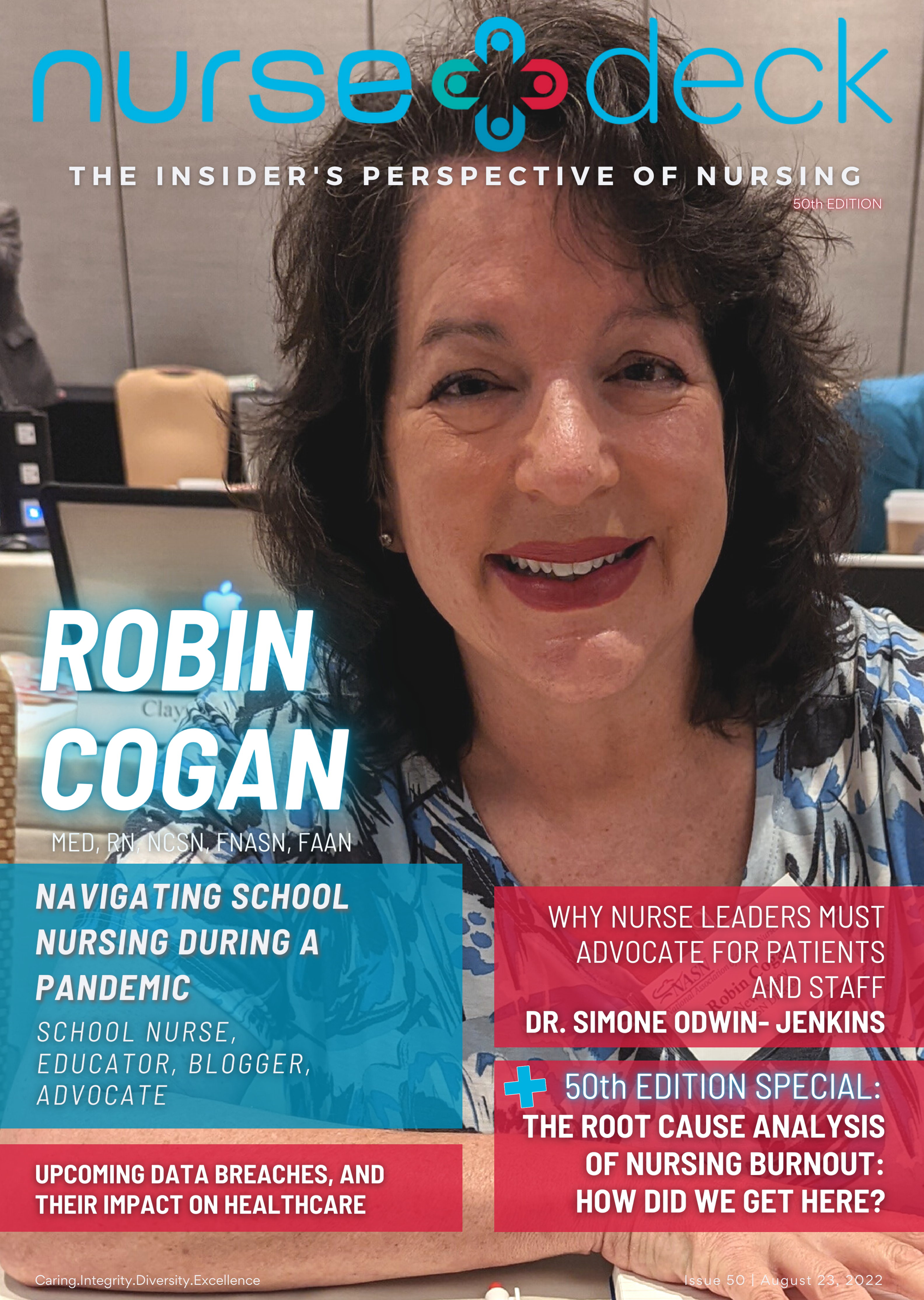

nurse deck
THE INSIDER'S PERSPECTIVE OF NURSING
50th EDITION
ROBIN COGAN
MED, RN, NCSN, FNASN, FAAN
NAVIGATING SCHOOL NURSING DURING A PANDEMIC
SCHOOL NURSE, EDUCATOR, BLOGGER, ADVOCATE
WHY NURSE LEADERS MUST ADVOCATE FOR PATIENTS AND STAFF
DR. SIMONE ODWIN- JENKINS
50th EDITION SPECIAL:
THE ROOT CAUSE ANALYSIS OF NURSING BURNOUT: HOW DID WE GET HERE?
UPCOMING DATA BREACHES, AND THEIR IMPACT ON HEALTHCARE
Caring.Integrity.Diversity.Excellence
Issue 50 | August 23, 2022

WHAT'S INSIDE...

If you're here for the Insider's Perspective, you've come to the right place. Each week we highlight stories from nurses in the field, bring you tips on leadership, mental health, and more. We also feature a Nurse of the Week - a nurse influencer doing incredible work we can all look up to.

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How did we get here?

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ROBIN COGAN

Navigating school nursing during a pandemic

Robin Cogan is relentlessly compassionate. dedicated, and determined to share the stories of others. It's why she's The Relentless School Nurse! This week, we talked with Robin Cogan about the changes to school nursing brought about by the pandemic, and what inspired her to share the stories of other school nurses on her blog, The Relentless School Nurse. This interview will have you rethinking the way healthcare in schools is structured, and what can be done to change it.

EDITOR'S NOTE
50th EDITION

To the incredible nursing community,

Hey! What's up? How's it going?

Just kidding! Now more than ever, those simple greetings elicit an anything-but-simple response, and let's be honest: you don't have time for that. However, when I boil it down, that is kind of what I want this magazine to be about: how it's really going. No sugarcoating, no feigned smiles. When I joined the NurseDeck team almost a year ago, the goal for this magazine was simple: uplift and amplify nurse voices to help facilitate the change our healthcare system so desperately needs.

That's the outward-facing goal, you know? But as I've worked with our amazing interview hosts (and NurseDeck ambassadors) RN Breanna Kinney-Orr and NP Jamie Smith, I realized something else: this magazine is also about showing nurses - at every level - they are worthy of recognition and celebration. From clinical instructor to nursing manager to nursepreneur to brand new nursing student - NurseDeck celebrates you!

When we interview nurses - whether it's a director at Kaiser Permanente or an LPN working in corrections - we try to get to the heart of why every nurse is in this work. We do this to remind the nurse's reading about their "why," but I hope we remind the nurses we feature, too! No one is immune from the widespread burnout plaguing the profession - that is one of the loudest takeaways from the 50 features we've now published.

Reaching 50 issues is an awesome milestone, and signifies almost one full year of publishing a weekly magazine. It's also exciting to see how it's grown, from including one #nurseoftheweek feature interview, to stories and commentary about important nursing issues, to #InTheField highlights of our amazing community, and now to all of the above plus our weekly column from RN Carolyn Harmon!

Here's my ask of you: keep telling us how we can grow. Keep showing us the best ways to support you. Most of all - join in! Send us your stories, in whatever format feels right to you! Help us continue our mission of amplifying nurse voices - the world needs it now more than ever.

Here's to the next 50 issues!

Julia Taliesin

& the NurseDeck team

Groups

Rewards

Wallet

Message

New post | Question | Article

NurseDeck is for everyone. Whether you're a student, new to the field, seasoned scrub or retired - our community involves you.

On NurseSocial, you can engage, connect and network with like-minded nursing professionals. Discuss current affairs, get advice from seasoned veterans, and earn and redeem social points to support nurse innovators and business owners.

Photo/Video | File | Post Anonymously | post

Join the community

Our leaderboard shows which NurseSocial users have been the most active - asking and answering questions, sharing their experiences, and joining groups they want to get involved in. We appreciate each and every one of these nurses for contributing to this growing community. Let's hear it for the all-time top 10!

Katrina Buchholz
2,622

Carolyn Harmon...
2,152

Mariah Edgington
2,122

Melissa Sherman
1,452

Rachel Grace
1,347

Jennifer Rodri...
1,273

Ottamissiah Mo...
1,247

Christina Aylo...
837

Lauren harback
776

Jasmine Joiner
424

Join in at social.nursedeck.com

nurse social

Apply to join Scrub Verified

Our community advocates are passionate nurses who share their stories with our community and their followers. There are many opportunities you will have as an advocate:

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- The opportunity to work with us on a long-term basis

How it works:

Entry qualifications:

- Nursing license must be active
- #InTheField submission
- Currently employed in any clinical setting or be a nurse entrepreneur
- Completed volunteer work, mentored or are publicly involved in promoting the well being or advancement of nursing professionals
- Adhere and promote guidelines set by the CDC, WHO, ANA, and your licensing board
- Submit at least one high resolution photo

Meet all requirements? Apply at nursedeck.com/scrub-verified.

Upcoming data breaches, and their impact on healthcare

nurse deck

By RN Carolyn Harmon
NurseDeck Columnist

Over the past few decades, as the healthcare delivery system has become inundated with technology and the introduction of electronic medical records (EMR), the risk of data breaches has threatened the nation.

The upward trend of the amount of information exposed is staggering. There were 4,419 healthcare data breaches of 500 or more records reported to the HHS Office for Civil Rights between 2009 and 2021. These breaches have resulted in the loss, theft, exposure, or impermissible disclosure of 314,063,186 healthcare records, equating to more than 94.63% of the 2021 population of the United States.

Over 300 million healthcare records!

Healthcare data breaches can be defined as "illegitimate access or disclosure of the protected health information that compromises the privacy and security of it." They're usually classified into two big categories: internal and external. Internal breaches are related to abusing privilege, improper access or disposal of information, loss or theft, or sharing confidential information with a third party which could be intentional or unintentional. External disclosures are from outside entities that are hacking or IT incidents such as malware attacks, ransomware, phishing, spyware, or any type of fraud.

Leading types of disclosure for breached protected healthcare information were found to be:

- Hacking incidents
- Theft or loss of information frequently through lost or stolen portable devices such as laptops or cell phones
- Unauthorized access (internal)
- Improper disposal of unnecessary data

As organizations, companies, and government agencies struggle to develop new strategies to battle the theft and loss of valuable private information, new concerns arise in this decade. Many countries do not

have data privacy laws in place to protect constituents from the use of protected information.

Health apps routinely share sensitive consumer data with third parties including social media firms, data brokers, and advertisers, according to a 2019 study from the British Medical Journal. This study highlighted these concerns among top-rated medical apps used in the United Kingdom, United States, Canada, and Australia. The results were shocking: 79% of these health and medical apps shared user information.

The recent ruling on Roe v. Wade has sparked new concerns about this wave of internet theft and tracking. Discussion and information sought on abortion topics are gaining momentum and fuelling the global debate regarding the safety of mobile health apps, some of which are used to track fertility. With changes to regulations regarding abortions, many women are left scouring the internet for information on abortion and alternative choices.

Some have a growing fear of information being linked directly to them and intruding into their digital footprint and even resulting in legal repercussions. This is one example of a multitude of safety concerns of personal and private health information being unknowingly shared.

All of this points to a larger issue of how personal health information (PHI) and internet security have converged, and how this can and should be regulated. There has been much discussion among government leaders as to how this growing concern should be addressed.

There is no single law regulating online privacy, but rather a patchwork of federal and state laws that hold a lot of gray areas that can be left for interpretation. A measured approach of both government regulations and responsible practices among healthcare organizations may be the most successful way to thwart and protect against healthcare data breaches.

Carolyn Harmon, BSN, RN, *is a nurse columnist with NurseDeck. She has over 24 years of nursing experience. She is currently a Perioperative Optimization Clinic staff and charge nurse. She also has 14 years of knowledge acquired from her role as an adult and pediatric ER and trauma nurse. Carolyn is passionate about mentoring and supporting nurses in all stages of their careers, as well as healthy work environments. Find her on NurseSocial as @carolyn (Carolyn Harmon) and on Instagram as @carolyn_bns_rn.*

Simone Odwin-Jenkins

DNP, MBA, BA, RN, NEA-BC

Why nurse leaders must advocate for patients and staff

MEET SIMONE

Dr. Simone Odwin-Jenkins, DNP, MBA, BA, RN, NEA-BC, is a healthcare leader with over 20 years of demonstrated leadership experience in acute care, ambulatory care and rehabilitative health care settings. She is skilled in employee development, mentoring of nurse leaders and staff nurses, healthcare management, patient experience, patient logistics & throughput, and team building. She currently serves as the director of nursing for acute care services at Ascension Seton Williamson Hospital. Connect with her on LinkedIn: linkedin.com/in/dr-simone-odwin-jenkins-dnp-mba-ba-rn-nea-bc-963352a1/,

Can you tell us how you got started in nursing and what motivated you to become a nurse?

One of my biggest motivations to become a nurse was when my sister had a child who was born with a disease called hydrops fetalis. She was in her ninth month of pregnancy, and we were all so looking forward to this baby. My niece was born, and that's when we found out that she was ill. I had already had my first child, and I was excited for my sister to experience motherhood, so this all came as a shock to us. I spent a lot of time with my sister in the hospital and stayed with my niece in the NICU. Prior to becoming a nurse, by the way, I was in accounting. As I spent time at Johns Hopkins Hospital watching the way the staff cared not only for my niece but for my sister, I wanted to be a part of that. I wanted to do something that really made a difference. So I went home one evening and thought about it. I spoke to my husband about changing my career and he was so supportive. That's how it started. I started looking at programs and what I needed to do to at least have the basics. I started taking some courses at the community college level to get the prereqs done and apply to nursing school - and here I am.

Can you tell us more about your advocacy as a director of nursing?

One of the things I'm a big advocate for is the patient experience and making sure my staff is caring for them to the best of their ability. I'm also a huge advocate for my staff. So, I feel very much compelled to discuss how we care for our staff and nurses. I think we typically think about improving patient satisfaction and I think before we can do that, we have to improve staff satisfaction with their work and their work environment. When I meet with staff, it’s sometimes during leader rounding. I round daily within my areas of responsibility, I touch base with the staff and managers. One of the things we have to do at my current place of employment is really meet our staff where they are. We have staff that have gone through quite a bit in the pandemic, and I think we need to really look at resources to support them so they can also take care of themselves, and then will be fully able to take care of our patients. You have to really work with your staff for them to understand that their mental health is important and we need to assist them with resources, as appropriate. If I can’t make the time to listen to the staff, I’ve failed. I like to round and communicate as much information as I can. I like to have a really deep and meaningful connection with my staff because I know once they feel that they are supported and well-cared-for, it will reflect in the care that they give patients.

So what is an acute healthcare setting? Can you explain that to us?

Sure. It's a hospital setting, like any other community hospital or academic medical center. Here in my hospital, a patient can see

services through the emergency room, ORs, procedural areas, etc. It's where patients come in with an acute injury or an acute illness that we care for. As Director of Nursing for Acute Care, my areas of responsibility are inpatient medical-surgical units and the Dialysis department.

Tell us what it's like to have worked in this type of setting now for over 20 years

It's eye-opening and interesting. It's vibrant, it sounds crazy, but it's vibrant, it's enriching, and it's enlightening. When our patients come to us, they know they're going to receive wonderful care. I love the fact that I'm able to train, teach, mentor, and grow the staff. I love the setting. I just love what I do. I think everyone should start in acute care. Everyone should be in an acute care facility. You see so much that's happening, all of the processes are here. But saying this, I have much respect for colleagues who work in outpatient and long term care settings. It's the continuum of care that keeps healthcare flourishing!

As a director of nursing, what do you do to create a respectful working environment for everyone?

It starts with speaking directly and respectfully to others. I like to address issues head-on. I like to meet and greet and get an understanding of who everyone is. At the heart of it all, you have to know who the folks are that you are working with. You have to understand what drives them. You have to understand their heart, and what breaks their heart. You have to really be able to connect at a personal level and be able to have that deep connection one-on-one, as well as the communication back and forth. Transparency is key. If I'm going to sit in my CMO's office, I'm going to be extremely transparent with what is happening and what I need from them. So, we have that connection where we can give and take and talk. People don't always agree, we can agree to disagree, but we walk away knowing that our purpose is the same: to care for our patients. You can't hide behind your computer or phone, you have to get out there where they are. If you want to make a change or be able to discuss an important topic, you have to get out of your office. So if you have to do a huddle right in the middle of the nurse's station, and say, "here's what's happening, here's what I need from you," then you have to be where the staff is. You cannot do it over the phone, you cannot do it on an email. Your presence in their space shows that you care and that the message that needs to be delivered is important and meaningful.

Tell us more about your approach in employee development and mentoring nurse leaders and staff nurses.

This is the core of what I do and what I love. When you step into a nurse leader job, it's important to consider the impact that you can have, in a positive manner. I love really tapping into what drives a new nurse or what drives someone seasoned. When I find that someone is interested in a particular thing, I look for ways to bring them into a conversation. I try to develop them and look at whether I can bring them into a certain meeting so they can hear what's happening. It's one of the things I truly enjoy. I do one-on-one mentoring with my staff, not only my nurse managers, but staff nurses who want to move into education or leadership, because I think it's important for them to not only see all the opportunities that are available. Some staff think that Leadership is not for them, but they haven't had an opportunity to experience it, it's not cookie cutter. Staff needs to understand what a work day may look like, and on any given day, the work changes. Some days can be difficult, and others, you walk out feeling so good about the work that you have done and the connections that have been made. Then the next day, you have the opportunity to experience what's to come all over again and be excited for the work. When I round and meet with staff, I ask them what they're looking for, and what kind of things they like to do, and then I listen to key messages. Maybe someone wants to be a part of the Fall Committee, or the Shared Governance Council, or they just want to be a part of something. So, I start working with them, to figure out what matters to them. It can be getting a nurse manager position, if that's what they're looking for. I work through

a lot of mentoring and coaching, which are two different things, so I have to sometimes work through things that don't feel great for someone and try to help them understand where we're going, and what they want to do. You're really building trust. As the leader, you're choosing to trust this person, and this person's choosing to trust you. You can talk through so many different things and get a good perspective on what's happening around both of us. I learn every day from my staff, and I'm open and listen to hear what I can do to help them. They know they can always reach out. So even if I've mentored someone,and they have moved on, we stay connected. It's a great experience to be able to offer that level of support. It's just something that I really enjoy.

What do you do to ensure your own leadership growth and development?

I just recently attended the CNO (Chief Nursing Officer) Academy that's been sponsored by Johnson & Johnson and AMN health. It was a three-day intensive, and I learned a lot. I always tried to do something in which I learn something new. I tried to do more educational activities. I keep current with all of the nursing organizations that I'm a part of because that's where I learn, that's how I keep current and connected. I was honored to be invited to attend the CNO academy, and I enjoyed every bit of it. I learned so much.

As an accomplished nursing leader and consultant, how do you encourage our current and future nurses to keep going and not stop, don't give up, and keep pursuing their nursing career?

I think you have to meet them where they are. There are times when people want to take a break. I've had some of my staff take a break, but I'm always reaching out, always staying connected. Asking them, what are you doing right now? Tell me what's going on? How can I help you? If I get something in my mailbox that I think is going to work for someone, I send it to them. All these things can be done remotely, and you can still get an education and learn from the comfort of your own home. There are times when someone may need to

take a break, but it's my job to continue to push and say, "okay, how long of a break are we talking about?" Especially if they're in school and they want to take a sabbatical. As you're taking your sabbatical, what are you doing to keep yourself still interested? Because I don't want someone to start something, stop it, and then go back. You always want to have someone behind them as a cheerleader saying you can do this.

How do you feel about the current working conditions for nurses?

I think that the pandemic highlighted the fact that we can do better. Organizations need to look for opportunities to consider different staffing models to meet the healthcare demand. We have been innovative during the pandemic, but we have suffered the loss of staff to retirement and/or travel which affects nurse staffing. Burnout is real. If you need help, please seek help. One of the many things this pandemic has taught us is that we did not care for ourselves very well. We don't take care of ourselves the way we should, and we are exhausted. I would like us to support and help each other more. If you see a colleague that looks frazzled, reach out and ask to help with something. Sometimes we're in our own little bubble, and we miss that there is a colleague in need. Stop what you are doing and look up; you may see someone that needs help and you may need to be that person to reach out. It's a long and tough road sometimes. Nursing is hard but fulfilling work, we don't need to add more and more on top of it. We need to take care of eachother.

SPECIAL

THE ROOT CAUSE ANALYSIS OF NURSING BURNOUT:

HOW DID WE GET HERE?

By Jennifer Stevens-Smith
MSN, RNIII, CPN

In an article from the March/April 2022 issue of Reader's Digest (1), Adam Piore asks, "Where Have All the Nurses Gone?" Piore suggests COVID-19 pushed nursing over the brink with the current nursing shortage, inadequate resources, and insufficient time to connect with our patients. While these issues represent causes leading to nursing burnout, I find this article only scratches the surface. To answer this rhetorical question adequately, we must take a deep dive into the root cause of nursing burnout. The answer, you will find, lies far beneath the surface where most nurses and medical professionals dare not tread for fear of retaliation: moral injury!

As a nurse, I have always believed we need to live up to Florence Nightingale's example: you must step out of what society deems proper behavior to challenge the status quo. The professional literature remains saturated with articles discussing nurse burnout. A single study (2) of more than 10,000 nurses from five different countries cited an incidence of burnout ranging from 54% (United States) to 32% (Scotland) which suggests burnout persists globally. The United States tops the list among nursing burnout, yet very few journals cite moral injury as a facet or subdivision of this pertinent issue. Journal articles instead shift focus to advances in technology where nurses become increasingly removed from time spent caring for patients, thus creating emotional exhaustion from increased workload demand, depersonalization from lack of social connections, and decreased feelings of personal achievement. I agree with this assessment, however I infer much more contributes to nurse burnout than mere effects from technological advancements. Why ignore the root cause of such a huge issue when patient safety remains at stake? After all, you can't fix what you fail to acknowledge. As a nurse and clinical leader, I must call it out and hold part of the medical sector accountable in the name of patient safety. I must be "the nursing voice" to salvage the professions' future.

Driven by monetary incentives, hospital administration today is corporatized and often makes unethical decisions which result in creating the burnout we see today. Let's travel back in time to look at the build-up of those decisions which have led nursing to the current state and the eventual descent into those creating moral injury. Back in the mid 2000's, executive leadership staffed the nursing, pediatric population per recommendation as a 3 to 1 ratio (meaning a 24-bed unit had 8 nurses). Now, executive leadership decided to cut the profession back to the bare minimum, called the ADC (average daily census). This means a 24-bed unit would now only have 5 to 6 nurses. When the unit is full, you take a bigger load of 4-5 patients instead of the previous 3 patient assignment. The reality is that the units are full most of the time. Executive leadership decisions set the stage for increased workload pre-pandemic, causing prolonged exposure to physical and emotional stressors which resulted in feelings of exhaustion, overwhelm, self-doubt, anxiety, bitterness, cynicism, and ineffectiveness. According to a 2014 study (3), burnout occurs when these prolonged exposures produce inadequate time for the nurse to process and reflect on the unconsciously absorbed distress from their workload creating compassion fatigue which leads to nurse burnout. Certainly, we saw this from COVID-19! The results of working multiple 12-hour shifts to meet the increased vagaries of staffing demands led to nursing burnout. Because leadership cut staffing to increase its profit margins prior to going into a projected nurse shortage, nursing had little if any time to reflect on the cumulative stress each 12-hour shift brought. Increasingly, this became the norm: less time to process our stress during the height of the COVID-19 pandemic. In a 2009 study (4), authors Chiesa & Serretti state, "Continuous stress may lead to unproductive rumination that consumes energy and strengthens the experience of stress itself." The seen or unseen consequences by leadership set the stage for today's nursing burnout and the so-called "Great Resignation" witnessed

today. The staffing shortage didn't create all the moral injury nurses sustained, yet literature still fails to acknowledge and adequately address moral injury. Why?

A 2021 study (5) defines moral injury as an experience where a person perpetrates, witnesses, or fails to prevent an act that conflicts with their moral values and beliefs. COVID-19 certainly brought moral injury into a blinding light. Nurses who felt obligated to pick up and work unprecedented hours during the pandemic and nursing shortage to keep patients safe. Nurses who were forced to go against isolation protocols due to lack of PPE (personal protective equipment), therefore exposing themselves along with their families to the virus. Nurses who believed they should be able to have the time to care properly for the sickest of their dying patients. But COVID-19 isn't the sole causative agent for moral injury. The silent cause of moral injury resulting in the highest level of nursing burnout is represented in the untold, unethical decisions made by those in power, executive leadership knowingly covering up cases such as Doctor Death, The King of Revision Spine Surgery, The Greedy Butcher, and The Butcher of Pakistan (6) - surgical cases publicly known throughout the U.S. - represent just a few of the untold moral injury cases nursing endured prior to 2020. Fortunately, I am a moral injury survivor, and there are many more like me.

My personal story began when only two-and-a-half years out of nursing school I moved to an orthopedic floor inside a top-ranked hospital. An orthopedic surgeon, who shall remain nameless, began working at five area hospitals in the region. He began recommending surgeries for patients who failed to meet the normal criteria for those needing spinal surgery. Also, he began performing new, experimental surgeries for patients undergoing spinal fusions.

At first, I noticed this orthopedic surgeon had a hospital badge, but overtime, I noticed he did not. Upon questioning my supervisor as to why he didn't display the hospital badge anymore, I was told he was working for himself. I was instructed to take verbal orders from this doctor because, since he no longer worked for the hospital, the residents could not write them for the attending. This was a red flag for me, as hospital policy stated verbal orders were only in cases of emergency such as the ED (emergency department) during a trauma, or in the OR (operating room) during surgery. As I began doing as I was told, I noticed the orthopedic surgeon didn't complete the verbal order process correctly. He did not follow the read back portion of the process. He was also incompetent to the correct dosing for Acetaminophen for a young, adult patient who was in pain and febrile. I corrected him, but this was against my scope of practice as a nurse. Pertinent orders were missing, and call-back times were longer than protocol. I was called and questioned by management as if I did something wrong because it took longer than two hours to reach the doctor for pain medication orders while a patient sat in pain.

I knew in my gut this was not right! It was against my moral and ethical values as a nurse, but what should I do? I didn't have enough information to make a formal complaint to the governing bodies like The Joint Commission (TJC) or The Centers for Medicare and Medicaid Services (CMS). Years went by and rumors spread around the hospital that both nurses and doctors escalated issues with more evidence up the chain of command. I watched as nurses who worked underneath this doctor were pulled and replaced by new nurses from inside the hospital to silence the bedside. The executive leadership knew what was going on, and they knowingly enabled this surgeon to continue harming patients. They granted him access to the operating room, allowing him to perform surgery despite discontinuing his hospital privileges. The question raised by many is that, if the surgeon did not qualify for hospital privileges, why was he allowed to perform surgery at all? Patient harm continued at all

"I knew in my gut this was not right! It was against my moral and ethical values as a nurse, but what should I do?"
nurse deck

five local hospitals that granted him access despite not having privileges at some of these institutions.

Eventually, rumors leaked outside the hospitals and the surgeon was investigated and arrested. He presented for a pre-trial hearing and an incompetent judge set bond. The orthopedic surgeon obtained a valid passport, boarded a plane, and flew back to his country of origin. Since 2013, over 50 patients have died from his botched surgeries. I read an article stating he possessed gaps in his resume' leading me to question whether he was a real doctor. More than 500 lawsuits have been filed against him, yet no ownership exists in the five hospitals. Several years later when the surgeon was extradited to the U.S, and stood trial, I watched as the hospital who employed me refused to answer a reporter after the court found the surgeon and all five hospitals guilty in a unanimous decision by the jury. Never did I imagine I would see this happen in a hospital when I signed up for nursing school, especially in a pediatric hospital! Why isn't executive leadership held to the same moral and medical ethics as the nursing profession?

For example, RaDonda Vaught, a Tennessee nurse, lost her license and went to trial related to fatigue, multiple 12-hour shifts, and an emergent medical situation. One mistake and suddenly the ramifications are handed to the nursing profession. Where is the accountability and ownership from executive leadership, especially with regards to purposeful harm and looking the other way? I underestimated the toll; knowing something was wrong and not knowing how to respond affected me profoundly. This ethical dilemma created the moral injury which led to my nursing burnout. I am not alone, but there is hope.

How do we move forward?

We move forward by identifying the root cause(s) of moral injury and involving those that provide the patient care in concert with executive leadership. To authentically create and sustain a patient-centric model of care, we must first embrace the voice of the care teams who then advocate for the patients. This shift requires the recruitment and retention of those in leadership positions who maintain their ethical compass. Ann Richardson, MBA and Healthcare Systems Transformations and Operations Consultant, understands our moral injury that comes from being silenced:

"As a hospital administrator for more than 25 years, I know the impact of moral injury on one's career and soul on a personal level. A career in healthcare administration is borne out of a deep passion for patient advocacy. At least, that is what I believed based on my mission when I chose to pursue and follow my dream to become a healthcare leader. The guiding principle I set for myself when I started this journey has always been that if I keep my finger on the pulse of the care teams, they will be better able to keep their finger on the patient's pulse. If I had to sum up the role of leadership in a healthcare organization or hospital system in one word, that would be advocacy. A very logical part, so I thought.

"What constitutes patient advocacy when you are a non-clinical healthcare leader? In the fee-for-service world of medicine in the United States, volume reigns as the dominant statistic that drives most decisions. External forces such as unfavorable third-party reimbursement from payers, onerous regulatory requirements, increasing labor and supply expense, the capital-intensive nature of medicine, and competition, to name a few, make it very challenging for hospital systems to produce a profit margin. The pressure to increase volume persists despite significant barriers, such as appropriate staffing, proper facility space, time, and financial resources. A leader advocating for the delivery of safe and quality patient care creates the infrastructure to support the clinical service, which has become more of a challenge over the years given the reimbursement scheme against

increased expenses. Even the not-for-profit healthcare organization must produce a profit margin to reinvest in clinical programs and infrastructure as well as keep pace with inflationary factors, to remain solvent and competitive.

"As healthcare organizations struggle to remain financially solvent and competitive in the market, the pressure to care for more patients persists despite staffing shortages. The tension today has created an even larger division between leadership and the workforce at-large. For those healthcare systems that do not foster a culture of psychological safety for the workforce, speaking up in advocacy of patients and care teams can have detrimental effects. Silencing is not a new problem in healthcare. Residents and fellows-in-training often fear retaliation or shaming when questioning the authority of a senior attending physician. Nurses fear the same when questioning a physician or those in leadership. Leaders are also silenced when the CEO leads with a dominant top-down management style. When the only audible voice allowed in a healthcare system is the CEO, the workforce will undoubtedly experience some degree of moral injury. I, too, have experienced silencing when addressing patient safety and inappropriate behavior of colleagues. There is often a code of silence in medicine and healthcare that is mafia-like, with incidents and concerns swept under the rug, never to be mentioned. When one experiences harm to their own person, witnesses harm to patients and others, and repeatedly is silenced with no recourse, it is natural to feel grief, guilt, remorse, shame, outrage, and despair.

"Many have spoken with their feet and walked away from medicine and healthcare in general. Nurses have continued to organize throughout the country, along with residents in a few prominent healthcare systems. The "fight" continues, but this is not the solution. The solution is to increase the accountability of boards of healthcare organizations, recruit executive leadership that are servant leaders at the core and who thrive on engaging and partnering with the workforce to better care for patients. It starts with one person: the CEO. One person can make a difference."

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INTERVIEW HOST

JAMIE SMITH
RN, NP, MSN
NURSEDECK AMBASSADOR & INTERVIEW HOST

Nurse Jamie hosts interviews for NurseDeck to share stories, resources & guides to help inspire and motivate the NurseDeck Community.

Jamie has been a registered nurse for over 13 years. She is an experienced nurse practitioner with a history in long-term care, medical-surgical geriatric nursing, and clinical pharmacology. She is also an educator and author.

I love hearing about startups. With NurseDeck we have our little patch of dirt at work time, to spruce up and help the nurses' community base. I love that there are people like NurseDeck trying to shake things up because we desperately need it.

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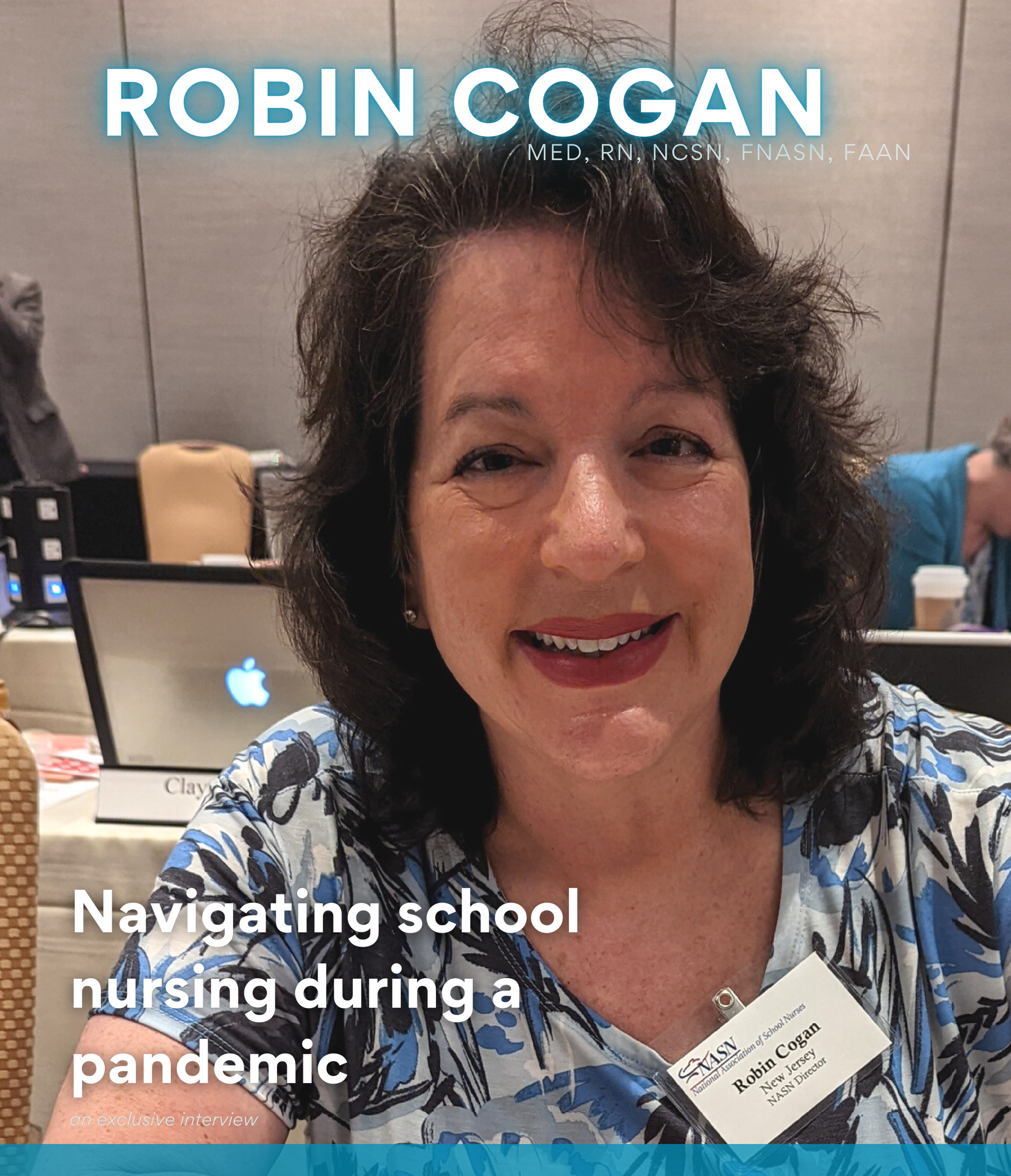

ROBIN COGAN

MED, RN, NCSN, FNASN, FAAN

Navigating school nursing during a pandemic

an exclusive interview

Robin Cogan has been working as a school nurse for over 20 years. She received her master's of education in Clinical, Counseling, and Applied Psychology from Wilmington University in 2009. She is also a part-time lecturer and clinical coordinator at the Rutgers-Camden School of Nursing. In addition, Robin writes a weekly blog called The Relentless School Nurse, where she aims to elevate the profile of nursing and writes about pressing health and safety issues for school nurses. Find her on Twitter as @RobinCogan.

Jamie Smith (JS): To start off with, what made you get into nursing? Can you tell us about your journey?

Robin Cogan (RC): I have more of a roundabout journey than I think many nurses. I did not start out wanting to be a nurse. I didn't have any interest in nursing at all. I was an artist, and when I went to college I studied art therapy and psychology. When I was in art therapy towards the end of the program where we had lots of practicums, immersed in the modality of our therapy within a hospital, I happened to be on the psychiatric floor of a general hospital. There was a group of nursing students coming through for their psych rotation. I realized from watching their interactions really carefully, that while I had lots of information about the psycho-emotional component of what was happening, I didn't understand the physical component of what was happening. I felt like I needed a more well-rounded understanding of mind, body, and spirit. I felt like I was missing really important information. At that time, at our therapy practice, you didn't need a master's for licensure. I either had to go on to get my master's in art therapy or possibly a master's in social work, but instead I went the opposite direction and got an associate's degree in nursing. I went really backwards in terms of my educational progression – I went from a bachelor's to an associate's degree. I did complete a master's in counseling years later, but that's the beginning of my nursing journey.

It is not helpful to us to stay quiet, and that was never more clear than during COVID.

JS: What drives you in the field of nursing? What makes you stay?

RC: I might have given you a different answer before COVID. In terms of what makes me stay – I'm still struggling with that one right now. I have been a nurse for 37 years. I have been a school nurse for 21 of those 37 years. More than half of my nursing career has been as a school nurse, and I am still a full-time school nurse. My association with Rutgers is what I call my summer-fall, winter-spring job. It's not my full time job. It's my way of giving back to the next generation of school nurses, but my full-time job is as a Camden city school nurse in Camden, New Jersey. What makes me stay is – you get into a rhythm. I think part of being a school nurse, especially as you're in a rhythm with a school, with a district, with the people, watching kids grow up – you're embedded in a school community, and before you know it, the years flow by. I think that's why I've stayed all these years. COVID changed a lot, though, so I'm still grappling with what my next steps are. One of the issues in school nursing is that there really is nowhere to grow. I've had the same job for 21 years. There's no internal structure for any upward mobility. I've

expanded horizontally and not vertically. I've expanded my education, I now write my blog, or I publish articles, I speak, I educate, but that's all in addition to my full-time job.

JS: I'm with you. I love to write. It's a stress reliever for me. So, as a lecturer and clinical coordinator at Rutgers Camden School of Nursing, tell us about the academic challenges in nursing education in response to the pandemic.

RC: I think we were all taken by surprise. There was a bit of whiplash going on at the beginning. I know we were not prepared to go full steam ahead into virtual learning, especially in a nursing program where it's so hands-on. Our program is so based on relationship building and cohorting and communication and having real-life experiences with children and families and community. The core of the program is in the summer, but COVID started in mid-March. We weren't ready to move it and become fully online within - it wasn't even six weeks. At Rutgers, I think we were all feeling the growing pains in the learning curve of what it meant to take a very intimate face-to-face encounter, whether it's pre-K to twelfth grade students or its adult learners, and create as robust a program as you could virtually. There was a lot of pivoting; there was a big learning curve, there were a lot of resources that were becoming available to us. In the middle of it, too, we were in the midst of not really understanding the impact of this awful virus. Where I am in New Jersey, we were one of the first really hardest-hit states. It was the most challenging time, but honestly, it got even much more challenging. Each phase of this pandemic has had its own difficulties, challenges, opportunities to really meet the moment, because each of these moments requires so much innovation and so much collaboration and admitting when things aren't working well, and then trying to address how to change that. There was no more business as usual. The schedule was gone, the rhythm of the school year was gone. Whether or not we could see our kids face-to-face was gone. Even when we did come back, it felt very sanitized. We're masking where some people are wearing face shields. It just felt unsafe for a very long time.

JS: You said that you had to redesign things within six weeks. Is that right? So you went from having that hands-on relationship to going remote?

RC: Yes. In my district, it's an urban district. You can't assume that everyone has devices at home or has internet access. What's come to light with COVID are all the things we know: the social determinants of health, the inequities that exist in certain communities. In my community of mostly brown and Black families, children were especially hit by those inequities. When most people were able to work from home because their jobs allowed it, my family members were all of a sudden considered essential workers because they worked in supermarkets or restaurants or homecare. While children may be home, maybe their families weren't home. So everything turned upside down and inside out, and there was a lot of miscommunication. Masking was not well explained from the beginning, which is, I think, why we're still fighting it.

JS: What interventions did you guys do at the Rutgers campus School of Nursing to maintain the quality of

nursing education?

RC: Regarding nursing education, we jumped head on into a literal boot camp of how to pivot to online learning. Before the semester started, I was able to take a design course on how to bring my face-to-face program online. It was a great course but boy, I had to move every single one of my syllabi, all of my projects, all of the assignments, all of my speakers. I had to redesign everything that I've ever done and put it into an online platform. What we decided is that, because we wanted to create that sense of a cohort, even though it was really hard, we were going to have a synchronous and asynchronous class. We very quickly redesigned everything. The content was still valuable and important, but we had to deliver it in a completely different way. Truthfully, we had to be incredibly flexible with ourselves, with our students, and with the university. I don't think we felt like we were walking on solid ground for a long time.

JS: Robin, what is relentlessness? Tell us more about The Relentless School Nurse and its mission and vision.

RC: Even within nursing, people outside of school nursing often have a very new view of what a school nurse is and what a school nurse does, and they don't always understand the full scope of our practice, the full the responsibilities we undertake, the fact that we work under a 21st century school nursing framework that is evidence-based, and what we do in terms of population health, the care coordination we provide, the mental health services supports we provide, and how we are the bridge between home and school – between learning and health. As we know, a child who is hungry is not going to be a good learner, a child who is not feeling well is not going to be a good learner. We are facing a generation of children who have extreme needs that many have not seen before. With COVID, that is even more amplified. Prior to COVID, school nurses spent up to 34% of our time on mental health issues and crying. A lot of people don't understand that, but think about what is happening out in the community, because what happens out of the community inevitably comes into school. A school is a community and we reflect the communities that we are around. Certainly the education piece is incredibly important, but within that are equally important things: the social and emotional state of the child. The culture and climate of a building is the building, and don't forget, we're also dealing with the

adults. One of the reasons I started The Relentless School Nurses was because I began to understand that people, even nurses, had no clue what it meant to be a school nurse. I felt like if we don't tell our own stories, other people will make up their stories about what we do. Along the way, I have been very involved in social media. I've met some amazing social media superstars who've taught me so much about the importance of being present on social media and telling your story. Nurses have this thing in their DNA, where they don't want to boast; they don't want to bring attention to themselves. I always say: you're not boasting, you are educating. You are educating the public about your work, what you do, who you've come across, what impact you've made. It is not helpful to us to stay quiet, and that was never more clear than during COVID. Maybe we are making better connections, with the media, with journalists, writing op-eds, putting information out there. As nurses, we do a fantastic job talking to each other about our specialty, but that doesn't help people understand the bigger role of what nurses do and who we are. So in between all of that, I started writing my blog, The Relentless School Nurse. Initially, I told stories from my health office, but I wanted to tell stories from other school nurses' offices. I felt like if I invited a school nurse to tell a story in their own words, that would encourage them to find their voice. I have to say, that's one of the things I'm most proud of: all of the guest contributors who have then gone on and done amazing things I think maybe started because they wrote a blog post in The Relentless School Nurse.

JS: If people want to learn more and read the blogs on The Relentless

> *If we don't tell our own stories, other people will make up their stories about what we do.*

School Nurse, how do they get there?

RC: The website is relentlessschoolnurse.com. I'm also very active on Twitter.

JS: Can you tell us how you feel about the current working conditions for nurses? What would be the best intervention to address it?

RC: I have lots of things to say about the current working conditions for nurses. I have held weekly, private school nurse support groups on Sunday nights at 7:00 p.m. School nurses from across the country have come to talk about their challenges, their upsets, what their week has been like. The information they have shared with me is just heartwrenching. I keep it anonymous, I don't collect names, but I do collect themes and quotes, and we have a very beleaguered, very concerned workforce that has truly been in the middle of some quite abusive circumstances. Unfortunately, masking or anything COVID-related has become a very political hot potato. There are factions that don't want to have their child participate and they want parent choice for anything COVID-related, but they're forgetting there are other people's

children in their children's school buildings. A child does not go to school alone, they go to school in a community.

JS: Tell us more about the weekly private meetings with nurses across the country.

RC: These groups have met on an ongoing basis, just to share in a safe space some of their experiences. Some of the discussions are things like – I'll give you two pretty extreme examples. There was a nurse who sent a child home because the child had COVID-like illness, and the mother was very angry with her. She didn't believe she had COVID. When she returned the child to school, she returned the child in a T-shirt - she is a first or second grader - the t-shirt was one of those ones you had to make up and it said in fancy letters: “My school nurse has” – it was a poop emoji, a big poop in the middle of her shirt - “for brains.” So “my school nurse has - blank - for brains.” On the back of the shirt, it said, “I don't have COVID.” I had another parent tell a nurse at another school – this was really upsetting. She was sending a child home and I think she was talking to a parent. The parent got irate and threatened her and said, “Get ready to meet your maker” - for doing her job for caring about other people's children. That's ultimately our responsibility. So I wrote about it: “Can we save our school nursing workforce?” Some of the quotes here, I think, are very revealing. One said, “I've been a nurse for 24 years, and I've never felt more demoralized, questioned or made to feel incompetent.”

JS: What are some changes you would like to see in healthcare after the pandemic?

RC: I think this is the time and space to have a real deep understanding of what we want to do and what we need it to look like. Because it cannot continue along the path that it's been. I have some thoughts about what could happen moving forward. One is that we need to work as a health services team, with staffing that meets the enormity of the challenge. School nurses cannot work in isolation anymore, because that was never sustainable. That was the bandaid. We need a robust school health services team, not one person. Also moving forward, we cannot be the de facto health department. Our health departments across this country are woefully underfunded, understaffed, and clearly had difficulty meeting the challenge of the contact tracing, pushing out the vaccination clinics, dealing with all of the logistics that went into once they became available. It has to be a team. These are groups that have to get out of their own bubbles and start working together. There needs to be a team of contact tracers embedded in school districts and buildings. School nurses are not the only staff members that can perform contact tracing. In fact, it's such an overwhelming and time consuming job that it takes away from the very essence of our real job, which is caring for children. It was an additional stressor. Are we missing something? Because we're so focused on contact tracing? Am I missing what's standing right in front of me? That's our school nurses' worst nightmare – that they've missed something very important. Districts need to partner with vendors to implement testing for staff and students to stop adding layer after layer of expectations on the shoulders of truly an already beleaguered workforce with no

support to share the load. And then: support your staff. Do not allow or excuse abusive behavior and language directed towards school nurses who are merely attempting to implement the public health mitigation strategies that keep students and staff safe. School nurses need to be supervised by other school nurse administrators and school nurse leaders. We need leadership that has an intimate understanding of the full scope of our practice. Create health services departments at the district level, because that would also give opportunities for school nurses like me to have upward mobility and grow our leadership skills, hone them, share them. I had to go outside of my school district to gain leadership skills. We can't be three places at once. Which means there should be more than one school nurse in a building, either we're the daily urgent care for everything under the sun, or we're part of a bigger picture of also helping schools identify processes and practices to keep school safe, right? Whether it's health and safety in the building, whether it's how we manage emergencies that happen in a building. Finally, as we know this is a huge problem, pay a wage commensurate with our professional expertise and education, create a salary scale that recognizes our work experience prior to entering school nursing.

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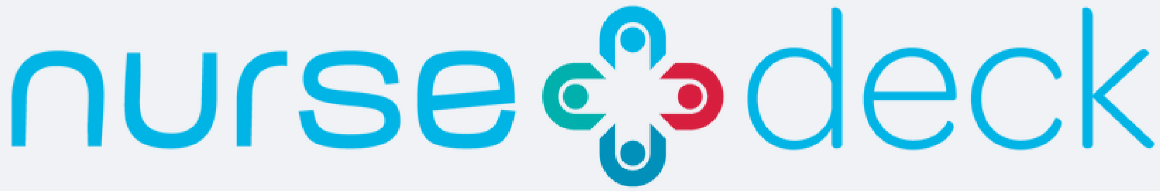
Mykyla Coleman BSN, RN	"I AM FIRST: A Guide for First Generation College Students"	kylakrafts.com/products/i-am-first-a-guide-for-first-generation-college-students
Janet Celli, RN BSN	CPR Associates of America	cprassociates.org
Tilda Shalof, RN, BScN, CNCC	"A Nurse's Story"	www.nursetilda.com/books
Diane Cannon, DNP, MHA, RN	Xapimed (competency tracking app)	xapimed.com
Lauren Harback, LPN	Built Bar ambassador (CODE: laurenh for discount)	built.com
Susan J. Farese, MSN, RN	"Poetic Expressions in Nursing: Sharing the Caring"	sjfcommunications.com/author-shop



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