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THE INSIDER'S PERSPECTIVE OF NURSING

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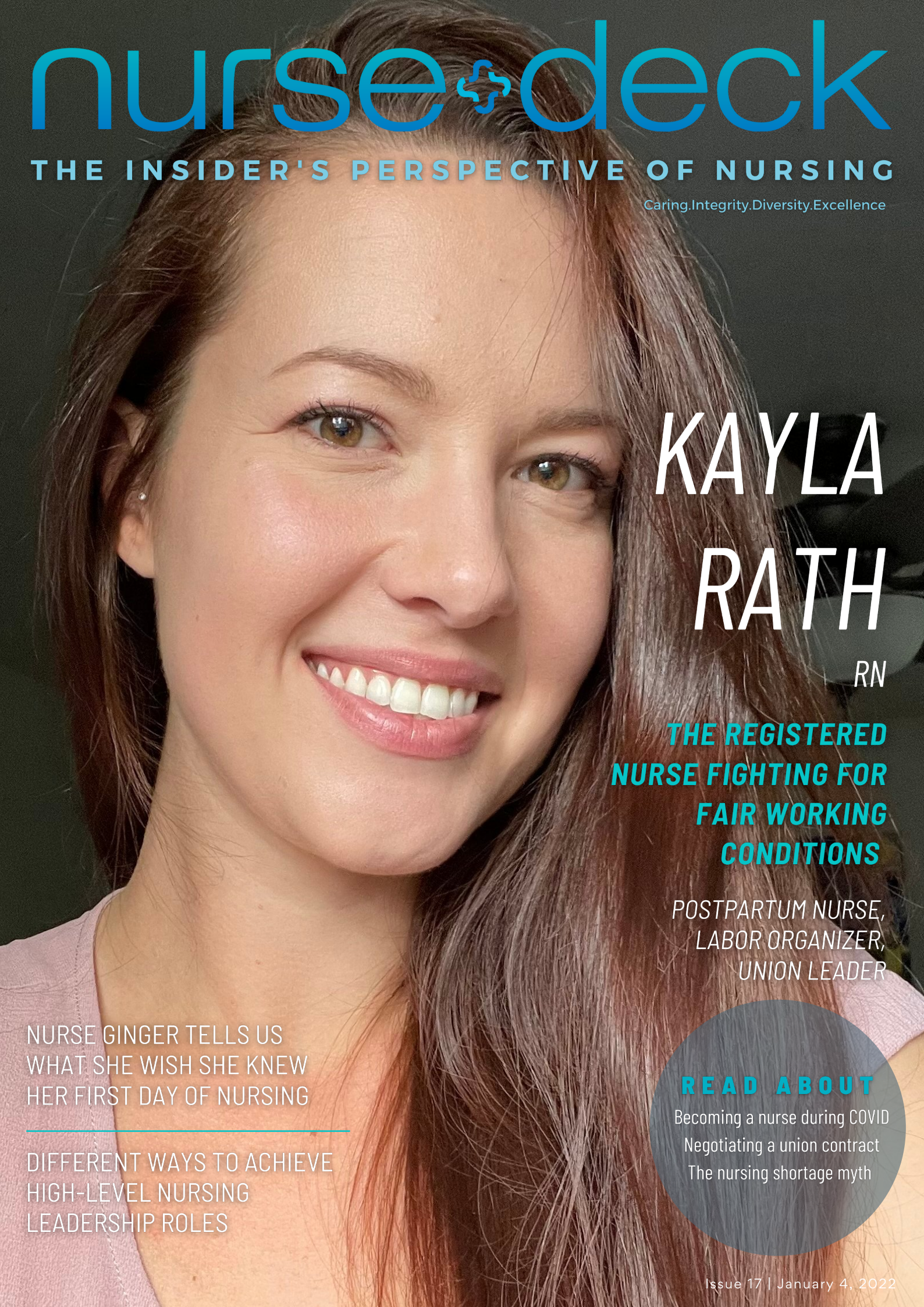


KAYLA RATH

RN

THE REGISTERED NURSE FIGHTING FOR FAIR WORKING CONDITIONS

POSTPARTUM NURSE,
LABOR ORGANIZER,
UNION LEADER

NURSE GINGER TELLS US WHAT SHE WISH SHE KNEW HER FIRST DAY OF NURSING

DIFFERENT WAYS TO ACHIEVE HIGH-LEVEL NURSING LEADERSHIP ROLES

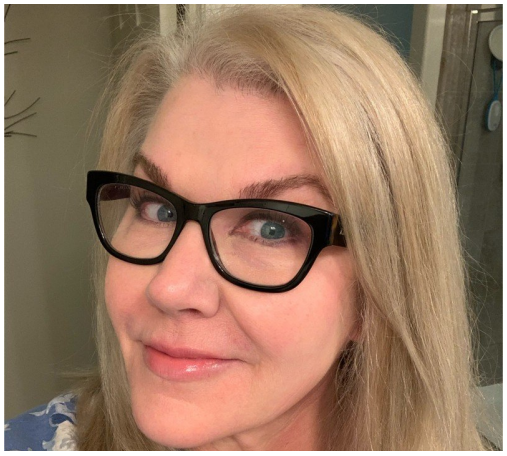
READ ABOUT

Becoming a nurse during COVID
Negotiating a union contract
The nursing shortage myth

Issue 17 | January 4, 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 #InTheField, 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.



KAYLA RATH

The registered nurse fighting for fair working conditions

Currently working as a postpartum nurse in Pittsburgh, Kayla told NurseDeck all about her experience starting her career right before the pandemic, and jumping into union organizing to negotiate a fair contract.

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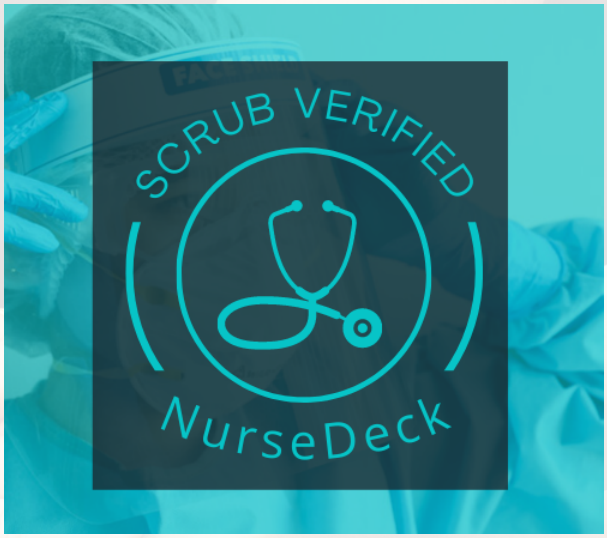

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Interested in travel nursing?

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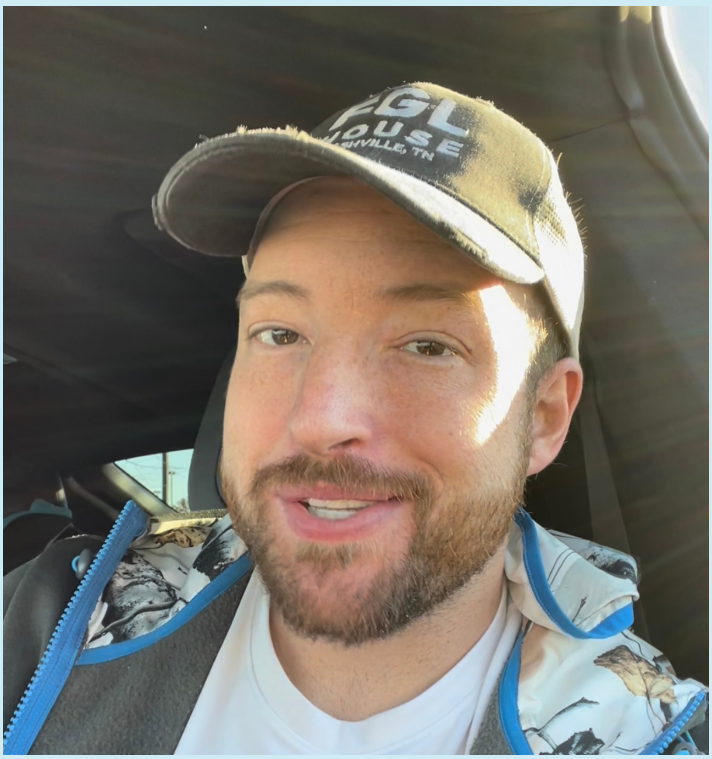
There's a new group on NurseDeck Social.



Richard Darnell (A.K.A. Travel Nurse Rich) is a full-time Travel Nurse and influencer. He graduated from Mercy College with an ASN in 2016 and continued online while working as a full-time RN to finish his Baccalaureate in 2020. Rich loves spending time with his wife Jocelyn and their two young children Levi and Jase when he's not at the bedside. The majority of the travel nurse contracts Rich takes are in the Intensive Care Unit and are through his travel company TNAA. In July of 2021, Rich started a travel nursing TikTok account because he wanted to help share what travel nursing is all about and how anyone can be a travel nurse just like him.

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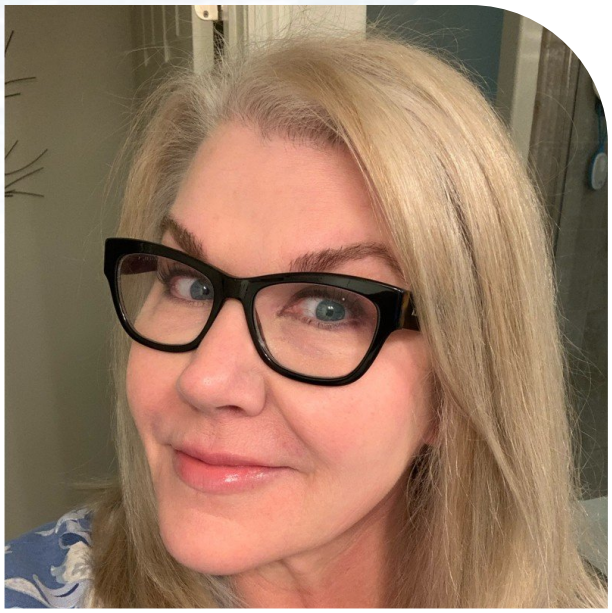
#InTheField

Nurse Ginger tells us what she wish she knew her first day of nursing

California-based hospice nurse Ginger Blackwell discusses self-care advice and what she would tell her former self on her first day of nursing.



Q: TRUE or FALSE: "Nurses eat their young."
A: True.

Q: What is your specialty and where are you based?
A: Hospice and Fresno, CA.

Q: Any self-care or mental health tips for new nurses?
A: Do your best to find balance! Taking care of ourselves is very important too! Make the time for some type of stress outlet that makes you feel good. Remember you can get through anything! Always be open to learning, you never quit learning in nursing.

Q: Given the opportunity to speak to yourself on Day 1 of nursing school, what advice would you give?
A: Doing care plans will become much easier later LOL! You will look back at nursing school someday and laugh at all of the funny things you did and the mistakes you made while learning and laugh! Find a great ear to speak with, use this ear for support, guidance and listening. I promise you will look back on this time in your life and never regret it. ▪

Different ways to achieve high-level nursing leadership roles

Currently, nurses are 4 million strong in the US, with almost half over the age of 50. As of 2018, 57% had achieved their BSN, and 18% had graduate degrees. Nurses with doctoral degrees doubled between 2010 and 2018, but still only accounted for 1% of the total workforce. Perhaps the most impressive figure is this: 500,00 nurses are projected to retire by 2022, driving a need for more than 1 million new nurses to replace them. Assuming that most leadership roles are filled by seasoned nurses, many of these spots will be the ones left vacant by this mass exodus.

In short—we need nursing leaders like never before!

If you feel your career path is aiming you towards nursing leadership, great! But, it's important for you to know the various roles available, how leadership styles differ, as well as what differentiates a nursing manager from a nursing leader.

Nurse manager vs. nurse leader —what's the difference?

More than just a difference in semantics, nurse managers and nurse leaders have distinctly different roles. In general, nursing leaders work with both nursing teams as well as overseeing patient care directives. They draw from a well of extensive clinical expertise in order to direct operations so that patients have the best healthcare possible.

In comparison, nursing managers focus more on team supervision. They tend to be more tuned in to the daily logistics of personnel management and are not as involved in improving patient health outcomes. In addition, nurse managers often oversee departmental needs like inventory, patient flow, and budgets. Nurse managers need to have experience in hiring and training staff, as well as coordinating with other departments in their facilities.

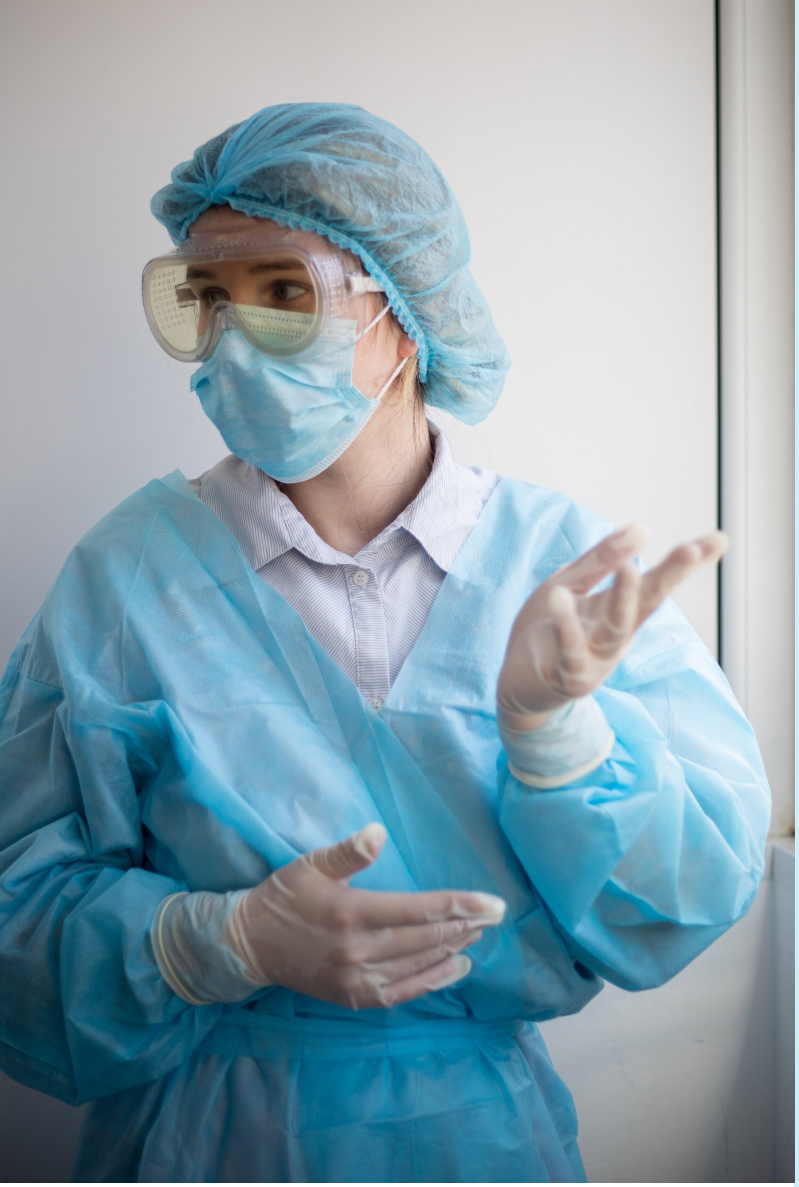
In short, nursing managers focus on the trees, and nursing leaders, the forest.

What are the different leadership styles?

Nursing leaders tend to operate from one particular style of leadership. The right style depends on your personality, your team's needs, and the culture of your organization. Highly effective leaders are those who are able to keep their egos reeled in, and put the good of the team and department over their own self-interests. Here are some examples of leadership styles and a brief overview of each:

Democratic Leaders place value on having a laterally unified team where everyone has equal input. Instead of issuing directives and delegating initiatives you decide on, you take into account what your team collectively thinks is best.

Authoritarian/Autocratic Leaders can be thought of as the parent who likes to say, "because I said so." While some autocratic leaders can be effective at managing large



organizations, generally speaking, no one appreciates being dictated to and morale can suffer.

Transformational Leaders recognize and value the autonomy of their teams and encourage innovative problem-solving. If you are constantly evaluating ways to improve systems, and love to mentor, this style can be very rewarding in an environment that encourages change.

Transactional Leaders use a "reward/punishment" approach to motivate their teams. This style can be helpful in terms of defining clear expectations, but using threats to manage behavior may inspire creative work-arounds.

Bureaucratic Leaders are often placed in their positions by promoting up from within, rather than being the best candidate for the job. The rigidity that comes from "checklist" leading can be stifling and restrictive, especially in healthcare environments where leaders should always be seeking new evidenced-based approaches.

Servant Leaders focus on leading by example. If you've ever been described as a "natural leader" than you may possess the trustworthiness and self-depreciating attitude that this style requires. Servant leaders are the "helpers" that Mr. Rogers told us to look for in times of crisis.

Laissez-Faire Leaders set their teams up for success with the appropriate resources and then get out of the way. Translated from the French, leave it be, this style of leadership can either be empowering to teams, or an immense source of frustration.

Charismatic Leaders have that "it" factor that makes people pay attention to them—for better or worse. This type of extrinsic motivator can bring out the best in people and inspire peak performace; however, charismatic leaders are prone to becoming hyper-focused on their own goals at the expense of their team's.

Gentle Leaders combine the best of transformational and servant leadership styles. They seek to better their teams, lead by example, and display a high level of emotional intelligence, compassion, and wisdom while doing so.

What are the different nursing leadership roles?

Nurses who aspire to attain nurse leadership roles need to have a graduate level degree. Which means—if you currently hold your Associates Degree in Nursing (ADN or ASN), you would first need to get your bachelors in nursing (BSN). From there, going on for your Master of Science in Nursing (MSN) or Doctor of Nursing Practice (DNP) is recommended. Pursuing Post-grad certificates or focusing on role specialties like Family Nurse Practitioner (FNP), Nurse Executive, or Nurse Educator are also options.

With degree in hand, nurse leaders are

employed in myriad of settings, ranging from hospitals, to ambulatory care centers, long-term care, and academia. Some examples are as follows:

Chief Nursing Officer (CNO)—oversees all other nursing departments and is the top of the nursing food chain, so to speak, for hospital nursing administrators.

Chief Executive Officer (CEO)—is the uppermost echelon of leadership positions in the hospital; this position combines medical knowledge, public relations, business acumen, and financial prowess.

Chief Operating Officer (COO)—if metrics and system analytics are in your wheelhouse of talents, this role offers plenty of both. As second in charge, the COO ensures that all daily functional operations of the hospital are running smoothly.

Chief Clinical Officer (CCO)—in this role, you would be in charge of recruiting and hiring clinical staff at the hospital, as well as provide a supervisory role for academic programs like medical residencies.

Dean of Nursing—in charge of a nursing program within a college or university, the dean of nursing must work closely with nursing education faculty to promote excellence.

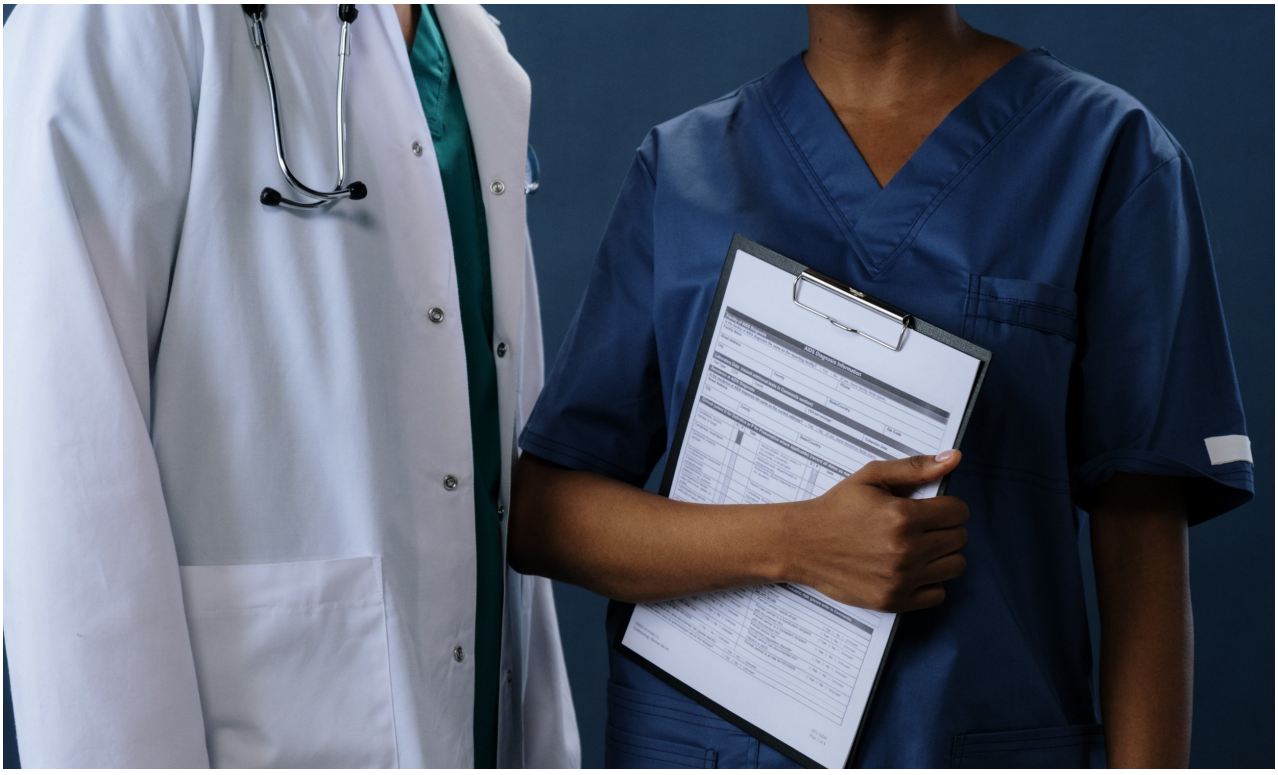
Clinical Nurse Leader—this position works with clinical staff as well as the community to ensure that patient care directives are being met within a hospital or other direct patient care setting.

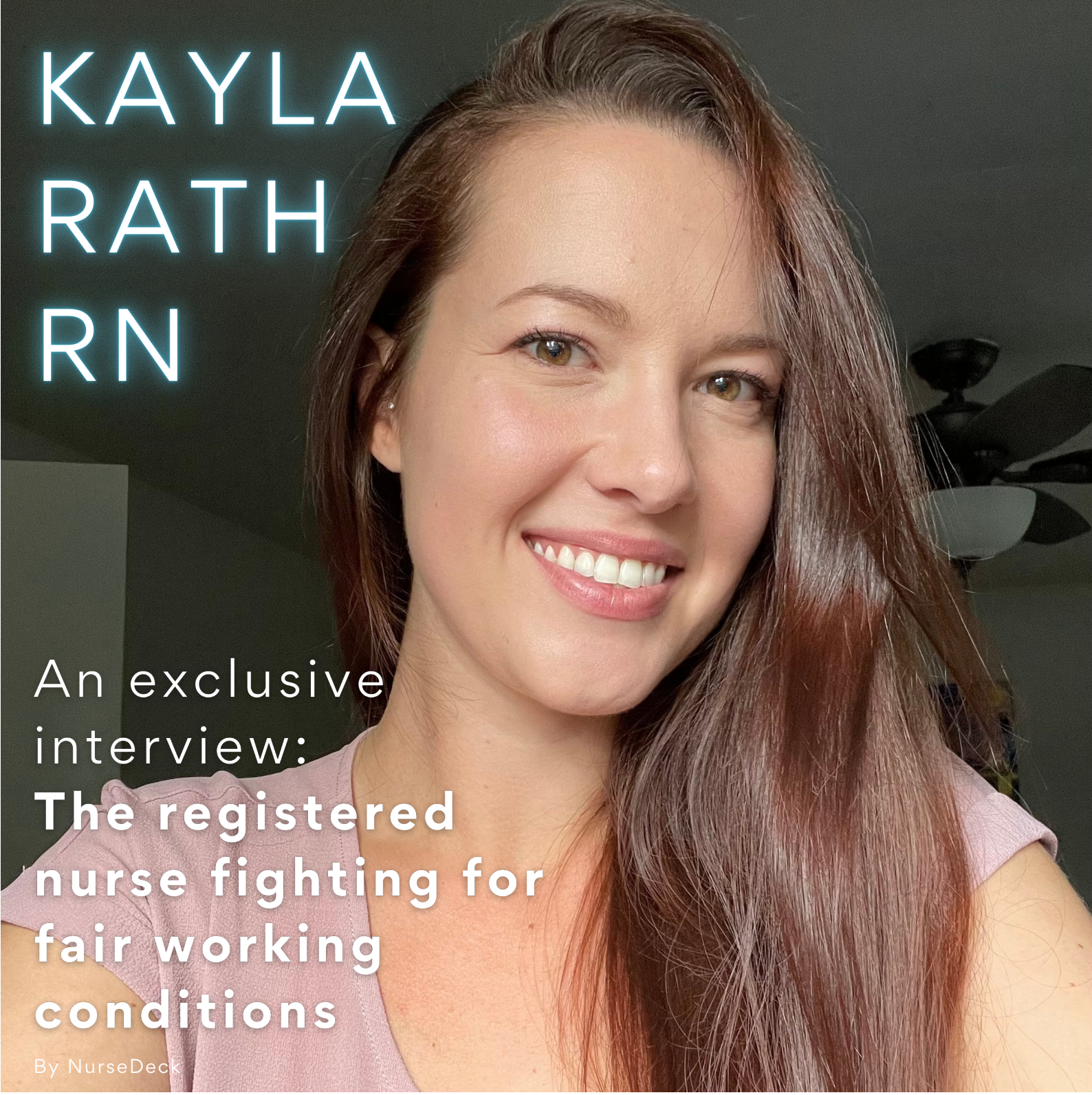
Patient Care Director—a patient-centered role that focuses on their well-being, as well as ensuring that the hospital remains in compliance with regulatory bodies.

Clinical Operations Director—this hospital-based role focuses on compliance and patient safety practices as well as performs staff management duties.

Director of Nursing (DON)—perhaps the most familiar on the list to hospital nurses, the DON is an accessible figure in the hospital who is responsible for all nursing staff and who serves as a liaison between them and administration.

Whatever leadership role you are striving towards, always remember to work with passion and empathy—both for your team and the patients you care for. ▪





KAYLA RATH RN

An exclusive interview: **The registered nurse fighting for fair working conditions**

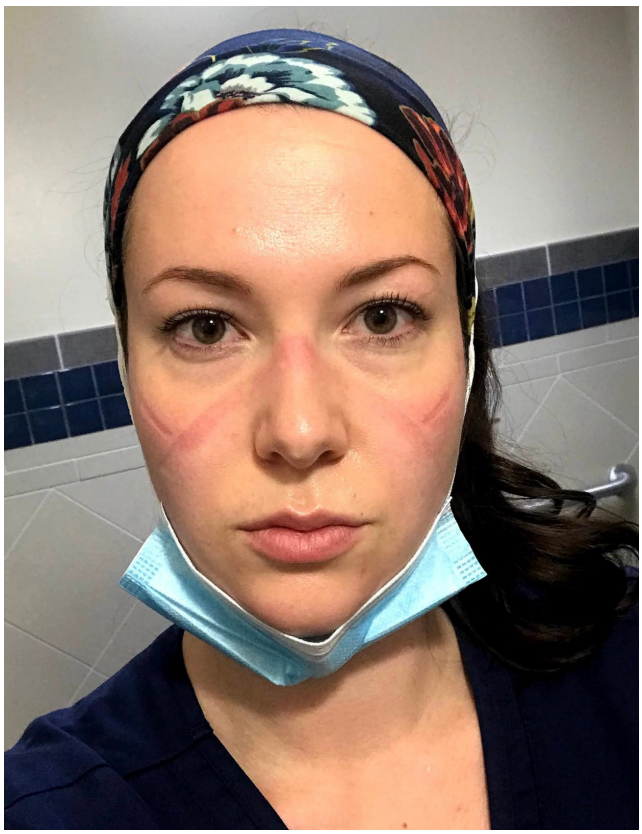
By NurseDeck

Kayla Rath works as a postpartum registered nurse on the maternal newborn unit at Allegheny Health Network in Pittsburgh, Pennsylvania. Kayla earned her first degree in biology on the pre-med track from Pennsylvania's University of the Sciences, but graduated from the University of Rochester's Accelerated Bachelor's Program for Non-Nurses in 2017 after trying out a few different jobs. She is licensed in New York and Pennsylvania, and is BLS and NRP certified. She also became a certified breastfeeding counselor in May. She moved to Pennsylvania just before the pandemic. In Pittsburgh, Kayla got involved with a union contract fight at her network, where she served on the negotiating committee.

NurseDeck (ND): Hi Kayla, thanks for being here today. So, we always start out with: how did you fall into nursing? Tell us about your journey, what made you decide to go into nursing?

Kayla Rath (KR): Wow, do we have a few hours? Well, I feel like I've always had that nurturing aspect to me. When I was younger, I always knew I wanted to be in healthcare, but I didn't necessarily know I wanted to be a nurse. For my first undergrad degree I did pre-med, and then decided not to go that route. I worked a bunch of different jobs for a few years after I graduated. At my last job before I went into nursing school, I worked with a bunch of nurses and they all loved their jobs, and I'm like, "I just want to do that, too. I want to make okay money and be excited about going to work." So that's when I went back to school for an accelerated nursing program. I originally wanted to do geriatrics, so I worked in a nursing home for a little bit. When we moved out to Pittsburgh, the summer before

> *Women make up the majority in the nursing profession. I think we're not as pushy about pay, and that has come to bite us.*



COVID hit, I jumped into postpartum. I actually started a month before COVID so I was just coming off my orientation.

ND: Talk about the ends of the spectrum, and welcome to nursing! So you were baptized by fire, which is par for the course. What kind of COVID precautions did your floor have for the moms and babies during COVID?

KR: Whereas years ago, when most people came to postpartum, they'd be like, "Oh, just put the baby in the nursery all night, we want to get some sleep. " It kind of transitioned to, "Hey, you should really have the baby in the room the whole time with you, especially for safety reasons," because we really didn't know how COVID was really transmitted, or what could happen to newborns if they got COVID. So there was a lot of nervousness around that.

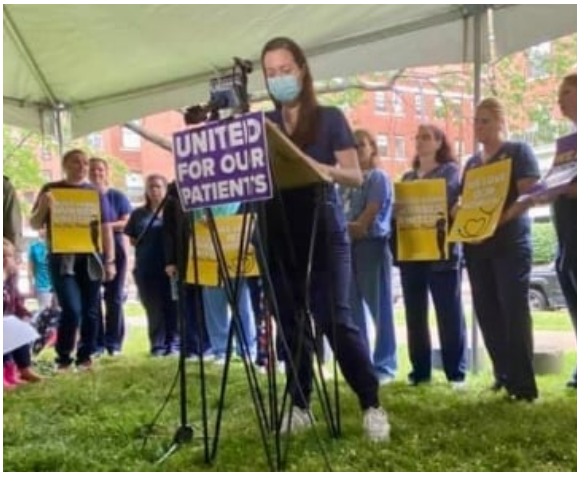
ND: Right! So, tell us about your passion. The other component of what you've been working on for the past couple of years - the big “U.”

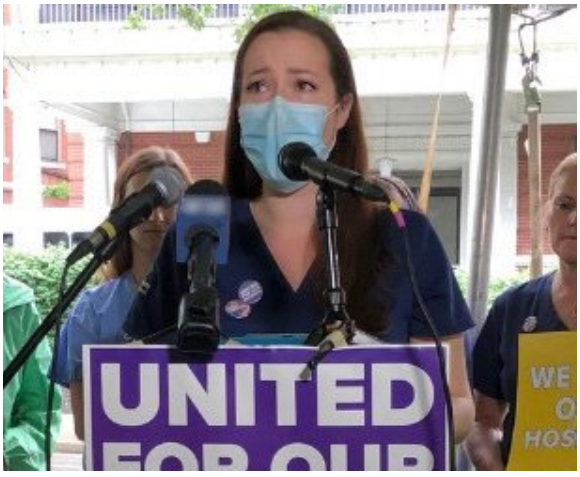
KR: Honestly, it's been a whirlwind. When I got hired right before the pandemic, there were rumblings about a union. People were like, "should we have a vote? Should we not have a vote? Is that something we want at this hospital?” Our network already had a few union hospitals, so that's how things got started. We saw them and what they had, their protections. When I got started there, I had a few seasoned nurses come up to me and say, “Hey, I know you're new, but this is the union. This is what we want to do, is this something you're interested in?" And I said, "yeah, let me go to a meeting and see what they have to say about it before I commit to anything." They really did not have to do any convincing: I was like, “yeah, I'm in, this is definitely something that I want to be a part of.”

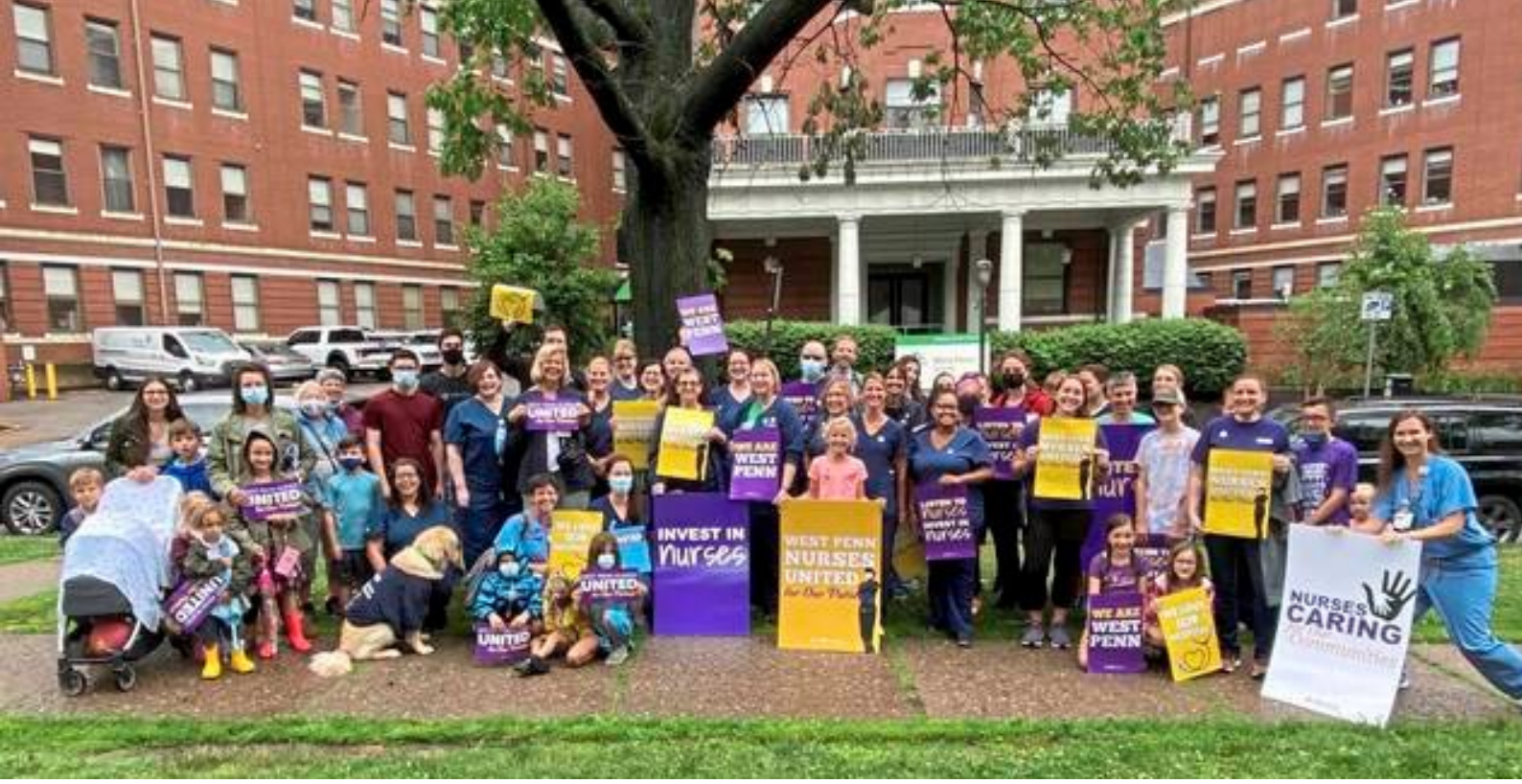
ND: What was the impetus that formed the connection of nurses to unionize? What were they fighting for?

KR: The main thing was staffing - 100% staffing. Then pay and benefits. I think that the pandemic only helped us gain traction - staffing just got worse and we had a lot of nurses that hadn't received raises in over 10 years because they’d been a nurse for over 20 years and hit their cap. With everything we went through during the pandemic, and them calling us heroes, and we were just like, “This is crazy. We need to, we need to fix this.” It was just nurses finally saying, “we want to be treated with respect, we want to have a say at the table.” Whereas before they could change anything at the drop of a hat. If they wanted to change your pay or not give us raises or do X-Y-Z they could do it. They didn't have to ask us first. Now that we have a contract, they have to come to us before they can change anything, which was really the goal of the contract - these kinds of protections. Women make up the majority in the nursing profession. I think we're not as pushy about pay, and that has come to bite us. I have talked to nurses on mine and other floors, and we had an issue where there were new nurses being paid more than seasoned nurses. Because nobody was talking, people weren't talking about what they're making. All of this started to come out because of the union, so we were able to implement a pay scale with everyone making what they should for their years of licensure, which is amazing.

ND: Right. We talk a lot about eating our young, but it can depend on the situation or crisis we were in. What do you think about it?







KR: I think high-stress environments have an impact. We don't have the staffing and during the pandemic, especially, we don't have those outlets. We used to be able to go to the gym or hang out with friends, and then the pandemic hit, and now you can't do anything. You go to work and come home and that's it. I've talked a little bit about my bullying situation at my first job. So, I always made a promise to myself that I wouldn't do that to other people because of what I went through and how horrible it was.

ND: Yeah, definitely. So, you have a contract. Take us through that process.

KR: What's funny is I didn't even know the half of it, or what I was signing up for. I started in February 2020 when they roped me in. I was on the nurse negotiating committee. We had at least one nurse from every unit and our unit had six on the committee. When everyone first started we had about 50 on the committee. Because we had to do everything through Zoom during COVID, we had people in and out on any given time, but 30 nurses at a time usually. We had people sign a petition saying they wanted to vote for a union, and that catapulted our union vote, which we did in August of last year. We actually didn't start negotiations until January of this year. The hospital kept pushing things back saying, "with COVID, we just can't start this process with you." But we finally started things in January. We would have meetings with the nurse negotiating committee and our union reps over Zoom, usually one day a week, nine to five. This was all volunteer, unpaid. We came up with proposals, things we wanted in our contract. We made sure we talked with every single unit before putting anything into the contract or into our proposal, because we wanted to make sure that every nurse had a say in what was going to happen to their unit. So, that took a long time. Intermixed in that we had full day meetings on Zoom with the hospital administration, which usually consisted of us giving them a proposal, and then us waiting all day to hear back. That was probably the most frustrating part about

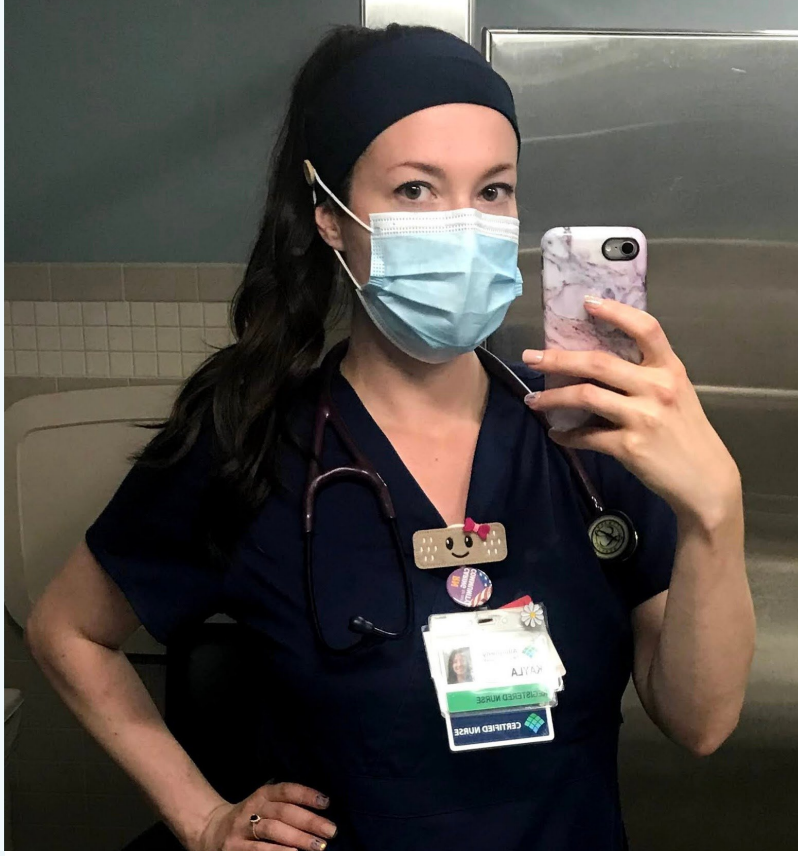
everything, just waiting, and sometimes they held onto things for months.

ND: So help me understand some of the key issues, like pay for a hospital nurse. Is it regional? Did you have the "bouncing from hospital to hospital phenomenon" to go for better pay?

KR: Before the pandemic, definitely, but once the pandemic hit, they wanted to go be travel nurses. They weren't full-time employees at any hospital. They just were a travel nurse and they'd take a 13 week contract or whatever, and be making double or triple what they were making at a hospital. Why? If you have to have COVID patients, you're not going to take $30 an hour over 150.

ND: So tell me about your day - you got your daytime job, your family, and now you're pulling this union together. What was that like?

KR: When the pandemic hit, for a lot of people that meant working from home and everything changed for them. For nurses and essential workers, we had this pandemic going on but we also went to work and had



to act like it wasn't a big deal. There's definitely a disconnect. We have a Facebook group for my unit, and during the height of the pandemic, every single shift someone would post, "hey, we need nurses, anyone want to pick up?" This was every single shift. So, just the stress of seeing that right before you're about to walk into your shift and knowing it's going to be a nightmare. Walking into the unit to find another seasoned nurse has left or put their two weeks in. It's sad because we've lost so many amazing nurses from burnout and stress, and we felt the hospital wasn't doing anything to retain us. That's a big, big reason we were pushing for the union - it was so easy for them to hand out $10,000 for new nurses to sign on, but what were they doing to retain who they have?

> *We've lost so many amazing nurses from burnout and stress, and we felt the hospital wasn't doing anything to retain us.*

ND: So let me ask you, as you're walking into the unit, where were the supervisors and leaders and administrative people? Were they on the floor helping you?

KR: I think you already know the answer to that. Like the

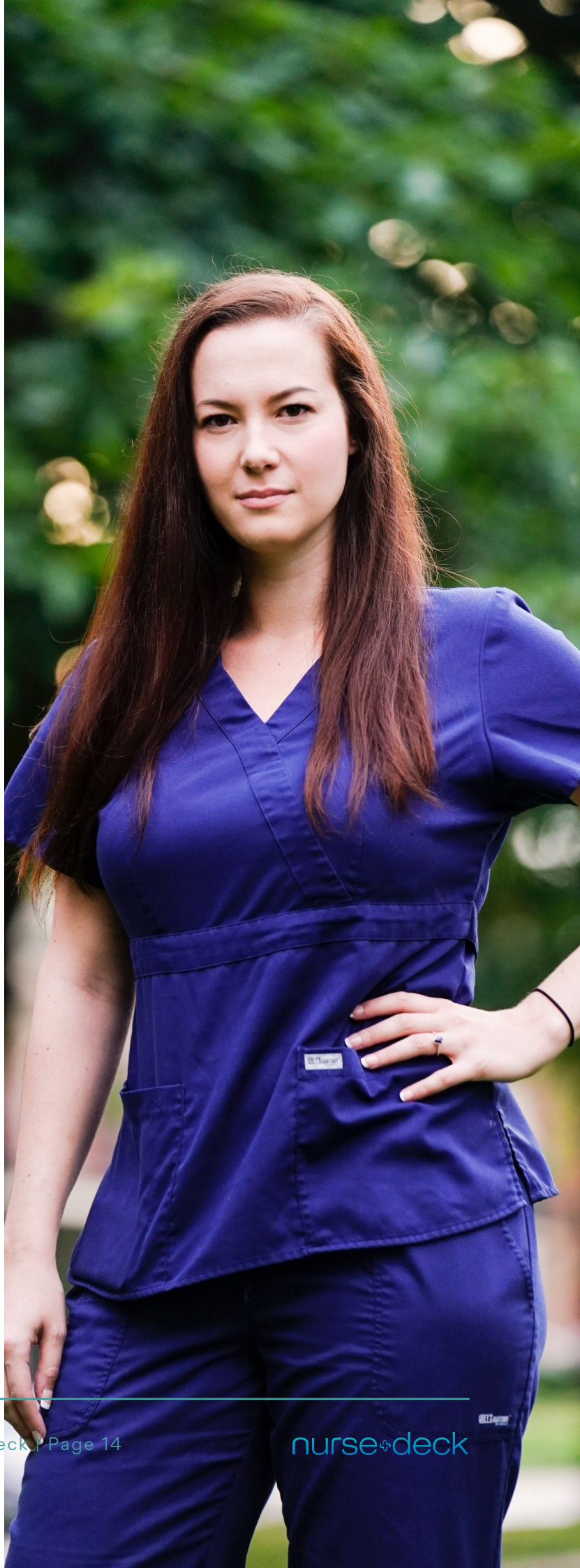
administration, I have never seen them on the floor. I think I saw them once during negotiations, because we had actually authorized a strike notice. So that was when they started showing up on the unit. Before that if we'd been so short staffed that we'd had to pull our manager or supervisor as a charge nurse. Not because they want to, but because we have no other choice.

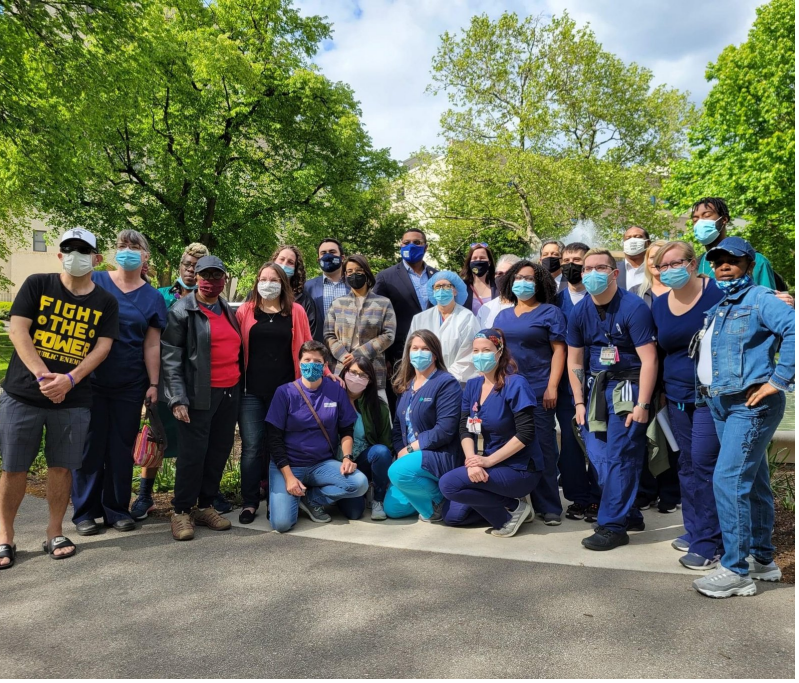
ND: So what happens if we all walk away? What happens to the quality of care?

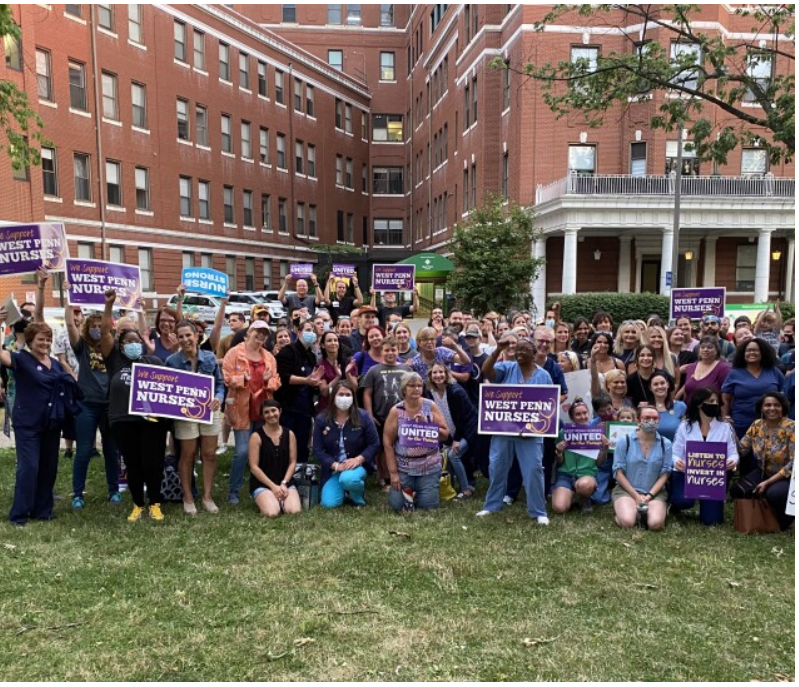
KR: I'm scared. I really hope it doesn't get to that point. But it looks like there's going to be another round and maybe more of COVID. It's not looking good, and there are a lot of people that could barely handle the first time. We have lost so many seasoned nurses - nurses that have been on my floor for at least two years or longer - and we're not replacing them with seasoned people, we're not replacing them with people who already know the job. That's fine - I didn't start on my unit knowing the job. I'm all about giving new nurses a chance, but when all of your new staff is just graduating from nursing school, and I'm looking around, and I've been there a year and a half, and I'm one of the most senior people on the floor, that is a very terrifying feeling.

ND: I cannot even imagine what it does to your stress level when you're the most seasoned nurse there. I am mind blown that you guys are even doing this.

KR: When I first started, we had so many more seasoned nurses. I looked up to them, I asked them for help if I was unsure. I've only been there a year and a half, but I've seen enough and like, I wouldn't say I'm the most experienced, but I feel like in most situations now I'm a lot calmer. When







it happens for the first time or even the second time, though, you're in such shock.

ND: So how do we get the public to better understand us and tell the public our story?

KR: I think that's the million dollar question. The thing that bothered me the most about this pandemic was all of the, "nurses are heroes" that turned us into martyrs. And the “oh, well you signed up for this and you're just going to do it and whatever happens happens.” We don't have a nursing shortage, we have nurses who do not want to be treated the way that they're being treated so they are leaving, it's not a shortage.

ND: That's what they told us back in 1970. We didn't have a nursing shortage then, and we don't have one now.

KR: Right? That's the hospital's way of being able to say, "well, we're not really going to do anything to fix this." Because if they actually did all the things we originally proposed in our contract proposals, even even half the things, things would change so drastically. We would hand them something and they would turn around and just say, “no,” straight up. That was how they negotiated.

ND: So let me ask, are we in need of nurses? Physicians?

KR: I think we need to treat them well, and then we'll have them.

ND: I’ve seen a robotic nurse, and then you have artificial intelligence. We can use AI appropriately but I don’t think it will ever take over.

KR: Even if they were to develop something, there's no way you could encompass everything a nurse does. I mean, we have so many hats. You would never be able to create an AI that does everything we do, and that's why I think it's so important nurses actually have a voice. You should say something, you should stand up for yourself, because what are they going to do without you? They treat you like you're expendable, but you're not, and you have that - that's your leverage.

ND: So, how do we move forward?

KR: We live in a country where our healthcare is monetized. So, you have doctors going to their patients

saying, “let's do the surgery,” when maybe they don't really need it. Or, maybe, they could have done therapy or something else and done the surgery. But it really is about the money, unfortunately, and that's so unethical. I don't think people realize - I don't even think I knew how crazy it was until I was knee deep in it and I saw some very unethical things going on. No one seems to notice.

ND: Oh, we notice.

KR: The people in it notice. I think people who aren't in health care don't really see that side of it.

ND: It's kind of interesting to me: the people who care for other humans are the most driven, passionate people, and just so abused by the system. If we don't take it, what happens to the person we're caring for?

KR: Right? Well, we do it because of our patients, but it doesn't make it right. It doesn't mean the hospitals or whoever we work for are off the hook just because we are compassionate people. I think we've got to get to a point where everyone says, “I deserve more than skipping my lunch or going an entire 12 hour shift without taking a pee break.” That is crazy, this is 2021.

ND: Those are the scars that we wear with pride, that we don't take care of ourselves. We are the last people to take care of ourselves, so maybe we have to start protecting each other.

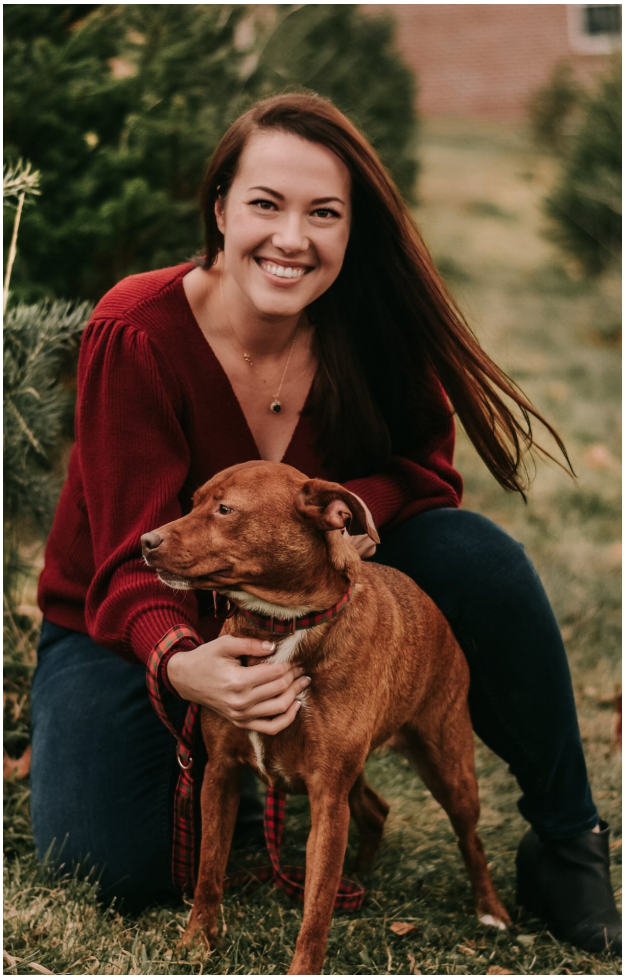
KR: Until we start saying that we're tired of what we've been going through and we're not going to take the abuse anymore, it's not going to change. Nothing's going to change, it's going to stay the same.

ND: I think we need to not only do that, we also have to build our own future. I love working with young people. What I have found is I'm surrounding myself with the younger generation and it just pumps me up.

KR: Well, that's the cool thing about nursing is that we're like one of the few professions where we have four generations working all at the same time with each other on the same level. I'm working with people who are much younger than me and I'm learning things about them, and I'm working with older people and I'm learning things about them. We're all teaching each other different things, and it's a very cool environment to be a part of.

ND: I love nursing. Thank you so much for being here and telling your story.

KR: Absolutely, thank you so much.■



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