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Ladies and gentlemen welcome to the Lieutenant Colonel Juanita Warman, Nursing Excellence Conference. The conference will begin in 10 minutes. Feel free to stop by the vendor tables before the conference begins. Located around the room, there's coffee located just outside this room as well. Please also take a moment to silence all cell phone and ensure your microphone is off for our virtual audience. Thank you.

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Good morning. Welcome to Madigan Army Medical Center's, 14th annual Lieutenant Colonel Juanita Warman, Nursing Excellence Conference. My name is Lieutenant Brenden Apolinario. I will be your host for today's program. I'd like to begin today with some administrative announcements. Our program today will last until approximately 1645. A number of breaks will be incorporated throughout the day so that you can network share ideas or use the restrooms. You will find restrooms conveniently located in the lobby of this building where the water fountain between them. Lunch will be provided between 12:50 and to 1320. The buffet will be set up at the back of the room. Please feel free to continue eating during the presentations. Conference Center staff will come around to pick up your plates. During breaks, please visit the vendor booths located around the room. As you entered, you should have picked up a program and an evaluation of today's presentations. Note that the presenters and committee members have no conflicts of interest or bias. In order to receive credit for today's conference, Please ensure you have signed the sign in roster attended all sessions. Registered for the course online, completed the post test and evaluation. You can find the instructions for the courser distraction on the table tents and the PowerPoint slides during the breaks. In your program you will find a small space to take notes on each presentation. Please take a moment to identify the exits in the event that we have to evacuate the building, please meet in the parking lot to the left of the building as you entered. Lastly, raffle tickets were electronically assigned to each registered participant free of charge for a chance to win gift cards and conference gear. We will also be giving away 40 Battlefield and disaster nursing pocket guides courtesy of the Tri Service Nursing Research Program. Designed to fit in the pocket of a uniform and endure rigorous field conditions. This unique pocket guide provides state-of-the-art evidence based recommendations for providing nursing care under exceptional conditions. Today marks the 14th annual Lieutenant Colonel Juanita Warman Nursing Excellence conference. The conference was posthumously named after Lieutenant Colonel Juanita Warman, who worked here. Madigan as the hospital bed manager before she and twelve others were tragically killed on November 5th, 2009, at Fort Hood, TX. You can find the full biography for Lieutenant Colonel Warman in your program. Today we have set up a full day of exciting presentations by many dynamic speakers. At this time it gives me great pleasure to introduce our opening speaker, Colonel Ann Sims-Columbia is our chief nursing Officer and Deputy Director of Nursing at Madigan. She holds a dual MHA and MBA from Baylor University. She is a fellow in the American College of Healthcare Executives and is a board certified nurse executive. Please help me. Welcome Colonel Ann Sims-Columbia.

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That good, sweet, good morning everybody. For those and thank you for the. Nice introduction. Hi, I have a new friend. Sorry guys, I have to put this on my computer this morning my printer was not playing fair with me, and so it's gonna be on the computer, which is not my norm. So. I am happy to see you all this morning. Bright, shiny faces. For those of you who are still in

masks. I'm sorry I don't get to see your smiles, but I appreciate the flexibility that we have now. But it's very nice to be able to see up here and smile. And I'd like to open this morning with a quote from Florence Nightingale. And she said let us never consider ourselves finished. Nurses, we must be learning all of our lives. And that is really what this conference is about. Kind of continuous learning. We're hearing from some amazing folks today. So good morning to everybody, distinguished guests and colleagues out in virtual land as well. So my honor today to open the 2023 Lieutenant Colonel Warman Nursing Excellence Conference first, I really want to take a moment to recognize the team responsible for making this happen. Miss Jessica Vailencour, Lieutenant Nate Anderson. Lieutenant Brenden Apolinario, our wonderful speaker, and Lieutenant Gillian Lee in the back who helped recognize these guys have put on an incredible program for us. So let's give them a round of applause. Formerly known as simply the Nursing Excellence Conference, this event began as a Unit Practice Council developed by some of the leaders in our room here, Colonel Currie, wherever you are, dear. There she is. Back in 2009 and then in 2010 was renamed in honor of Lieutenant Colonel Juanita Warman, Lieutenant Colonel, Warman as a reserve Army Nurse Corps officer. Psychiatric nurse practitioner, who was serving at Madigan Army Medical Center when she volunteered to deploy to Iraq in 2009. She was processing at the SRP site in Fort Hood, TX that November when the unthinkable happened. A service member entered the building and opened fire on all of the soldiers inside, the Lieutenant Colonel Warman was killed on that November Day when she threw herself on top of another soldier in an attempt to shield him from the gunfire. That soldier did survive. Unfortunately, Colonel Warman did not. She exemplified excellence on that day through her selfless service and personal courage. The American Nurses Credentialing Center has a magnet recognition program, and that program suggests that these four components demonstrate nursing excellence, empirical outcomes, new knowledge innovations and improvements, and exemplary professional practice. Those are the pillars of what we wish to achieve today. We're hoping that over the course of this day, you'll be able to gain some new insight into the art of nursing and a pursuit of nursing excellence. The team has done a remarkable job in coordinating presentations from some of the brightest and most educated minds in Army nursing. We are very fortunate to have them here and online and to be learning from these geniuses today, I'm in awe, to be honest. My hope is that you leave this conference feeling energized and inspired with a new level of appreciation for the profession that we're in. And I'll end my little opening with another quote from our beloved Florence, which I think speaks to the why of this conference. Nursing is an art and if it's to be, made an art. It requires exclusive devotion as hard a preparation as any painter or sculptor's work. We are sculptors, we are painters. We are artists, and we are nurses. Stay prepared, stay passionate, enjoy the conference. Have a wonderful day, everybody.

Totally messed up your stuff.

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Thank you, Colonel Sims-Columbia. Each of our speakers is getting a small token of appreciation. And if you don't mind coming back? Yeah. Inside is a Yeti Tumblr and a gift card to a Starbucks to get the first cup of coffee. Thank you. Thank you, ma'am.

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Really quick, I just wanted to say this field guy that y'all are handing out, if you've seen me in the field, I will put that thing to the test.

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It is now my privilege to introduce our first speaker. Miss Caryn Green specializes in vascular access and infusion therapy. She is a transformational nurse leader who inspires and provides nurses at Madigan with opportunities for growth. Caryn served in the Army as a medic prior to becoming a nurse and began her career Madigan in 2005. She is a part of the interventional Radiology team and has been graciously loaned to the Outpatient Infusion Center to work with that team during their transition from an inpatient to an outpatient service. She is a certified infusion nurse and vascular access board certified. Please help me welcome, Miss Caryn Green.

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Good morning. Can you hear me am I on? OK, do I need to stand here the whole time? Yeah, alright. Great. Good morning. I am super excited to be here and talk to you this morning about missed and rationed nursing care. I think it's great to be outside of the hospital with everybody. And I'm sorry. I just wanna double check just here at the hospital or this. I can't walk here. OK, alright. I just wonder where my box is. I'm a mover. So I just want to say this isn't probably the lightest subject to start out with for the day, but I'm hoping that by the end of the conversation that will feel better about it. Hold on. There we go. OK, so let's start out with the disclosures. I don't have any relevant financial or non-financial relationships to disclose related to any content of this activity and these views expressed in my presentation are those of mine and don't necessarily reflect the official policy or position of the Department of Defense, nor are the US government. Umm, so today we'll talk about what is missed, nursing care and practice a little bit about rationed nursing care and what's the difference and recognizing that within our practice summarize the impact that that has on patient safety and job satisfaction for us. And we'll also talk about some strategies for improvement in what we can do about it. So Doctor Beatrice Kalisch and Doctor Maria Schubert were the first folks that were starting out in defining what it is. They did some research, gathered all the data together and missed nursing care is defined as any aspect of standard required nursing care that is delayed, partially completed or not completed at all and then rationed care kind of sounds the same, but not quite, because that's more intentional. So we're thinking about it and deciding that we can't do that. It doesn't fit in with our system so. OK, so here's some accepted standards of care. Obviously vascular access focused. That's my jam. And so that's where, that's where I've leaned towards. So we know that we want to do a CHG bath every day for somebody who has a central line. We know that helps decrease central line infections. We assess any vascular access device at least every four hours. And if they're confused or can't report concerns to us than that's every one to two hours. If we have an IV that doesn't have an indication that needs to come out, right? So. All of these are vascular access focused and there's other things too, so. Can anybody think of nonvascular access things like we ambulate three times a day. That's a national standard, right? We do mouth care daily. We make sure that a patient receives their food while it's still warm, or if they called to go to the restroom that were there in 5 minutes, right? Or what are some other ones? I'm sorry. Pain management, yes. So there are lots of standards that we know, but I think we can also maybe get into maybe not quite yet, but as we get into the talk, maybe get into a more vulnerable space with each other and be able to talk about, yes, that's happening and that's happening because of me and the care that I'm giving and the whether it's systems issues or competency that I need to build that those things are happening in my practice in my area and that it's not acceptable, right. There's an article that Doctor Helm wrote several years ago related to vascular access. Specifically, it's called Accepted, But Unacceptable, and I think that fits nice with this. It's happening a lot. Masks are optional now. Today's the last day for the COVID tent where we're getting back to normal,

right? But while we were staying loose in the knees and figuring out how to roll during COVID, some systems that might have been broken or we had to flex on those and it's time that. Now that we are loosening up or, you know, masks optional and getting back to what is normal that we need to evaluate our systems that we need to get back to or whether we need those same systems but not continue to function in a broken way with systems that aren't happening. And even evaluate some of our evaluation and auditing systems that we had weren't happening, I think. Our hand washing audits, right? Like, I think that wasn't happening for a while. It wasn't at the top of the list, and it didn't really get done consistently in all areas for some of the time or training we had to flex on some of that. Our nursing orientation was taken from a couple of days to one day. And so we need to evaluate was that a great, is that giving us what we need or do we need to reevaluate that now that we're? Coming out of where we've been. So why did I choose missed nursing care and rationed nursing care to talk about? Umm, I'm pretty sure that when I was asked to speak today that it was because somebody wanted to hear about vascular access. And I'm also pretty sure that you also didn't want me to soapbox again on high quality flushing. Or did you tape your lineup, or did you document how much PICC was outside of the insertion site? The things I'm likely to stop and talk to anybody and nerd out about in the hallway, right? So when I was trying to think about what to talk about, I remembered last year I was on 6 North and I was talking to an experienced nurse who she had called me. I was down in IR and asked me to help with an IV because she told me the patient has been poked and poked and poked and. There were just a really difficult start and it was early in the morning, so sometimes what happens is I'll get that. But the nurse may have gotten information from report, but they really haven't had time to fully assess the situation. So I I dipped into the chart real quick to see what exactly had been going on. How long had the patient been here, where had their IVs been that had failed? Was the patient confused? What were they going to be getting? Or I mean, were they leaving that afternoon or could I advocate for them in some other way? And there was nothing strange. It was really just the patient had had an IV for a few days, and it went bad overnight. An IV was placed overnight, and that was all that was charted on it. So I went up thinking, well, it's probably just the hustle of the morning. Let me help them out. And not expecting anything really that interesting, but it was. And I didn't have the right equipment. And actually the patient needed to go to IR for something more significant of a line that would be appropriate for them. And so after we got outside of the room, I touched base with the nurse and I was like, wow, I had no idea, you know, that this was the situation. The documentation does not reflect this at all. And she says, well, I took care of the patient yesterday. And so she had had the patient before. And so I was like, really, because I'm just really surprised. And I think I'm really kind and put things out there really great. But. I hit a tender spot because I was like, you know, if the right documentation had been in there when we have to assess every four hours, that means we have to document it too. So we can see progression of what's happening. If a patient's losing a line every couple of hours or. Umm, they had five attempts at one IV. That tells a much different story than what I saw on the record. She gave me kind of the crazy lady laugh. Like, are you kidding me? Like, that is not able to happen right now. I'm barely able to give medications. I have this other patient that needs to be changed. Nobody's eaten. I don't know if vital signs are getting. She's literally told me you were disconnected from reality, lady. Like I did not. And of course, I was a little bit defensive because I was like, I worked on 6 North for 10 years and I know. And so I had to step back for a second. And then as I'm walking off the floor, I realized. I am disconnected a little bit. I'm not in a primary care setting and really evaluate like. Well, bottom line, it touched my heart. She just felt so deflated and she felt like it was hopeless and that there wasn't an answer and that really that that was acceptable there. There was no red flag like my. I'm not doing everything I need to do. It was. That's how it is now. You know, so that's why I wanted to talk about this. And I actually started looking at information related to missed vascular access tasks. Right. And when I started looking it up more, I found out that vascular

access is actually one of the least often missed tasks. Vascular access medications, blood sugars, things that get charted or things that have to happen to do a treatment or they're short in nature. Those things tend to get done more often. So of course I found a swing to tie it back to vascular access. You'll find out. Thanks for chiming in on those things. OK, so why is this even important so? For patients, when we have missed nursing care, there is increased falls, impaired skin integrity, infections, medication errors and the 30 day readmission, especially heart failure and acute myocardial infarction. All of those things go up. And then of course the satisfaction goes down. And then for nurses, we have increased burnout anxiety, fatigue, moral distress. None of that's good stuff. And we get bummed out with our job. We're a lot of people quite quitting in the nursing field, right. So even if you're coming in, you're thinking, what am I gonna do next? Colonel Taylor-Clark. Doctor Taylor-Clark. She did a presentation that was really impactful last year to me and to talk about work they've been doing on identifying potentially preventable reasons why nurses are intending to leave a job. And what really hit home for me is some of the points in there were our work environment and dissatisfaction with management, right. So there's work being done on that. There's system work. We'll talk more about that. On strategies later on, but it's a big deal. This missed nursing care contributing to decreased job satisfaction is not helping us at all with the nursing shortage right at Madigan. If we're trying to pull people in. We need to get on it. We need to get on a new battery, Miss Jess. OK, so let's do a question show of hands. How often when people are surveyed and they're asked on the last. Thank you. On the last shift that they had, did you were you able to complete all of the required care that you were supposed to complete, or did you not? So this question, I'm saying it backwards. How often did nurses report missing some required component of care? So show of hands if you think it was less than 45% of the time. Yeah, I got ahead and made a statement. OK, you guys are smart. So what about if it is more than 45% of the time? Yeah, you're right. So can you Click to next slide? Perfect. So yes, you're right. So. If you take the studies over the last five to 10 years and you pull them all together between 45 and 98% of the time, it's around the 80th percentile or 80% that most often is quoted as nurses reporting that they've missed some required component or delayed component of care. Next slide. Ohm. Thank you. OK, so we're getting a little more vulnerable here, right? So hallway conversations informal. Let me talk to my nurse buddies. I'm, like, on for real. Is this even a thing? Like, I'm gonna talk about this. Is this anybody even gonna think this is important except for me and my, you know, squirrel moment on this feeling bad situation and everybody felt like I got so much passion back in the responses that. Hey, can you look at my presentation and what do you think? Am I hitting home and they're like, oh, yeah, this point and ohh I was really impressed. But things that I heard are. When I asked about mouth care, so some of it I just solicited. Like, do you miss any nursing care? Do you see? It took a little bit of conversation because people feel a little bit funny and honest. Obviously, these are people that felt comfortable talking to me. It wasn't an anonymous sheet of paper. But when I asked how, if they did mouth care, because I don't remember when I was on the floor that that was always a really high thing on my To Do List. If I was busy, I felt like if I could get to it, that's that was a good thing to do. And I'm pretty sure. That the patient would benefit from that. And they said, I don't even have a place to check that off on my list that it needs to get done. It's not high if somebody's got something going on or wrong, then we'll do that. But it wasn't on even the high priority list to get done for the day or a lot of a couple of people didn't know that it was requirement to chart the amount of line outside of the insertion line for a PICC. That's how we verify that it's still in the correct position if everything else is working good. Somebody told me that if their patient sleeping, they're not gonna wake him up to check their IV, so they just chart that. It's OK. I mean, that was a real moment and a moment of honesty. And I appreciate that that was happening, but I think we're doing that a lot. We don't have a system set up to allow people to be like, it's either do it every four hours. And or you don't do it, but there's no. Like, this doesn't make sense to do it. And I'm permission, right? There's no Plan B. Well, it my

patient is sleeping. Sleep hygiene is also really important, right. So we just need to make sure we have those systems set up. So there's a lot alright. So I put some I got a little vulnerable for you. Does anybody feel comfortable sharing anything else, like or is it too early still sit? I planted somebody in the audience to help me out here. Oh, Angela, what do you have? I'm currently I'm detailed that OIS and we infused weight-based medications and we didn't have a scale so we couldn't verify weight to verify that we're giving the correct dose and through being crafty, we tactfully acquired a scale and we are now weighing patients and have had made doses adjustments based on those. So we're providing better care either we were under-dosing or overdosing. Yeah, so sometimes we miss care because of lack of resources or lack of knowledge or the importance of it. Thanks, Angela. Does anybody else have? Yes. Colonel Swiger. Umm. Mm-hmm. There. With the system and the band and the medicine at the same time, but like geography would not allow me to do that. Hmm, without printing the MARs, which was not allowed. Alright, so I always said that I did 2 patient identifiers at the bedside with the computer and the wristband. But I missed that every time. Yeah, thank you. Anybody else? Yeah. Yeah. Right. Patient denied you have the patient, so there is the speaker of being able to check other patients because patients. Right. So that's one of the things that could affect. You're right. Like just too much for the time that you've got. Yeah. And I would be curious, we'll talk about it later, like communication and teamwork, right. And assignment distribution and I think that that will fall into that area too. Check the bag. Right. You're going to the office, right? Right. Right, exactly. Yeah. Is it even possible? Right, like, realistic? Is that what you're saying? Yeah. Yes. Hmm. Right. And is that accepted practice right? Yeah. But do we audit that? OK. Yeah. Thanks. OK, thanks. I appreciate that you guys are contributing. That's awesome. Oh, it's not the battery, it's me. Yeah, she's. Did you put them in backwards? They were backwards that was the problem. Ohh. Alright, next slide please. So all that time I thought I was finally clicking forward. You were doing it. The next slide, so good. Oh my gosh. Right now, while we're waiting on this, I did not say hi to all our folks virtually or back at the hospital. And I wanna say thank you for being there. And I know getting parts of today, but being there at the hospital and holding the fort down so that we can be here together. OK so I started to mention this earlier so. Types of missed, delayed, or omitted nursing care. Umm, when there were the survey tools have main categories. The main survey tool that was started by Doctor Kalisch was the missed care tool and then Doctor Schubert. There's another team that used the RN forecast tool. And there's other ones, but in general. For what my presentation is using the missed care survey tool and the main categories that they looked at, they found that the most frequently missed care was ambulation that nursing assistants and nurses reported was ambulation and. Mouth care. And the least missed care had to do with vital signs, blood glucose monitoring, intravenous therapy and administrating administering medications. So I've put up here and you can see that we tend to delay or lower prioritize tasks that have to do with emotion or psychological needs and. Rate Physiological needs higher on the To Do List part of that is because the things on the right are quicker to do right. So if a task has an ambiguous time frame that we can't really put our fingers on if we know that it might take us 1/2 an hour, it might take us 10 minutes to ambulate somebody we might need to get somebody else. We are not gonna tackle that first because we'll need. We could check out five or six of these quick things that if we don't do them. You would see an immediate problem with right? Or if we don't do a blood glucose or give a medicine. Any of these things, then the outcome would be a more immediate that we would potentially have a problem with, whereas on the other side on the left-hand side, if these things go, don't get done more often, those things happen in days or after the patient goes home and we don't see those outcomes. So. Ohh, you're amazing. Thank you. You could just let me think I was doing alright so. Doctor Kalisch and her team came up with this model. It's a the conceptual framework that is linear and it goes by the structure, the process and then the outcomes. So the structure, like things that feed into the process, the process being missed nursing care and then what are the outcomes or the

consequences of that. So this is a general generic model for missed nursing care and then lots of organizations. They have like an infection control model for a missed care. They have a L&D nurses focused and ED focus to PACU focus. Lots of folks have gone out and took an taken the survey tool to fit their area or their organization and then. Plugged in what they thought was important to paint a picture of in this model. So in general most of them have the hospital characteristics. There's been a lot of talk about magnet versus not magnet and whether you're teaching hospital. If you're smaller or if you're bigger. UM. But it's environment, right? Like hospital environment that's in that section and then unit characteristics, your teamwork, your communication, the nurse skill level, those kind of things go into that unit characteristics spot and then the caregiver and then the two main points are always on this model staff outcomes and patient outcomes. So like patient safety stuff will be on patient outcomes satisfaction. And then on staff outcome, it's frequently. Related to burnout and satisfaction or dissatisfaction. And they don't know actually which way this goes. There's a lot of work that has to be done, a lot of it's association or we think, but we don't know whether the actually it's the burnout that's causing well, this is the wrong slide. We don't know if it's the burnout that's causing missed nursing care or the missed nursing care that's causing burnout, right? Yeah, yeah. But it's there's no evidence to prove one way or another. We feel that it's. Tied together, but we don't know which way. And you know, I think you're probably right there. Colonel Swiger. OK, so these are the things that feed into miss nursing care. We know staffing feeds into missed nursing care. If we had an abundance of staff, but it is not the only thing. It it's not the only thing materials we talked about. Umm, we didn't have the scale for doing the weight or. A demand for patient care. So if you have fluctuations, if you're at a unit where you like post surgical and you receive influx of patients at a certain time of day or the ED, do you have the right staff at the right times of day and then relationships and communication have to do with teamwork? Are we talking to each other? Are we handling, do we do? Do we huddle in the middle of the day together, do we? Do we let our nursing assistants do we get them invested in what's happening with the patient or do we just expect the tasks to be done? There's lots that feed into these different areas. So this is a one liner with lots of words that go with this slide, but for each 10% increase in reported missed care, it's associated with a 16% greater risk of death. So that's like a striking statement. But really we know if we're not ambulating our patient that there's an increased risk for DVT, they'll decompensate they may not leave as soon from the hospital because they're not walking as well. That risk for pneumonia. There. Ambulation there's risk with not giving proper nutrition or giving food when it's warm, there's risk for. Hygiene, missed hygiene care is really big in the in the news right now, especially for vascular access, because mouth care and bathing the CHG bathing have are well researched and evidence based that those things decrease central line bloodstream infections and you might think that's only central lines. But last year there was some changes made to where reporting requirements for bacteremia used to just be for central lines. And now there are changes being made to where it will be all bacteremia and that if you don't have a known cause, right. So if the person doesn't have a UTI and then they got bacteremia or pneumonia and they got bacteremia or central line and they got bacteremia, well guess what, the culprit's gonna be that everybody has in the hospital any guesses. The Peripheral IV, right. So that's really great news for the vascular access community because we'll get more focus on on our peripheral IVs. There's some problems probably with that and financially and I think that will be really cumbersome. So systems will have to be figured out, but. But missed hygiene care is going to be more of a focus and more reportable. And I think we will probably likely have that more auditable, too. When I was looking at the chart audits for on the floor, that wasn't something that was on the chart audit form. And here's another vulnerable= moment. So I'm detailed to OIS right now. And for years we've had this wonderful team called the Madigan IV Surveillance Team. Very proud of it. If any of you are out there in the virtual world from the teams past. We would do that monthly and one of the things we would audit where were the

CHG baths getting done, where they getting documented. Last, I think it's been at least three or four months since we've done it. We decided right now while we're low staffed in IR while I'm detailed OIS that we need to move that to quarterly. I don't know that there's any other thing. I don't know that that's something that. It's being looked at by anybody else, right? So that's another system that we have to evaluate. Is that being accomplished some other way? Does that need to be looked at? But yeah, that's not getting done. Alright, let's do a case study. It's a tough subject. You've, I feel really emotional about it. Have you guys heard a term called raison d'etre? Have you heard that? I'm sure I'm slaughtering it for saying it's a French word and I tried to do like some YouTube videos on how to do a French are, but do you know how to say it? Yes, that's it. Thank you. So it means reason to be or. Umm reason for being and it was an article I read about that. If you're a professional nurse, if you have, if you know these things will help your patient have better outcomes but you aren't able to do these things, then you can't feel good about what you're doing. If you're passionate, if you have raison d'etre. Then it will then that won't sit right with you, right? And then you won't feel good and. And you will probably likely not continue to do something that you don't feel good about, and so you will find something else that you can feel successful at. It's not. It's not good business for our hospital to have people not feeling good at when they leave the door, right? So let's do a case study. We'll take an experienced nurse on a medical surgical ward, Dayshift 3 patients and they have a heads up from the ED. This doesn't look like a terribly crazy assignment coming in the door, but any of us who've worked the floor for a minute can see lots of potential for crazy in this mix right here. And you happen to come up for a random UA today and you got to get that done by 11, right? So even if we just think about the morning. Umm, I'm already reading into this a little bit. Anybody pick up on any concerns here? Alright. It's only three patients, right? Umm, yeah, so there's a lot to fit into this morning. I'm pretty sure the CNA sitting in a one to one and the charge nurse is probably gonna go to your multi DC rounds. The this is a already has potential next slide. So even if we just look at like focus on the things that I focus on, right, like, OK, you gotta get the CHG bath done sometime in your shift or maybe that's something you're gonna punt to night shift. That's always a question. What am I going to pass on to night shift? You got several patients with antibiotics. You have to get your. I'm seeing IV assessments and documentation. You have to get all your assessments and documentations done. And is it still that you have to do it in the first four hours of the shift? Do you still have to do that? So you have to do all of the care and all of the documentation in the first four hours of the shift, right? And you have to do your UA and you have that new admit coming. And the DC planning meeting and you have that patient leaving at noon, right? So it's just crazy town thinking that all of that stuff can happen. But we are unlikely to resource with our teammates if we feel like they have like loads, right? If we don't feel like there's somebody that can assist us anymore than we could assist somebody else, we are not gonna put up the flag. Right. So there has to be my question to the nurse I was talking about with the charting thing after I breathed. And I went back was how do you know which things are OK not to do like, I think I went through this. I don't remember ever like consistently going to the head nurse and saying, hey, I'm not getting this stuff done, but I don't ever remember questioning that I didn't have the authority to just decide what doesn't get done right. So let's just say there's 100 things we know there's way more than 100 things, but so let's just say there's 100 things you have to do. And you can't do 25 of them, do you? Just get to decide what 25 required things you don't get done. I mean, we're using. We're professional nurses. We're using our critical thinking. Right. And I'm just wondering. If there is a Plan B right, is there anything that says it's OK? Don't worry about it. Those 25. I know today's crazy. I don't have any resources or answers. These 25 things are OK to not do today. Please try to do them, but they're OK not to do. Is there any Plan B like that ever that you hear? Yes, ma'am. Umm. OK. But it's only by order of the governor's. Ohh so big time stuff last I think in December. OK. Because we have so many staffing crises, that's where we're at the state of work. Thank you.

Yeah. So it is a, it's a tough one because if you go and you leave for that day and you didn't complete those 25 things. You can't feel satisfied about that either, unless you've developed the habit or you've normalized it, and that's not good either, right? So we we don't wanna normalize that. We don't. Do patient education. We don't provide the emotional support. We're not regularly ambulating the patients. We don't want to normalize that. There's an article that came out last year called ****** nursing, the new norm, and it's pretty good. A lot of the articles that come out, some of the books that are written on it, are professionals who've either them themselves have been in the hospital or they had a family member in the hospital. And we're just really deflated about the state of care that they got. And I think that. Hearing their words is hard and impactful, and I would encourage you. It's a good article to read. Umm, but we don't wanna normalize any of this either. I'm starting been stuck on this slide for a while. Where are we at in time? I don't see a clock here anywhere. That's. OK, good. Alright, next slide. Thank you. OK. Umm, so these are. You know, we talked about this, this is like duplicate information here. So we can go ahead and pass on by this one. So if we're talking about, we talked a little bit about patient outcomes. So let's talk a little bit about us, about job satisfaction. We touched on it a little bit, but this has been pretty well studied. It's not just nurses, you know, we're hearing a lot about teachers in the news right now about bus drivers, we're. Airports, the people in the airplanes, there are a lot of folks that are in general feeling dissatisfied or burnt out about their jobs. But for nursing because we're nurses and that's what we're gonna focus on. When we're exhausted, when we doubt our competence, when we don't feel like we're doing the right thing initially, we're gonna work harder because we still have, you know, our rosy glasses. And we're like, I can do this. I know that this is possible because this is what I learned in school or one day a couple weeks ago, I made it all happen. So we work harder. We might stay late. We might. Neglect our breaks. Umm, there's lots that we can take extra classes, watch YouTube videos online at home to try and get some strategies, and we'll put a lot of legwork in to try and make it work. And then we also will maybe not take as good care of ourselves we might come to work half an hour an hour early. We might stay a couple hours later to finish some charting. We might decide that the breaks aren't worth the consequences of not getting your stuff done. Umm. Or we might not have those hallway conversations or build our community within our work environment. We've talked about that in OIS and establishing our culture and what our values are and what behaviors we expect to see with those and what we need and setting up that unit. Umm, one of the values that's important to us is community and the behavior that supports that is giving ourselves the time to be able to bond. So every morning during our huddle, it's not a 5 minute. We're done. We spend time together and we build our community and then we check in with each other throughout the day and we're doing today, right? Like we are here today. We had to justify that. We have a plan of. You know, somebody's back given an antibiotic today, but we take value in the community that we're building, the conversations that can happen. If we spend time with that, you know what happened a couple of weeks ago, I found out that the little scrolly thing on the mouse, you can click it, you can click it and then like have the control the scroll. Really I would have never learned that if I wasn't like, hey person, come over here. Let's look at this monograph and nerd out together on this medicine that's new to us. Right. So we have to spend time with each other to learn as well and to be close enough with each other that we can say. Umm are you at all able to help me with something really important that I can't get done right? Umm. Yeah, so, so then. If we work hard and that doesn't help, and if we deny ourselves our needs and that still doesn't help. Then we're going to become irritable, right? Probably cynical. Probably a little snippy. And with that, because we've got a lot going on, we're not engaging within our community. Our teamwork isn't happening. We're already feeling crummy coming into shift. We're tired. We might not be sleeping well. I don't know about you. I can tell you that even I haven't worked on the floor in 10 plus years. I still every once in a while we'll have that weird nightmare where you wake up. And it's like 3/4 of the way through your

shift and you still haven't looked at the orders and somebody's on the floor and it's a hot mess. And I haven't done that for a while. So I can imagine that somebody that's in the thick of it, you maybe not be sleeping very well if it's not, if you're if it's not going well. And then, you know, we internalize a lot. We think well, is it me? You know, it seems like everybody else is, even if the same skill is or the same tasks are being completed if others are seeming OK with that. And why am I so bothered? Why does it bother me that I can't get this stuff done right? Like, what's wrong with me? Umm. And then we just if we if we don't quit before then. We can't keep carrying that much and feeling that ****** all the time, right? Like you just have to stop caring a little bit or you'll go bonkers. So compassion fatigue and then serious stuff. Right? Chronic fatigue syndrome, PTSD, depression. That is literally stuff that happens to nurses that don't get it into a good system. So it's smart to leave if you can't get into a group that can support you being a high quality functioning nurse. The thing about that. Yes, it's kind of our responsibility, right? It's not just on our organization to make that happen. Alright. Can you go back when I'm actually going to talk for a second here? This isn't new. The nursing shortage. So when I got here in 2005, I got hired in on a GWOT position. So the global war on terrorism, terrorism was happening and there was a huge nursing shortage. There was actually. And a Senate report there was an executive summary that went out in 2006 talking about the nursing shortage. It more focused, and I think the military like, what are we gonna do? We're really short. And what? How can we entice people to come in? And it's not just money. So that they were thinking, you know, maybe we don't send people on deployment as often or there were lots of strategies in place to try and make it a more appealing. Ask offer and they anticipated that by the year 2020 there would be a 30% nursing shortfall within the civilian and military community. So we got to get it together so that that's not a problem. Well, what else happened in 2020? Right. Double whammy right there. But even that's not the only last time it happened. Cuz Beatrice Kalisch, who I feel like I want to meet her. I'm like a super fan right now of her she has been. She's published, like over 140 documents and she her first one was published the year I was born more than 50 years ago, and she published an article in 76 about the nursing shortage during World War Two. And. And then starting the Ohh it's how did she put it? The Cadet nurse corps in World War Two. And I thought that was just so crazy. So her passion and her focus and her career. She's a I don't. I couldn't find anything about this year. But she's been a professor at a University of Michigan, has been on teamwork leadership, international nursing and on missed nursing care. She's done a heavy load of her work. Has been on that super. Passionate about it, her book that she authored was published by the American Nurses Association in 2015, so a little dated, but I think super great information in there and strategies. I have it if anybody wants to borrow it and they don't mind a lot of highlighting and tagged pages, then you are welcome to borrow it. It's a good read because we have some work to do here, so somebody should be asking you to borrow this book literally. I think that it's a good starting point. Umm, so we can move on. Thank you. Let's do a polling question. Do you routinely take a break at least every two hours? What? Ohhh. My gosh, I'm so surprised. Is there anybody who can be vulnerable and say that they take a break every two hours? Good job, but I don't do inpatient care. Oh, OK. Well, good job. We all need breaks, right? It is good to step away and take a break. But the CDC and NIOSH, there's several organizations Joint Commission they're noted. They're putting a focus, a spotlight on the nurse burnout and the shortages and how that affects nursing care. And one of that's highlights is making sure that we take breaks. We know that if we step away, even if it's just to take a walk around the hall or go look at the mountain outside and the window or maybe do a couple of silly jumping jacks or maybe our nurse managers can put a few games together that are like. Some incentive or you know something creative in a little outside the box to get us away from the patients. I was working with somebody once. I was not a break or lunch taker. For a while and I had so many tell me they're like, do you think you're so important that everything is gonna fall apart if you go off the floor for 15 minutes? Right. Like we got this. And so that, you know, it was like really

self-centered. To think that I had to be there for things to be OK and it really was not. I didn't have much situational awareness to know that I have a team and that. For them to be able to ask me for help, I need to be able to ask them for help too, like we need to be able to work on that together. So breaks are super, super important and that's some work that we can do, yes. Yeah. That's awesome. Do you do it? I love it. Did you hear that? So she has her phone set to prompt her for a break every two hours. And maybe it's not going to the break room. And sitting and watching TV or eating something. But stretching. And what did you say? Stretching and. Looking out the window, that's all it takes, and there's evidence that supports that. Just doing that, we don't know how long it has an effect, so maybe that's why we need to do it every two hours. But we know that that helps decrease errors. Just to do that, which increases patient safety. No, you're good. Thank you. OK, so for nurses. We need to take some ownership of this and we are professional nurses, so even if you don't have the bandwidth to personally start a new PI project like I'm gonna figure out a way that we can all cover breaks every two hours and everybody's going to get at least 5 minutes right or 10 minutes. I can think that that would feel a little bit like you would do that crazy lady laugh or crazy person laugh if you thought about taking on a task like that. But there's lots of people that can, right? Like when I went to the nurse and I was like, why aren't you documenting? Did it a I think she should have thrown it right back to me and said, hey, aren't you in charge of this? Like, can you help me figure out a way to make this happen? Because I would really like to do that. But I see no way where I can make that as important to me. And my situation is it is to you. Right. So the same with is Eloa here today. Do we have long care here today or Candida? I didn't ask permission to put think of this too. Same with wound care, right? Like, I was just talking to her. Hallway conversation the other day. And it's really hard because we've been missing a lot of the skin assessments when patients come in and then we kind of have to own those wounds because it's not documented. When they first came in, that they had them. And it's just like, you know, someone important. Why can't it just get done, you know? Umm, I think if I were that nurse who didn't do it, I would be like, yeah, that is really important. I don't know how I can get all of the things done that need to get done. Can you help think of a system you know? There's we're a Team. Not just within our unit. We're a Team within the hospital, right. If Patrick Smith is asking us to do something, infection control, something different. And it seems laughable that we could figure out how to do that or Debbie. Then we put it back at them. Yeah, I wanna do that. I see your evidence. That sounds great. I can't do that. Like it needs to come a different way or it needs to be packaged differently or something else. Got to go. So involve your nurse leaders. Involve the other people in the hospital. Even if within your small family in your unit that you can't tackle that. And in itself. Personally, something that you can do to feel better and to not have to wait for resources. You can always increase your competency and if we can do that, the hospital that's great. But this is your professional license and your tool bag and you and I don't know if this is wrong, union wise to say or whatever, but I feel personally like it's my responsibility to update my practice and that to keep my skills up today. And to have all the tools I need to do the care that I need to do, especially if resources are. If there aren't many resources I want to be able to do as many things that I want to be proficient and as many things as possible so that I don't have to always go resource with somebody so you can just make sure that what you can control, that you can do that. Ohm. Uh, we can put it on our patients a little bit, right? Like this is what the day looks like. I want to be able to come and spend time with you. I'll have about 10 minutes here. Can you please call me if your IV feels funny? Otherwise, I'll see you at this time, or we need to do some education today. If I don't get to you by 2:00, o'clock, get on it. Because we need to do that, right. Like this stuff is important to them. They need to know the plan. We can ask them if something wasn't great. There is the form. Can you please say something about that because I could really use your voice in my fight to get something changed, right? We can involve our patients. There's a lot of literature on routinize using care routinize care, making a routine out of your

day so. Umm that it's built into your system. This was the same thing with the weight, so we identified. Ohhh my gosh, we're giving weight-based meds. Well, OK. This patient had weight eight months ago. They're feeling better now that they're on their Med. I wonder. They're probably not the same weight anymore. OK, we need to get. We need to scale all of this stuff. So we identified all this stuff, got still started doing the weights most of the time it was not in our system and. For all that we knew that that was the right thing. We weren't catching everybody and then, well, we'll do it at check in then. So the front desk person was doing the arm bands because that was hard for us to get the armband on everybody. And so then they were doing the temperature cuz we needed to do temperatures on everybody. And now they're also doing weight. The problem was the weight was getting down. The weight was getting the computer. But where we calculating the dose off the way? No. So now we have a little card and hopefully I'm so hopeful that we can get rid of this stuff. Once we get it in our routine that, that's what we do. So we're not like it's like driving a stick when you first start out, it's really choppy and bouncy and awkward. I think that once we get it under, it's just our system, it will work out, but making a routine out of it. And this is just the way we roll, right? This is how we do it then. Then that will help. Communicating with team members, so I had briefly mentioned a mid-shift huddle. Does anybody in here do a mid-shift huddle routinely? When things get nutty, do you do a huddle? Yeah, it seems counterintuitive, right? But it's so helpful when things are really going crazy to just say, OK, stop, you know, sometimes it takes a good experienced charge nurse to be able to see that that will be what helps the situation. I was talking to Jeremy O'Bryan and Brad Baumgardner a couple weeks ago, and I brought up that I was going to be have time to spend with you this morning on this. And I was like. You know, it's something that really. We hold so tight we don't want to admit that we're not doing everything that we're supposed to be doing, whether it's because we don't want to get in trouble or we feel incompetent or. Or we don't think anybody can do anything about it or that it would matter to anybody else because nobody else is getting it done. We don't talk about it very much and I'm wanting to engage with them to see, like, how can we talk about it? How can we not just be stuck in our own selves and just not doing it? Because I'm pretty sure I would not pick the right 25 things to not get done. I do not know everything about everything. So I don't know. If I'm so busy, I'm not going to be able to order that correctly anyway. So I'm really good suggestion out of that meeting was doing a real quick mid shift huddle and then just a quick go around. What's your biggest headache and then everybody can kind of check in with each other and you can just fire it off really quick and you can identify what resources available if no resources are available and the headaches are pretty awesome, then we're going to engage with people outside of the unit, yes. Say, hey, what are the thing that they advised us to do? Put in a PSR (patient safety report). They. And awareness. You shouldn't be shameful to put in a PSR, because what it is it open for discussion. So if you are routinely missing these things, be honest about it. Do a PSR. It doesn't mean you're punishing, punishing anyone. You're opening a discussion, making an awareness so that a different view keep coming towards. How do we address this right. What do you think and when you see an influx of those PSR's on the same topic, you go back to the table to talk about it and make a round table solution. I love it. Thank you so much. That's perfect. And I would say that that's probably why we were able to have such impactful change in OIS was because of the safety involvement from the Safety office in our system, so. Thank you. And then we need to figure out a system if when people miss care, are you going to your head nurse? Or your NCOIC on the regular? Anybody. I didn't. But if it's something serious, like if I didn't give, like, a really important medication, I wasn't sure what to do about it. But honestly. I did not, but that's something that they should know about, right? Like ohh all of my nurses are regularly not getting 25% of the stuff done. I need to figure this out. This is now a safety issue. I need to at least make sure those 25 things they are choosing are on the list of things to get done or whether they're the OK things not to get done. So a good suggestion. One article was that you

have a Plan B as a leader. We're still in nursing though. So the next slide? Thank you. So for leaders is that you develop a Plan B so that when you are involved with your team and you are noticing that there is no way for your team to get all of those things done that you can engage with them and let them still be able to be successful at the end of the day, right? Let them be able to leave knowing that they have a place that they can come and say I can't get all this stuff done or I didn't get it done. The things I didn't do were these things. That are on your list or for the people that. Umm, I think for everybody. I mean, at some point like if we're just not getting stuff done like CHG baths. That's a safety issue. That's something that needs to be addressed, and we can't just not say anything and it's cumbersome as that might be to go to the head nurses on the regular and be getting. I'm not getting stuff done. I'm not getting stuff done. If you're not, then you're head nurse cannot assess whether you need support of training or strategies for how you can get it done because they can evaluate your system or whether they need to reorganize, how it shift goes or they need to. Get involved with senior management. They can't work that unless you say something and the bottom line is that we're here for our patients and patient safety is what matters and missed nursing care you saw in that impactful slide at the beginning effects patient safety, extremely effects, patient safety, even if it's not immediate. Overall. OK. So leaders. Umm, there's a there's a need for building a positive ownership within the culture. Another thing that Jeremy and Brad had shared because we were talking about building trust is that you want your team to be able to. We used to call it cross monitoring in the old days. I don't know if it's still called that, but you wanna be able to. I want to say police, but that's probably the not right word either. But you wanna be able to call each other out on stuff, right? Like you want to be able to identify within your team and have a culture that supportive and like ohh hey, I just heard you talking about that. But did you know this update happen but you don't want to only have to have a nurse leader that has to recognize that stuff. Some of these teams are pretty big. It's different if you have a five or six person team. But if you have a 70, 80, 24 hour team you can't be there all the time. So you want to. And build a positive ownership culture with high expectations. You know, just some. Expect greatness because we have a lot of great people, right? Don't set the bar too low for your group. UM. So you might have to redesign your care teams and you they may have been doing it that way forever. If we if we get our teams interested in the question. I think historically when I've wanted to make a change. It's hard for one person to do it, but if you start a hallway conversation and then you get. Some key players on the team and you get some excitement built and you make it, just not your own enthusiasm about it that it, it seems to snowball. You'll have a few people are like, oh, here comes the good idea fairy game, you know, but in general you'll get enough people interested in enough people who like the article you're throwing out there or who are having problems with the same thing that you're having, that they'll want to join in your. PI or QI or whatever you have time to work on. Thank you. Perfect. A big thing is being transparent with staffing and resources, just the thought that staffing is short, Makes nurses feel like there's a problem. So when staffing isn't short and we think it's short, then we behave like it's that we're short. And so if we're not really clear that, hey, Madigan, we know that the world is talking about the nursing shortage. But we're actually right on board for cuz we've decreased our patient load, right. So even though we don't have a ton of nurses, we have the right amount of nurses for the patients that we're taking care of. We got you right. If all we hear is nursing shortage, we're seeing places closed down. We know we're on divert in some things. We may think that the world's on fire at Madigan when really we're being taken care of. But there's no transparency for us to see. Hey, I got you, you know. And then it goes the opposite way too. Colonel Swiger and I were in and several folks were in a decision brief about OIS and we were asking for the world. I mean, we were asking for a lot. And I had no awareness at all about some of the limitations and some of the things that we're being closed down. And so I just really, it was impactful to me that you were like, yes, this would be really great. But right now when we can't even do this other thing, it's not OK to ask for this world,

right? So I think having. situational awareness. At all levels is important not just at the senior levels, so that we can all have an idea of what's going on. And then. The decreasing work interruptions. That's one of the biggest things that nurses identify that contribute to missed nursing care are the non-nursing care, the interruptions and then non patient care related tasks. So answering phones, transporting patients, cleaning things, dealing with broken equipment. Admin tasks on work time. Those kind of things were, uh, reported as uh, most often. OK, thank you. OK, as an organization, this is kind of tagged on to leadership, but at a bigger level systems level, right? So we wanna make sure that we have technology that supports what we wanna do that it is searchable by the end user for information that we need, which it completely stinks right now. And I know it's a work in progress, but we cannot as an end user say is this even an issue or can I find out quickly it's a process to figure that out. That's my beef with but, but also making sure that it flows or all the things where we need them to be are the things we need to document in 20 different places. Can we? Can we have that be different? I think we know that's a hard a hard sell right now, but we still have to ask and we still have to put out there that's a problem. Just like we have patient centered care, we need learner centered education. Who's out here from MCED (Madigan Consolidated Education Division)? I know I saw MCED out there. Are you? Are they still out there out there? I've I. Strongly believe that we all come into this at a different with different skills, different passions, different experiences, and that a brand new nurse needs one thing, a brand new nurse with a lot of passion needs something different than we all need to be assessed. Where we're at, for what education we need, and we need to get the right education and support and resources and not one-size-fits-all that's happening sometimes with so just making sure that we have systems in place. To provide that. And I'm doing some pretty strong call outs right now, but I think you must know that I love Madigan or I wouldn't have been here for 18 years, right? Major Clayton, I was just talking about like, OK, good. OK. So let's just see here, I wanna get on because there's a case study. I think we're working really hard on some of these things the resource availability. We know it's a problem as nurses, we need to just keep saying it's a problem. We can't just assume that it's being taken care of because our assumption will likely be wrong. Maybe something else is being taken care of, but we need to be speaking and not just assume it can't be taking care of or that it is being taken care of. And then there needs to be transparency with metrics when you're auditing us, tell us or. Say I want to know like what is the results? There should be a posting on the board and there are on some things. But we know that this helps us to do better to see where we have struggled and it's energizing to see when we make gains. OK. Thank you. So just really quick to touch on silence and I've spoken about this throughout. Umm, just that? Have some compassion for yourself. I think you can tell from being here today. That we're not alone. We're all missing care and it's just not. It's not even just primary care. I've missed care. I haven't been doing primary care. There's things that I'm not doing that I should be doing, but it's a different focus. But that. That I would hope that what you leave with is that a little bit of power to remember that. Your strength in being a professional nurse. And your responsibility, right? So. Our responsibility as a nurse and responsibility to the service that we're all in, regardless of whether you're military, civilian, do, do we still do the oath as a civilian now, who's new in here? Did you do an oath? Yeah, we all do it. And we we've promised to. To show up right to do the good things, to take care of our patients, to be professional, to stand up for what's right. And that's not even talking about the. A lot of things that the ANA says that we are supposed to be doing as nurses too, right? And then watch out for your buddies. It's a hard one because I think right and I'm not really sure how to connect it and have it hit home. That. That you have to say something about it, and if you over say it and you're always just saying. Hey boss, I'm not get my stuff done again. Hey, boss, I'm not getting my stuff done again. And if the same thing is happening, then that's on that boss. Right. And it's on that boss to figure out a system like, OK, cool. I'm so glad you've told me the last two weeks. Every time you've been here that you're not getting your stuff done.

I get it. And now I have this plan for this. You don't need to come with some you again. Unless this other thing is happening. Right. So trust that your leadership can develop a system to handle new reporting to them. And please, please do the PSRs. I appreciate that so much that you said that because that is a. Systems, a hospital wide, way non-punitive way of identifying when systems are broken at a bigger level, right? Umm, OK, so let's go. We're gonna skip through. I was so afraid I wouldn't have enough to talk about. This is such a good group, OK. So the benefits of transparency, not just from leadership and in our hospital being transparent but from the hospital or from us being transparent, it's therapeutic when we talk about it that's been researched, we know if we're not trying to bottle that up and hide it and be secretive or push that balloon under the water, that's not feeling good. So we don't want to see it anymore at that takes a lot of work. So if we are transparent then. We'll keep our nurses better. We'll be happier, our patients will be safer. And as an organization, we will be closer to where we wanna be as that's fair and just culture that we want, we're gonna see case study next. And I just want to point out these are the same patients per day shift. Nothing worked out. And then we're gonna work. They were gonna work out on night shift for this new nurse because they were gonna use all the things we've been learning about that. We'll skip that cuz I have a really pretty mountain picture and I got to tell you what we got out of this. So key takeaways. It's a worldwide phenomenon, missed nursing care. If, if you do not think that missed nursing care is happening within your world, you are not noticing it. You are. You're maybe burnt out or you have normalized things. It is happening. It has impact on patient safety, nurse retention, burnout, health. We don't want to normalize it. We don't want to remain silent. We want to empower each other and ourselves to report it and fix systems. We can do this. We've done it in the past. We just need to lean in a little bit and get this done. And then. We could go to the next slide. The last slide, mostly take some of my energy, take energy from each other, feel your power. Do your stances, roar, do whatever you need to do, but just please don't feel hopeless about this and please feel it's important because even if it's like it's just a bed bath, that's you feeling that the last person, the last person and take your breaks. Isn't this cool mountain picture? It's a totally crummy. I was standing at the window looking outside. Look at the shadow. I've been here looking at the mountain many years and I've never seen the shadow coming off of the mountain, so that was really cool, but I really appreciated talking. Did I take up the Question Time too? OK. Any questions? All right. Yes, ma'am. Thank you. Notes feverishly, because if I were a staff member or head nurse out there right now, I'd be freaking out that my staff is going to come to me and ask right where they can let go, right? And I know right now I don't think we know the answer to that question. And when we don't know an answer to a question, that's when we come in as scientists to try and help answer that question. And so I see like a whole project coming off of this because as we move forward into prolonged field. care in a military environment where we have 25 patients each, we're gonna have to ration our care and we need to know what's OK to let go and what's not OK to let go at what stage? So I just wanted to ask you, do you have any ideas from the literature? Could you tease out any of the things that were the lowest risk to let go of and then we should do a project. Ohh yeah. Well, I did look at Vascular access first cuz I thought, did we really need to look at the IV every four hours? Like if somebody's not infusing and they're. Do we really need to? The standard says you know the standards are peer reviewed and highly cited and they huh. Yes, and it very rarely says a specific time, it usually says per policy. This says very specifically every four hours. So I did look for a few things like what can we get rid of? What is OK not to do? I don't know yet. But I am sure cuz I have stacks and stacks of literature. This is a really hot topic right now. I'm sure you know and especially as we're tackling this nursing shortage and nurse burnout and trying to keep our novice nurses are leaving. If you don't. It would be take a lot for me to leave being a nurse because that's all I've done for a long time, but if you've only been a nurse for a year and it sucks as bad as this, why would you even stay a nurse? Plus the younger generation, they don't have like they don't build value the same way

we do and keeping a job forever. So they're kind of probably be OK. I have a Bachelor's degree. So what it's in nursing. I could do this other job, you know. So we need to get on this and make sure that we keep, I don't know the answer, but I have lots of resources. We'll figure it out and I don't have any bandwidth. Yes, but I would love to spend time with you. Yeah, but. But that's my crazy lady laugh. Thank you everybody.

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So on behalf of our planning committee, the Madigan leadership and all the lieutenants that are ultrasound IV users, Caryn, we value your presence and your expertise. So thank you. I will now announce the 14 winning names for the first door prizes. Winners will receive either a gift card, mug or badge reel with a battlefield and disaster nursing pocket guide. I asked that if I call your name, Please wait till I announce all the names and assemble on Lieutenant Lee in the back of the room to receive your gift. The first names. Andrea Smith. LaRae McCutcheon, Stephanie Stevens, Cris Garate. Brooklyn Finley. Debbie Hood. Christine Robledo. Dawn Allen. Sijan Karki Khadka. Madison Shelton, Briana Jones, Missy Route, Christine Kreager and Lieutenant Aaron Tu. If any of those are virtual attendees, we will send an e-mail for you to receive your gift at a later time. We are now going to take a break. Please visit the vendor displays located around the room. Please be back in your seats by 0940.

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It is my privilege to introduce our next speaker, Lieutenant Colonel Tanisha Currie, is originally from Chicago, IL. She attended the University of Oklahoma Health Sciences for her Bachelor of Science and Nursing shortly after graduating College in 2003, she worked as a clinical staff nurse and leader at the Mayo Clinic in Rochester, MN. In 2008, Lieutenant Colonel Currie accepted a direct Commission into the Army Nurse Corps. And was assigned to Joint Base Lewis-McChord, Washington. Lieutenant Colonel Currie completed her master's degree in management and leadership from Webster University in 2016 and obtained a certificate in Healthcare Project Management from the American University in 2021. She has applied her leadership knowledge and experiences to several hospital organizations within clinical, academic, and combat operational settings. Lieutenant Colonel Currie graduated from the Uniformed Services University of the Health Sciences in Bethesda, MD, with a PhD in nursing science in May 2022. Her research concentration is in nutrition and brain health. Lieutenant Colonel Currie has published 3 peer reviewed journal articles in Health and Human Experience, Molecules and her most recent publication in February 2023. Within the new Nutrients journal titled Considerations for Optimizing Warfighter Psychological Health with a research based flavonoid approach, a review given Lieutenant Colonel Currie's background and research interests, she seeks to inspire organizations. Through principles of nutrition, brain health, leadership and optimal work performance, please help me welcome, Lieutenant Colonel Tanisha Currie. This is for you.

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Mic. Check. We are good. OK. Can everyone hear me. Fantastic. Well, first I want to say thank you. Thank you to the planners of the conference as well as for continuing the legacy of what started 14 years ago. And I must say, and I absolutely must agree with the Colonel Sims-Columbia, when she talked about how brilliant these LTs were in setting up this, this conference, Caryn, I think you led the way, my friend. Ohh, I think he led the way. You know when it came to bringing the pain in a good way and so. And I think that they you drop dropped them off to me just in reference for a hug and to talk about a little bit of lighter topic on food.

Alright. Oops, so today my presentation will be on the Role of Nutrition and Health and Human Performance, a Nurse's Perspective. So let's talk a little bit about Colonel Juanita Warman. I will tell you I was the first Lieutenant at the time at Madigan Army Medical Center. And I remember right before she left off. And I said to her, ma'am, I said, ma'am, you know, so how do you feel about everything getting ready to deploy? And she said to me, she said Lieutenant. Colonel, she said, Lieutenant Currie, she's she said, I'm looking forward to deploying. I get the opportunity to do something I'm very passionate about to be able to take care of soldiers. As well as to provide mental health for them as you. As you know, she's also a certified psychiatric nurse practitioner. Ah. She was also excellent and one of the things that she stated she said there's so much to do, so many lives to touch, and I think that still rings so true. So disclaimer is the views expressed herein are those of myself and they do not reflect the position or the policy of DHA, BAMC, Department of Defense nor agency within the government and that I have no financial interest or relationships to disclose. So today we're going to talk a little bit about the challenges of healthcare provider resiliency, explain the relationship between diet and performance. Whoops. Identify DoD health optimization and initiatives for performance and readiness, discuss the challenges of the military nutrition environment as well as holistic health and fitness, and recognize that there's bio active compounds of foods. And how they also interact in this relationship to our health. And then lastly, how leaders can get involved and engaged as well? So once again, the title of today's presentation is Health and Human Performance, A Nurses Perspective. So here's my question to you if health and if Health and Human performance were measured in financial currency, would you be thriving, maintaining, or bankrupt? Bankrupt. You know, it didn't feel like that long ago, around January 2020, right, when COVID-19 had occurred, it all shook us. You know, at first when they began to talk about COVID-19, I was actually, during the time I was in my doing my dissertation. And I said, OK, give them about three months. Then hopefully the tides will turn here. But kept watching the news. Nope. It's still not turning. And so then we found ourselves going from this. Anomaly to all of a sudden we're in an epidemic. Essentially, it's a disease that affects a large amount of people to now we're in a pandemic that spread it over multiple countries as well as continents. The National Institute of Mental Health reported that close to 20 million people had at least one bout of depression. And spreading further out is that there was also too an increase in suicide rates. There's a report that came out from the Center for Disease Control that has stated that there was close to 50,000 individuals that had suicide within the United States. That is huge. While we still were living in this unpredictable environment. Increased occupational hazards as well as risk. And then as well as there was a lack of family considerations. And so we saw many nurses, not just military nurses, but we also, who else did we see side by side with us? We saw civilian nurses side by side with us during this pandemic and so more pressure was placed on individual versus the health care centers versus the healthcare system. This also led to a lack of self-care such as poor diet, lack of exercise, maladaptive coping as well as unhealthy stress. And so I love what Doctor Murthy states within this he states that as we transition towards recovery, we have a moral obligation to address. The long standing crisis are burnout, exhaustion and moral distress across the health community, we owe healthcare workers far more than our gratitude. We owe them an urgent debt and an urgent debt of action. So in other words, we deserve more than a pat on the back, but we deserve real, systematic changes. And so the army proposed a solution which was Holistic Health and Fitness. Holistic Health and Fitness looks at 5 different components, which are mental readiness, sleep readiness, spiritual readiness, physical readiness, as well as nutrition readiness. I feel sorry. I feel like I wanna move around a lot, but not sure if you can hear me. Not good with mic. OK. Can you hear me OK? Wonderful. So let's take a look at some statistics. So the health of the force is stated that according within 2021, they're 18% of soldiers they were obese, 15% were diagnosed with one or more behavioral health issue, while 49% were diagnosed with a new injury. And it was largely musculoskeletal

injury and 9% were diagnosed with the sleep disorder. All of this essentially came down to the bottom line in that our poor health, it threatens readiness. And So what is H2F? H2F was developed in 2020. And it was created as an enterprise wide system encompassing both the physical readiness as well as the nonphysical elements of optimized human performance. The physical elements meaning the personnel as well as the equipment and the nonphysical, more so the attributes of the mental readiness, the sleep readiness, nutrition as well as spiritual. H2F's whole focus is the interest in overall wellness injury prevention and faster soldier recovery, and it's also a way of life. And it applies not only to active duty, reserve, but also DA civilians as well. And so I reached out to one of my colleagues because there was a study that was done in reference to the space of H2F and USARIEM and her team looked at the effect of personnel element of the armies holistic health and fitness and what they had looked at with this. Essentially those units that had H2F units, they were tanked up with physical therapists, registered dietitians, occupational therapists, athletic trainers, as well as strength conditioning specialists. The biggest thing to know is that within these units they were they were actually embedded within these line units, so they were additional assets. So if a soldier had an injury or they were struggling with their weight, then these ad hoc personnel from the H2F can fix it. And so they did a comparative study where they looked at H2F and they wanted to look at how did those soldiers fare. The ones that were within the H2F unit versus the ones that were not. And so the result had showed that those units that had H2F in their assets, that they did better in their physical readiness, their nutrition readiness as well as within the domain of musculoskeletal injuries, they had decreased and stabilized or decreased pain levels. So why should nurses care about H2F? Because we're war fighters, too, and it provides a framework to inventory ourselves and others. And also line units because we take care of many of the war fighters, the line units is whoa, you know, are also too are also too looking at do we know H2F as well so H2F at its core it's about balance and so this may look different for everyone but universally addressing the five domains will serve to optimize health and performance. So it's not the question of. How do we get ready but ready, but rather, how can we stay ready? Another perspective is how we should treat strategically creating an environment where we have the time, the space, as well as the opportunity to be our best as war fighters and as well as civilians. Now I'm gonna go into two different components. I'm gonna look at the nutrition readiness and I'm going to look at the mental readiness of H2F. So nutrition have to stay at the forefront here. CDC had reported that there's four main causes of diet related diseases, and it's due to poor nutrition, lack of physical activity, excessive alcohol, as well as tobacco use. And then the White House, not too long ago, had came out with the report. How many guys have seen this report, by the way? It was a OK there's one. Yes. So it was a report that had came out. And one of the concerns was food insecurity. And so there were five strategies that were proposed. So one is that we need to improve our food access as well as our affordability. So this includes expanding on the SNAP program or Substance Nutrition Assistance Program. The second thing is that we need to figure out a way on how do we integrate nutrition and health. So this includes more nutrition training as well as more obesity training. The third thing is that we need to empower our consumers to have access to healthy choices. So not just having labels on the back of products, but also having labels on the front of our packaging. The fourth thing is that we need to move more. We need to support our physical activity for all, so improving, increasing more access to outdoor events. And then the fifth thing is that we need to enhance nutrition, food security and research. So I wanted to ask you guys, how do you guys how let's see here, how do you do overall when it comes to nutrition readiness, would you say? With a raised hands, would you say pretty good? Oh, great. OK, Miss Hodge. OK, great. How about for mental readiness? Ohh. Yes, OK. Excellent. What do you do for your mental readiness? [Audience member speaking, unable to hear first part] Absolutely. Do you feel guilty about it. I used to. I no longer do. Because if you think about it. And this is not a dig on men. Women carry an incredible mental load of not just your work, but ohh. I've got a plan

for the dogs to go to the vet. I have to do the grocery shopping and make sure that it's I can pick it up on the way home. Right. Place the order. The kids are gonna be due for their sports physicals. It's all the additional mental load that's invisible that we carry along with the duties that you do see us carry out as moms, sisters, mothers, aunts, right, caregivers, employee, spouse. So yeah, so if you're doing all of these things, then it's OK for everybody else to, yeah, go place right for twice a week. Get your get your time with your friends and do your thing. Why is it not OK for me to Allow myself to do the same thing, right? So a good gut check for me is if I'm willing to say it to somebody I love, then I should be able to do that self-love and say it to myself as well. Outstanding excellent. And so I saw another hand raised back there. No. Ohh yes. Mm-hmm. Absolutely. How about for your spiritual readiness? How would you say you're doing on that? OK, alright, excellent. OK, so there are some points in there where we, you know, we do very well at and then there's some other points in there like hey, we need to do a little bit more, but how often do we actually talk to that about each other on sharing those tips and strategies? Yes. And that's one thing that we need to you know, we definitely need to improve. And so as we think about. Nutrition, we need to also to realize that when we compare this within the social ecological model, this one is a specific geared towards nutrition, but nurses are involved in every single segment of that and nurses can be. And so when we think about the typical American diet, that's actually a. Our regular term, and it's called, actually Standardize American Diet, is what it stands for and it's full of a lot of ultra processed food up. So I think I do see a little bit of lettuce within here, but really we need to go more towards a whole food plant forward diet. And so as we look at this picture, this collage, as you can see, you know nurses again, they're at the forefront. You know, they're taking care of the patients, a very busy culture. But when are we finding time as well to be able to eat? And if we do a lot of times, we're grabbing for the quick, the cheap. A items within here and so when we think about also as well the social ecological model, uh. So when we think about the social ecological model. You know there's opportunities within here that one we can take care of self. We can also to look at access to see you know what are some ways in which we can impact that as well as well as to provide is to provide recommendations on how we can get better within our organization and our culture as a relates to nutrition for instance at Madigan here is there a Wellness group is there. A Wellness policy. Ohh. Outstanding. Excellent. See you guys are always way ahead. And so when I put this picture up. A lot of times, you know, with this picture, you know, I've heard soldiers say like, hey, we have one of those on our post. So the truth of the matter is that less than half of all service members consume the minimum intake of fruits and vegetables, and soldiers largely consume a westernized diet to be qualified as more of a pro inflammatory status diet, one that has free radical production. And it leads to endothelial dysfunction as well as lipid profiles. High lipid profiles, which can also lead to cardiovascular as well as neurodegenerative diseases which are linked to oxidative stress. As well as inflammation, so diets rich in fruits and vegetables containing flavonoids may improve cardiovascular as well as brain health, and emerging research has begun to show that nutrition may play a role in our health. So now we're going to move on to the nutrition. I'm sorry to the mental readiness of this discussion. So our suicide rates are still too high. General Austin has stated that still one too many soldiers are gone due to suicide while our rates have decreased within this last year to 519 by suicide over the past couple years past prior years it was around harboring around the 580. We still have rising rates of outside behavioral health referrals. Which sometimes you know, I wonder if it's a matter of trust, but also there's also another factor near. We also are just very short when it comes to behavioral health practitioners as well. And so for those that don't know how many know that we're also authorized 12 free sessions a year for counseling, whether it's verbal in person or on the phone from military one source, military family. OK, pretty good. So our current strategies and addressing depression or mental health is counseling also to pharmacological therapies as well. But part of the problem with, for instance, some of our medications is that it has a difficult time in crossing the

blood brain barrier. And so that's why nutrition has become such an interest within science because for instance, some foods such as our berries have been shown to be able to cross the blood brain barrier. And that at the UM, in that at the linchpin between all of this is a role of inflammation and how it can actually affect that. So let's take a look at the monoamine hypothesis of depression. The monoamine hypothesis depression looks at the balance between our serotonin, our. Dopamine. As well as our norepinephrine levels. And you see that ghost like feature up there. That's our monoamine oxidase enzyme. Destroying your transmitter. One of his whole jobs in life is to be able to ensure that there is a balance between our neurotransmitters. So that's the healthy state of an individual who has these neurotransmitters firing across back and forth from our neurons in connecting to the receptors on the post synaptic and bypassing the Clef. But an individual that is depressed, as you can see, they have a decrease in neural decreased neurotransmitters. And when this occurs? Ohh man. It can. It can impact our mood, our learning sleep as well as our appetite. And as I spoke of again earlier about the challenges of some traditional approaches. So now, aside from using pharmacological counseling, which is great, we can also couple it with nutrition as well to help promote psychological health. So then I was really interested in wanting to see, you know, with this really with this really work. And so I tested a cell model, a couple cell models actually one was a heart model. And so I grew it in this cell. I yes, I grew this cell line. So one was a heart cell and then the other one was a brain cell model. So I tested various different berry extracts. So elderberry, aronia berry, tart, cherry, elderberry and cranberry. And I wanted to know, well, if I give these feed these cells, these very extracts, will they actually decrease inflammation, oxidative stress? They did. And then I did the same test on the brain model and what I found was that was that the cranberry extract did the best at reducing oxidative stress as well as inflammation. And so the bottom line is to eat your berries. So food psychology and dietary strategies. So it's a little bit of a challenge of how do we see food sometimes you know people will say, you know, oh man, that's bad to eat or this is, you know, really good to eat. And sometimes I find myself after speaking to individuals about food, they'll often hide their carbs. And I said it's OK. I'm all about food appreciation. There's no need to food confess or anything like that because I tell you the truth. I like brownies with walnuts, but it's all about balance. And so how do you see food and also what narrative Are you operating for as well? Are you eating for comfort, or are you eating actually to fuel your brain? And so we need to have a mindset change towards food and look at more. So how can you make food work for you? And so this was an interesting study. It's so these are a couple studies here. It's on health promoting foods and bio active compounds. This first study that was done by Ebenezer et al looked at.