (Schmidt & Brown, 2019; Mackey & Bassendowski 2017). Consistently, most models define EBP as (1) a lifelong problem-solving approach, (2) shared decision making with the professional, patient, and others, (3) integrating best evidence from high-quality studies, (4) grounded in scientific theory, (5) valuing patient experiences and preferences, and (6) incorporating clinical expertise (including clinical appraisal of evidence from patient records, quality projects, and evaluation of other robust sources of information and available resources) (Melnyk et al., 2017; Cullen et al., 2017; Schmidt & Brown, 2019). The American Nurses Association endorses the nurse’s role in EBP in the Nursing Scope and Standards of Practice (ANA, 2015).

It can be confusing to distinguish EBP from quality improvement (QI) and research. While distinct concepts, they flow nicely one to another. If the current state of understanding and best available evidence for a question is compelling, then EBP will be instituted through policy and practice change with associated education and evaluation.

Of methodologies (such as DMAIC, LEAN, or PDSA) may be applied to explore implementing the practice in specific units or settings. If the evidence is not compelling, then a research study is the appropriate next step (Dang & Dearholt, 2018). This research then further informs the appraisal that is integrated with clinical expertise and patient preference to impact decision making.

In addition to integrating theory, research, and clinical expertise, EBP taps the wealth of knowledge and expertise of the patient and caregivers. This crucial component of the EBP model is the incorporation of appropriate care decisions based on the unique patient experience. Beyond involving patients and families in decision making, nurses and other health care professionals may also serve as EBP leaders and resources in their own regions or communities. Models define EBP as (1) a lifelong problem-solving approach, (2) shared decision making with the professional, patient, and others, (3) integrating best evidence from high-quality studies, (4) grounded in scientific theory, (5) valuing patient experiences and preferences, and (6) incorporating clinical expertise (including clinical appraisal of evidence from patient records, quality projects, and evaluation of other robust sources of information and available resources) (Melnyk et al., 2017; Cullen et al., 2017; Schmidt & Brown, 2019). The American Nurses Association endorses the nurse’s role in EBP in the Nursing Scope and Standards of Practice (ANA, 2015).

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satisfied workforce with associated recruitment and retention improvements (Melnyk et al., 2017), and positive worksite accreditation (such as The Joint Commission) and recognition (such as ANCC Magnet®). EBP is a key strategy to achieving the aspirations embedded in the mission of any healthcare organization.

### Table 1. EBP Resources and strategies for Organizations

<table>
<thead>
<tr>
<th>What you want to do</th>
<th>Tool</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess organizational culture and environment to support EBP</td>
<td>ANCC Pathway to Excellence Program</td>
<td><a href="https://www.nursingworld.org/organizational-programs/pathway/">https://www.nursingworld.org/organizational-programs/pathway/</a></td>
</tr>
<tr>
<td></td>
<td>ARCC Model</td>
<td>Melnyk et al., 2014.</td>
</tr>
<tr>
<td>Establish local organizational resources</td>
<td>Library services, including reference librarian</td>
<td>Hire a Nurse Scientist either employed by your organization or in partnership with a local university or research institution.</td>
</tr>
<tr>
<td>Infuse EBP throughout infrastructure, including mission, vision, position descriptions, evaluation criteria, clinical advancement programs, policies, &amp; procedures, and shared governance charters</td>
<td>Strategic planning</td>
<td>Leadership endorsement and modeling</td>
</tr>
<tr>
<td></td>
<td>Create an EBP model</td>
<td>Melnyk et al., 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melnyk et al., 2017</td>
</tr>
<tr>
<td>Establish EBP mentors</td>
<td>Creation of position descriptions</td>
<td>Education opportunities for mentoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Melnyk et al., 2017, p. 189</td>
</tr>
<tr>
<td>Select or develop and regularly evaluate an EBP model</td>
<td>Examples of EBP models include (but not limited to):</td>
<td>Revised: Iowa Model Collaboration, 2017; Cullen et al., 2017</td>
</tr>
<tr>
<td></td>
<td>• Iowa Model of Evidence-based Practice</td>
<td>Revised: Dang &amp; Dearholt, 2017</td>
</tr>
<tr>
<td></td>
<td>• The Johns Hopkins Nursing Evidence-Based Practice Model</td>
<td>Stevens, 2012</td>
</tr>
<tr>
<td>Create an infrastructure that supports ongoing quest for knowledge for all nurses in organization</td>
<td>Support nurses in quest for:</td>
<td>Melnyk et al., 2017</td>
</tr>
<tr>
<td></td>
<td>• continuing education (BSN, MSN, DNP, PhD)</td>
<td>active membership in professional organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>professional certification</td>
</tr>
<tr>
<td></td>
<td>Integration of EBP competencies</td>
<td>A good starting place is the references for this article.</td>
</tr>
<tr>
<td>Advocate for EBP throughout the organization</td>
<td>Read EBP texts and journal articles</td>
<td>Implementation Handbook for Patient and Family Advisories (AHRQ, n.d.)</td>
</tr>
<tr>
<td></td>
<td>Attend an EBP conference and present what you learned to your organization</td>
<td>Overcoming barriers</td>
</tr>
<tr>
<td></td>
<td>Regular dialogue between frontline staff and leadership about what is needed to support a culture of EBP.</td>
<td>A good starting place is the references for this article.</td>
</tr>
<tr>
<td></td>
<td>Establish Patient and Family Advisories</td>
<td>Implementation Handbook for Patient and Family Advisories (AHRQ, n.d.)</td>
</tr>
</tbody>
</table>

### Table 2. EBP Resources and Strategies for Nurses

<table>
<thead>
<tr>
<th>What you want to do</th>
<th>Tool or Strategy</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying practice questions</td>
<td>Staff meeting and EBP Council discussions</td>
<td>Patel et al., 2011</td>
</tr>
<tr>
<td></td>
<td>Journal Clubs</td>
<td><a href="https://www.nursingcenter.com/evidencebasedpractice/notes">https://www.nursingcenter.com/evidencebasedpractice/notes</a> ABSN/?d=8917691</td>
</tr>
<tr>
<td></td>
<td>Organization based</td>
<td>Schmidt &amp; Brown, 2019, p.11-12.</td>
</tr>
<tr>
<td>Overcoming barriers</td>
<td>A good starting place is the references for this article.</td>
<td>Implementation Handbook for Patient and Family Advisories (AHRQ, n.d.)</td>
</tr>
</tbody>
</table>

### References

diagnose and manage behavioral health conditions. Providers are not comfortable with or trained to address psychosocial issues, but many primary care visita.

As many as 70% of primary care visits stem from mental health conditions. Forty percent of Virginia is federally designated as a mental health professional shortage area. Forty to 75% of Virginia’s citizens needing behavioral health services. More than 100,000 people are suffering from untreated mental illness in the state. In October 2018, there were 84 psych NP job postings in Virginia. Psych NPs practice in all sectors - primary care medical practices, university counseling centers, hospital in-patient units, substance abuse programs, public mental health agencies, residential treatment - and in all areas of the state. In 2018, there were 54 psych NP jobs in Virginia posted on Indeed.com, ranging from $102,000 to $105,000.

Not only are psych NPs in great demand, they love their work! When asked about their dream job, many psych NPs say, “I’m in it now.”

The Virginia Health Care Foundation offers scholarships for NPs to earn their post-master’s psych NP certificate. To learn more, please go to VHCF’s website, https://www.vhcf.org/for-those-help/resources-for-providers/nurse-practitioner-resources/psych-mental-health-np-scholarship/.

Continuing Education continued from page 11


Psychiatric-mental health nurse practitioners play a key role in helping Virginia address the gap between demand and available behavioral health providers. Unfortunately, there are only 275 psych NPs practicing in Virginia. Half of all Virginia localities don’t have any.

The Virginia Health Care Foundation offers scholarships for NPs to earn their post-master’s psych NP certificate. To learn more, please go to VHCF’s website, https://www.vhcf.org/for-those-help/resources-for-providers/nurse-practitioner-resources/psych-mental-health-np-scholarship/ or contact the Foundation at PsychNP@vhcf.org or 804.828.5804.
Clinical Nurse Specialists: System Innovators for Population Health and Nursing Practice

Linda Thurby-Hay, DNP, RN, ACNS-BC

Clinical nurse specialists are educationally prepared and nationally certified to advance the health of a patient population, whether that patient has a particular health problem, is receiving care on a specialized unit, or requires a particular type of care. As discussed in a previous article in Virginia Nurses Today, the ultimate goal is to prepare and nationally certify to advance the health of a patient population, whether that patient requires hospitalization. Her health system answered the call for better mental health care requirements, within a primary care practice, and when patients participated, Dr. Altice wondered the fate of the patient outcomes. She called on Sarah Taylor, MSN, RN, AGCNS-BC to lay the foundation for such an environment by leading the facility in attaining American Nurses Credentialing Center’s Pathways to Excellence. She called on Sarah Taylor, MSN, RN, AGCNS-BC to lay the foundation for such an environment by leading the facility in attaining American Nurses Credentialing Center’s Pathways to Excellence. The culmination of their work was the embedding of clinical guidelines within the electronic health record and development of a system-wide educational effort to ensure that frontline caregivers were prepared to execute state-of-the-science care.

Sometimes system innovations require organizational reform, and the CNS is the right person for the job! Carol Stefaniak, MSN, RN, a chief nursing officer in Hampton Roads, understands that better patient outcomes result when empowered professional nurses work in a healthy practice environment. To accomplish that end, Ms. Stefaniak believes professional nurses must "own their own practice" and can do so best when working in an environment that not only supports their professional growth and development, but guides them in achieving their individual professional nursing goals. She called on Sarah Taylor, MSN, RN, AGCNS-BC to lay the foundation for such an environment by leading the facility in attaining American Nurses Credentialing Center’s Pathways to Excellence. The culmination of their work was the embedding of clinical guidelines within the electronic health record and development of a system-wide educational effort to ensure that frontline caregivers were prepared to execute state-of-the-science care.

Sarah has begun the work by educating nursing staff during orientation and daily rounds as well as at nursing town halls in the foundations of empowered nursing practice, shared governance, excellence in practice, peer review and evidence-based practice, and encouraging their participation in committee development. This effort will also provide a mechanism for advancement in the facility’s professional nurse advancement program. These are just three examples of the impact of the CNS in championing system innovations that meet the challenges of today’s health care environment. CNSs remain skilled at enhancing the health and well-being of specialty populations through program development, and empowering professional nurses in executing evidence-based care within a healthy practice environment. If you are interested in exploring the CNS role, join the Virginia Association of Clinical Nurse Specialists in April 2019 for our annual conference.

Margaret (Meg) Scheaffel BSN, RN, MBA-MHA, chief nursing officer of Carilion Clinic, will be the keynote speaker and share her perspective on the "Value of the Clinical Nurse Specialist in Today’s Health Care System.”

References:
General’s Office, essentially serving as the COO of the ANC. During this time, I worked very closely with the nursing leadership of the other services. Completing my PhD two years after retiring allowed me to explore some other nursing positions that I’d never thought of, like working as the director of education for AONE, as a nurse consultant for the nursing division of the Department of Health and Human Services’ Basic Health Program, and as an associate dean of academics at Duke University School of Nursing. Through these experiences, I learned that I was best suited and positioned for service, and that I like taking care of people who take care of patients. Being able to go back into a chief nursing officer position at Shore Memorial Hospital on the Eastern Shore was perfect for me, and serving as the chief nursing officer for Riverside Health System was a tremendous opportunity to allow me to use a great deal of what I learned and experienced throughout my career, especially my time in the Army Nurse Corps. To anyone interested in serving their country, I would say that there is no better time to follow your dream. Being able to serve huge responsibility, but it is also an enormous honor. For me, there wasn’t a more gratifying career than serving in the Army Nurse Corps.

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Reflections on Serving continued from page 1

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Spotlight on a Virginia Nurse Leader

Joyce A. Hahn, PhD, RN, NEA-BC, FNAP, FAAN
Assistant Professor, George Washington University School of Nursing
NOBC VNA Representative

The Nurses on Boards Coalition (NOBC) was established in 2014 in response to the landmark 2010 Institute of Medicine (IOM) report, The Future of Nursing: Leading Change, Advancing Health, which called for increasing the number of nurses on boards and commissions (IOM, 2010). The American Nurses Foundation, the philanthropic arm of ANA, is a founding member of the Nurses on Boards Coalition. Representing national nursing organizations and partners, NOBC set as its goal to fill at least 10,000 board seats by 2020 to increase nursing’s presence on corporate, health-related, and other boards and commissions at the local, state, and national levels. To date, 5,018 board seats have been filled with nurses (NOBC, 2018).

VNA participates in NOBC through an appointed Virginia nursing representative, who works to place Virginia nurses on national boards and commissions. Currently, our representative is Dr. Joyce Hahn. VNA also maintains current lists of available opportunities and interested nurses, which helps the association to support and recommend Virginia nurses to local and state board positions in addition to the NOBC-identified openings on corporate, governmental, non-profit, advisory, governance boards, commissions, panels, and task forces.

Have you ever considered serving on a board or governing body? The main requirement is something you probably already have—passion for the nursing profession!

Lisa Speller, BSN, RN certainly possesses this passion! She serves as a policy assistant at the Virginia Department of Health Professions (DHP) and is assigned to the Virginia Board of Nursing (BON) staff. Lisa is an example of a nurse who has taken this passion for nursing, combined it with her professional experience and interest in policy, and used this combination to attain a state regulatory body appointment.

Can you highlight which nursing career experiences prepared you for your current role?

My nursing career started in the critical care setting and then moved into home-based care for the bulk of my clinical experience. In home-based care, a nurse is working within a community of those who are often underserved and vulnerable members of our communities. This experience provided me with an avenue to advocate and interact with health care providers, discuss with them the importance of these services and work to further educate the community on home-based care.

After working in home-based care for many years, I transitioned into managed care, leading a marketing and community outreach team. The goal of my team was to provide access to resources within the community to seniors and those at risk for health issues. The opportunity further enhanced my community-based approach to health care education.

Working to stay true to my sense of responsibility to improve access to quality health care and education. I worked in the community to advocate for more opportunities to connect communities and health care. This assisted me in developing a knowledge of health policy and connected me into the political arena working to assist in getting strong advocates elected.

Making the decision to leave direct patient care and supervision for me was about having a voice and being able to advocate for community members to have continued access to care. In 2017, I was appointed by Mayor Levar Stoney of Richmond as a senior policy advisor. In the role of advisor, I was able to continue my work in advocating for community access, as well as improving the view of government in relation to public service and engagement. I was able to bridge the gap between government and community.

In 2018, Governor Ralph Northam appointed me to the DHP and Board of Nursing. In my role at DHP, I am able to continue work in health care policy and nursing regulation, as well as continue to focus on the needs of our community.

How did you decide the Department of Health Professions would be a good fit for your talents?

I do believe my appointment to the DHP is a good fit. My background in leadership, management, marketing and operation in the health care setting provided me with the experience to have input within the agency in a variety of areas. As for my policy background, I started a non-profit organization, Communities Empowerment Alliance, geared to educating the at-risk communities in matters of health care. My experience at the mayor’s office developing policies around access and access to health care as it relates to governmental policy gives me a strong policy background.

Can you describe the appointment process for your DHP role as policy assistant?

I was appointed to my role by Governor Ralph Northam. The process for an appointment varies from individual to individual. My process involved interviews with the transition team for the Governor just prior to his assuming office. My active role in the community had led to several recommendations to participate in a policy role within the new Governor’s administration.

Could you explain your role and contributions to the Department of Health Professions? As a health care policy and government relations professional, I work on special projects related to the agency as a whole, as well as projects directly tied to the Board of Nursing. I have assisted with the nurse practitioner legislation and regulatory process and most recently with agency succession planning. Expanding duties now include reviewing BON Guidance Documents and becoming involved with the BON Disciplinary Process. I primarily attend the Board of Nursing and Joint BON and Medicine meetings where I can participate because of my involvement with the BON. However, I can attend all board meeting within DHP to observe and learn how these boards function. Just recently, I began working with the Massage Therapy Advisory Board.

What advice would you offer to other nurses interested in a board appointment?

I would encourage nurses to become engaged in their local, state, and federal government; gain knowledge regarding who is representing their locality; work to support legislation with impact on the nursing profession; advocate for the areas of health care that are of interest to them personally;
Looking Ahead at Medicaid Expansion

Dr. Daniel Cary, Secretary of Health and Human Resources

Before joining Governor Ralph S. Northam’s administration as Secretary of Health and Human Resources at the beginning of 2018, I practiced as a cardiologist in Lynchburg for almost 20 years before moving into leadership roles with Centra, where I served as Senior Vice President and Chief Medical Officer. I know firsthand experience that nurses are the backbone of care in hospitals, clinics, and their communities. I thought it important to share with you the Northam administration’s biggest priorities in the areas of health and human services.

You may be familiar with the concept of the “triple aim” in healthcare, which refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. In the Northam administration, we have our own version of the triple aim with the simultaneous goals of strengthening the foundation of our economy, maximizing taxpayer dollars, and giving every person, particularly every child, the same shot for a healthy, safe, and successful life.

These goals mean different things across different secretariats, but we are applying them to five priority areas: Medicaid expansion; behavioral health and developmental services; substance use disorder treatment and prevention; women’s health; and children’s health and services.

I’m proud that Medicaid expansion is now a reality in Virginia. State agencies began accepting applications for enrollment on November 1, and beginning January 1, 2019, more adults will have access to quality, low, or no-cost health coverage, resulting in the largest increase in health coverage in the Commonwealth’s history. Expanding access for adults is part of a “whole family” approach. We recognize that children are healthier when their parents are healthy and healthier families result in healthy, economically thriving communities. It is my hope that this expansion will have expanded Medicaid eligibility have seen positive health outcomes for children and families, including a drop in their infant mortality rates.

As nurses, you know all too well the costs of being uninsured and unsecured. I would encourage you to reach out to those in your community who might be eligible. Visit coverva.org for more information on who is eligible and how to apply.

Medicaid expansion will help many Virginians access needed health care and services, but there is much work left to do. Our office is focused on aligning mental health programs and providers to improve integration of screening and treatment into schools, primary care, emergency departments, jails, and courts. We know that people are best served when we meet their needs wherever they present. Like many things across the country, Virginians have been substantially impacted by the opioid and addiction crisis. Too many families have lost loved ones to this crisis or are struggling to get resources and treatment for substance use disorders. We are working with our local communities to build capacity to effectively respond to this crisis through coalition development, limiting the availability of prescription opioids for misuse, establishing patient pathways, investing in treatment, providing and supporting services for people in recovery.

In Virginia (Lenowisco Health District in Wise County and Health Brigade in the city of Richmond) are now approved and operational comprehensive harm reduction programs. These programs interrupt infectious disease transmission and increase access to services such as testing, referral to substance use disorder treatment, and the disposal of hypodermic syringes along with the provision of sterile ones.

We’re also making progress in the area of reproductive health. Medicaid expansion on November 1, 2018, an estimated 49 percent of Virginia women reported that their pregnancy was unintended. Women in Virginia now have greater access to long-acting reversible contraceptives (LARCs), through changes in Medicaid program benefits, as well as a $6 million state investment to provide LARCs to low-income women over the next two years. We recently entered into contracts with twelve health care providers across the state to provide these services, which will help ensure the continuing availability of LARCs is not a barrier to reproductive health care.

We are seeing the rates of maternal mortality rise in Virginia as a part of the national trend. Current maternal mortality rates have risen particularly for African-American women. In a country and Commonwealth as wealthy as ours, this is simply unacceptable. The Northam administration is working to collaborate with health care and human service providers to determine the root cause of the increase and reverse this trend.

It is also worth mentioning that approximately 50% of the Medicaid expansion population are women. Some will be new mothers who will newly be eligible for consistent health coverage who are currently now only covered during pregnancy and 90 days after. Additionally, many are young women without children as such it is simple unacceptable that these women are eligible for LARCs. This is simply unacceptability.

As the Governor is a pediatrician, I am sure it is no surprise that we have expanded these health care options as a top priority. The Governor recently established a Children’s Cabinet with a renewed focus on early childhood development and school readiness, nutrition and food security, and establishing a system of care for responding to childhood trauma. Over the next several years, we will be implementing a new model of care for children as part of the Families First Prevention Services Act, which will allow us to use dollars traditionally allowed for foster care to prevent children from entering the foster care system now only covered during pregnancy and 90 days after. Additionally, many are young women without children as such the Governor is also concerned that these women are not being provided with contraceptives.

We have a lot of work ahead of us, but we appreciate your partnership and support. Thank you for your commitment to the health of Virginians and for the work you do every day to make our Commonwealth a healthier place to live.
The American Nurses Credentialing Center (ANCC) recommends registered nurses display their credentials in the following preferred order:

1. Highest earned degree
2. Licensure
3. State designations or requirements
4. National certifications
5. Awards and honors
6. Other recommendations

Why is this order recommended?
The education degree comes first because it is a “permanent” credential, meaning it cannot be taken away except under extreme circumstances. The next two credentials (licensure and state designations/requirements) are required for you to practice. National certification is sometimes voluntary, and awards, honors, and other recognitions are always voluntary.

Why do we need a standard way to list credentials?
Standardized listing ensures that everyone, including nurses, healthcare providers, third-party payers, government officials, and patients, understands the significance and value of nursing credentials.

What are some examples of credentials?
Educational degrees include doctoral degrees (PhD, DrPH, DNS, EdD, DNP), master’s degrees (MSN, MS, MA), bachelor’s degrees (BS, BSN, BA), and associate degrees (AD, ADN).

Licensure credentials include RN and LPN.

State designations or requirements recognize authority to practice at a more advanced level in that state and include APRN (Advanced Practice Registered Nurse), NP (Nurse Practitioner), and CNS (Clinical Nurse Specialist).

National certification, which is awarded through accredited certifying bodies such as the American Nurses Credentialing Center (ANCC), includes RN-BC (Registered Nurse-Board Certified) and FNP-BC (Family Nurse Practitioner-Board Certified).

Awards and honors recognize outstanding achievements in nursing such as FAAN (Fellow of the American Academy of Nursing).

Other certifications include non-nursing certifications that recognize additional skills. One example is the EMT-Basic/EMT, awarded by the National Registry of Emergency Medical Technicians.

Do I have to list my credentials?
On legal documents such as prescriptions and notes on medical records, you must use the credentials required by your state for your area of practice, for example, Susans Jones, RN, or Joyce Smith, APRN.

In professional endeavors such as speaking, writing for publication, or providing testimony before a legislative body, use all your relevant credentials. Note that journals sometimes order credentials differently, and it is acceptable to conform to their style.

I have several of the same type of credentials. How do I choose?
List the highest education degree first, for example, Michael Anderson, PhD, MSN. In most cases, one degree is enough, but if your second degree is in another relevant field, you may choose to list it. For example, a nurse executive might choose Nancy Gordon, MBA, MSN, RN. Note that the highest non-nursing degree is listed first followed by the highest nursing degree. A nurse who has a master’s in a non-nursing field might choose Anne Peterson, MEd, BSN, RN. If you have a doctorate and a master’s degree, omit your baccalaureate degree.

Multiple nursing certifications may be listed in the order you prefer, but consider listing them either in order of relevance to your practice or in the order they were obtained, with the most recent first. Always list non-nursing certifications last.

For more information about how ANCC promotes excellent in nursing, visit www.nursingworld.org/ancc/about-ancc/

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Successful assignments require attention to the needs of both nurses and patients.

YOUR MANAGER wants you to learn how to make nurse patient assignments. What? Already? When did you become a senior nurse on your floor? But you’re up to the challenge and ready to learn the process.

Nurse-patient assignments help coordinate daily unit activities, matching nurses with patients to meet unit and patient needs for a specific length of time. If you are new to this challenge, try these eight tips as a guide for making nurse-patient assignments.

1. Find a mentor
Most nurses learn to make nurse-patient assignments from a colleague. Consider asking if you can observe your charge nurse make assignments. Ask questions to learn what factors are taken into consideration for each assignment. Nurses who make assignments are aware of their importance and are serious in their efforts to consider every piece of information when making them. By asking questions, you’ll better understand how priorities are set and the thought that’s given to each assignment.

Making nurse-patient assignments is challenging, but with your mentor’s help, you’ll move from novice to competent in no time.

2. Gather your supplies (knowledge)
Before completing any nursing task, you need to gather your supplies. In this case, that means knowledge. You’ll need information about the unit, the nurses, and the patients. (See What you need to know.) Some of this information you already know, and some you’ll need to gather. But make sure you have everything you need before you begin making assignments. Missing and unknown information is dangerous and may jeopardize patient and staff safety.

The unit and its environment will set the foundation for your assignments. The environment (unit physical layout, average patient length of stay (LOS)) defines your process and assignment configuration (nurse-to-patient ratios). You’re probably familiar with your unit’s layout and patient flow, but do you know the average LOS or nurse-to-patient ratios? Do you know what time of day most admissions and discharges occur or the timing of certain daily activities? And do other nursing duties need to be covered (rapid response, on call to another unit)? Review your unit’s policy and procedures manual for unit staffing and assignment guidelines. The American Nurses Association’s ANA’s Principles for Nurse Staffing 2nd edition also is an excellent resource.

Review the assignment sheet or whiteboard used on your unit. It has clues to the information you need. It provides the framework for the assignment-making process, including staff constraints, additional duties that must be covered, and patient factors most important on your unit. Use the electronic health record (EHR) to generate various useful pieces of patient information. You also can use the census sheet, patient acuity list, or other documents of nursing activity, such as a generic hospital patient summary or a unit-specific patient report that includes important patient factors.

Depending on your unit, the shift, and the patient population, you’ll need to consider different factors when making assignments. Ask yourself these questions: What patient information is important for my unit? Does my unit generate a patient acuity or workload factor? What are the time-consuming tasks on my unit (medications, dressing changes, psychosocial support, total care, isolation)? Which patients require higher surveillance or monitoring?

Finally, always talk to the clinical nurses caring for the patients. Patient conditions change faster than they can be documented in the EHR, so rely on the clinical nurses to confirm each patient’s acuity and individual nurses’ workloads. Nurses want to be asked for input about their patients’ condition, and they’re your best resource.

Now ask yourself: How well do I know the other nurses on my unit? This knowledge is the last piece of information you need before you can make assignments. The names of the nurses assigned to the shift can be found on the unit schedule or a staffing list from a centralized staffing office. If you know the nurses and have worked with them, you’ll be able to determine who has the most and least experience, who’s been on the floor the longest, and who has specialty certifications. You’ll also want to keep in mind who the newest nurses are and who’s still on orientation.

3. Decide on the process
Now that you’ve gathered the information you need, you’re ready to develop your plan for assigning nurses. This step usually combines the unit layout with your patient flow. Nurses typically use one of three processes–area, direct, or group–to make assignments. (See Choose your process.)
Set priorities for the shift

The purpose of nurse-patient assignments is to provide the best and safest care to patients, but other goals will compete for consideration and priority. This is where making assignments gets tricky. You must consider continuity of care, new nurse orientation, patient requests and satisfaction, staff well-being, fairness, equal distribution of the workload, nurse development, and workload completion.

Make the assignments

Grab your writing instrument and pencil in that first nurse’s name. This first match should satisfy your highest priority. For example, if nurse and any other returning nurses are reassigned to the patients they had on their previous shift. If, however, you have a complex patient with a higher-than-average acuity, you just assigned your best nurse to this patient. After you’ve satisfied your highest priority, move to your next highest priority and match nurses with unassigned patients and areas.

Sounds easy, right? Frequently, though, you’ll be faced with competing priorities that aren’t easy to rate, and completing the assignments may take a few tries. You want to satisfy as many of your priorities as you can while also delivering safe, quality nursing care to patients. You’ll shuffle, move, and change assignments many times before you’re satisfied that you’ve maximized your priorities and the potential for positive outcomes. Congratulate yourself—the nurse-patient assignments are finally made.

Adjust the assignments

You just made the assignments, so why do you need to adjust them? The nurse-patient assignment list is a living, breathing document. It involves people who are constantly changing— their conditions improve and deteriorate, they’re admitted and discharged, and their nursing needs can change in an instant. The assignment process requires constant evaluation and reevaluation of information and priorities. And that’s why the assignments are usually written in pencil on paper or in marker on a dry-erase board. As the charge nurse, you must communicate with patients and staff throughout the shift and react to changing needs by updating assignments. Your goal is to ensure patients receive the best care possible; how that’s accomplished can change from minute to minute.

Evaluate success

What’s the best way to evaluate the success of your nurse-patient assignments? Think back to your priorities and goals. Did all the patients receive safe, quality care? Did you maintain continuity of care? Did the new nurse get the best orientation experience? Were the assignments fair? Measure success based on patient and nurse outcomes.

Check in with the nurses and patients to get their feedback. Ask how the assignment went. Did everyone get his or her work done? Were all the patients’ needs met? What could have been done better? Get specifics. Transparency is key here. Explain your rationale for each assignment (including your focus on patient safety) and keep in mind that you have more information than the nurses. You’re directing activity across the entire unit, so you see the big picture. Your colleagues will be much more understanding when you share your perspective. When you speak with patients, ask about their experiences and if all their needs were met.

Choose your process

Your nurse-patient assignment process may be dictated by unit layout, patient census, or nurse-to-patient ratio. Most nurses use one of three assignment processes.

Area assignment

This process involves assigning nurses and patients to areas. If you work in the emergency department (ED) or postanesthesia care unit (PACU), you likely make nurse-patient assignments this way. A nurse is assigned to an area, such as triage in the ED or Beds 1 and 2 in the PACU, and then patients are assigned to each area throughout the shift.

Direct assignment

The second option is to assign each nurse directly to a patient. This process works best on units with a lower patient census and nurse-to-patient ratio. For example, on a higher-acuity unit, such as an intensive care unit, the nurse is matched with one or two patients, so a direct assignment is made.

Group assignment

With the third option, you assign patients to groups and then assign the nurse to a group. Bigger units have higher censuses and nurse-to-patient ratios (1:5 or 1:8). They also can have unique physical features or layouts that direct how assignments are made. A unit might be separated by hallways, divided into pods, or just too large for one nurse to safely provide care to patients in rooms at opposite ends of the unit. So, grouping patients together based on unit geography and other acuity/workload factors may be the safest and most effective way to make assignments.

You also can combine processes. For example, in a labor and delivery unit, you can assign one nurse to the triage area (area process) while another nurse is assigned to one or two specific patients (direct process).

Unit characteristics direct your process for making assignments. Your process will remain the same unless your unit’s geography or patient characteristics (length of stay, nurse-patient ratio) change.

Keep practicing

Nurse-patient assignments never lose their complexity, but you’ll get better at recognizing potential pitfalls and maximizing patient and nurse outcomes. Keep practicing and remember that good assignments contribute to nurses’ overall job satisfaction.

Stephanie B. Allen is an assistant professor at Pace University in Pleasantville, New York.

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Selected references


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