



# Clinical Leadership

The  
21<sup>st</sup> Century Model  
for Navy Nursing





## Foreword

**M**any books have been written describing the concepts of nursing care, nursing practice, nursing development, and nursing career paths. We, in the Navy Nurse Corps, have rightly seen fit to adapt many of the well-known models to our practice in the military. We have successfully used individual models to define the scopes of our practice; create pathways for specific career progression in a military environment; and outline professional and specialty requirements to ensure compatibility and alignment with our civilian and Sister Service colleagues. These models provided structure in defining who Navy Nurses are and what they do during a time when “moving out” of the clinical environment was the accepted, perhaps even expected path to promotion and

assignments of real (and perceived) greater responsibility and authority.

The previous models provided a solid career path until September 11, 2001. The country and our Corps changed forever on that day. We were immediately jettisoned into the roles for which we had originally sworn an oath; “to protect and defend the Constitution and the country whose course it directs.” The uniform we wear symbolizes more than ever the care we give in a real wartime environment. This is the Navy Nurse Corps of the twenty-first century. A Corps that has re-focused what our roles are in order to be ready to provide care wherever and whenever called upon. Our mission is to provide that care on the battlefield, in countries in distress from natural disasters, and at home. In order to do this, all Navy Nurses need to be clinically competent and confident at all ranks, and in all specialties.

This publication is not a historical review of Navy Nursing. We already have many books which accurately and eloquently document where we have been. Although our history

certainly lays our foundation, the work being done by today’s Navy Nurse is most assuredly making history for the future. Today’s nurse is required to quickly adapt and transition from providing care in our most state-of-the-art medical centers to places as remote as Afghanistan; aboard anti-piracy ships off the coast of Africa; or in the horrific post-earthquake ruins of Haiti. The model described in this book illustrates the integration of clinical competency and leadership as it applies to the journey all Navy Nurses take throughout their careers that specifically prepares them for experiences beyond the confines of a brick and mortar hospital or clinic.

In the initial chapters we will describe the evolution of this model. Chapter 1 will quickly walk you through the chronology of the career development models used in the Navy Nurse Corps to guide nurses as they began to set up their career goals and objectives. These models clearly provided the way ahead for us and were the fundamental building blocks for

where we are today. However, their linear focus on operational readiness, leadership development, and professional development as distinct and separate tracks in a nurse’s career development presented challenges to nurses post-9/11.

Chapters 2, 3, and 4 discuss what each nurse’s responsibility is for his/her own development if they are to be truly successful in the Navy. From new graduate to highly trained and specialized clinical nurse, these chapters outline the steps it takes to hone clinical and leadership skills in order to become ready for any and all operational assignments. Establishing and maintaining clinical skills, honing those skills through specialty certification and continued graduate education, and the leadership development that begins the first day of Officer Indoctrination classes, form the triad of requirements that each nurse builds upon through their experiences as clinical leaders.

The results of achieving clinical competence and the clinical leadership necessary to be successful in the Navy Nurse Corps are no

better exemplified than through the operational experiences these nurses have when deployed. Chapter 5 captures the essence of this preparation, describing how Navy Nurses adapt to any environment in which they are asked to perform. The relevance of Navy Nursing has never been more recognized; the demand for Navy Nurses never more prevalent than today. Now, more than ever before, we are in non-traditional operational settings and successfully demonstrating the value of our contributions to the mission at hand.

Chapter 6 ties it all together for you. Navy Nurses in today's environment are multi-dimensional officers; equally strong in all three domains of clinical competence, leadership, and operational capability. Through the use of vignettes, you will be provided vivid examples of how Navy Nurses apply their skills in all environments; from major medical centers to humanitarian missions in austere countries.

Recognizing that we are, indeed, one Navy, Chapter 7 provides a parallel journey for our Navy Nurses

in the Reserve Component (RC). Since Operation Desert Storm, our RC Navy Nurses have been actively engaged in deployments in theater, and in our Medical Treatment Facilities at home and overseas. They have also been extremely supportive during our humanitarian missions aboard our hospital ships, USNS COMFORT (T-AH 20) and USNS MERCY (T-AH 19). The need to ensure clinical competency becomes even more relevant when we depend on our RC nurses to perform duties that they may not necessarily perform in their civilian roles. Success for today's Navy Nurse Reservists is highly contingent on their ability to perform their clinical duties as assigned immediately upon activation. Use of this model has been instrumental in identifying the gaps in clinical and leadership development and providing a framework from which to work to ensure a highly functioning and ready Reserve Component.

Chapter 8 gets to the heart of why we decided to write this book at all. Never before has there been a more important time for our nurses to take time for introspection about

where they are in their careers. Self-assessment of personal and professional goals, considering the needs of family, and identifying strengths to leverage for continued success in their careers, as well as identifying those areas in need of further development are actions each nurse must perform in order to make the right career choices. The ongoing high operational tempo we experience today will continue for the foreseeable future and must be a consideration in each nurse's personal self-assessment. Learning to be nimble and to deal with ambiguity are life skills for success which build the resiliency nurses will need as they make the choice to stay or to go.

At the end of the day, it really is all about balance. In the last chapter, Chapter 9, we come full-circle, looking inwardly to understand what is best for ourselves and for our families and significant others. We call this the "healing chapter" because it reminds us that in order to be resilient and face the stressors that life in the Navy and in general brings us, we must take

responsibility for first taking care of ourselves and then each other. Fitness — physical, emotional, spiritual, and social — is a lifelong commitment if Navy Nurses are to continue to be the successful leaders they have always been.

In the end, what you do with this information remains to be seen. Navy Nurse Corps leaders of tomorrow cannot perform as we

have in the past and be successful. We are faced with challenges more far-reaching than those of our predecessors. As volunteers, our staff willingly commit to our core values by choice. How we use this model to shape our future and the future of our Corps will determine our continued relevance and success. As individuals, what you do with your career is truly up to

you. Our hope is that at the end of your naval service, however long, you have no regrets; you can do more than live with the decisions you made; you can rejoice in them because those decisions and experience made you the Navy Nurse you are today. To share these ideas will be the greatest gift we can give you.

A handwritten signature in black ink, reading "CM AnnytoFowler". The signature is written in a cursive, flowing style.



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# Chapter 1

## Model Development

### A Look Back

**A**merican Military Nursing was forged during the Civil War, out of the desire to care for the wounded, the ill and the injured, and a very deep sense of patriotism and loyalty. Both the Confederate and Union armies “recruited” women who did not possess formal nurse training for service during war time. During this period, some six thousand women were recruited and trained as lay nurses. When the war ended in 1865, the Army reverted to the practice of using enlisted men for patient care in its hospitals, and the female lay nurses returned to their homes.

In 1901, the Nurse Corps became a permanent Staff Corps of the Medical Department under the Army Reorganization Act (31 Stat. 753) passed by Congress, and nurses were

appointed to the Regular Army for three-year periods. The Navy Nurse Corps was formally established by Congress on May 13, 1908, appointing a “superintendent, chief nurses, nurses, and reserve nurses [who] shall be subject to an examination as to their professional, moral, and physical fitness . . .” (Public Law Number 115, 1909, p. 127, 146).



From the beginning, it was clear that Navy Nurses were intended to have exceptional clinical competence (professional fitness), a strong sense of leadership (moral and mental fitness), and readiness for operational duties (physical fitness). Navy

Nurses were to be ‘Clinical Leaders’ at every career stage, through patient care and collaboration with doctors, and other members of the health care team. Throughout their more than one hundred year history, Navy Nurses have defined and refined the clinical practice in hospitals, on the battlefield, and in remote, austere locations, demonstrating selfless acts of service and heroism in caring for all patients.

During the Vietnam era, our nation experienced many changes in social reform, health care legislation, and the economy. Among them, roles for women and minorities in the Navy expanded, Congress enacted Medicare and Medicaid Legislation, and health insurers grappled with how to contain rising health care costs in a nation facing economic challenges. This societal context translated to leadership advancements for nurses in the Navy Nurse Corps. As competent leaders and clinicians in wartime, nurses were now afforded opportunities to hold executive level leadership positions in the Navy. This included the establishment of the Director, Navy

Nurse Corps, at the rank of Rear Admiral. Simultaneously, the nursing profession was advancing in the clinical realm, affording Navy Nurses the opportunity to work in expanded scopes of practice as Licensed Independent Practitioners and Clinical Nurse Specialists. These added clinical practice arenas prompted the Nurse Corps to review its organizational structure in the 1970s. Career pathways were created in administration, nursing practice/administration, and education (Sterner, 1996).

From the late 1970s through 1990, Navy Medicine continued to expand roles for nurses in areas beyond the clinical bedside and Directorate of Nursing Services to include Commanding Officer of a Medical Treatment Facility and Deputy Chief, Health Care Operations, Bureau of Medicine and Surgery. As a result, it became imperative to prepare Nurse Corps officers for selection to these expanded leadership assignments. The Nurse Corps published “The Blueprint of Navy Nursing” in 1990. The “Blueprint” was the first training guide of its kind to formally codify

career mentoring. Until this time, career mentoring was performed through informal processes such as telephonic communication with the Assignment Officer or one-on-one meetings with the Senior Nurse at each hospital. The “Blueprint” was used to formally guide Nurse Corps officers in assignment options leading to positions of increasing responsibility; and outlining career milestones that could lead to sought after positions.

During the 1990s, the Navy expanded the duty opportunities where women could work, resulting in opening assignments of nurses — both male and female — to expanded missions in non-traditional hospital settings including service aboard ships and in combat service support roles with the Marine Corps. Platforms were reconfigured to accommodate both male and female sailors, and operational medicine now included health promotion and education to a more diverse population. Navy Medicine and health care nationwide entered the information era with the advent of the internet and the growth of personal computer

use. Health care technology transformed how patients were cared for. Patients became health care consumers and took an active role in managing their health care.

The Navy Nurse Corps responded to these expanded health care needs by publishing the Officer Career Guide. Like the “Blueprint,” this guide articulated milestones for success as a Navy Nurse, but was organized based on the roles of a Clinical Nurse Specialist: Education, Leadership, Research, Administration, and Clinical Practice. Navy Nurses recognized that there was a shift in “where” nurses cared for patients and that the care continuum expanded to include patient and family teaching. Nurses were patient advocates within a managed care environment, and the Clinical Nurse Specialist was used as a conceptual framework in the “Officer Career Guide” was the result.

The Guide’s primary purpose was “to ensure qualified officers are available to take on progressive responsibilities within the Navy Medical Department.” Three basic objectives were highlighted:

- 1) Provide for maximum professional growth and subsequent use of each officer’s abilities, aptitudes, interests, accumulated knowledge, and acquired skills;
- 2) Evolve and maintain a highly qualified Corps in order to ensure nursing services are professional, efficient, and effective during peacetime operations and able to meet any contingency requirement; and
- 3) Develop officers capable of assuming senior leadership responsibilities within the Navy Medical Department.

Though cognizance of the contingency requirement existed, the Career Guide aimed to develop officers in a peacetime environment with a focus on “progressive responsibilities” to assume senior leadership positions. It was the norm for nurses to leave the clinical bedside and work administratively by leading, mentoring, and teaching others who were providing direct patient care.

In August 1990, Iraqi forces invaded and occupied the country of Kuwait. This conflict ended in February 1991, when an international coalition of forces led by the United States drove the Iraqi forces from Kuwait. Navy Nurses were called into action to support Operations Desert Shield and Desert Storm, ending the peacetime environment in which our Corps had functioned for fifteen years. In the spring of 1994, a Department of the Navy Policy Paper entitled “Navy Medicine — Shaping the Change” posited a shift from global war and open ocean warfare to a “focus on regional conflicts and joint operations,” and highlighted the affect on the entire Navy, including Navy Medicine (Department of the Navy Policy, 1994, para 1). Navy Medical personnel would now be called on to assist in humanitarian, disaster relief, and peacekeeping missions, as well as support for conventional wartime contingencies, however, it would be another seven years until our nation was forced to test this theory.



### A Renewed Focus

The events of September 11, 2001 changed Navy Nursing significantly. On that morning, nineteen terrorists worked simultaneously to hijack four commercial airplanes and use them as weapons of destruction against the people of the U.S. In response, President George W. Bush declared a Global War on Terrorism. Within months, the Bush administration deployed military forces to Afghanistan and Kuwait. In early 2003, Coalition Forces invaded Iraq. Daily operations for Navy Medicine became a balancing act in creating a fit and ready mili-

tary force, ready to deploy with the warfighter to provide medical support in forward deployed settings, and caring for warfighters, their families and retirees at home.

The health care and personnel demands resulting from increased deployments required a joint effort inside and outside of the Department of Defense, and the use of active duty, reserve, civil service, and contracted personnel was required to sustain equilibrium.

By April 2004, five hundred active duty nurses (17 percent of the Active Component (AC) force) had deployed in support of Operation Iraqi Free-

dom to USNS COMFORT (T-AH 20), Fleet Hospitals, Casualty Receiving Treatment Ships, Shock Trauma Platoons, and with the Marines. The second largest recall of reserve Navy Nurses since Desert Storm had simultaneously occurred, filling more than four hundred reserve mobilization requests (25 percent of the Reserve Component force).

The Global War on Terrorism began amidst a continued and growing national nursing shortage, and the Nurse Corps was not immune to its affects. Recruitment efforts were not meeting goal in the years prior to 2006, and nurses leaving the Navy outnumbered those entering. Additionally, the high operational tempo meant that by 2006 many Nurse Corps officers were facing a second or third deployment. At the end of 2006, Navy Nurse Corps manning was at ninety one percent with a deficit of 286 active duty nurses.

Compounding these recruiting and retention challenges, a review of military medical manpower was conducted in 2004 which contested the size of military medicine.

Through this Medical Readiness Review (MRR), it was determined that the change in conventional warfighting strategies produced fewer casualties which should then result in a requirement for smaller medical staffing configurations. As a result of the MRR findings, Congress authorized the conversion of military positions to civilian positions. Now the Nurse Corps not only had to recruit, deploy, and retain a smaller force, but also had to compete with the civilian sector to recruit staff to fill newly converted civilian nurse vacancies.

The ability to successfully sustain an increased operational tempo while maintaining a simultaneous, ongoing requirement to care for service members, their families and retirees at home, would require a focused strategic effort. Navy Nurse Corps leadership worked to develop short and long term strategies. These strategies aimed to ensure nurses at all ranks had the appropriate professional expertise and leadership to deploy and practice in all settings while at war, as well as to expand Navy Nurse recruitment and

retention amidst a national nursing shortage.

Beginning in 2005, Nurse Corps strategic planning efforts focused on balancing the need to meet the benefit mission and operational readiness requirements, addressing the challenges affecting recruitment, retention, and the relevance nurses in uniform. Throughout the strategic planning activities, it was evident that clinical leadership and competence were central themes. Men and women enter the field of nursing in order to provide care to patients. Men and women enter the military and become Navy Nurses in order to care for patients in and out of harm's way.

While the Nurse Corps has broadened its opportunities in leadership, education, research and administration, the fundamental mission remains the same. Navy Nurses "[are a] deployable medical capability that can go anywhere, anytime, with flexibility, interoperability, and agility." Clinical leadership and competence are what make Navy Nursing relevant. Clinical sustainment policies were created

to ensure that 100 percent of Navy Nurses are ready to deploy. These policies validated the relevance of our clinical practice in any setting, and incentivized men and women to join and stay in the Navy Nurse Corps. In addition to clinical sustainment, the Nurse Corps focused on initiatives to improve recruitment and retention through bonuses and student educational programs.

In her testimony before the Senate Appropriations Committee, Subcommittee on Defense, Rear Admiral Christine M. Bruzek-Kohler stated, "At Military Medical Treatment Facilities, in the operational theater, on humanitarian missions, and working in a joint environment, Navy Nurses are clinically agile and trained to mission requirements." Force shaping policy and training requirements are "focused on operational medicine and evidenced-based health care" as the key to supporting the warfighter while also providing the finest care to our uniformed service members and beneficiaries" (March 7, 2007). These efforts resulted in the achievement of recruitment goals from 2006 to the present. However,

retention of personnel continued to be an issue. The appropriation of retention funding in 2006, through the Health Professional Loan Repayment Program and subsequent programs, such as the Registered Nurse Incentive Special Pay in 2008, has helped to incentivize Navy Nurses to "Stay Navy." In 2008, for the first time, Nurse Corps accessions outnumbered its losses.

With short-term initiatives in place to address clinical competency, recruiting, and retention, the Nurse Corps turned its strategic planning focus toward long-term strategies that would shape the Corps and build Clinical Leaders for the future. The goal of these long-term strategies was to ensure that the right numbers of nurses with the right training are detailed in the right assignments at the right time. The vision supporting these goals was to become the premier employer of choice for active, reserve, civilian, and contract nurses.

To begin the process of long-term strategic planning, nursing leaders were asked to review existing surveys on retention and satisfaction

among Navy Nurses. The leaders reported that leadership, training, and mentoring for executive medicine roles influenced overall satisfaction and retention efforts. In a 2005 Chief of Naval Personnel Quick Poll Survey, less than half of the Navy Nurse Corps respondents reported being very satisfied or satisfied with Nurse Corps leadership. Additionally, internal junior officer focus groups revealed questions as to how personnel were selected and trained to fulfill leadership roles. A research study was performed in which leadership competencies and associated knowledge, skills, and abilities specific to mid-level and senior executive Nurse Corps officers were identified (Palarca, 2007). Armed with this information, strategic goal teams were established in Clinical Excellence, Force Shaping, Recruitment and Retention, Communication, Mentorship and Leadership to assess and formulate action plans to improve overall satisfaction and retention, while simultaneously promoting the need for Clinical Leadership.

## A Model to Guide Our Future

Through the work of the strategic goal teams, it became evident that the existing Officer Career Guide and Nurse Corps Career Planning Chart did not support the aim of Navy Nurses functioning as Clinical Leaders throughout the different phases of their careers. The Leadership Goal Team set out to review and update these documents to be in alignment with Navy Nurse Corps strategy and policies. Previous work to update the guide was implemented through the Navy's Task Force EXCEL (Excellence through Commitment to Education and Learning). It was envisioned that an interactive online tool would be developed to assist Nurse Corps officers in their career goals. The online tool was to be based on a five-vector model with the following key areas of focus: professional development, personal development, leadership, certifications, qualifications and performance. Work on this tool began in 2004, however was halted in 2006, when systems and resources could not fully support the initiative.

The Nurse Corps Career Planning Chart was created in 2005, as an update to the 1991 Officer Career Guide. The Planning Chart attempted to highlight opportunities available to Nurse Corps officers in their pursuit of personal and professional excellence and followed five career tracks. These tracks included the original three tracks of Administration, Nursing Practice/Administration, and Education. The track entitled, "Nursing Practice/Administration" was changed to simply state "Clinical." Two new tracks, "Operational" and "Research" were added. The matrix format was used to demonstrate the wide-variety of career paths available to the Navy Nurse Corps officer, and the multiple opportunities which the officer could consider at different ranks of his/her career.

The Planning Chart was successful at consolidating a wealth of information into a one page document. In the accompanying write-up, reviewers were reminded of the importance of clinical excellence for a professional nurse and readiness preparations throughout all ranks

and all career tracks. Nurses were told that careers did not necessarily progress linearly through a single tract, and that assignment to a particular position might not occur at the exact rank and grade indicated on the chart. However, the visual representation of the career chart did not adequately support this written reminder. The stove-piped representation of five career tracks often gave Nurse Corps officers an excuse to stay in one track without the continued pursuit of balance between operational readiness, clinical sustainment, and leadership development. A new model was needed in order to demonstrate the dynamic flow of one's career and to provide a conceptual framework for "Clinical Leadership."

The development of the Clinical Leadership Model began in early 2008. The original design began with clinical skills represented as the foundation of the Navy Nurse's career. This foundation is expanded through the pursuit of specialized skills, clinical certification, and advanced practice degrees. The model included the need to

maintain operational readiness and development as a leader, culminating in the achievement of clinical confidence and competence to fulfill a multitude of roles, as defined as Clinical Leadership. The Clinical Leadership Model has been refined to clearly demonstrate the importance of all three domains: Operational Readiness, Professional Development, and Leadership. However, clinical competence remains the heart of the model.

The original design attempted to correlate military rank with the titles of various positions one could hold throughout a career. However, it was concluded that this would give an inaccurate impression. Job assignments vary with rank, but also with facility size and opportunity. Nurses should focus less on the title of the position for which they are assigned, and more on their ability to remain clinically competent and operationally ready, while continuing to

develop as a leader. The overarching goal of the clinical leadership model is to strive for balance between the three domains of operational readiness, clinical proficiency, and leadership development throughout all phases of a Navy Nurse's career. Clinical Leadership is the result of this balance, and clinical leaders are necessary at all ranks within the Navy Nurse Corps.



## Chapter 2

### The Foundation of Navy Nursing

#### Navy Nurse Corps Accession

**P**rior to 2002, nursing diploma graduates, associate degree nurses and individuals who graduated from a state accredited school were eligible to join the Navy Nurse Corps. Through their clinically focused education, these nurses possessed the strong clinical assessment and patient care skills necessary to care for ill and injured patients in hospital settings. However, as technology, science and the American health care system evolved, nurses gained expanded opportunities to care for patients outside the hospital. This included roles in patient education, disease management, community health, care coordination, and case management. Nurses not only had to be clinically competent, they

also needed expanded skills in management, leadership, health insurance, and public health strategies. Recognizing this, the American Association of Colleges of Nursing (AACN), in its 2000 Position Statement, recommended the baccalaureate degree become the entry level degree for professional nursing, stating “Rapidly expanding clinical knowledge and mounting complexities in health care mandate that professional nurses possess educational preparation commensurate with the diversified responsibilities required of them.” A baccalaureate degree emphasizes leadership and management skills, wellness, and community nursing, and prepares nurses to work in expanded roles in health promotion, disease management and coordination of care within the complexities of a modern health care system (Ellis, 2004).

To execute its mission, the Navy Nurse Corps requires its nurses to take on a multitude of roles in our medical treatment facilities and in forward deployed settings. Navy Nurses demonstrate

clinical leadership very early on in their careers. Hence in 2002, the Department of the Navy began requiring all Navy Nurses to have graduated from a school of nursing accredited by the National League

for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE) since they confer a nursing baccalaureate or advanced nursing degree.

A Navy Captain reflects upon her decision to join the service upon graduating with her Bachelor of Science in Nursing (BSN) from the University of Arkansas in 1983:

Upon graduating from college, joining the Navy was never among the career choices I would have ever considered. I suspected that the nurses who settled for military service might not be bright enough to get “real” jobs. However, my roommate had visited the recruiting fair and talked to the medical programs recruiter on numerous occasions and told me I was incorrect in my initial assumption. It was only after she told me about a recruiting trip to San Diego, California, that I began to feign any interest in the Navy at all. I grew up an Air Force brat and had completed my senior nursing clinical

seminar with an active duty Pediatric Nurse Practitioner (Colonel, United States Air Force). So if any of the Armed Services were going to get the nod, I had decided it would be those mighty defenders of the air.

Needless to say, the rest is history. I fell in love with the sun and the surf of San Diego, the quaint “pink palace” hospital in Balboa Park and of course those smart white summer uniforms. I returned to Arkansas wanting to be nothing other than a Navy Nurse. I joined the Navy a few months later with no bonus, no scholarship and only a verbal agreement from the recruiter that my roommate and I would be assigned to our first duty station together. That was almost twenty-five years ago. How little of the Navy and the world I knew in my hometown of twenty-six thousand!

## Bedrock of the Navy Nurse Corps — Clinical Skills

In joining the Nurse Corps, nurses must meet the necessary prerequisites of both degree and licensure, as well be infused with the desire to serve their nation. In Officer Development School, a six-week Navy introduction for new staff officers, nurses learn military regulations, traditions, and etiquette. For most, their first duty station is also their first opportunity to integrate several roles simultaneously: naval officer, nurse, and Navy Nurse. Much like their line counterparts who serve on ships, onboard submarines or in aircraft, Navy Nurses spend their first duty station developing their professional skills and experience within their field. In this case, nurses become competent in independently providing nursing care in one or more clinical specialty areas, such as medical-surgical, pediatrics, or mother-infant.

Depending on their entry level practice experience and education, new nurses gain skills at differing

speeds through the five stages of nursing competence: novice, advanced beginner, competent, proficient and expert (Benner, 1984) (Figure 2.1).

newly arriving to a medical/surgical ward, are characterized as novices. They rely on checklists, memorization and discussion with their clinical preceptors during orientation.

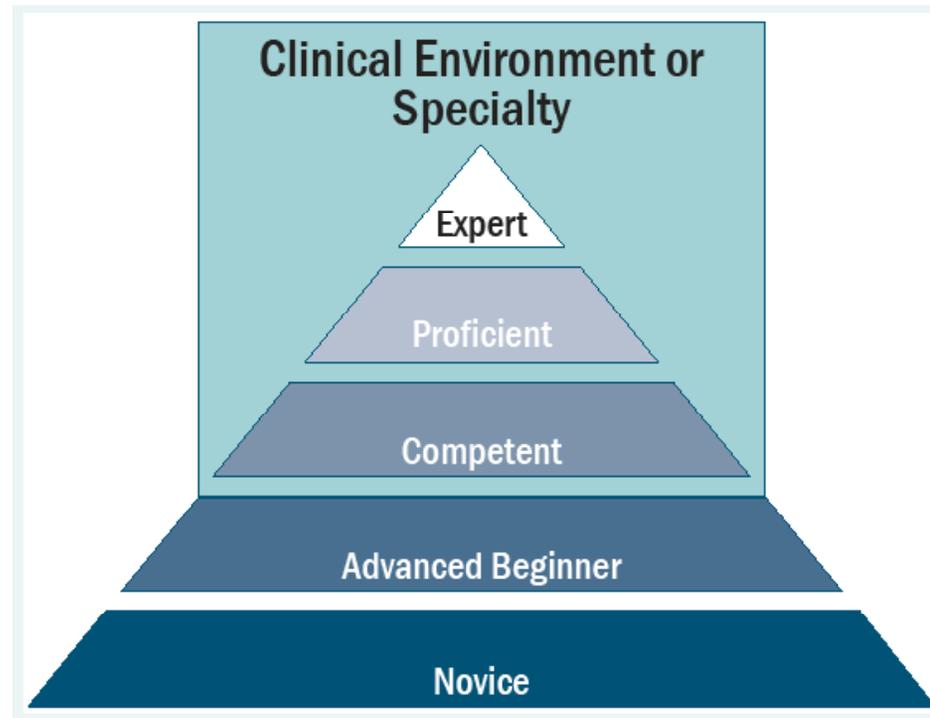


Figure 2.1 — Benner's Stages of Nursing Competence

Benner qualitatively described the phenomena of stages of nursing skill and rapidly became a seminal work taught within many nursing schools. Her work continues to resonate throughout the profession. In applying her framework, Ensigns,

These nurses quickly become adept at their clinical practice and move from novice to advanced beginner to competent by the time they reach the rank of Lieutenant Junior Grade (generally two years from an Ensign). Navy Nursing has focused

on achieving the competent stage, as this represents the level of safe and effective independent nursing practice. Depending on whether he or she remains in the same or a related clinical area, this nurse can hone their clinical skills to become proficient and even expert as they mature into a “seasoned Lieutenant.” The goal is to take these novice accessions and cultivate them into clinical experts who are capable of treating patients in multiple environments—deployed, aboard ship, in academic medical centers, or remote overseas clinics—while simultaneously serving as a role model and mentor to the nurse they work alongside.

The “Clinical Skills Foundation” of the Clinical Leadership Model is the foundation upon which Navy Nursing rests. No matter what rank the nurse achieves, what position he or she may hold, or where they may practice, clinical competence consistently translates into success. Consider nurses in nonclinical positions, whether as an infection control nurse, a quality assurance manager, or a nurse executive;

though not executing hands-on patient care daily, why do these individuals need to be nurses? They all share clinical competence. Clinical competence generates multiple second and third order effects; driving sound clinical judgment and critical reasoning skills. It also provides a profound experience and knowledge of the health care process; how care is delivered, how professionals think and behave, and familiarity with the very reason for our profession: patients. Withdraw clinical competence and the body of our profession collapses without the supporting skeleton.

### Navy Nursing Clinical Competence

Navy Nursing Clinical Competence is defined as “the demonstrated, measurable integration of the knowledge, skills and attitudes required to provide quality, safe and independent nursing care within a defined practice role” (Bloom, 1956; National State Boards of Nursing, 1999; Benner, 1984; JCAHO, 2005). Clinical competence is necessary to provide quality care,

is an expectation of the patients cared for, and is an integral part of the interdisciplinary health care team of Navy Medicine. As part of its enterprise plan for managing human resources, entitled “Human Capital Strategy,” the Navy views nurses as a human resources capital asset, as important as an aircraft carrier and as enduring as a naval base. Nurses have a value and a strategic cost to an organization which must be aggressively optimized for mission success. To be an effective asset, the nurse must be not only being trained and ready, but must also demonstrate critical reasoning and clinical judgment within the clinical area in which he or she practice. The requirements and practices within the operating room are very different than in behavioral health, for instance, each has its own patient presentations and responses, requiring different knowledge and skill sets.

Unless we, as nurses, continue to deliver appropriate, timely, compassionate clinical care we become valueless to our patients, our service, and our nation.

## History of Clinical Assessment

The classic measure of nursing clinical preparation, the orientation checklist, has been around since the early days of nursing; a laundry list of procedures, tasks, locations, and trivia passed down on clinical units like a sacred recipe from generation to generation. Each time an untoward event or staff action occurred, another entry made the list. As word processing tools replaced the typewriter, the fonts got smaller, items became more detailed, and the page count grew as if nursing competency could be measured by word count. Amazingly, items never came off the list.

In the late 1950's, education and cognitive researchers developed new ideas on competency, such as Bloom's work (1956), which combined cognitive — and mental skills (knowledge); psychomotor — manual or physical skills (skills); and affective — feelings or emotional areas (attitudes) components. It took almost fifty years for the concept of competency to overtake the orientation checklist,

indeed; many early “competencies” were merely renamed checklists.

## Measuring Competence

In the past ten years, nursing educators and researchers have grappled with the complexities of defining and measuring clinical competence. In a 2002 article in the *Journal of Advanced Nursing*, researchers conducted a review of nursing competency strategies and found confusion abounds about the definition of nursing competence. Most of the methods used to define and measure competence have not been developed systematically nor has measurement validity or reliability been addressed (Watson, Stimpson, Topping, Porrock, 2002, p 39). More recently, research studies have reviewed various competency measurement methods including testing, certification, adult learning concepts, skills assessment, simulation and portfolio development. These studies determined that employers and nurses alike appreciate a competencies measurement approach that accurately captures a nurse's experience in both the measured

skill and the critical thinking involved in caring for patients requiring the use of this skill.

In the early 2000's, the Joint Commission, which inspects and certifies health care organizations and facilities, developed standards requiring the facility to determine and assess staff competence. Hence competency development and implementation became an integral part of staff education and training.

## Developing Navy Nursing Standardized Competencies

In late 2006, the Clinical Excellence Strategic Initiative Team took on the task of creating standardized competencies within Navy Nursing — one standard (per specialty) consistent at all facilities and deployed locations. The group used several sources including Benner's Novice to Expert Model as a framework for describing the development of a nurse's competence and skill. Evidence-based Knowledge, Skills and Abilities (KSAs) built primarily upon the professional nursing specialty organizations' core curricula,

seminal texts and core competencies, helped further define competencies; items which the nurse must demonstrate to show their readiness to deliver safe and effective professional nursing care. The Initiative Team engaged the Nursing Specialty Leaders to lead the development of each clinical competency.

### Creation of Competencies

Determining nursing competence within a specialty or practice area is based upon incremental layers. This approach ensures flexibility for Navy and local needs, while guaranteeing



Figure 2.2 — Foundation of Nursing Competence

standardization within national and international practice (Figure 2.2).

First, the competency author reviews the professional specialty organization for their defining and reference clinical standards within a given specialty. This may include a core curriculum (published textbook/reference work of the scope of the specialty and key components, skills, and knowledge contained within), practice standards, statement(s) on practice scope or professional competencies (tool for identifying and assessing competence). An example is the American Academy of Critical Care Nurses' core curriculum, practice scope and standards for critical care nurses. Some specialties have more than one professional organization whose works must be harmonized and integrated.

The author then reviews the current works used to define and assess nursing competency in use. This may include published literature search results and products used in Navy, as well as Army, Air Force, and other federal organizations. The various works differ in scope, detail, and content. The author assim-

lates these products to ensure the resultant competency is reflective of the practice experienced at the bedside. Military and Navy unique and specific practice is clearly detailed, as well as any prerequisites (such as Advanced Cardiac Life Support for a critical care nurse) and standardized electronic training. In the integration, a key focus is on usability: a one hundred page comprehensive tome will not be effective in practice; most competencies are eleven to seventeen landscape pages at their core. The competency is also referenced so that each KSA listed has additional information available for the preceptor (person assessing competency) or nurse under review. Often the reference is to a specific nursing procedure manual entry. Such citation makes the work representative of the larger evidence-based practice. Not every potential case or detailed variant can be covered. As professionals, a key trait to be assessed is the nurse's critical reasoning and clinical judgment — the ability to correctly apply general principles for a situation not explicitly covered.

An approved and fielded competency becomes standard throughout Navy Medicine. When used in a specific setting, the command's senior nurse also looks at issues and needs unique to that hospital/clinic or unit. These may be items that are problem prone, infrequently occurring, or somehow locally distinct. This prevents a one-size-fits-all mismatch and allows adjustments for local need.

Since the competency defines nursing practice within the specialty, the nurse also receives orientation for local policy, processes, and application. This ensures readiness to deliver safe, effective nursing care within the specialty that is both standard through the Navy and meeting local variations and eccentricities that occur in deployed, overseas, and remote locations. Each competency is updated annually using the same process minus the pilot testing. This ensures changes in practice, reference work, and specialty is reflected in a timely manner.

Clinical competency is assessed at multiple milestones: when a nurse

arrives to a new specialty; every two years as a yardstick of clinical performance; when requesting identification within a specialty, and when preparing for a deployment on a humanitarian or contingency assignment. Feedback through the

command senior nurses, specialty communities, and individuals are considered for incorporation into both process and product. This builds a sense of community, and ownership, for the competency as indicative of the nurse's practice.

#### Vignette from a LT:

I can still vividly recall the anxiety I felt when I received the call from the Main Operating Room, alerting me that the a fresh Coronary Artery Bypass Graft had trouble coming off bypass and would be returning to the Intensive Care Unit with an Intra Aortic Balloon Pump and on multiple medication drips. I was only a Lieutenant and had worked in the Intensive Care Unit at the Naval Medical Center San Diego for two years, but was senior in grade and experience to the Lieutenant Junior Grade (LTJG or JG) who was standing beside me wide-eyed with fear of the unknown as the patient and his entourage of cardiothoracic surgeons, anesthesiologist and technicians descended upon us.

The JG looked at me and said, "I am so glad you are working with me tonight!" I thought to myself, she thinks I know what I'm doing and that I'm calm, cool and collected. I had better not let her down.

While I might not have felt this way on the inside, on the outside, my behavior, actions and communications all indicated that I was in control. And why shouldn't I be? I was a top-notch critical care nurse (a Critical Care Registered Nurse (CCRN) who was renowned as one of the elite few in the ICU cross-trained to care for the most complex cardiothoracic patients. I was respected by my subordinates, peers, seniors, and most importantly by the surgeons for my clinical expertise. So what I lacked in self confidence, I made up for in clinical competence. ♦

## Maintaining Competence: Development of Clinical Skills Sustainment

In the years leading up to September 11, 2001, during an era of peacetime operations, the Navy right-sized its force in response to a changing national military strategy. Additionally, expanded roles for women in the Navy and advances in the health care system, afforded nurses the opportunity to excel in non-traditional nursing functions including leadership and executive medicine positions. Following the horrific attacks on our nation on September 11th, combat operations executed in Iraq and Afghanistan increased the demand for clinical nurses at the bedside, not only to care for patients as part of the peacetime mission, but to deploy and care for patients in harm's way. This simultaneous, dual mission, required nurses at all ranks to be clinically competent in a critical wartime nursing specialty, such as emergency, critical care, psychiatric, medical-surgical, or perioperative nursing.

To achieve this deployment readiness, the Director, Navy Nurse Corps and Navy Medicine Regional Commanders enacted the Standard Organizational Policy for Nurse Assignment, Staffing and Operational Clinical Skills Sustainment in 2006. The policy directed Directors of Nursing and Senior Nurses to ensure their Nurse Corps officers were operationally competent and clinically proficient. Previously, nurses that had taken an administrative tract (nursing administration, education and training, staff specialist positions) generally did not maintain a clinical practice or routinely deliver care. Clinical sustainment was a particularly important initiative as Navy Medicine evolved and changed in response to the new challenges stemming from the Global War on Terrorism, specifically the personnel strain to simultaneously deploy trained, competent nurses and provide care within the facility at home.

The policy, modeled after an earlier U.S. Air Force clinical sustainment initiative, stipulated that Nurse Corps Officers other than

licensed independent practitioners or Certified Registered Nurse Anesthetists (CRNA) would sustain operational clinical competence by completing a minimum of 168 annual clinical hours in one of the following areas: Intensive Care, Medical/Surgical, Perioperative, Emergency, Maternal/Infant, Mental Health or Post Anesthesia nursing. Nurse practitioners in Family Practice, Pediatrics, Women's Health, Midwifery, and Mental Health, regardless of assignment, were charged to maintain certification, gain privileges, and complete a minimum of two hundred patient contact hours annually. A CRNA must complete 850 hours over his or her two year recertification period. Other Advanced Practice Nurses with specialties in Emergency, Critical Care and Adult Acute Care were to maintain certification if available and practice in that role as the facility could best allow.

Ideally, Nurse Corps officers should not be assigned outside of their primary specialty for more than one tour. Nurse Corps officers given the primary subspecialty

codes of Manpower Systems Analysis, Education and Training Management Systems, or Health Care Management and assigned a secondary clinical code were charged with sustaining competency by completing the minimum hours for their secondary specialty. Should these nurses need to deploy, it would be in their secondary skill.

The collaboration between the naval hospital/clinic Executive Leadership Team and the Director of Nursing (DNS)/Senior Nurse Executive (SNE) was critical to the successful implementation of this initiative. The DNS/SNE was challenged to make every effort to execute local staffing assignments to reflect the intent of this policy. He or she was encouraged to educate nurses and review their progress with this policy semi-annually to ensure compliance and continual operational deployment readiness.

What seemed to be a policy that made sense led to a plethora of questions, chief among them: “How could remote commands or ambulatory clinics address clinical skills sustainment for specialties not

available in their facility?” Creative thinking led to plausible solutions including sending officers to a larger military hospital when financially feasible, establishing a Memorandum of Understanding (MOU) with area hospitals, encouraging moonlighting, and/or communicating with assignment officers at regular intervals to ensure that certain specialties were not assigned to outpatient or multi-service ward hospitals.

### Fortifying our Foundation

Throughout their career continuum, Navy Nurses are responsive, capable, and continually ready to provide the finest care “Anytime, Anywhere.” Maintaining our clinical proficiency, especially in critical wartime specialties, aligns directly with the Chief Naval Operations’ priority of Enhanced Readiness: “Maintaining our war fighting readiness will ensure we are an agile, capable and ready force” (Chief Naval Operations, Admiral Gary Roughead’s Message to the Fleet, October 2007). In hospitals, the operational theater, on humanitar-

ian missions, or working in a joint environment, Navy Nurses are clinically agile and trained to mission requirements (Raimondo, Pierce, and Bruzek-Kohler, 2008).

Navy Nurses provide state of the art specialty nursing care as members of the health care team in our varying location and role — hospital and clinic; contingency, humanitarian. Readiness and clinical proficiency are key elements to our success in meeting Navy Medicine’s mission. The mission of Navy Medicine evolves as world events and politics change: humanitarian missions to the Pacific Rim following a devastating tsunami, wartime deployments to Iraq, nation building in Afghanistan, and counter-terrorism in the Horn of Africa. Navy Nurses must continuously evaluate their training programs and clinical competencies, enhance their effectiveness through lessons learned, and allocate appropriate resources (personnel, time and funding) to improve their capabilities. Individuals returning from their missions provide invaluable feedback, making Navy Medicine a continuously learning organization.

No matter what rank you achieve, the number of academic achievements and certifications you earn,

the duty station you tirelessly seek, the assignment you long to fill or your number of years of service, your

value to the Navy Nurse Corps is based on your clinical competence.

Vignette from a CAPT:

Beginning each spring, Friday is Double Headers night at the local community ballpark where my fourteen year old son plays. My husband and I head there immediately after work every week. With my current work schedule, I sometimes miss games. However, this particular night, I did make the game and there was more action than I had ever imagined.

I was chatting with a group of mothers about planning a potluck to celebrate the end of baseball season when I noticed a couple of other moms standing together not far from the field. One was beckoning and calling us over. Thinking they merely wanted us to join them for a photo opportunity, we slowly sauntered over. It was only when I got closer that I recognized the fear in one of the women's faces and the unforgettable vacant stare of the other as she began seizing. It was a full blown, text book tonic-clonic seizure, complete with a period of unresponsiveness, airway compromise and an exceedingly lengthy postictal phase (so long such that the lay bystanders were convinced that the woman had suffered a stroke).

I was the only nurse at the field. The other parents who quickly rallied to assist with the emergency included a state trooper who activated the Emergency Medical System and two chiropractors who were pretty rusty in their Basic Life Support skills. I took charge of the patient during her seizure and recovery; directing the activities of all helpers and giving a report to the Emergency Medical Technicians.

Once the event was over and the patient was being transported to the hospital, I was thanked by many who saw me in action. One of the chiropractors approached me and said, "So what kind of nurse are you?" I thought for a minute and replied, "I guess a jack of all trades: a Navy Nurse." I further explained that while I worked in an administrative role now, I had extensive experience in critical care, medical/surgical and ambulatory care. Later I learned from a neighbor that team parents attributed my quick thinking and actions to the fact that I was a Navy Nurse.

While we may find ourselves in less clinical environments over the years, our take charge demeanor, emergency responsiveness, and clinical sustainment marks us for what we truly are and will always be known: Navy Nurses. ♦



# Chapter 3

## Professional Development, Clinical Specialization, and Advanced Education

### Definition of Professional Development

**N**ursing professional development is the lifelong process of active participation in learning activities that assist in developing and maintaining continuing competence, enhancing professional practice, and supporting achievement of their career goals (American Nurses Association [ANA], 2004). Staff development, academic education, and continuing education are all pieces of the Navy Nursing career journey; and each plays an important role as nurses gain knowledge and confidence in their abilities to care for our unique patient population. Navy Nurses must be responsive, capable and continually ready to provide state of the art specialty nursing care as members of the health care team in our Military Treatment Facili-



ties (MTFs), Operational Theaters and in Humanitarian Relief efforts.

Unlike traditional nursing, military warfare offers a different workplace situation for Navy Nurses. Navy Nurses learn to work fast and make critical decisions. Every day, lives are on the line, and they provide the link to the care military patients need. They work seamlessly with doctors and technicians, quickly developing the synergy needed to keep the war wounded alive. When not on the front line or in the field, Navy Nurses continu-

ally attend training opportunities and are sent to school to upgrade their degrees at either college campuses or through online courses in a variety of nursing specialties. This continuing education has an emphasis on the following critical war time specialties:

- Critical Care Nurses focus on the care of critically ill or unstable patients. Critical care nurses can be found working in a wide variety of environments and specialties, such as intensive and coronary care units and the post anesthesia care unit.
- Emergency Nurses care for patients in the emergency or critical phase of their illness or injury. While this is common to many nursing specialties, the key difference is that an emergency nurse is skilled at dealing with people in the initial phase when a diagnosis has not yet been made and every second counts.
- Medical-Surgical Nurses form the foundation upon which all other specialties are based and are the largest group of practicing professionals. Medical-surgical nurses provide holistic care for patients across the life span, in a broad range of settings, applying their knowledge to all body systems and disease processes.
- Nurse Anesthetist is an Advanced Practice Registered Nurse qualified by advanced training in an accredited graduate level program to manage the care of the patient during the administration of anesthesia in medical and surgical situations.
- Family Nurse Practitioner, by advanced education and clinical experience, has acquired expert knowledge and skill. The family nurse practitioner acts as a nurse clinician, functioning independently within standing orders or protocols and collaborating with associates to implement a plan of care. The services of family nurse practitioners are increasingly in demand.

- Psychiatric or Mental Health Nurses care for people of all ages with mental illness or distress, such as schizophrenia, bipolar disorder, psychosis, depression or dementia. Nurses in this area receive additional training in counseling, building a therapeutic alliance, dealing with challenging behavior, and the administration of psychiatric medication.

The professionalization of nursing has been accompanied by recognition of the need to change the culture in Navy Nursing to “nurse first and always.” To promote clinical experts and shape the future of Navy Nursing through professional development from novice to expert, the Navy Nurse Corps reviews, assesses, and identifies opportunities for professional growth and knowledge in all nursing disciplines. Navy Nurses build confidence through a structured, professional transition-into-practice model that is customized to individual developmental needs that promote clinical skills and knowledge in world-class academic

medical institutions. They develop leadership skills that positively impact the clinical practice environment and patient outcomes.

Whether through formal education, continuing education, or certification, Navy Nurses pride themselves on their flexibility and adaptability. They develop their professional nursing practice in a supportive environment committed to mentoring, coaching and continued learning. Lifelong professional development ensures that Navy Nurses are continually ready to provide the finest in care wherever and whenever they may be called upon.

### Clinical Specialty Certification

Navy Nurses are expected to recognize and respond to a plethora of new demands arising from an ever-changing and increasingly complex health care system. New regulations, accreditation processes, professional standards, increased accountabilities, and financial priorities require more direct care nurses and nurse leaders to gain and sustain competencies in evolving

arenas of practice, quality, and safe patient care. The American Nurses Association (ANA) defines certification as “a means of measuring competency, and the identification of competent nurses that will promote the public welfare for quality in health care” (American Nurses Association [ANA], 2004).

Research has shown that certified nurses have more confidence, competence, credibility, and control and commit fewer errors (ANCC, 2005). Certification has far-reaching benefits; it offers extensive advantages throughout the health care system, benefiting patients and their families, nurses and their colleagues, as well as the Medical Treatment Facilities and operational platforms that employ these certified nurse corps professionals. It is, quite simply, an asset to the entire nursing field. Certified nurses participate in nursing specialty professional organizations and meet strong professional development requirements. By keeping abreast of the latest developments in health care practice advancements, technology, and making continuing

education a priority, certified nurses not only maintain their competence to practice, but also boost their professional self-confidence and serve as subject matter experts.

Navy Nurses who have expanded their nursing knowledge and have made continuing professional development a priority assure our beneficiaries that they have the skills and experience to effectively and safely deliver top-notch care. Certification contributes to a nurse's professional growth, patient care, and personal pride which validate specialized knowledge and professional credibility. It is a requirement for certain areas of nursing practice, and a tremendous asset for all others. Find your clinical passion, and take the first step towards bettering your professional future by applying for nursing certification.

### DUINS/Graduate Level Education

The Navy Nurse Corps is committed to educational excellence in professional development and offers a variety of programs. Currently, the Nurse Corps selects and funds, on

average, seventy three nurses per year to attend Duty under Instruction (DUINS). Nurse Corps officers who participate in full-time DUINS receive full pay and allowances, as well as all tuition and fees. Each year, the Nurse Corps publishes updated training requirements for each of the clinical nursing specialties, using current and projected manning levels in each specialty. Training opportunities are determined by the Director of the Nurse Corps, and may include selection for graduate studies as a Clinical Nurse Specialist (CNS) or Advanced Practice Nurse (APN). Additionally, nurses can pursue graduate degrees from the Naval Postgraduate School, Army/Baylor Program in Health Administration or in Education and Training Management. Post-Master's Certification and Doctoral Degree Programs are also available.

Nurses who have been selected to specialize as a Clinical Nurse Specialist may also take extra courses to become licensed and credentialed as a nurse practitioner in a particular specialty. These nurses who take a dual degree track

will then go on to practice as both a CNS and a Nurse Practitioner.

Full-time DUINS for Nurse Corps officers gives the necessary preparation to meet critical advanced education needs, broaden overall nursing knowledge base, and promote critical thinking skills. In addition full-time DUINS for Nurse Corps officers enable the Nurse Corps to fulfill its mission and benefit the Navy and the individual by:

- 1) Ensuring higher levels of professional knowledge.
- 2) Giving incentives for recruitment and retention of personnel with ability, dedication, and capacity for growth.
- 3) Recognizing educational aspirations of individuals through advanced degrees and certification programs.

Attaining an advanced degree opens many doors for future assignments, and is an excellent mechanism to continue supporting the Chief of Naval Operations' (CNO) initiatives.

Navy Nurses own the keys to their own destinies; they have proven themselves as both professional Nurses and Naval officers. Now is the time to take the next step, a step into the future as a leader, clinical specialist, and health care educator. Now is the time to take your career to the next level and prepare yourself to meet the continuing challenges of Force Health Protection as we continue to wage the war on terrorism. Advanced practice education allows nurses to contribute to their subspecialties' needs, care for their comrades under arms when ill or injured, and to help shape the health care force of tomorrow. Selecting a program of study through DUINS that incorporates clinical program participation with a blend of leadership, administration, management, and education allows Navy Nurses to be prepared for future opportunities.

Upon graduation from a fully accredited program, the Nurse Corps officer is assigned a primary subspecialty code, and detailed according to that primary specialty selected for at the completion of DUINS. The follow-on-tour after graduation

from DUINS is known as the "utilization tour" where they are assigned to a billet reflecting the selected area of study. All DUINS graduate students are world-wide assignable and deployable according to the needs of the organization.

### Competence to Confidence

In health care literature, the term competency is often used to describe the knowledge to be able to perform at a particular task (Schroeter, 2008). According to Norman competency extends to more than just knowledge. It includes the understanding of clinical, technical, and communication skills, and the ability to problem solve through the use of clinical judgment (1985). Navy Nurses must be adaptable to multiple nursing environments and know that psychomotor skills are important but, performed without a thorough understanding, they do not constitute nursing. Concurrently, up to date nursing knowledge of health and disease processes is of little use without the appropriate nursing skills to implement. This is why Navy

Nurses must maintain clinical proficiencies throughout their careers.

Competencies are used to create unique standards within disciplines and specialties. As delineated in Chapter 2, Dr. Patricia Benner's hallmark work demonstrates a measurable continuum from novice, through advanced beginner, competency, and proficiency to expert practice (1984). The Joint Commission on Accreditation of Healthcare Organizations reported that competency assessment is "a determination of an individual's skills, knowledge, and capability to meet defined expectations (2005). Commonly, professions use external measures for assuring competence. Qualification for practice is assured by licensing laws and by professional standards. Familiar examples in nursing for assuring competency include: licensing exams for practice entry, continuing education (CE) for renewal of practice license, work-based orientation programs, and graduation from an accredited program of study."

Navy nursing does not rely on self-reflection as the sole method to assure our beneficiaries, the

public and ourselves that nurses are competent. Nor is it satisfied that external measures such as licensing laws, continuing education, or competency-based evaluations will provide the absolute assurance of competency. The Navy Nurse Corps has recognized that determining competency is a complex construct that requires numerous measures not easily resolved nevertheless crucial to the trust that has been placed on them by their constituency. Navy Nurses individually and collectively:

- 1) Identify competencies central to nursing;
- 2) Participate in groups' influential to competency measurement;
- 3) Be informed about competency issues; and
- 4) Think proactively and raise questions about competency whether it is broadly or narrowly defined.

Nurses have many opportunities to gain competence and confidence through a myriad of experiences. Such opportunities include professional organization affiliation, certification, mentoring, precepting, research and publication.

Selecting a specialty within an area of practice can help you become an expert, maybe even an indispensable one. This enhances coworker confidence and helps you develop into a leader. Consider cross-training to other specialty areas, whether from back office to procedure rooms, from the bedside to post anesthesia care unit or even by floating to other similar units. Cross-training offers an introduction and transition into specialty areas including labor and delivery, perioperative, or critical care. Taking on a leadership role by participating in internal interdisciplinary groups that guide the care and services of your command can enlighten you about the administrative and leadership structure and functions of your command. You could be a

nurse representative on councils and committees that focus on education, quality and patient safety, policy and procedure, or professional development. Volunteer for committees or community outreach activities by getting involved in your community, participating in health screenings and speakers' bureaus to help you develop skills in communication. The leadership and organizational skills gained by participating in command councils and volunteering are qualities command leadership looks for when reviewing resumes and interviewing for potential leadership opportunities. You are encouraged to always seek out these and other opportunities to expand your scope of leadership. Never stop learning or growing as a clinical leader.



# Chapter 4

## Leadership Development

### Oath of Office

"I, (Your Name), do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God."

## Definition of Leadership Development

Each of us joined the Navy with the hope and dream to make a difference and to be part of something bigger than ourselves. Regardless of accession route, our careers as Navy Nurse Corps officers began with the solemn Oath of Office. A statutory requirement as prescribed by Section 3331, Title 5, United States Code, the Oath of Office prescribes the moral responsibility expected of officers in the United States Uniformed Services. Taking this oath is affirmation that each of us is bound in good conscience to perform the duties of a commissioned officer in the United States Navy. Embodying the cornerstone and heart of military leadership, the oath conveys the magnitude of our obligation and allegiance to our great nation. Your acceptance of the Oath of Office is the first step in your commitment to service and leadership as a military officer.

The duality of a Navy Nurse Corps officer's role is delineated by the obligations to meet both clinical and military standards. However, there

is a stark distinction between being a nurse in the Navy and being a Navy Nurse. As imperative as it is to cultivate our nursing practice and sustain our clinical competency, it is equally important to apply the same commitment and discipline in maintaining our military knowledge as a means to foster leadership development. While our basic military knowledge foundation begins with prior enlisted service, officer indoctrination training through Officer Development School (ODS) or Naval Reserve Officers Training Corps (NROTC), we must take an active role in the continuous development of our military knowledge throughout the length of our entire careers in order to understand mission requirements and to best support our fellow Service members. Cultivating our military knowledge is not only paramount to augmenting our professional development, but it is also an integral facet of leadership development. In addition, we must continually strive to develop leadership in ourselves and in others.

In general, the basic qualifications and military knowledge

required of Naval officers can be characterized in the three areas of: professional competency, general education, and personal development. Professional competency and general education for Naval officers are typically rooted in the fundamentals of naval history, organizational structure, military administrative policies and procedures, military law, sea power and maritime affairs, navigation, naval operations, and seamanship. General education can be augmented through military training opportunities and suggested professional reading, such as the Chief of Naval Operations reading list. While the depth of professional competency and general education typically vary among Line and Unrestricted Line officers, the essence of personal development is a common thread among all Naval officers, as it is based on the ethos within our core values of honor, courage, and commitment. The words of John Paul Jones continue to embody relevance and significance in describing how we should tailor our personal development:

“It is by no means enough that an officer of the Navy should be a capable mariner. He must be that, of course, but also a great deal more. He should be as well a gentleman of liberal education, refined manners, punctilious courtesy, and the nicest sense of personal honor.

Coming now to view the naval officer aboard ship, and in relation to those under his command, he should be the soul of tact, patience, justice, firmness, and charity. No meritorious act of a subordinate should escape his attention or be left pass without its reward, even if the reward be only one word of approval. Conversely, he should not be blind to a single fault in any subordinate, though at the same time he should be quick and unfailing to distinguish error from malice, thoughtlessness from incompetency, and well-meant shortcoming from heedless or stupid blunder. As he should be universal and impartial in his rewards and approval of merit, so should he be judicial and unbending in his punishment or reproof of misconduct” (Mack, Paulsen, 1991, p. 20-21).

## Nurse Corps Leadership Progression

Tasked to meet the competing missions of military readiness and deployment, peacekeeping, humanitarian efforts, and health optimization for beneficiaries, Navy health care leaders must possess the flexibility to adapt their leadership and executive skills to the ever-changing military health system. Within Navy medicine, our roles as Navy Nurse Corps officers are continually evolving and advancing. Our leadership responsibilities at the various levels remain constant but the competencies and skill sets to perform those duties require constant self-evaluation and personal growth. As leaders, we must constantly evaluate and upgrade our professional skills, knowledge, and abilities. Through competency research, the Nurse Corps has been able to improve upon its leadership development.

In general, competency research seeks to improve health care management and education (Shewchuk, O’Connor, Fine, 2005, p. 32-47). The Defense Appropriations Act of 1992 required that Military Treat-

ment Facility (MTF) commanders demonstrate professional administrative skills. Consequently, a tri-service task force was assembled to identify the relevant managerial and leadership competencies needed to lead effectively. In 1996, a joint collaboration among the Army, Navy, and Air Force medical departments identified the executive skills required of MTF commanders throughout the Department of Defense (DoD). With representation from the three services, the Joint Medical Executive Skills Development Group (JMESDG) was comprised of subject matter experts (SME) to assess and prioritize the relevant DoD executive competencies. The JMESDG identified forty executive competencies and developed a core curriculum for education and training purposes. The efforts of the JMESDG working group identified required skills and, more importantly, they delineated and defined the behaviors and knowledge necessary to show competency in that skill (Schneider, 1999).

Under the leadership and strategic direction of Rear Admiral Chris-

tine Bruzek-Kohler, 21st Director of the Nurse Corps, competency research for the Navy Nurse Corps was conducted to improve management and leadership development and to provide the academic bedrock for the development of the Clinical Leadership Model. In April 2006, a Delphi health care executive competency study was conducted to determine the relevant competencies and important associated knowledge, skills, and abilities (KSAs) required of Navy Nurse executives. In September 2006, a similar Delphi study was initiated to identify the relevant competencies and important associated KSAs required of mid-level Navy Nurses.

The senior level Navy Nurse executive competencies utilized were: business management, executive leadership, professional development, global awareness and interoperability, communications, and personnel management. The mid-level competency domains were: management, leadership, professional development, personal development, clinical growth and sustainment, deployment readiness

and interoperability, communications, and regulatory guidelines. While the future of health care systems continues to evolve and become more complex, the studies indicated that the basic elements of personal integrity, mentorship, and communication remain essential to leadership development for mid-level and senior Nurse Corps Officers.

The current operational environment and force reshaping efforts have changed the environment of the Navy Nurse Corps. Consequently, the demand for clinical expertise and strong situational leadership is even greater. Given the challenge of meeting the Military Health System's (MHS) mission of enhancing the Department of Defense and the nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to their care, these field-generated competencies indicate alignment with health optimization, patient-centered care and a broadening view of readiness and medical deploy ability.

With the increase in operational tempo and continued military pres-

ence overseas, joint capability and interoperability among the military services and the Veterans Affairs are being promulgated as a necessity to achieve economies of scale, promote resource consolidation, and provide seamless health care for active duty service members and veterans. Consequently, the emergence of interoperability as a domain within both Navy Nurse leadership studies may be the product of the Military Health System's transformation efforts.

### The Scope of Our Leadership Responsibilities

Identifying core leadership competencies has been a critical link in ensuring future Nurse Corps leaders possess the relevant competencies and requisite knowledge, skills, and abilities to lead tomorrow's Navy Nurse Corps. The results of the competency studies have been integrated in the Clinical Leadership Model to provide the critical link among educational offerings, role-based experiences, timely mentoring, and specific career milestones.

As a community of practice, our Nurse Corps must have a foundation built upon clinical relevance, leadership development, and mentorship. With the bifurcation of our professional responsibility to our patients and to those we lead, our initial development as leaders must encompass the understanding of basic military knowledge and the attainment of clinical competency. Both are essential to leadership development within the Nurse Corps and both cannot be obtained without mentorship. As we progress in our clinical and professional practice, our leadership and mentorship responsibilities incur a greater scope as we transcend from managerial roles to greater positions of authority and accountability.

Our responsibilities as Navy Nurse Corps leaders are profound in consideration of the evolving health care landscape, dynamic operational environment, and fluid demands of the military mission. The significance and magnitude of our roles as leaders within Navy Medicine are dependent on our adaptability, agility, and commitment to life-long learning.

## Junior Officer Development

### Ensign to Lieutenant

From the point of active duty entry, the initial basic phase of military leadership should build upon the tenets from officer indoctrination training to develop ourselves morally, mentally, and physically. Upon reporting to your first duty station, military indoctrination continues as you orient to the demands and culture of the command and your role as a staff nurse. Regardless of what type of medical facility and nursing unit you are first assigned, your focus primarily must be on building clinical competence and self-confidence as a leader. The concomitant objectives for personal growth and training at this initial juncture should involve the ability to provide safe, skilled, and holistic patient care in addition to defining personal identity as a Naval officer and strengthening military bearing. As a new graduate nurse, this transition can seem challenging but will be facilitated through the precept, mentorship, and support of fellow nurses and corpsmen. As you

become more rooted in your professional competency, the expectation is that you will gradually assume the roles and duties of a preceptor and mentor for fellow nurses and new corpsmen. A Nurse Corps Captain, currently serving in the role of a Senior Nurse Executive, advised that at this level, “the Nurse Corps officer should focus on developing and honing his/her nursing skills. One cannot be an effective Nurse Corps officer without having a solid clinical foundation. At this level, one “may” be involved in collateral duties, but these duties should not be the major focus of this officer.” The lifeblood of our Navy Nurse Corps is dependent on our ability to foster clinical competency and sustain our organizational relevance through on-going mentorship and leadership at all levels.

As a newly graduated nurse and newly commissioned officer, the orientation period to the acute health care setting is centered on the development of direct patient care skills, management abilities, organizational knowledge, and critical thinking skills. These knowledge,

skills, and abilities are the precursor to the typical junior officer assignments of the seasoned staff nurse, such as team leader during a shift, shift or permanent charge nurse, and division officer. While the opportunities for assignment as a charge nurse and/or division officer are not available for all junior Nurse Corps officers, the expectation at this level for leadership is that you have the mettle and clinical prowess to serve as an advocate for your patients, fellow nurses, and corpsmen. You cannot accomplish this if you cannot demonstrate your ethical integrity, sound clinical practice, and an ability to teach and motivate others.

## Mid-level Officer Development

### Senior Lieutenant to Lieutenant Commander

With increased clinical competence and general military understanding, the junior-level nurse advances to mid-level expertise in his/her leadership development. Each Nurse Corps officer progresses at different rates but the expectation

is that you seek out broad clinical and managerial experiences through a diversity of tours and jobs to appreciate how Navy Medicine operates and is resourced. Most importantly, clinical expertise should be maintained and sustained through the pursuit of on-going training, certification, and advanced education.

Assignment diversity should include a variety in duty station locations and scope. You should have a blend of experience from various sized military treatment facilities in overseas and continental United States locations. Seek out opportunities with the Marine Corps and with other Services. In addition, you should seek out non-traditional tours, such as operational deployment, instructor duty, recruiting duty, or a staff tour at headquarters command. This will widen your lens and understanding of Navy Medicine's operations and priorities.

Regardless of your duty location, you should assume positions of increased responsibility and strive to be an active leader not just in your clinical community of practice but within your command. Assignments

as a division officer or department head along with a variety of collateral duties will help in understanding the organizational hierarchy and administrative policies to better serve your fellow Medical Department officers and colleagues.

Most importantly though, always do your job well. As one Senior Nurse Executive stated, "First of all, one needs to do their best at the primary duty to which they are assigned. There is no one job that will make them successful. Succeeding at their primary job and also seeking challenging opportunities develops a Nurse Corps officer into a well-rounded leader. A nurse should not be afraid to seek out challenging tasks and should not be afraid to take risks. The Nurse Corps does not benefit from nurses who stay in their comfort zone. Having titles during one's career does not make one successful. Doing a good job at one's primary duty makes a successful Nurse Corps leader."

At this point, recurring education and training is necessary to maintain and sustain both your clinical excellence and military acumen. You

should begin to actively pursue and attain an advanced degree. While the primary focus of your higher level education should be clinically-based, you should seek out educational opportunities to expand your knowledge in other areas relevant to the Navy and the Military Health System, such as military law, business planning, human resources, clinic management, and contingency planning.

A Senior Nurse Executive offered this advice in particular for the mid-level officer: She shares: at the senior O-3 to O-4 level, this officer should still be active clinically and should be focusing on mentoring Junior Officers. All along the way, these officers should be looking for leadership opportunities. However, they all must remember to execute their primary duty, whether it is as a staff nurse or a division officer, and then give time to their collaterals. At this level too many nurses often-times concentrate on collaterals, yet they neglect their primary clinical duties. Along the way, nurses need to step out of their comfort zone and learn about the different

aspects of health care. A successful nurse has a situational awareness of the issues within the entire organization; the Military Health System Bureau of Medicine and Surgery (BUMED), and Medical Treatment Facility levels.

### Senior-level Officer Development Commander to Captain

“As a senior officer, you have the responsibility toward the mission of the department and the command, even if you are not in a leadership position. Make sure that comes out with everything you do,” advised a, Nurse Corps Captain serving as Regional SNE, Assistant Chief of Staff of Navy Medicine West and former MTF Commanding Officer. Advancing towards the senior level of leadership development does not necessarily entail a specific set of career milestones or duty assignments, because the key is always doing your primary job well, wherever that may be and in whatever capacity that is. To be a relevant force for Navy Medicine, the Nurse Corps needs a variety of leaders with

subject matter expertise within the clinical, administrative, education, research, and operational realms. While the executive medicine career pathway is not chosen by all Nurse Corps leaders, the prerequisite for senior leadership in the Nurse Corps is a demonstrated and proven ability to lead and direct in tough and challenging environments through sustained superior performance in all assigned roles within a variety of assignments. In the words of Rear Admiral Bruzek-Kohler:

“My advice for ‘making it to the O-6 level’ is the same I give every officer trying to make it to any level: your performance and the achievements therein define who and what you are and they absolutely need to be reflected in your fitness report. These include the essential achievements that reflect what you will contribute as a future leader in the Nurse Corps and within the Navy Medical Department. So you look for the assignments that challenge you, broaden your scope of responsibility and authority, and make you ‘stretch’ and learn even while performing within the assignment. No-

tice I didn't mention anything about where that assignment could be. To me, it really doesn't matter where you work but what you do and who you are. People notice leaders; they stand out in a crowd."

Additionally, experiential knowledge should be complemented through advanced graduate and professional education, such as a graduate degree in a clinical specialty and/or Joint Professional Military Education courses. At this juncture, an advanced education and/or professional certification are critical in proving your commitment to life-long learning. Achievement of an advanced degree is a requirement for any Nurse Corps officers seeking to attain the rank of Captain.

Regardless of what specialty career pathway you choose, clinical competency should be maintained by all Nurse Corps leaders. The depth of clinical competency will vary based on your specialty and assignment. At a minimum, you should be aware of current standards of care and the trends within evidence-based medicine. This is critical to demonstrating the profes-

sional relevance and credibility of our Corps, especially if you choose executive medicine. We fail as Nurse Corps leaders if we cannot serve as advocates for our patients in any role we fulfill. As Rear Admiral Bruzek-Kohler eloquently stated, "Clinical competency is an absolute requirement if you wish to credibly run a health care organization. I don't think you need to be a specialized practitioner to be successful, but you do need to understand the practice of nursing and medicine, be aware of recent changes and improvements in patient care and practices, and be able to "speak" medical to your clinical leaders. More importantly, your facility leaders, directors, department heads, etc. need to trust that you are there to support them in providing the best possible patient care. It is essential that you are their advocate and that they can depend on you to lead them with integrity, honesty, and consistency. Having the clinical competency reflective of your Corps is the underpinning that makes you a credible health care leader."

## Executive Medicine

For those senior Nurse Corps leaders in pursuit of executive medicine, the key influential factors for achieving a position within executive medicine include mentorship and success in a variety of positions. As one Nurse Corps senior leader stated, "The world of nursing is dynamic. In order to make it to the 0-6 level in the next five-to-ten years, one needs to be aware of 'the world around you.' In other words, what are the challenges that other hospitals are facing in terms of nursing? Strategic thinking is key to being successful ... if one is seriously aiming to be at the executive level, then having and being a strong mentor is a must. The mentor plays a huge role in guiding the Nurse Corps officer who wants to develop the skills needed to be a successful officer."

A former Commanding Officer also added this advice for those in pursuit of executive medicine:

"A transition to Executive Medicine is a choice the senior officer has to make usually at the 0-5

level. The first appreciation the officer has to have is what distinguishes a senior officer from a junior officer. What do you do differently as an O-5 that you didn't do as an O-4? This includes a curiosity regarding what occurs at the senior level at your command. What does the ESC (Executive Steering Committee) do? How can you observe? What duties can you volunteer for that will gain you entry to the ESC and other decision making bodies?

A mentor for executive medicine is invaluable. If you want to know more about being an XO, make an appointment with the XO, who will give you lots of great insight. The same is true with the DNS positions. These mentors can help with assignments, screening packages, and recommendations.

An assignment as a Director of a service or Associate Director in a big facility is great preparation for executive medicine. Filling in for that person can offer a great exposure if you can act for them occasionally. A variety of experiences, inpatient, outpatient, large and small facilities, and an OCONUS tour are prepara-

tory to a well rounded officer. However, these opportunities are not mandatory if your specialty limits you to certain facilities, or your family situation calls for homesteading, because it is what you do with each tour is most important. As a senior officer, you have the responsibility toward the mission of the department and the command, even if you are not in a leadership position. Make sure that comes out with everything you do.

So, show that curiosity, explore the new bounds of a senior officer, get a mentor, and accomplish the mission. That is the making of an executive."

Rear Admiral Bruzek-Kohler summarized it best by offering:

"As for executive medicine; you need to begin your self-assessment long before becoming an O-6. Assignments of leadership should be preparing you for continued levels of experience that take you first to one unit, then a department, clear up to the position of a DNS, SNE or Officer-in-Charge. By the time you become a Director, you need to have already

begun looking at the organization of health care much beyond that which you saw within the scope of your nursing practice.

You now need to understand how all the parts fit the whole and how each inter-relates to each other. I recommend expanding your educational experiences either through a Master of Business Administration, Master of Health Administration, Master of Public Health, or at least through active participation in other health care related professional organizations to again broaden your perspective on leading an organization. It takes courage to take on the most difficult, challenging, and exhilarating positions in the Medical Department! You must want to be in executive medicine because you desire to move completely out of what has become your comfort zone: generally speaking that is our world of nursing.

You need to relate to others of all different Corps as peers in some cases, and as subordinates in others, while continuing to render them the respect and dig-

nity they deserve. Decide how far you think you want to go and don't take no for an answer. I think you need all the essential experiences as a Division Officer, Department Head, and DNS/SNE, as well as an off-ramp in one of our many staff organizations to be the best, well-rounded executive you can be. Certainly, in the future, operational experience will be the norm, if not the expectation.

But, fundamentally, you must really want the job. Being an Executive Officer of any sized facility is truly a thankless job; you run the entire organization and get none of the credit and all of the headaches! But that is the best "internship" anyone gets to be the best Commanding Officer they can be. It is the time to learn everything there is to running a hospital. That experience will serve you well when you become a Commanding Officer because you will no longer be looking internally at your facility (because that's what your Executive Officer will be doing) but will move externally to develop and support relationships

within your external military, civilian, and political communities."

### The Leadership Crucible

Today's military health care leaders face the leadership crucible of meeting military mission requirements within an environment of increased operational tempo and variable health care industry expectations. Transformation of the military health system is ongoing in order to meet the needs of the combatant commander and service member customer group as well as the beneficiary customer group. To be the catalysts for organizational progress and innovation, Navy Nurse leaders must constantly evaluate and upgrade their professional skills, knowledge, and abilities to ensure alignment of priorities with the operational and health support mission.

Leadership development for Nurse Corps officers must be rooted in professional competence, compassion, and moral character. There are many qualities common among many notable leaders, but as Vice Admiral William P. Lawrence

once said:

"First is moral courage—to know right from wrong, to do what is right regardless of the consequences and to maintain standards even though at the time it might be unpopular. In our profession there simply has to be a high degree of truth and honesty or we won't function properly. Without it, lives can be lost, battles can be lost, and the security of the country placed in jeopardy. I've never known a fine military leader who didn't possess a high standard of ethics and personal integrity" (Mack & Paulsen, 1991, p. 21).

As leaders, our moral fiber will continually be tested time and time again. Clinical and leadership competencies must be anchored within a base of moral responsibility and ethical values. By having solid foundations in clinical skills, professional development, and leadership, Nurse Corps officers can have the confidence to withstand the demands of any role and excel in any given situation.

**The Delphi Technique —  
A Multiple Iteration Decision-making Methodology**

Originally developed by the Research and Development (RAND) Corporation, the Delphi technique has been in use since the late 1960s. The Delphi method is used to determine priorities and forecast future trends (Dalkey, 1969; Delbecq, Van de Ven, & Gustafson, 1975, p. 83-107). The process involves a series of questionnaires and ends when consensus has been achieved among participants or when sufficient information has been exchanged. By directly extracting knowledge from the current experts rather than conducting a literature search, the Delphi technique allows for a more accurate representation and sharing of scientific or technical information (Delbecq et al.).

A multiple iteration decision-making methodology, the Delphi technique allows for anonymity in aggregating expert opinion within a specific profession, because the questionnaires are completed individually. This allows individual group members to express his/her own opinions and judge ideas on the basis of merit without the influence of group interaction →

Domain	#1 KSA	#2 KSA	#3 KSA
Business Management	Strategic planning and management skills	Ability to articulate nursing contributions to military medicine and impact within business plan: breaks out nursing contributions so it is not considered "just part of the overhead"	Ability to interpret data on which to base decisions
Executive Leadership	Maintains the utmost integrity: has the trust of all members inside and outside the organization	Team-building: collaborate with all disciplines as part of the healthcare team	Communication skills
Professional Development	Communication skills: ability to communicate in all forms	Ability to lead and mentor junior personnel	Ability to hold all accountable for personal and professional actions
Global Awareness and Interoperability	Ability to lead and manage change	Ability to dialogue with Line Navy and other military leadership regarding military medicine	Ability to develop a plan to ensure adequate and appropriate training of personnel prior to operational deployments
Communication	Ability to actively listen	Ability to communicate across all levels of the health care continuum — from the perspective of the patient, nurse, health organization, and business organization	Interpersonal skills: connect with your people, know your people and your colleagues, be forthright, which is different than being brutally honest
Personnel Management	Mentoring and counseling abilities with military and civilian staff	Ability to be creative with staffing and scheduling	Knowledge of factors that affect retention, such as work hours and job satisfaction

## The Delphi Technique — A Multiple Iteration Decision-making Methodology

(continued from page 35)  
and domineering politics. Also, the iteration of the questionnaire over a number of phases allows the opportunity for respondents to modify their opinions without fear of losing credibility in the eyes of their peers. Prior to the completion of the next subsequent phase, or wave, controlled feedback from each previous questionnaire is provided through summary statistics, usually represented as a mean or median value, to reflect the opinions of their anonymous colleagues' responses. In doing so, feedback captures the true zeitgeist of the overall group. Consequently, the Delphi allows true manifestation of group members' opinions and not just the most dominant or vocal force (Rowe & Wright, 1999, p. 353-375).

Used across several disciplines to include planning projects for urban development, education, and health care, the Delphi method has been recently cited in numerous health care executive studies to determine priorities and forecast future trends to identify core competencies. This research has

contributed to the literature in the administrative and clinical specialty fields of medicine, nursing, dentistry and pharmacy. Over the past twelve years, more than twenty executive health

care competency studies have been conducted using the Delphi technique by Army-Baylor University H&BA graduate faculty and students (Finstuen & Mangelsdorff, 2005, p. 24-26). ♦

Competency Domain	Top 2 KSAs
Management	Critical thinking and problem solving skills Able to maintain professionalism in all situations
Leadership	Able to motivate and inspire staff and colleagues to accomplish mission / tasks even in difficult work environments Ability to mentor junior nurses, provide advice on career / promotion, and teach nurses how to become managers
Professional Development	Ability to teach and educate novice nurses and corpsmen Foster growth and development of junior sailors
Personal Development	Critical thinking skills Self-motivation and initiative
Clinical Growth and Sustainment	Sound-decision making abilities without compromising ethical values Current skills to provide professional nursing care to patients and their families in area of expertise
Deployment Readiness and Interoperability	Ability to prepare staff for deployments Ability to interact and work with our sister services in their environments
Communications	Ability to communicate with professionals from multiple disciplines to do what is best for the patient Able to deal with conflict or at least willingness to resolve conflict
Regulatory Guidelines	Understand, articulate, and ensure compliance with regulatory agencies and statutes Knowledge of military regulations for active duty and reserve



## Chapter 5

Operational Readiness:  
Clinical, Confident, and  
Adaptable

**T**his chapter is dedicated to all those who have cared for our ill and injured servicemen and women. Each operational experience or deployment is a unique opportunity to serve our country by caring for others and, in doing so we become more ourselves and a greater source of healing and growth to others.

In this chapter, you will read the accounts of several Navy Nurses who have deployed into harm's way. As they describe their experiences and insights, it provides a valuable opportunity for you to better understand how their professional nursing expertise and leadership development prepared them to be operationally ready for deployment. The Clinical Leadership Model, as described in previous chapters, purports that professional and leadership expertise

prepares the Nurse Corps officer for success in any operational environment. The operational deployments described in this chapter will span a diverse scope of missions, where Navy Nurses care for wounded warriors, collaborate with other Services and Foreign militaries, and mentor host nationals. The stories are forthright and compelling, the lessons are timeless, and serve to remind us of the formidable spirit of Navy Nurses. These officers were successful in the ultimate call to support and defend, because they were prepared as both consummate clinicians and Navy leaders.

### Operational Readiness Defined

In the military, an operation refers to “military action, mission, or maneuver including its planning and execution”. Specifically, regarding our military medical mission, we may define operational as the “performance of a practical work or of something involving the practical application of principles or processes”. Readiness refers to “mental and physical preparation for some action

or experience”. Webster also refers to readiness as “willingly disposed”.

Operational Readiness is composed of multiple elements that can be subdivided into both professional and personal areas. Our operational readiness is defined by the extent of our awareness of ourselves as both professionals (nurse and military officer) and people dedicated to serving others. While clinical competence is essential to the performance of our nursing duties in an operational setting, an honest self-assessment of our courage and commitment to the mission is also critical to our operational readiness success.

Operational Readiness has little tolerance for holding back. It requires that we give our all in confidence and, in giving our all we enable ourselves to fold that experience into our readiness for future operations as we mentor the next generation.

### Clinical Competence

Clinical Competence is the core of Readiness. As officers, you have chosen the role of Nurse, caring for our injured and ill. That competence

puts into practice what you learned in college to provide safe and effective care. Clinical Competence also empowers you; it fuels hope because it is what enables you to make a difference, knowing that your actions can bring about a future different from the present (Groopman, 2003, p.26). It is not enough to be at the warrior’s side. You must be prepared to do your part as they too prepare to do theirs.

In order to be successful in any operational environment, you have to have all the elements depicted in the Clinical Leadership Model: professional, clinical competence, leadership, and operational readiness. It is the culmination of your clinical excellence and confidence as a leader, which makes you best prepared for a wide variety of operational roles.

### Leadership: Critical Thinking and Adaptability

No matter where you are on Dr. Benner’s developmental scale, operational roles demand all from you and more. They inspire you to

regularly assess and reassess your practice, the situation, and refine your critical thinking skills in support of optimal patient outcomes.

“Critical thinking is a desire to seek, patience to doubt, fondness to meditate, slowness to assert, readiness to consider, carefulness to dispose and set in order; and hatred for every kind of imposture” (Bacon, 1605).

Critical thinking has its root in the discipline that you acquired through training and experience. Professional development through higher education is one way to pursue such discipline. As leaders and mentors, you are responsible for creating an environment that encourages such a discipline and fosters it in practice. It is what enables you to accomplish the mission in spite of

changing circumstances so that you learn to adapt and overcome.

You are taught in nursing school to adapt and be flexible; to intervene based on your patient’s needs and responses. In the operational environment, your opportunity to learn to be flexible and adapt increases exponentially. Adaptability is required daily in the deployed setting. Navy Nurses serve on U.S. soil and in foreign lands, with foreign Services and our sister Services, and provide care to patients on land, air and sea. Logistics change from operation to operation, so you must be ready to seamlessly adapt to the use of different supplies and equipment. Using critical thinking and adaptability, Navy Nurses are critical to the health care team. Navy Nurses have more leadership

experience as an Ensign, than most Ensigns do throughout the Navy.

How, then, do you become ready so that you might act effectively? To be ready for a deployment, you must work diligently to grow as seasoned professionals in the Medical Treatment Facility (MTF). You will stretch past your comfort zone and be challenged to cross-train to other specialty areas, as well as take on diverse collateral duties and leadership opportunities. You should seek additional formal opportunities for study, certification or advanced professional education. Operational Readiness requires you to be flexible, adaptable, and creative. This strengthens you professionally and personally so that you can practice expert care in any environment.

Vignette from a CDR, NC:

As a novice nurse, I had key mentors: experienced nurses and corpsmen that made caring for others look easy. We utilized a team-leading nursing approach where we constantly communicated and lent mutual support to accomplish quality care for our patients. I learned about the power of team work above the individual’s effort. Self

confidence alone is not enough to support the success of the team. The team’s confidence is a result of its collective acknowledgement of their interdependence and desire to grow and perform. A shared vision of providing safe and quality care for people was what bound us together and it was that shared vision that enabled us to learn from each other. I learned that assertiveness was what enabled me →

Vignette from a CDR, NC (cont. from page 39)

to learn about leading and caring and to share what I had learned with others.

My first two years in the Navy were spent between a Medical-Psychiatric-Pediatrics Ward and an Intensive Care Unit. My mentors were nurses, and I also learned invaluable lessons from our corpsmen and licensed vocational nurses. They walked me through modeling the assessment and care of the whole patient, encouraging me to be confident in my skills and training. I had cared for patients as a volunteer in high school, and as both a part-time nurse's aide and full-time student nurse during my last two years of college. I had been fortunate in having some exposure to the military culture as a NROTC midshipman. What I had yet to learn was clinical leadership as a nurse and just exactly what the military would expect of me as a Nurse Corps officer.

The rest of my career has been spent in all areas of nursing with the exception of the OR. Of all the areas I

worked, my preference was for the emergency room. I felt at my best when I was helping people through moments of crisis. Some only wanted my presence or my clinical skills. Others needed me to help them remember their own strength and ability to endure for themselves or in support of their ill family members. Looking back, my varied care experiences (Med-Surg, PACU, SDS, ER, ICU, and Primary Care) prepared me well for the clinical flexibility required in deployments, particularly humanitarian care missions where all these skills are utilized to care for a variety of patients.

More recently, my assigned duties have been in the area of quality or continuous improvement where the "patient" is the center of the healthcare system. With the patient at the center, our strategy in quality and continuous improvement is focused on providing safe, effective care. I enjoy this work because it requires a holistic approach for sustained improvement, not unlike the training I received in assessing and caring for the human body. ♦

## Leadership Development: Character and Commitment

"The development of character is at the heart of our development, not just as leaders but as human beings."

—John Maxwell

It takes character to be a part of the military mission, a unique journey into the unknown. Such uncertainty also poses many opportunities for you to make the choice of character or compromise, and, therein, lays your opportunity to take the risk for growth versus to compromise for the status quo.

One of my skippers used to ask one final question at Mast of each of the Chain of Command, "Would you go to war with this Sailor?" Character and commitment shows others that you have jumped in with both feet, focusing your efforts on accomplishing the operational mission.



Service cultures. Adapting, cooperating and excelling in Tri-Service assignments are essential to achieve common mission success in the new norm and requirement for the Twenty-first Century. It requires an understanding of not only self, the culture of other Services, but also foreign militaries.

Webster's dictionary defines leadership development as the ability to realize the potentialities, to aid in the growth, to strengthen, to cause to unfold gradually and is the position or office of a leader with the capacity or ability to lead. Nurses in operational settings exemplify this concept. They have excelled because of what they brought to the table. There is no one prototype to success. A variety of different roles and skills are required; nurses on deployment have served as ambassadors, leaders, and trainers. Nurse Corps officers overcome because of their clinical prowess, leadership finesse, and determined team spirit.

There will always be an operational role for Navy Nurses, for it is the reason we wear the uniform.

Vignette from a CDR, NC:

Operation Iraqi Freedom 1 drew upon me as a woman, a person, an American, a nurse and as a military officer even in the days before I departed. Deployment is an all encompassing experience if you let it be. At the time, I was totally open to it because I was afraid holding back would impact my ability to help others at a crucial time for our nation. It was a test of my commitment to serve

those who defend us at a very tough time in my personal life.

This is not just what the military asks of us, but what life demands of us, to be present even at our weakest moments. In hindsight, I was unable to be totally present for both my family and patients simultaneously. So, I focused my efforts on what was in front of me, my patients, my unit and my strength both to care and to fight, if necessary." ♦

Vignette from a CDR, NC, FNP:

I have had a very diverse career as a Family Nurse Practitioner for thirty years. The last eighteen years have been in the U.S. Navy. While working at the Department of Veterans Affairs (VA), I encountered numerous patients with a wide variety of war stories. I realized that military medicine would be an opportunity to give back to my country as well as provide quality care to active duty members, beneficiaries, and retirees. I was commissioned in 1992 as a LTJG.

I was deployed to the Gulf aboard USS NIMITZ in 2005. Though that was an excellent experience, I found my recent deployment to Afghanistan to hold much more significance for me.

In August 2009 I was deployed to Afghanistan for 264 days of Individual Augmentation. While there I was the OIC for Cooperative Medical Assistance. During my tenure there I experienced the human toll that thirty years of war on a country have taken. Malnutrition, lack of technology, unemployment, terrorism, and corruption were all evident. I decided that ➔

Vignette from a CDR, NC, FNP (cont. from page 42):

there had to be a way to make an impact on this country and its people to improve their health and quality of life. As I traveled through the provinces it was evident that clean water, sanitary conditions, malnutrition, and housing/protection from the elements were desperately needed. Also, the threat of terrorism loomed daily in the hearts and minds of the Afghan people.

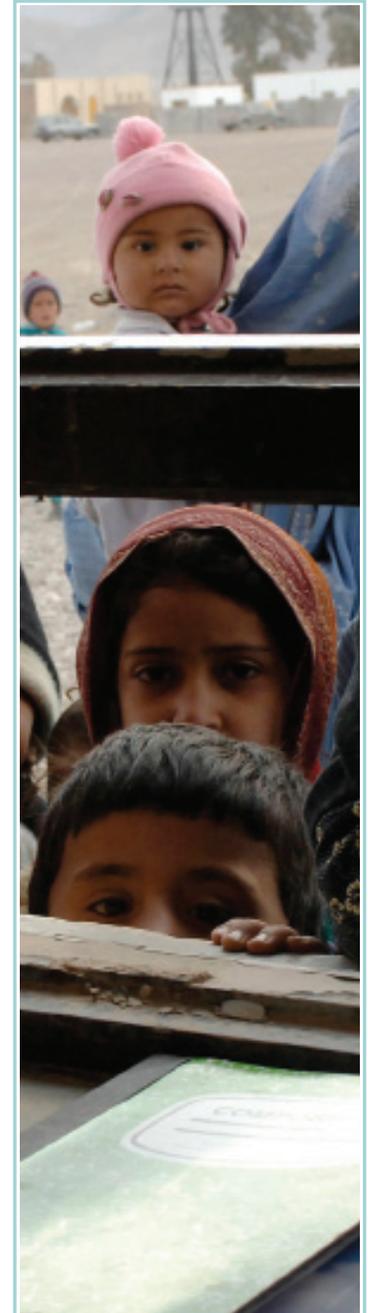
I employed basic skills from my early nursing training to categorize the needs of the people and then spread out to include needs of the country. Next, I developed and implemented a comprehensive counterinsurgency (COIN) campaign strategy by tapping the creative energies of the diverse medical professionals in my team. We integrated health service support to Provincial Reconstruction Teams (PRTs), Agribusiness Development Teams (ADTs) and Special Operations Forces (SOF) in an austere and volatile combat environment. Sustainable capacity building programs were developed and implemented in order to provide an Afghan investment in the future of their country as well as fighting terrorism. There were numerous rockets that were fired at us and often times IEDs were encountered while on missions “outside the wire”. During these engagements the combat training received prior to deployment was of great benefit.

While visiting provinces and districts I experienced the wrath that malnutrition can have on the children. Twenty-five percent of children in Afghanistan will die from malnutrition before reaching five years of age. A Strong Food

(SF) Program was initiated. These engagements provided intensive medical monitoring and clinical treatment to over 2531 malnourished children in nine provinces in Regional Command East and South. Also, a campaign was initiated teaching basic personal hygiene to prevent diarrhea and dysentery, as well as clean water and proper latrine placement programs were initiated. These programs will have a positive and lasting impact in Afghanistan.

The basic education I received as a nurse as well as the managerial and leadership programs I have taken over the years in the Navy gave me the basis to recognize needs, devise a plan, and implement the programs. I also believe that prayer for guidance assisted me often. The more ravages of war that I encountered the more I persevered. I felt the Afghan people needed to become partners in a program that would be self sustainable by the Afghan people and permit the military to withdraw and leave the country with its dignity and people improved.

Also, I realized that we in the United States are so blessed and fortunate to have all that we enjoy. The most important is freedom. When we complain about not having the newest car or latest games it behooves us to remember that in many other parts of the world people are worrying about food, shelter, clothing, the basic necessities of life. This experience has made me feel both humble and fortunate. It is an ever present reminder to strive for excellence and that all we do is important and will make a lasting impact on those whom we interact. ♦



Vignette from a CDR, NC, FNP:

I graduated from the Family Nurse Practitioner (FNP) program in May, 2001 and headed to the Naval Hospital, Corpus Christi for my utilization tour. Corpus had a lot to offer a new graduate FNP. I had supportive medical staff colleagues, a fellow FNP peer filling the other of the two new FNP billets, and a Commanding Officer who was an icon in the Nurse Corps and an FNP herself. I had been selected for LCDR and was proud to begin the Advanced Practice Nursing phase of my career with so many doors opening before me. A few short months into my tour, America and the direction of the U.S. military and my career were changed forever. By 2003 the Naval Hospital Corpus Christi was committing staff to Operation Iraqi Freedom in support of Marine Corps Units from Camp Pendleton. I knew that my operational assignment was no different and fully expected that my turn would come. On Christmas Eve, 2003, while riding home from my sister's, my cell phone rang. It was my SNE advising me that indeed, my turn had come. Within two months, I had processed through Camp Pendleton and was heading for Iraq as the Senior Nurse of a Surgical Company. I had no way of anticipating the experiences that would come to pass over the next seven months in Fallujah.

Within days of our arrival, the Battle for Fallujah had begun, and the challenges of our operational tempo became immediately apparent. Our Marines and Coalition Forces were actively engaging the insurgency, and the results of

urban warfare became the work of our unit for the next many months. An early and pivotal event was a rocket explosion within 5 meters of our medical building. Two of the unfortunate victims of this "indirect fire" were an Army surgeon and a Combat Medic from the medical staff that our team was replacing. In spite of rapid intervention and expert care, their wounds were too grave, and these two hero soldiers made the ultimate sacrifice just days before their deployment was to end. The raw emotions of that moment have waned over time, but the effects on my life and career have been indelible. I have now had years to ponder the impact of that rocket, the literal and remote targets of its shrapnel, the deadliness of its concussive force, and the explosive velocity of life-altering change experienced by all of us in Bravo Surgical Company on that day in March, 2004.

In the immediate aftermath of the death of our colleagues, there were many possible outcomes available to our Company. For most of us, this was our first deployment. For most of us, our understanding of our role in a Surgical Company was only known through nominal pre-deployment training experiences and our individual clinical backgrounds. For most of us, our perspective on a war zone was limited to scant paragraphs describing casualties and death tolls buried somewhere in our local newspapers — or not. It is still my contention that nothing could have prepared me for the experiences that I had in Fallujah. However, the noteworthy and ➔

Vignette from a CDR, NC, FNP (cont. from page 44): remarkable accomplishments of our team were nothing short of amazing. I am still inspired and humbled by the talents, the skill sets, the leadership, the caring, the brother- and sisterhood, the energy, the initiative, and the successful mission accomplishment of our Surgical Company in Fallujah, Iraq in 2004. How does a relatively random group of strangers, linked only by their professional roles and a set of deployment orders, come together in a completely foreign environment and achieve so much? It is also my contention that a crisis will bring out the best or the worst in us. I feel fortunate that the best is what we gave and that our outcomes were positive, in spite of tragic loss and constant challenge.

I find myself thinking about Fallujah a lot again recently. My military career continues; I have remained a practicing clinician, with expanding roles in leadership, additional overseas duty, the most recent Specialty Leader of the Navy Family Nurse Practitioner Community, and am within a few weeks of deploying again. I have already been away from home for almost four months. Pre-deployment training has expanded in complexity since 2004. This time, I'll be heading to Afghanistan, again to a region of heightened insurgent activity and violence. My role this time is different. It is not my primary responsibility to take care of combat casualties. However, the places where we deploy and the missions to which we are assigned guarantee the potential. I go

well prepared but with great hope that Tactical Combat Casualty Care, Care Under Fire, and Combat Lifesaver Skills will stay locked away in my toolkit this go around. My billet for this deployment is as the Senior Medical Officer for a Provincial Reconstruction Team (PRT) in Khost, Afghanistan.

Over the last several months, I have come to understand the PRT mission more clearly. I have been working and training with my team, learning many new skills from the Army Infantry arsenal. I have demonstrated my “shoot, move, and communicate” skills, learned phrases in Pashto, and have survived the lanes of IED explosions and live fire during Mounted Combat Patrol. The training seems focused on military kinetic engagements, all required and vital to tactical mission success and team safety, but the mission is about counterinsurgency (COIN), and my specific role is to positively influence health sector development in impoverished and war-torn Afghanistan with the over-arching goal of helping to legitimize the Central Government of Afghanistan. There have been many, many times in my career where I have paused, pondered, and declared out loud, “Who would have imagined that a Navy Nurse would be doing this?” And then... I answer my own question, from the perspective of knowledge, experience, skill, clinical leadership, confidence, and care, “Who else could do it better?” ♦



Vignette from a LT, NC:

I graduated from George Mason University in 1990 with my BSN. I have enjoyed open heart and transplant surgery, neuroscience, wellness and nursing education through the years.

Reading about Florence Nightingale and the military nurses whose story was told in a book called *We Band of Angels* I often wondered if I could do it: Nursing under great duress with no thought of my welfare.

Well I got my answer when I joined the Navy at the young age of thirty-nine and was deployed to Cuba. I was the charge nurse for over three hundred detainees in maximum security facility. I had a great team of four corpsmen with varying degrees of experience and we were also responsible for the care of guard staff.

One particularly difficult day, we got a call that a guard was down on the cell block. Our team went out quickly we were given the clear to enter the area by security. The noise level was overwhelming as the site of a guard lying on the ground brought the detainees to yelling, banging and throwing anything and everything they could at us and the down guard.

It was the first time in my life I experienced such concentration that blocked the noise out and brought my senses to the highest of acuity. Our bodies shielded the guard, we did a quick assessment and I had to determine to pack and go or start treatment on the scene. Since I had the welfare of more than just my patient to consider I gave the order to pack and go. We successfully removed the unconscious guard without incident and the detainees started to calm

down as we exited. The medical area was close by and the guard was conscious before we entered treatment room. We stabilized him and called for the squad to take him to the hospital for further evaluation and monitoring.

Through my many years of nursing I have worked codes in controlled setting of a hospital or clinic as well as rural motor vehicle accident scenes but never had to worry about my safety or team member's safety. In the five months I worked maximum security I developed a trust like no other with my teammates, as well as with myself to believe in the quick decisions I made on my feet in riot gear and uncertain situations.

You come through it with faith and support of your team. You walk away knowing you cannot always make a difference when someone has full intention of harming you or your shipmate even though you are there to meet their needs and keep them alive. However you grow and walk proud because you did your job with integrity, professionalism and knowledge that the underlying mission was taking care of one another, having their back and helping them through the daily conflicts this sensitive and high profile mission presented us.

I wish that when I was a younger "green" nurse that I had faith in the nurse that would become, but that is perhaps what we all must face when it comes right down to it. You rise above after all by taking the pledge, living the Navy life and knowing you are made of the right stuff. It continues to be an honor to not only be a Nurse but a Navy Nurse. The Navy has given me a broader arena to experience and practice nursing while making an impact on the world. ♦





Vignette from a CDR, NC:

I joined the Navy to expand my nursing experiences and career opportunities. I was a practicing nurse and was recruited as a direct commission. My sister and brother were in the Navy and I have uncles that served in the Korean War and World Wars. My clinical and professional background is Medical/Surgical, Emergency Room (ER), Neonatal Intensive Care Unit/Pediatric Intensive Care Unit (NICU/PICU).

I held a nontraditional nursing role for my deployment. My deployment was for a year with 1st Marine Division HQ in Fallujah Iraq. I served as the evacuation officer in charge (OIC) and my team and I were responsible for the evacuation of wounded Marines, Sailors, Soldiers, and Airman for the entire Al Anbar Area of Operations. Serving in a non-traditional nursing role was both challenging and rewarding. I utilized my nursing triage skills and background to assist corpsmen, medics, and Marines on the battlefield when fear and inexperience

came into play and assistance was needed to ensure the correct level of casualty evacuation was conducted whether by ground or air.

In addition to monitoring evacuation operations, we also monitored combat operations and assisted as necessary with casualty planning and evacuation. I learned a great deal about Marine Corps combat operations and the multifaceted units that support them. I spent time with tank Battalion as well as infantry, artillery, and fires learning the mission and operations of these units. My situational awareness (SA) had to be at its highest due to the fact that we conducted evacuation and current combat operations 24/7. To have a full understanding of each supporting element and their role in combat operations was fundamental to adequately plan and support them in carrying out the mission. Additionally, the Colonel relied on us for vital information for his SA.

Being deployed for a year was challenging, rewarding, and tiring. We did pre-deployment training prior to the →



Vignette from a CDR, NC:

I have been practicing the art of nursing for more than twenty years now; in fact it's more second nature than practice. I have appreciated the Nurse Corps on many accounts; four have been listed as a way to help me collect my thoughts and I would like to share them with you as an outline for this chapter on Operational Nursing.

First, leadership development starts early in the life of a Navy Nurse. As an Ensign in the Nurses Corps, leadership training starts on day one. In my case, my first days as a navy nurse were spent in an open bay ward at the old Naval Hospital Portsmouth (NHP), which by the way seems like just yesterday). My responsibility was to oversee myself, two Government Service (GS) nurses and four corpsmen. Those days helped to prepare me for the position I fill now as the Senior Nurse Officer at Naval Medical Center San Diego's Emergency Department. Those first few days are now more than twenty years ago. I credit my success today partly on the guidance and direction I received then, either by design or by necessity from Senior Nurses in leadership positions. The future leadership roles I would be expected to fill would be missing the fundamental elements of leadership (guidance, mentoring, understanding, fairness, equality, patients, example, etc.) and would have taken much longer to develop if the refiner's fire were not stoked on my behalf by the leaders of my past. All of us have been dependent upon senior nursing leadership to set the example, to guide us, and to help us to see clearly.

Over the years, Navy Nurse Corps leaders have invited us to follow, have lead the way and help shape us into the leaders we are today.

As a Senior Nurse, I have had the privilege to start the leadership development of junior nurses who work along side of me. From peace time assignments to battlefield operations there must be organization and structure if there is to be success. Good leadership is the key to that success. For the most part, junior nurses want to be leaders; they realize their future in the Navy is dependent on developing good leadership styles. Many are waiting for their opportunity to enter center stage, to be put to the test and to develop them into tomorrow's Nursing Leadership.

It was my privilege and responsibility to assume the title of Senior Nurse during three deployments into harm's way. My last deployment to Afghanistan has proven to be the defining moment in my naval career as a nurse leader and it is from this experience I wish to share with you.

When I received my orders to Afghanistan there was nothing in them that stated I would be the Senior Nurse, only that I would be deployed for approximately two hundred twenty days. As I reported on the assigned day to NMPS SAN DIEGO I began to look for the senior ranking Nurse Corps officer deploying with me, to introduce myself and to begin the initial necessary steps of organization (finding out the numbers of nurses deploying, rank, experience, etc); steps I have learned are vital for success in ➔



Vignette from a CDR, NC (continued from page 51):

advanced degrees in order to progress in our career of endeavor. I have come to believe an advanced degree is part of a process of finishing a leader professionally; a tempering process used to refine thought process, to hone abilities in preparation for events in life such as war or managing a department filled with complex individuals who need refining themselves. I know I struggled at times during the process of obtaining my advanced degree to find the best way of completing multiple assignments, not only on time, but with the right way to produce the quality of work needed to bring the highest marks. When you think about it, it is the exact same process one uses in upper management to reach goals and accomplish objectives. Experience teaches us to make the best choices first, to follow our instinct, to seek advice from other professionals in the process and then proceed as though all depends on us to achieve the objective. It's not to say that an advanced degree is going to make you the all knowing, always right leader; I've been wrong more times than I would care to admit. But where does the experience in life or career come from if one does not first find it in the classroom? Does it come from making choices in life where the lessons learned can cost time, equipment or lives? Now correct me if I'm wrong, isn't better to fail on a project in the classroom and learn from it, than it is to have failed in the field where the cost may be a vital piece of equipment needed to accomplish the objective or worse, someone's life or limb? Is failure to perform

or to make the correct choice due to the lack of experience in critical thinking, planning and/or in accomplishing goals and objective when in matters the most? These are very important points one needs to consider when asking "why should I go back to school?" Are you prepared enough without an advance degree in your area of nursing or profession to progress forward with confidence? I can tell you our esteemed colleagues in the practice of medicine are not and we would not let them touch us or one of our family members if they had not gone through the processes of advanced degrees in medicine.

This may be a moot point now, but one might argue that experience is part of life as a mature adult finding their way through an unclear future and I would have to agree, but would add this caveat: lessons learned in the classroom can be transferred into real life events where critical thinking is needed to save lives and equipment. I firmly believe and have witnessed for myself that knowledge gained in advanced degree preparation enables a leader to prepare themselves for real life wins. ♦



Vignette from a CDR, NC (continued from page 53):  
heal for those men and women who have paid the ultimate price with their lives or physical injuries. The same can be said for those who provided the care for them.

During my deployments, the trying times of triage, assessments and intense stress, I have witnessed too many junior nurses who were ill prepared for what they had to face in the aftermath of battle. I watched them breakdown and for a time, become unable to perform their duties. When you realize you can't quit, go home or transfer to another ward, you are there and you have to make the best of it, because there is no one else to take your place. Either you rise to the occasion or you become a victim yourself. That's the kind reality that hurts and if you are not prepared, it can be disastrous psychologically.

Having nurses operationally ready is not only about fulfilling the requirements of the paper work, physicals and immunizations; that's the easy part. The hardest part is getting our nurses and corpsmen ready psychologically. That means doing all we can to prepare our staff before they deploy into harm's way. As leaders, we are given the assignment of selecting which of our staff will deploy. We have a moral responsibility to get them ready at all costs.

To me, clinical leadership is a developed style of leadership, a process learned through experience. When one is afforded a length of time in an area sufficient enough to gain knowledge, clinical skills are learned and leadership opportunities will naturally present in part due to com-

petency and ability. Together, the combination of learned skills and leadership ability produce a clinical leader who is effective.

In the beginning, finding your way in nursing can be a little daunting if you're not sure what area of nursing you want to pursue. Like a kid in a candy shop, there are so many choices. I will put a plug in here for the value of a good mentor; they are vital shaping a new nurse in paths that lead to a successful career. Knowledge gained from experience by one who has worked the floor is invaluable to those we lead and mentor. New nurses come into the Navy wanting the world and wanting it now. Many do not know where they want to work or where they will be in a year. Just by talking with them, identifying their interests, their goals or what they like to do, we can help start them on the right path which ultimately leads to a successful career. Helping a new nurse make the best choice for them in the area of nursing they will thrive in, is invaluable to the success of the individual and sets the stage for a competent clinical leader.

I have always considered myself one of the lucky ones. I found out early what I wanted to do and pursued it until I obtained an assignment in the ICU. Later, I was given the opportunity to work in the PACU and the ED. My nursing career has been an adventure ever since I signed on the dotted line. I have enjoyed the journey and will treasure the experience for the rest of my life.

My operational nursing experiences have been based in clinical leadership. For years I've worked in the →



The question is not if you will deploy, but when and where. Take the advice of these Nurse Corps officers and prepare now, so you are ready for operational success as a clinical leader.

Being prepared for missions outside of routine clinical environments is what sets Navy Nurses apart from

their civilian colleagues. Every assignment you receive; every opportunity to stand as a leader both clinically and as a naval officer, prepares you to step into operational roles that are both challenging and rewarding. The Clinical Leadership Model illustrates how all those times you wondered why you were asked

to do what we were doing crystallize when you are part of a Marine unit in Afghanistan or aboard USNS COMFORT (T-AH 20) headed for a humanitarian mission in Haiti. To “hit the deck running,” and do it successfully; that’s what being a Navy Nurse is all about.





## Chapter 6

### Clinical Leadership: Putting it All Together!

**T**he three domains of the Clinical Leadership Model (see Diagram 6.1) are comprised of Professional Development, Leadership Development and Operational Readiness as outlined in the previous three chapters. These three essential building blocks, when practiced together, culminate in clinical leadership within the Navy Nurse Corps. These inter-related domains are like the three legs of a tripod. They further strengthen each individual leg and support the mission of a strong supportive structure. Navy Nurse Corps officers are on the healthcare team, strengthening it with their professional nursing practice and expertise born out of a strong clinical skills foundation. Together with their leadership experience and professional expertise, these professional nurses can deploy and care for the warfighter wher-

ever they go. This chapter will show how the three domains of this tripod are interrelated and build upon each other as illustrated by real life stories shared by Navy Nurse Corps officers at different phases of their careers.

A Clinical Leader is a multi-dimensional Navy Nurse Corps officer simultaneously adept in all three domains. Putting these three domains together in action provides us the ultimate professional goal of each and every Navy Nurse

Corps officer. This clinical leadership is what makes the Navy Nurse successful and relevant throughout his or her career. The clinical leader emerges as the professional and clinical expert in their field of Nursing. He or she is the passionate, clinical, “go-to” expert, certified or Master’s degree prepared in their chosen field. At the same time, they have mastered the officer role as a model officer and leader at their current rank. These men and women are able to apply their clinical expertise, leadership skills, critical thinking and judgment anywhere, from the technologically advanced academic medical center to the most austere operational environment. This is a dynamic process that requires the officer to continue learning and applying the competencies of all three domains in order to achieve maximum effectiveness.

The corollary is also true. A Navy Nurse cannot be a clinical leader unless he or she continues to be relevant in all three domains. If the officer is competent in only two instead of all three domains, just



Diagram 6.1 — Clinical Leadership Model



Vignette from a LTJG (continued from page 59):  
bolus of Dilaudid and stated that he would be up to assess the patient after clinic. It was currently 1300 in the afternoon and clinic would not be over until close to 1700. I paged the resident and I got the same answer. I administered the additional pain medication, hoping to make the patient more comfortable but I knew there was an underlying problem. While this was going on, I felt nervous and a little on edge. I wanted the physicians to assess the patient within minutes of calling them because my gut instinct was telling me that something was not right. I consulted with a few of my nurse colleagues and we all agreed that something had to be done. After a few more phone calls up the chain of command, a physician arrived and shared my concern. The team of doctors decided to take the patient to surgery that night to further investigate what was going on in his leg. The Marine went into surgery and the doctors removed a large hematoma and nearly one liter of blood. He returned to the ward one hemovac and two Jackson Pratt drains, as his leg was not ready to be closed

completely. I visited the Marine's room and he thanked me for being his advocate.

I consider this a success story even though there were a few bumps along the way. I learned to trust my clinical judgment for the first time. After a deployment to Kuwait, where I focused on my clinical skills and operation readiness, I had to tackle the leadership aspect as the charge nurse on a busy and often hectic ward. I was managing the floor nurses and corpsmen while keeping in tuned to the patients' ever-changing statuses. The job of running the ward can be a daunting task for anyone and as a LTJG I felt overwhelmed at times. I let this particular story, however, give me the confidence to speak out when I know something is not right. I used my voice to communicate the patient's situation effectively to the physicians and I acted quickly. If I could replay the events of the day, I would have been more insistent that the doctors see the patient immediately. As the charge nurse, it was my goal to keep all the patients on the ward safe and I think I accomplished that mission for the day. ♦

Vignette from a LT:

Nursing school prepared me to be a nurse; Officer Indoctrination School prepared me to be a Naval Officer. As a Medical-Surgical nurse at the National Naval Medical Center (NNMC) on the Surgical Ward 5-East, I refined my nursing and leadership skills. After eighteen months on 5-East, I was selected to be a permanent Charge Nurse.

I came into nursing with the knowledge, will, and determination to provide safe and compassionate care to all of my patients ... however, some days tried my tolerance. The day-to-day activities and challenges are what molded my ability to plan, organize, and manage the workings of

Vignette from a LT:

During August 2001, I was the Charge Nurse on 5-East. The day started like any other with surgical patients coming and going. Sometime around noon, I believe, we were notified Walter Reed Army Medical Center (WRAMC) had lost power and the generators failed too. NNMC and WRAMC were scrambling to discharge patients that could go home, and at the same time, NNMC was preparing to receive the patients that couldn't.

Inpatient bed management routinely was handled at the ward level by the Charge Nurse, but with the vast amount of patients that were going to be arriving, similar to a mass casualty, the Director of Nursing took on that role assigning the WRAMC patients as they arrived. I couldn't have been more relieved that she was now

a busy peacetime surgical ward. The nursing staff, patients, and medical providers all participated in my development, but it was my department leadership that made the biggest impact on me.

I was a LTJG and they allowed me to run the ward, but were right there if I ran into an issue or problem I couldn't handle. They supported and guided me whether I was right or wrong. That foundation of mentorship reduced my fears of "Nurses eating their young", which made it rather easy for me to say "I would be more than happy to let you speak with my supervisor." Alleviating that specific fear of a junior nurse is monumental in their professional development. ♦

responsible for that task. We provided continuous available bed space after our Ward Medical Officer coordinated discharge and ICU transfers. In theory, an attempt was made to keep Medicine patients with Medicine patients, and Surgery patients with Surgery Patients ... it wasn't always the case; just needed to get the patients into an assigned bed.

We called in additional staff, and NNMC staff picked up care for these patients since WRAMC staff was still in the process of moving patients from one facility to the other. We had to be creative in how we maximized our bed space ... we were fortunate to have a husband and wife admitted at the same time but on different wards, so it made sense to put them both in the same room, and we did. ➔




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Vignette from a LT (continued from page 61):

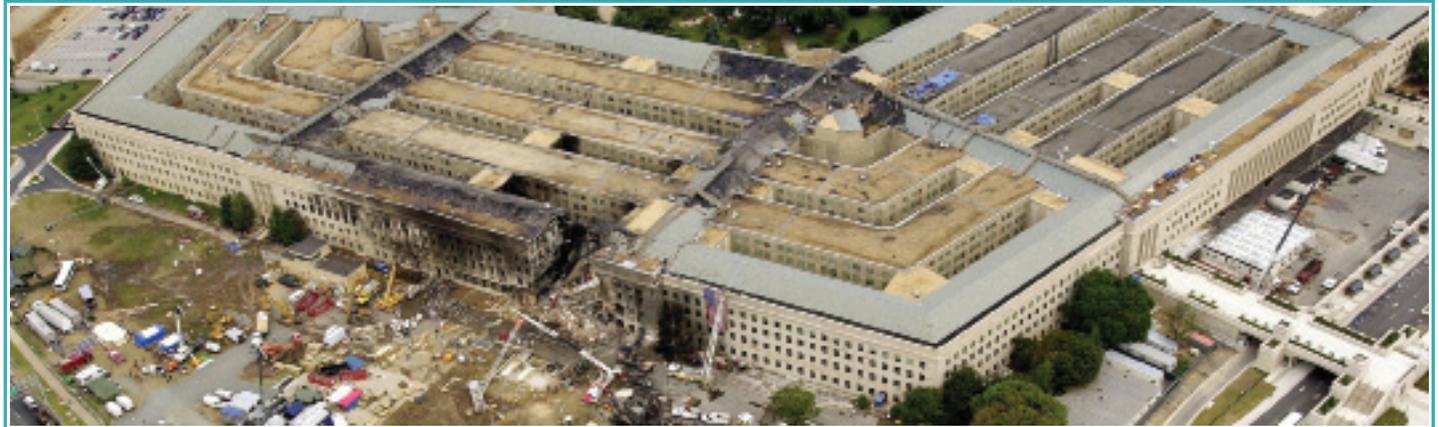
Once all the patients were relocated and settled, it was kind of business as usual. NNMC staff took care of NNMC patients and WRAMC took care of WRAMC patients ... but the two groups of patients were not all gathered together in a block of rooms, they were commingled. It was expected for the WRAMC patients to be with us for about two days, but they were with us for about a week, maybe a bit more, if I recall correctly. After a shift or two, I realized this division of patients and staff just wasn't working, we did things differently than they did. For example, something as simple as changing bed sheets ... we did it every day, they did it every third day. The increased tension from the "Them" versus "Us" mentality, (which didn't escape the doctors either), needed to end if we were going to effectively take care of all of the patients. It was sort of like Military Medicine's own Army-Navy Game.

I talked with my Department Head and theirs; we had a meeting with the entire staff, and told them the plan to do

patient care assignments as I normally would ... each nurse gets a block of rooms, regardless of the patient. When making daily assignments, I had to take into account the skill level of the Army staff. They have LPNs, where we have corpsmen.

It all worked! It's a comfort level thing for most I think. The WRAMC staff was out of their comfort zone, and they were "invading ours." That put everyone on edge, but when we transferred the patients back, as crazy as it seemed with paper charts flying everywhere, there was organization and order. Someone even asked me "How do you always seem to stay so calm?" I responded "If I get spun up, then I am of no use to anyone."

We sometimes forget that nursing is nursing and we all have the same goal ... that different Services can work in harmony together. Fortunately or unfortunately, this entire event was fortuitous ... because about three weeks later, 9-11 happened. ♦



Vignette from a LT:  
9-11 and the Pentagon

It was a Tuesday, a trivial fact that for some reason I remember, and my Department Head returned to the ward from a meeting. She looked extremely concerned and grabbed me and a few others. We went into an empty patient room by the Nurse's Station and turned on the TV. What we were seeing was something out of a movie . . . it was the replay of the first plane hitting the Twin Towers. I thought, out loud probably, "that's unbelievable" and I clearly remember thinking it was an accident . . . and then the second plane hit. We were all in disbelief and shocked. How could this be happening? Here? In our country?

As the next hour or so passed, the New York flights were all we were thinking about. Then, at 0937 another plane hit closer to home and crashed into the Pentagon. The NNMC campus didn't have a fence enclosing the property, so I believe Security manned the access roads and closed the base to all incoming traffic except for emergency person-

nel. An immediate recall was instituted to account for all military personnel and call in all available staff . . . cell phone lines were flooded and didn't work, but we did reach some staff and some others just came in. We cleared the hospital of all patients just as we did for the WRAMC power outage. I didn't expect to need to do this again so soon.

The news was reporting frequently about the conditions at the Pentagon and we were frantically preparing to receive patients, I realized if anyone survived, they would take them to the closest hospital and that was in Virginia. We didn't get any casualties but everyone was now looking into the future. In the following couple of days, USNS COMFORT (T-AH 20) was preparing to deploy to New York. Most of the staffing for USNS COMFORT (T-AH 20) comes from NNMC, so the list of needed assets changed with every minute it seemed. I went home about 1800 that evening and I remember being angry and sad, as well as frustrated we, as a military, weren't able to intercept the plane bound for the Pentagon. I cried. ♦

These vignettes illustrate how quickly the junior officers transitioned from their role as a new nurse and clinician to one of teacher, mentor and leader. As the officers grew into confident and competent professional nurses, they also grew in their leadership role, taking care of their patients, the corpsmen, and training new staff. They showed that everything they do in the execution of their job helped them to grow and prepare for deployment and the care of their patients. They, themselves, grew in the continuum, moving from novice to expert, honing their clinical and leadership skill capabilities as a Navy Nurse. The junior Nurse Corps officer may have had several clinical assignments during their first and second duty stations. They often moved from the medical or surgical floor to a specialty care area of their choosing. Nurses then progress towards completing the requirements for advanced clinical training and/or certification.

Vignette from a LCDR:

I joined the Navy Nurse Corps in 1998 after graduating from the University of Illinois in Chicago. I decided to join the Navy while I was in the middle of my nursing education and applied through the Navy's Nurse Candidate Program. I wanted to join the Navy so I could have a challenging career and experience nursing in different settings. I also was interested in becoming a CRNA (Certified Registered Nurse Anesthetist). After graduating from college, the Navy moved me to the Naval Medical Center San Diego where I began my nursing career. I worked for two years on a challenging medical/surgical ward, and then transferred to the ICU (Intensive Care Unit) where I worked for an additional two years. While in the ICU I began to put together my application package for the Navy NNCAP (Nurse Corps Anesthesia Program). I applied to NNCAP in 2001, was accepted and began my education in Nursing Anesthesia in the Fall of 2002. I graduated from the NNCAP and Georgetown University in February of 2005. Immediately after graduating I was transferred back to the Naval Medical Center San Diego where I began my career as a CRNA.

During my first tour as a CRNA and only having worked in that position for eight months, I deployed to Al Asad, Iraq with Med Battalion out of Camp Pendleton. I was deployed from February 2006 until August 2006. I can say I was quite nervous, excited, and scared to know I would be working in an austere environment, and never having deployed, I just didn't know what to expect. While in Al Asad, I

worked alongside an Anesthesiologist and a stellar group of nurses, corpsmen, and doctors. We operated on over 177 patients in the seven months we were there, including U.S. military and civilians, Iraq military, police, and Iraqi civilians.

During my tour in Iraq, I learned a lot. I learned how to live with other people I didn't know, but soon got to know very well. Some of my most cherished friendships are those that I made while on deployment and still have today. I learned a great deal about how to improve my practice, especially working with an experienced anesthesiologist. I can say that I picked his brain every chance I could. I feel that we both worked very well together and developed a cohesive working relationship. I learned how to cope with seeing horrific injuries and seeing the young men who suffered them. I learned how to put aside what I saw and focus on providing the best care that I could give. This was something that was hard for me in the beginning never having seen these injuries before.

I have always felt that my training in the NNCAP had well prepared me for taking care of a variety of patients, and I did feel prepared for taking care of the trauma patients. But once I saw the nature of these injuries and realized the somewhat limited resources we had to work with, I quickly learned how to safely treat these patients and get them to the next level of care. In training to become a CRNA, all the equipment you could ever need is at your disposal and when taking care of trauma patients in a trauma hospital setting, you are not taught how to handle these patients →

Vignette from a LCDR  
(continued from page 64):  
with no advanced monitoring. Our hospital in Al Asad did have a lot of equipment and we actually had anesthesia machines, a staple for our practice, but we didn't have some of the equipment that we had back home.

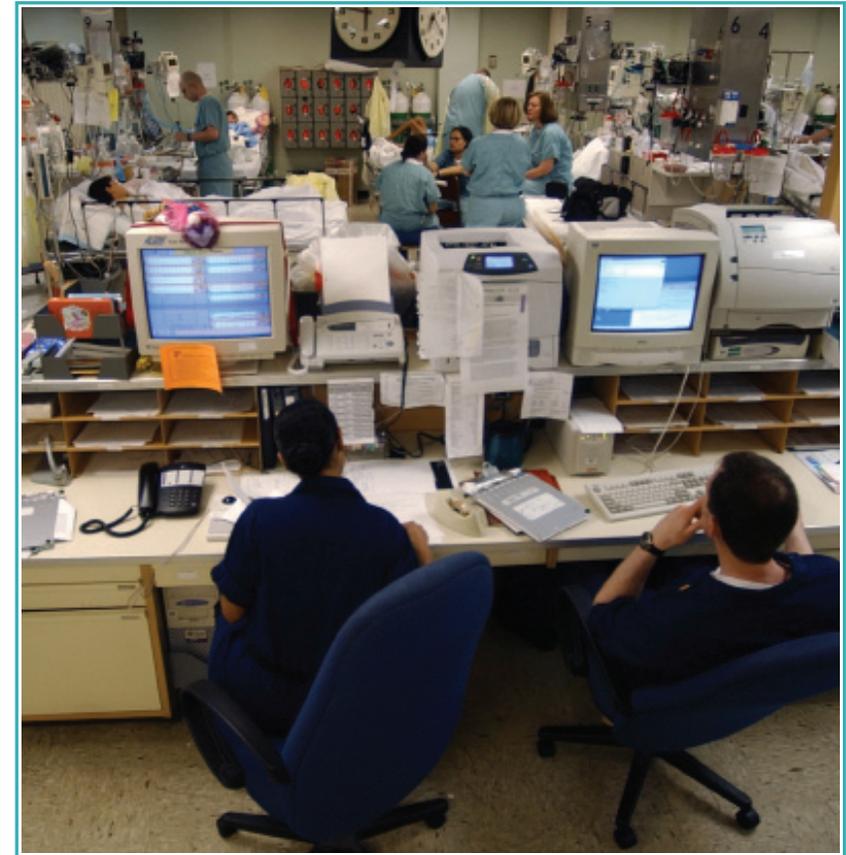
One of the most valuable experiences I had while deployed to Al Asad was being directly involved with training of our nursing and corpsmen. This was essential to our success in providing optimal care for our patients. Our anesthesiologist and I were constantly teaching on topics such as monitoring, fluid and electrolyte balance, ventilated

patients, drugs, blood loss and blood transfusion equipment. We were both an integral part of training our nursing staff in getting prepared to fly patients to the next level of care.

When I think back to my deployment, I can say that I am very fortunate to have had this experience and to have been deployed with the staff I was with. No matter the situation we were faced with, we all learned to rely on each other and help each other out. If I had to do it all over again, I would in a second and I don't think I would change anything. I do feel that this experience has influenced my clinical practice today as I feel even more prepared to care for trauma patients. ♦

The preceding vignettes show how these officers mastered their clinical and leadership competencies and continued to grow as mid-grade officers. Nurses at this level are now placed in formal leadership positions as Division Officer or Charge Nurse of a Nursing Unit, Ward or Clinic. The ultimate goal is to complete an

advanced professional certification or a graduate degree in a specialty area. Those who complete this have found their clinical passion in a specific community of practice in the Navy Nurse Corps, and are now able to assume greater leadership responsibility and complexity in a role as Division Officer. They were mentored by their seniors and as



a result also prepare their juniors. They contribute to the Navy Nurse Corps by leading, mentoring and preparing their junior nurses and corpsmen to be professionally and personally prepared for deployments and future professional and leadership roles.



The senior officer vignettes highlight how these officers have grown based on their increased scope of responsibility in both the professional and leadership domains. Despite the senior and executive leadership roles these officers hold, it remains essential for them to maintain their clinical readiness and competence so that they are clinically agile and professionally relevant to deliver the dual mission in the Medical Treatment Facility and forward deployed. These Senior Nurse Corps officers continue to grow in each domain and integrate their professional, leadership and op-

Vignette from a CAPT:

Overall, my deployments, along with billets as a Division Officer (first line leader) of the ER in Okinawa, Division Officer of a Medical/Surgical/Oncology unit at Naval Medical Center San Diego (NMCS D) and Department Head (middle management) of Critical Care at NMCS D, represent the Clinical Leadership Model where I have had the

opportunities over my career to hold positions of clinical excellence, operational excellence, and leadership. These experiences have culminated in my current position as Senior Nurse Executive/Director of Nursing Services (Executive, Chief Nursing Officer) at Naval Hospital Camp Pendleton, and I feel competent to practice and lead anywhere, anytime. ♦

erational knowledge in everything that they do as senior Navy Nurse Corps leaders.

The operational environment described in Chapter five presents many unique challenges affecting the Nurse Corps officer's ability to provide safe, quality patient care to the warfighter. Navy Nurse Corps officers are able to succeed in this varied and unpredictable environment because they are experienced clinicians and leaders. Their leadership judgment is based on their understanding of clinical care. Deployment, on the other hand, draws on more than just their

clinical/professional expertise and leadership ability. The wartime environment will challenge the Navy Nurse's organizational skills, critical thinking, teamwork, interpersonal skills, and flexibility. The operational environment is without unlimited resources, technology, and expert assistance, and serves as the ultimate test of our ability to deliver quality care to the warfighter anytime, anywhere. Deploying and caring for our warfighter away and at home is what makes military nursing and the Navy Nurse Corps officers different from our civilian nursing counterparts.



Vignette from a LT:

When I arrived at Naval Hospital Camp Pendleton as a Lieutenant in August 1992, I was eager to deploy. I was assigned to the ICU and later the Emergency Department when the civilian contract was converted to military. In March 1994, I deployed to Zagreb, Croatia with Fleet Hospital SIX, one of four ICU nurses and twenty-four total nurses, to support OPERATION PROVIDE PROMISE, a United Nations' mission. Although I was an experienced Trauma/ICU nurse, I had only been working as a Navy Nurse for less than two years. As we prepared for deployment, I attended Fleet Hospital Training School, just in time training for work in a field hospital. I had already attended Combat Casualty Care Course (C-4) in January 1993. We were given the warning order to deploy in December 1993. In February 1993, there had been a bombing in a Sarajevo market place with numerous casualties. We arrived in theater in March 1993. I was excited to be putting my clinical specialty, knowledge, and experience to use. We had a U.S. Marine Corps detachment to provide perimeter security within the compound located near Zagreb International Airport.

As a young Nurse Corps Officer, I was confident in my clinical skills and ready to receive casualties. I was excited to mentor corpsmen and nurses less experienced and junior to me. I was able to go on medevac missions and care for patients en route to Germany prior to the time when the Nurse Corps offered any formal En Route Care training, or even helicopter or fixed wing training.

As far as situational awareness is concerned, we received reports from our chain of command regarding operational issues in the region and potential threats to us on the compound. I never felt scared or worried that we'd be in great danger. I trusted the team of United Nations (UN) personnel providing us with security beyond our own perimeter.

I'm not sure where to start on the feelings and emotions which I experienced throughout the deployment. Looking back, there were times of frustration with "the system," for example, when we could call back to the U.S. and ask friends at MTFs to mail us medical supplies because we could not get fast them enough via the UN Supply Chain. There had been an overhead trapeze bed ordered by the unit that preceded us, which still had not arrived three months into our tour. A Seabee Unit deployed with us ended up building one from scrap metal and pulleys taken from gym equipment so that we could care for amputee patients. I had brought my "Fundamentals of Nursing" text book, and it was from a photo in this book that the Seabee created the trapeze bed. In order to provide our ICU patients with comfortable beds, as opposed to North Atlantic Treaty Organization (NATO) litters and cots, we moved twin beds into the ICU. However, the mattresses made nursing care difficult and potentially not safe since they were much lower to the ground than the cots. So we improvised and put double and triple mattresses on top. These beds had no ability to raise and lower the head or foot. ➔





#### Vignette from a LCDR:

I was the Ship's Nurse on USS CARL VINSON (CVN-70), where I was assigned from 2000-2002. It was while we were deployed on a Western Pacific deployment that the events of September 11th occurred. I can't begin to convey the emotions that occurred during that event as our ship's crew prepared for the upcoming bombing missions and OPERATION ENDURING FREEDOM. I was a member of more than just a medical team, and came to understand the "Line Navy" and what it really meant to be a member of the support element.

From a clinical nursing leadership perspective, as the only nurse aboard, I, like all carrier nurses, had numerous responsibilities. I was the Medical Training Team Officer, the medical department's representative on the ITT (Inte-

grated Training Team) which created all the GQ (General Quarters) scenarios and drills to prepare the ship for war. I was the BLS Affiliate Faculty member and responsible for not only teaching BLS to all who required that training for their jobs, but also for coordinating the program at sea. I taught first aid for all the personnel assigned to repair lockers and battle stations on the ship. I was the ship's expert in women's health issues, not because this was my background, but because this was a need. I had to look up a lot of information and teach myself before I could teach or counsel others. From a Naval Officer perspective, I also qualified as ACDO (Assistant Command Duty Officer) In Port, a ship-wide leadership position. Overall, the hours were very long, eighteen hour days were the norm. However, this was one of the most rewarding tour of my career. ◆

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#### Vignette from a CDR:

I deployed as the Senior Nurse Executive/Director of Nursing aboard USNS MERCY (T-AH 19). My permanent assignment to Mercy's ship's company occurred in November of 2004. My predecessor assured me this assignment would be easy, "The ship has not deployed anywhere in twelve years; in fact, they call it Building 19 since it is firmly affixed to the pier." Nothing could be further from what actually occurred. On December 26, 2004, the earthquake and subsequent tsunami in Southeast Asia propelled the USNS MERCY forward in Disaster Relief and Humanitarian missions, which have continued to shape strategic planning and policy today. What

we did then has better prepared us for the current mission in Haiti.

My clinical and leadership experiences in the Navy well prepared me for this unique mission. Within four days I had met with the augmented nurses who would become my department heads, and together we planned as much as we could with our broad mission goal of "Go West and do good things." We learned en route that we'd be augmented by civilian volunteers, mainly from the NGO (Non-Governmental Organization) Project Hope. As we embarked volunteers from all over the United States and additional U.S. Public Health Service members, it ➔

Vignette from a CDR (continued from page 70):

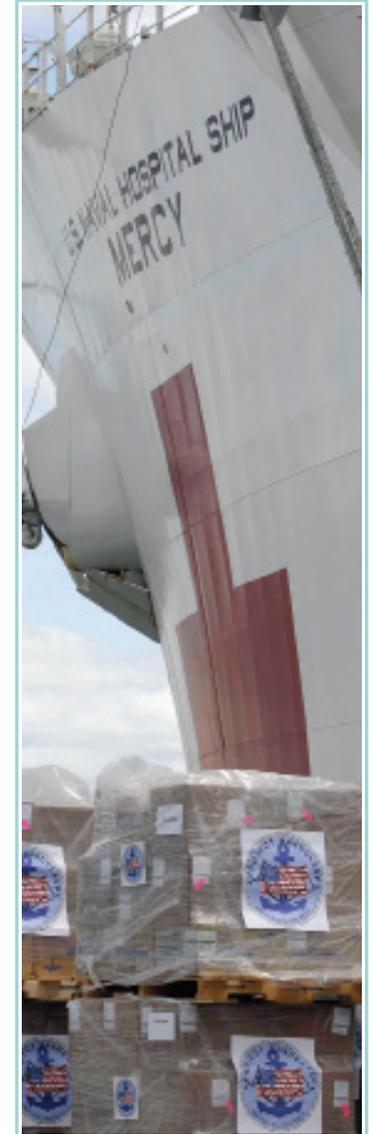
was a wonderful opportunity and challenge to develop this “team of teams.” Once we had reached Banda Aceh, Indonesia, we had passed through the stages of “Forming, Storming, Norming, and Performing,” and were ready to go ashore or bring patients aboard the ship. We supported both these clinical sites in addition to providing clinical education to nurses and physicians ashore. I had the opportunity to network with the senior nurses at the local hospital to integrate our staff into what was left of their staff for patient care during the day. I attended numerous multidisciplinary, multinational meetings, sharing USNS MERCY’s capabilities and activities with representatives from all other relief organizations and the host nation.

Two of my greatest challenges were staffing both the ship and ashore missions, always cognizant of the limited number of seats on helicopters transiting patients and staff between the ship and shore. The NGO volunteers could only get time off their permanent jobs for three to four weeks. At first, they left at the end of their time, despite a full ship of patients. We learned quickly that manning in waves had to occur at obvious flow points between mission sites, when patients were no longer on board. Medical translation was a second critical element.

Translators had to be strategically placed throughout the ship to meet the needs of the physicians rounding, the nurses’ efforts to pre-op patients and to witness informed consent, and general care of patients who made efforts to convey their symptoms to the entire team. We also learned there is a vast difference between general language translation and medical translation.

Probably the most important thing I learned was to get the various teams that would comprise the Mercy’s team together, to take time to introduce ourselves and learn what each agency or member brought to the team in terms of experiences and skills. Expectation management was also important, keeping clear lines of communication so that everyone felt a part of the mission, whether they stayed aboard the ship, or went ashore. Managing everyone’s expectations of getting ashore at least once was a challenge given the transportation and logistics’ limitations. Flexibility was again critical.

Being flexible and ready to transition into a new role was important to my success. I was comfortable functioning in a very autonomous role and understood the importance of being like an ambassador, representing the USNS MERCY and the U.S. in my discussions with host nation personnel. ➔





These diverse operational vignettes show the scope of clinical experience required by Navy Nurse Corps officers when deployed away from the MTF in support of the warfighter or humanitarian missions. The officers conveyed that they had mastered a level of clinical expertise commensurate to their rank and experience, and completed the

necessary competencies required to work in either the Intensive Care Unit or the Neonatal Intensive Care Unit at a Medical Center or Teaching Hospital. They were confident in their clinical abilities and were the recognized clinical expert on their unit because of the clinical and leadership work experience obtained in the MTF. As a result,

they had oriented and precepted new officers, nurses and corpsmen to their unit, sponsored a newly reporting officer and corpsmen, led their unit as shift charge nurse, and mastered several collateral duties of their nursing unit. To the untrained eye assorted collateral duties such as education, scheduling or supply officer of the ward, unit or clinic do not seem like leadership development training; however, the Nurse Corps officer is mastering the leadership jobs and competencies commensurate with their rank and within their scope of control. They are gaining both depth and breadth in their leadership and management experience which is designed to better prepare these officers to lead in a variety of nursing and healthcare roles. Stories like these are told in Navy Medical Treatment Facilities around the world, including Navy Medicine's medical centers, hospitals, and clinics both in the Continental United States (CONUS) and overseas.

The Navy Nurses featured in the operational vignettes have shown that when you leave the comfort

of your Medical Treatment Facility work environment, resources, and work role, you also leave an area of unlimited resources and state of the art technology to both assist in the diagnosis and treatment of our patients. The deployed environment demands that the Navy Nurse be creative and figure out new ways to deliver safe patient care. This challenging clinical environment where the Nurse Corps officer cares for the warfighter or the host national requires a clinically competent and experienced leader. In addition, the essential competencies of the day require the Navy Nurse to be an extraordinarily calm, inventive, resourceful and resilient member of the healthcare team. As one LT described, “flexibility in your clinical practice, via cross-training, ability to live in a tent without the luxuries of home, to stretch beyond what you know to learn more clinically, professionally, and personally, is what this experience and my Navy career has been all about.”

Despite these challenges, Nurse Corps officers articulated that they were able to provide safe and

relevant care because they had been well prepared as clinical leaders. They were able to synthesize and use their organizational skills so as to adeptly devise a plan of care, and manage the basic hierarchy of needs for either a patient or a medical department. In order to be effective in the operational environment, they all stated that in addition to being prepared professionally as a clinician and leader, flexibility, strong interpersonal and team skills are critical. The solid foundation of professional and leadership development is built in the MTF, requiring the officer to set professional goals such as clinical certification, advanced education and the challenge of varied leadership responsibilities and assignments. As our Marine counterparts say in order to be successful, “we must train like we fight and fight like we train.” If we are to be able to care for our patients and staff in the most arduous of circumstances when deployed, we must prepare each day in the MTF.

So what happens after deployment when the Navy Nurse Corps

officer returns home to the MTF? The training cycle must continue. It is now the professional and leadership responsibility of the chain of command to engage and encourage the returning Nurse Corps officer to share their deployment lessons learned with their colleagues. Those returning will gladly share and teach valuable lessons to their seniors and juniors alike, if encouraged. They want to share what they have learned and they have a vested interest to ensure that the next group is better prepared than they were to deploy.

The mid-grade and senior officers in the Medical Treatment Facility set the leadership tone for sharing and incorporating these lessons learned on the unit, ward, or clinic. The officers in leadership positions also quickly realize that the Nurse Corps officers returning from deployment have a different professional, clinical, and leadership confidence and demeanor than before deployment. How could they not? They have grown professionally and personally and have held greater responsibility than ever before.

These nurses are forever changed because of what they have learned and accomplished. These capable staff members have shown what they know and will require a greater leadership challenge or broader scope of responsibility despite their junior rank. Staff members returning home also welcome the opportunity to prepare others for deployment while working in the MTF, because somehow they know that they are still caring for the Soldier, Sailor, Airman and Marine they left behind by preparing the next wave of colleagues to deploy.

This also sets new clinical leadership challenges for the first line, mid-grade and senior leader alike. As the leader of these returning nurses, we need to value them for what they know, challenge them to utilize and share this new level of competence, and support and care for them during this time of

“transition” as they return from war or deployment. Taking these lessons from the operational environment back to the MTF changes the long-range view of the mission completely for everyone. Those returning understand the world in a completely different way; they see the interrelationship between the professional and leadership development of your staff as essential competencies to success in the operational or wartime environment. They understand that sharing lessons learned is the lifeblood to refining the professional and leadership development of Nurse Corps officers. Without deliberately using the lessons learned from those who have deployed, at the local MTF or professional specialty level, the Nurse Corps officer loses a vital opportunity to strengthen their practice, leadership and operational readiness.

As a clinical leader, we fully integrate all three domains because each synergistically builds on the other. Despite how junior a nurse is, when he or she returns from a busy deployment, whether war or a humanitarian disaster, everything clicks together. This is why there is no surrogate for clinical competence and sound leadership experience. There is a renewed commitment to excellence and training the next generation of nurses.

As nurses, we are in the business of caring for others, and preventing illness and injury both as professional nurses and as leaders. In addition to fortifying the nurse’s practice with additional current information from the operational environment, allowing our deployed nurses to tell their stories and prepare others, helps to heal them of the silent challenges and horrors of war.



# Chapter 7

## The Reserve Component

**O**n July 22nd last year [2008] I had the distinct honor of reporting to the Chief of Naval Operations (CNO), Admiral Gary Roughead, as the twelfth Chief of Navy Reserve. In that capacity, I have the privilege of working for over sixty seven thousand Sailors in our Navy's Reserve Component (RC). I take to heart that each of them has promised to "support and defend the Constitution of the United States, against all enemies, foreign and domestic". That promise is their covenant to our Nation, and my covenant back to these Sailors is to do everything I can to make their service truly meaningful, significant, and rewarding. These Sailors form an incredibly capable and motivated force, and they deserve nothing less. I find

myself amazed and truly in awe of the daily sacrifices our RC Sailors are making for our Nation and our Navy (Statement of Dirk J. Debbink, Chief, United States Navy Reserve, Committee on Senate Armed Services Subcommittee on Personnel, [given] March 25, 2009).



## Introduction

The United States Navy Reserve, (known as the U.S. Naval Reserve until 2005), is the Reserve Component of the U.S. Navy. It is one of the seven Reserve Components of the U.S. military, with the remaining Components belonging to the Army, Marines, Air Force, Coast Guard, Air National Guard, and Army National Guard. These seven Reserve Components are responsible for 45 percent of the military's manpower. Whereas the Air and Army National Guard units are assigned to and controlled by the states, the other five RCs are always under the control of our Commander in Chief, the U.S. President (Umansky, 2009; United States Navy Reserve, 2009).

If you are currently not a Reservist then you may not know about the Navy Reserve or understand its workings; however, one day you may find yourself leaving active duty. The goal of this chapter is to help you familiarize yourself with the Navy Reserve and the benefits of joining. Regardless of your status, you will

have many opportunities to meet, work, deploy, and socialize with Navy Reserve Nurses. This chapter will help you understand that today's Reserve Component Nurse is not just a "weekend warrior"; he or she is a valued member of the Navy health care team. The bottom line is that you cannot work or deploy without considering Navy Reserve Nurses one of your team's key medical assets.

## Our Heritage: Where Did We Come From?

In 1908, President Theodore Roosevelt established the Navy Nurse Corps, with the first Navy Nurses assigned to the Naval Hospital in Washington, DC.

In 1916 the Naval Reserve Force was established, allowing the Navy Medical Department to recruit nurses. The Naval Appropriations Act of 1920 recognized the NNC as part of the "Navy Establishment. In 1942, Public Law 654 authorized Navy Nurses to be commissioned as officers. Most importantly, the Army-Navy Nurses Act of 1947 made the Nurse Corps an official Staff Corps

of the U.S. Navy, permitting the NNC Volunteer Reserve Program to commence (Beyea, 2008; Bowman, 1927; Quinn, 1947).

Reserve Navy Nurses were critical medical assets in World War I and WW II. After WW II, reserve nurses were integrated into the regular Corps [while] others continued on active service at their own request. The larger portion of reserve nurses returned to civilian life, but remained members of the reserve. Between 1945 and 1950, new appointments in the reserve continued, and many of these young women volunteered their services. As a result, both regular and reserve components were on duty in the Nurse Corps in June 1950. Even so, it was evident that there were not enough nurses to meet the staffing requirements created by the Korean Conflict (Jones, 1951, p. 286).

Jones further explains that the mobilization of reserve nurses for the Korean Conflict was facilitated by having a pool of commissioned reserve nurses (1951). They were able to pull from this pool, with no

ensuing delay in mobilization. This process involved reviewing their records at the Navy Bureau of Medicine and Surgery and making recommendations to the Bureau of Naval Personnel, which in turn issued orders to each approved nurse. Hardships ensued, as they continue to today, for those who were in school using their G.I. Bill, those who were employed in institutions that would be burdened by their absence, and those with family responsibilities.

Navy Reserve Nurses have also played an integral role in the Vietnam War, the Persian Gulf War, and the wars in both Iraq and Afghanistan. Many Reserve Nurses joined humanitarian missions to Haiti in the wake of a devastating earthquake on the small Caribbean island. Historically, these nurses have always been willing to step up when and where their skills have been needed the most.

### Total Force Policy

In the 1970s the concept of a Total Force Policy was born whereby the Active and Reserve

Components for all of the services were integrated to meet operational goals as one seamless force. However, the cultures between the two components remained distinct until the 1990s, when the Reserve Component shifted from a “force in waiting” to a “force in use.” Today: [t]he active force is now responsible for the training and readiness of the reserve forces and is receiving their status reports. This realignment of responsibility is consistent with the Chief of Naval Operation’s expectations for creating a more integrated total force (Force Structure, 2005).

### Categories of Navy Reserve Status

Nurses can join the Navy Reserve as civilians via direct accession or after release from active duty. If you are new to Navy Nursing, then you know that your initial military service obligation (MSO) is eight years. When you separate from active duty and have not met your obligation, then your remaining time will be served in the Reserves.

**All Reservists are Assigned to One of Six Navy Reserve Categories (see Figure 7.1)**

Selected Reserve Forces (SELRES), Full Time Support (FTS), the Individual Ready Reserve (IRR), the Standby Reserve/Active, the Standby Reserve/Inactive, or the Retired Reserve Program. Members in reserve active status (e.g., SELRES, FTS, IRR, and Standby Reserve/Active) are eligible for promotion; members in an inactive or retired status are not eligible for promotion. Most nurse reservists are in the Ready Reserve, which is made up of two sections: the SELRES and the IRR (About the Reserve, 2009). Reservists that drill for pay and retirement points, at least two days a month, and two weeks every year via annual training (AT), fall into the SELRES category.

IRR members that drill without pay participate in voluntary training units (VTUs) and are usually senior reservists that no longer have a paid billet; however, they do accrue retirement points for each day that they drill and they are eligible to perform ATs and active duty for training (ADT). The IRR members that comprise the active status pool (ASP) do not drill; however,

they can accrue retirement points by participating in approved correspondence courses, performing active duty for special work (ADSW) or ADT, and/or assisting with funeral honors duty. At this point you may be wondering, “What is the rationale for the IRR?” Basically, it maintains a list of high caliber NR nurses that can be involuntarily recalled to active duty on very short notice via a presidential order.

What is the purpose of accruing retirement points for any reservist eligible to do so (especially for the members in the VTU that do not receive any pay for their drills)? Why “work for

free?” The answer is to earn retirement points, which are an important factor in calculating retirement pay. The majority of reservists aim for maintaining a “sat” (satisfactory) year in retirement points by accruing at least fifty points per anniversary year. Most reservists are not in the NR for the pay; they are in it because they respect the core values of the Navy (e.g., honor, courage, and commitment), are honored to provide service to their country, like being a part of something bigger than themselves, and they want to provide the best nursing care possible to our injured Sailors and Marines (Cox, 2010).

STATUS				
Active			Inactive	Retired
<b>Ready Reserve</b> (on the RASL)		<b>Standby Reserve Active</b> (on the RASL)  USNR-S1  Key Federal Employee & Hardship	<b>Standby Reserve Inactive</b> (on the ISL)  USNR-S2  Can't Earn Retirement Points or Promote	<b>Retired Reserve</b> (on the Reserve Retired List)  USNR-RET  Qualified for Non-Regular Retirement (SELRES) or Regular Retirement (TAR)
<b>Select Reserve (SELRES)</b>  Assigned to Mob Billet, First to Mobilize	<b>Individual Ready Reserve (IRR)</b>  Voluntary Training Unit (VTU)  CNRF  Drill Non-Pay			
<b>Full Time Support (FTS)</b>  TAR, CANREC OYR	<b>Active Status Pool (ASP)</b>  NRPC	<b>Sat Year Via Non-Pay Drills &amp; Correspondence Courses</b>		

Figure 7.1 — Navy Reserve Categories

Today “the [NR] consists of approximately 66,700 [55,600 SELRES and 11,100 FTS] officers and enlisted personnel who serve in every state and territory as well as overseas. There are an additional fifty thousand members of the IRR”

(United States Navy Reserve, 2009). “They serve in all fifty states, drilling from a total of 128 [NOSCs] split into five regional Reserve component commands” (Hill, 2009). “Today’s [NR] composes 20 percent of the Navy’s Total Force. Standing on even

ground with Active Duty personnel, reservists make a valuable contribution to ongoing Navy operations. And train with the best the Navy has to offer” (About the Reserve, 2009). Table 7.1 describes the NR Mission and Vision Statement.

<p><b>Navy Reserve Mission</b></p>	<p>The mission of the [NR] is to provide strategic depth and deliver operational capabilities to our Navy and Marine Corps team, and Joint forces, from peace to war.</p>
<p><b>Navy Reserve Vision</b></p>	<ul style="list-style-type: none"> <li>• Our vision for the [NR] is to be a provider of choice for essential naval warfighting capabilities and expertise, strategically aligned with mission requirements and valued for our readiness, innovation, and agility to respond to any situation.</li> <li>• We provide the Navy with strategic depth by maintaining unsurpassed individual, command, and force readiness. We are ready to surge forward – anytime, anywhere – from peace to war.</li> <li>• Our flexibility, responsiveness, and ability to serve across a wide spectrum of operations clearly enhance the Navy Total Force; act as a true force multiplier; and provide unique skill sets toward fulfilling Navy’s requirements in an increasingly uncertain world.</li> <li>• We deliver timely, cost-effective operational capabilities, through our people and equipment, which are relevant and valued by the Navy. We serve alongside active component Sailors and deliver capabilities that are unmatched for quality.</li> <li>• As Navy’s standard for on-demand expertise, we deliver full-time excellence through part-time and full-time service. Our contributions to national security are enabled by policies, processes, and administrative systems that are transparent and seamless, making it easy for Sailors and their families to serve.</li> <li>• We are the Force that others want to join and our diversity reflects the face of the nation. We give Sailors options that allow them to achieve a true life/work balance while they “Stay Navy” and continue contributing to our warfighting effectiveness.</li> <li>• Our actions and resources are fully aligned to achieve this vision. We are committed to supporting the Fleet and Combatant Commands, ready and fully integrated. We value the contributions of each and every reservist, recognizing service can and does vary from a few days per year to full-time service. Within our lifelines we provide support to our Sailors, individually and proactively. We stand ready to assist service members’ families, whenever and wherever they need our help. And finally, we recognize, respect, and honor the civilian employers whose support enables our Navy Reservists to serve our Navy and our Nation.</li> </ul>
<p><b>Strategic Focus Areas</b></p>	<ol style="list-style-type: none"> <li>1. Deliver a Ready and Accessible Force.</li> <li>2. Provide Valued Capabilities.</li> <li>3. Enable the Continuum of Service.</li> </ol>

Table 7.1 — Navy Reserve Mission and Vision

## A Parallel Journey

Since September 11, 2001, the integration of the Navy Nurse Corps' Active Component and Reserve Component has been unprecedented. Nurses have been working side by side supporting our fellow servicemen and women and their families in Medical Treatment Facilities, in Overseas Contingency Operations (OCO), and on humanitarian missions. Over 70 percent of nurses in the Reserve Component have been mobilized, and well over one hundred Nurse Corps Reservists have provided contributory support through Active Duty for Special Work (ADSW) and Active Duty for Training (ADT). "Nurses serving in the reserves no longer think in terms of 'if' they will be mobilized but "when" they will be mobilized (Cox, 2010, p. 1).

Clinical proficiency, adaptability, and a commitment to patient care have always been the core values of Navy Nurses regardless of whether they serve in the Active or Reserve Components. Post 9/11, nursing in the Navy necessitated a renewed focus on operationalizing

what those core values meant in response to the changing geopolitical landscape. Navy Nurses in both Components were experiencing a parallel journey as the demand for clinical expertise increased, particularly with the skills identified as critical wartime specialties. The Clinical Leadership Model developed in 2008 Strategic Plan clearly delineated that clinical excellence would be the foundation from which all other priorities would originate.

## Applying the Model to the RC

Reserve Navy Nurse Corps leaders embraced the commitment to clinical excellence at every level, particularly given that almost all requests for mobilized Reservists after 9/11 were to fill a clinical requirement. The Deputy Director of the Navy Nurse Corps Reserve Component charged Senior Nurse Executives (SNEs) with ensuring that their nurses were fully ready to deploy clinically when called upon to do so. Although Reservists had the opportunity to pursue nontraditional nursing roles in their jobs in

the civilian sector, which was valuable and noteworthy, it was equally important that they maintained competency in the clinical skills the Reserve Component might need upon mobilization. The SNEs of the Operational Health Support Units (OHSUs) developed clinical trackers to oversee compliance with the NAVMED 06-013 "Clinical Sustainment Policy" and to facilitate improved training opportunities for nurses who had not been working clinically in their civilian jobs.

The SNEs surveyed all of the nurses in their detachments, determining that about 10 percent of Reservists might have difficulty achieving the 168 requisite clinical hours. Creative solutions to assist these nurses in meeting the clinical sustainment policy were implemented through a variety of funding resources. Also, Reserve Nurses, who had been in nontraditional or nonclinical civilian jobs, were afforded the opportunity to attend the Sustainment Readiness to Advance Readiness Skills (STARS) program, originally developed to support nurses in the Air

Force Reserve Nurse Corps. After attending the STARS program, nurses were expected to maintain their clinical skills through drills, Active Duty Training (ADT), extended Annual Training (ATs), and Inactive Duty Training Travel (IDTT). Subsequently, SNEs worked with their members to facilitate a sustained and enriched clinical experience.

Clinical excellence is comprised of both clinical sustainment and competence. The Navy Nurse Corps Reserve Component now utilizes standardized nursing competencies developed by the Nurse Corps Clinical Excellence Strategic Initiative Team. Today, Reservists are encouraged to utilize these competencies when performing their reserve duties or when working in their civilian jobs; to remain competent.

### Force Shaping, Recruitment, and Retention

The dynamic environment of changing requirements necessitated an intense review of the billet structure to ensure that Reservists were able to meet sustained mobili-

zation demands. A team comprised of manpower analysts and community managers convened and brought forth recommendations. This realignment of billets proved to be valuable in two ways. First, it focused prioritization of critically unmanned specialties and clinical skills. Second, the alignment justified the need to increase the number of Advanced Practice Nurse billets, especially in mental health. For the first time in the history of the Reserve Component there were billets assigned for Mental Health Advanced Practice Nurses, which undoubtedly addressed the concerns of this nurse:

As an advanced practice nurse in psychiatric nursing, I believe that my clinical expertise has never been recognized by the Navy... Because there have been no billets for advanced practice nurses, I have had to create useful tasks as I have recognized them while on annual training or during recalls. Luckily, I have many years of experience in varied settings

and can usually see opportunities to create more efficient approaches to tasks at hand. During the recent war, it seems even more likely that psychiatric nurses could be useful seeing some of the many traumatized patients who are returning, yet there seemed to be no opportunity for nurses to do what we have the skills and credentials to do. Advanced Practice Nurses obtained masters degrees so that we could do advanced practice roles, including practicing crisis intervention, independent psychotherapy, and now we even have some who can safely prescribe medications. In spite of that, the Navy seemingly does not want nurses to do these things.

In early 2009, two policies were implemented that would have a significant impact on shaping the Reserve Component. The first was a memorandum issued by the Bureau of Naval Personnel that directed the reserves to use Reserve Officer force-shaping measures to include

accessions, affiliation, promotion assignments, and retention actions in order to balance the Selected Reserves (SELRES) inventory.

The second policy decoupled the Reserve Component from the Active Component. Decoupling means that promotion opportunities in the Reserves would no longer be tied to the Active Component promotion plan numbers. For example, if the Active Component were planning to promote twenty Captains, thirty Commanders and forty Lieutenant Commanders, then the Reserve Component would have to promote the same number. By decoupling, Reserve Component promotion opportunities would now be determined based upon vacancy at each rank.

Recruitment and retention, which were part of the Navy Nurse Corps Strategy, are germane to force shaping. The Reserve Component had difficulty meeting its recruiting goals in the past. To address this need, recruiting bonuses have been authorized for critical wartime specialties and an expansion of eligible communities was requested.

Keeping in line with the policy for incentive specialty pay (ISP), the Reserve Component requested a retention bonus for undermanned critical communities as well.

Stipend programs, another recruitment tool, allow nurses to attend graduate school for programs that meet critical wartime specialty requirements. The reservist is then obligated to serve a two year commitment for every year of advanced education. Recently, stipend programs have also been used as retention tools through collaboration with specialty pay program managers.

Several recent studies examined retention of nurses in the Reserves (EW Christensen et al, 2008 and Cox, 2008). These studies indicate that retention in the Reserves is robust and that mobilization is a strong satisfier of intent to remain in the Reserve Component. When a Reservist experiences high job satisfaction with a mobilization or recall, the probability of retention was high:

If the main question is, “Am I likely to get out of the Navy because I was recalled? The

answer is absolutely not. I know why I joined the Navy, and it was to hopefully give more than I received. The courage and innocence that I see in the faces of these young sailors is all that I need to want to be there for them with the hope of making a difference. The other reason that I want to stay is that I’m proud to be a Navy Nurse because it goes far beyond nursing. The challenge to be a leader, to grow and learn new information on a regular basis is very appealing to me.

### Leading from the Front

The Reserve Component has consistently placed a strong emphasis on preparing its nurses to be excellent leaders and mentors in the Navy Nurse Corps. Toolkits for SNEs are developed and disseminated to all Office of Health Support Units. Recognizing that effective communication is essential to leaders and mentors, multi-modal methods of communication are employed through list serves, newsletters, blogs, video telecon-

ferences, and webinars. A quarterly bulletin is written to ensure that all nurses are updated about current efforts and events affecting the Corps. Finally, bi-monthly video teleconferences are held with SNEs and Specialty Leaders.

One need not look very far before seeing nursing leaders in the Reserve Component integrated and working alongside nurses in the Active Component. Whether it be on the Federal Nursing Research Council, the Tri-Service Research Nursing Program (TSNRP), training at the Defense Medical Readiness Training Institute, or participating on the Trauma Care Advisory Board, SNEs in the Medical Treatment Facilities and OHSUs are constantly looking for staffing solutions regarding all gaps, all predicated on the notion that partnering provides for a richer training experience.

Applying the Clinical Leadership Model to the Reserve Component is not all that different when compared to the Active Component. Nurses need to be clinically competent in order to be operationally ready to serve when called:



I was mobilized for one year to work as a nurse practitioner in a primary care clinic at an MTF. The atmosphere in the clinic was very stressful as sustained deployments of personnel resulted in staffing challenges that seemed to never end. After three months I was asked to become the Clinic Manager

in addition to seeing patients. Recognizing the staff had been through so much change (and all change does not equate with progress), we worked hard to find a way to reinvigorate the team and make sure our processes both improved the working conditions for the staff and the experiences for the patients.

At my farewell party I was asked by the staff where I was going for my next duty station. I replied “home”, since I was a reservist. About two years later I ran into one of the doctors who worked in the clinic when I did. She asked me if I had any availability on my calendar to get together as she was now the manager of the clinic and wanted a mentor. I thought to myself, this truly is seamless integration!

### Operational Readiness: Rendering Care on the Battlefield and Providing Humanitarian Assistance

The developing challenges facing nurses in the Active Component and Reserve Component are unprecedented and Navy Nurses are poised and clinically capable to respond to the ever increasing demands. Training to meet operational commitments is vitally important and to that end, the Navy Nurse Corps Reserve Component increased the number of nurses it

allows to attend the Joint Forces Combat Trauma Management Course, the Trauma Nurse Care Course, the Advanced Burn Life Support, and the Combat Casualty Care Course. The NATO mission in Kandahar is the finest example of optimizing clinical capability between Active and Reserve Nurses. An intentional effort has been made to ensure that Reserve Nurses working in preeminent Level 1 and 2 trauma centers and universities around the nation were placed on that particular mission.

One SNE wrote to say:

I couldn't survive without [nurse one] and [nurse two], both Reserve Nurse Corps Commanders. They have taken charge of my Medical–Surgical Unit and ICU, and are keeping everyone on their toes.

Reserve Component Nurses continue to deploy as clinical leaders in Iraq, Afghanistan, Kuwait, and Landstuhl, Germany. Accordingly, there are universal themes

woven throughout deployment which provide a context for shared experiences. Nurses are present throughout the processes of caring: through life, death, and grief; as well as the renewal and transformation of the body, mind and spirit. War heightens these processes and elevates their acuity.

A junior Nurse Corps Reservist shares her experience:

As I entered my patient's room, I was shocked to see him on a Med/Surg ward. He had three chest tubes, three Jackson-Pratt drains, a stapled incision running from sternum to pelvis, bruising over his entire trunk area, about twenty sites where shrapnel had been removed and he had been throwing up all night. I still remember the patient asking “Are we going to do that now?” as I brought forward the nasogastric tube. While taping down the inserted tube, one corner of his mouth pulled up as he tried to smile. As miserable and pained as he

must have been, he never lost his military bearing or respect.

Due to complications and a bowel obstruction, [the patient] stayed at Landstuhl Regional Medical Center (LRMC) for ten days. The usual length of stay was three days. He had highs and lows during those long ten days. He learned that his best friend and roommate were killed in the same blast that injured him. I would chart in his room or visit on my days off to keep his spirits up. I carried his last remaining chest tube while he got a haircut and bought him his favorite snack.

Then one day I went to work and he was gone. I learned that he had finally been medically evacuated home. Nurses, corpsmen, medics, and airmen from all three branches of the Armed Forces cared for patients on a daily basis, but we were fortunate to be able to provide a holistic approach to healthcare by utilizing the expertise of physicians, Chaplains, pharmacists, respiratory therapists, occupational therapists, and dietitians. Every mem-

ber of the team contributed to the care and healing of our patients.

It has now been about two years since I've seen that same patient. Recently, he shared a heartwarming story about his recovery. He was invited to a ceremony in a small Arkansas town where a new church had been constructed and named in honor of his Sergeant killed in the same blast. It opened with the Sergeant's seventeen year old son playing "Amazing Grace" on his saxophone. He gave a speech, in uniform, sharing with the town what kind of Soldier he was, and how his last days were spent. He told me he felt honored to be there and truly part of their family.

The Sergeant told me that first day I met him he felt he was saved so he could go on to do something good with his life. I know I will continue to follow his recovery. Sometimes I wish I could put a suit of armor around him to protect him from any more pain. Every time I get an update from him I thank [him] for allowing me to share and

participate in his recovery and all he has taught me. No more questioning. I know why and how I got to this point in my life.

Mobilization to serve one another has been a nascent experience for many as expressed by another deployed Reserve Component officer:

I experienced a different level of nursing, which was more intense, personal and challenging. Twelve years of civilian trauma and flight experience definitely helped me, but it was a different kind of trauma and a different level of care. I experienced extreme highs and lows on the emotional curve. I left the deployed setting a better nurse and a better person. It was an honor to take care of these patients in that setting. This was a life changing experience both personally and professionally.

Similar sentiments were echoed from another nurse deployed during OIF:



Being deployed to a combat zone was a life changing event for me, and most of the individuals with whom I deployed. As an Officer, I witnessed many examples of extreme professionalism, courage, and humanity. I was amazed at the incredible imagination, innovation, and humor of the medical personnel and the Line person-

nel. Serving with and for the Marines has been the highlight of my military career.

Since 2006 there have been nurses who have been mobilized as case managers to support wounded/ill/injured Marines, Sailors, and their families. As case managers, they are caring for warriors and their families by providing for

a successful transition to a life post combat. Assisting them throughout their phases of recovery has been an honor for the nurses and the value they have provided has been greatly appreciated by the members in receipt of their care.

A Nurse Case Manager's editorial:

Working with the wounded men and women was an incredible experience. This group of young people (and some not so young) is truly remarkable. They show so much kindness and patience towards everyone they meet. Many face years of very difficult rehabilitation, but they take it all in stride. To use a saying from many of them, "it is what it is". They accept their injuries and are proud to have served their country. Although young, they have a maturity far beyond their years. They are this country's future leaders, and I have no doubt they will lead well. They epitomize the Navy's Core Values of honor, courage, and commitment.

For the past eighteen months, I have been mobilized with Navy Safe Harbor as a nonmedical Care Manager. In this position I work with the wounded, ill, and injured. Here again is an incredible experience to be able to assist in ways that should be the norm, rather than the exception. I am able to remove some of the barriers and red tape that plague our system and help the Sailor or Coast Guardsman either return to duty or transition to civilian life. These service members have served their country and it is our duty to assist in making their transition to civilian life as easy and seamless as possible.

An increased commitment to humanitarian assistance and disaster relief has offered an enthusiastic conduit of service for NNC reservists. Since 2008, over three hundred nurses have provided contributory support onboard USNS COMFORT (T-AH 20), USNS MERCY (T-AH 19), Medical Readiness Training Exercises (MEDRETEs), and Innovative

Readiness Training (IRT) missions.

Humanitarian assistance to underdeveloped countries requires extensive collaboration and planning. MEDRETEs are humanitarian assistance missions that occur in South and Central America following coordination with the U.S. Southern Command (SOUTHCOM). A reserve medical team of about thirty five personnel provided preventative medical care, dental care, and eye exams. The support for these missions requires intense administrative and logistical planning. Reservists have been key pioneers in developing a logistics team to standardize the planning for these missions. This team was staffed by personnel with significant experience in executing humanitarian assistance missions.

### Managing Challenges as We Balance the Role of the Citizen Sailor in the Reserves

Nurses serving in the Reserve Component face unique challenges as they seek to balance their many competing priorities. Work-life bal-

ance is even more complicated by the fact that a nurse may have two responsibilities, to their civilian and to their military professions. Several policy changes were enacted to support reserve personnel and their civilian employers. These policies were developed to recognize the necessary time employers and families need in order to prepare for mobilization. Once viewed as a frustration by drilling Reservists, these policies now support them to solely focus on preparations for deployment.

When nurses are deployed, the focus becomes caring for the patients and their shipmates; that is why the endeavor to serve continues. Caring for those who defend our country is salient to the calling of any nurse who chooses a career in the military.

### Conclusion

The goal of this chapter was to introduce the complexities of the Naval Reserve Nurse. Tenants of the Clinical Leadership Model apply similarly to our Reserve Component Nurses, recognizing their unique-

ness in dividing their professional expertise. With this in mind, we leave you with this thought:

The ongoing mission of the [Navy Reserve] is to provide strategic depth and deliver the full range of operational capabilities to the Navy and Marine Corps team as

well as to Joint forces — in peacetime and in times of war. In an increasingly uncertain world, this mission evolves to meet changing initiatives. Whether as individuals or as units, Reservists will only become more critical in the big picture; serving side-by-side with

active duty counterparts in direct support of the Fleet and making the most of proven and potential abilities. Leading lives of pride, purpose and heroism on a mission that serves a greater cause (United States Navy Reserve, 2009).



## Chapter 8

### One Nurse's Self-Assessment

**S**elf-assessment is a process by which people learn more about themselves: their interests and passions, personality and style, and strengths and weaknesses. In the context of employment and vocation, this process can be formal or informal, and can assist an individual in setting and accomplishing goals, as well as developing strategies to reach those goals. If you talk to any Navy Nurse, you will soon find there are many strategies leading to a successful career. This is the purpose and beauty of the Clinical Leadership Model. There is no one right way. Some nurses gained their experience as critical care nurses, deploying aboard aircraft carriers while others understood clinical nursing and were able to successfully translate it to clinical informatics. These nurses rarely deployed, but knew



what tools and technology deployed nurses needed to effectively do their job on the ship. These successful Clinical Leaders conducted self-assessments at different points in their careers that enabled them to thoroughly know themselves and set goals that would be both personally advantageous, as well as instrumental to our Corps. I share with you these common themes using my own self-assessment as an example.

## Self-Assessment Theme #1: Your Clinical Skills Foundation Matters

April 1992

As an Ensign, married to a Marine, my only career goal is to be stationed together, and to work as few night shifts as possible. As a new nurse, I am scared to death of telling my Director for Nursing that I am interested in medical-surgical nursing. I don't want to make any waves ... I just found out I am assigned to the Newborn Nursery.

At the beginning of my Naval Career, I was given a booklet in Officer Indoctrination School. I think it was called The Blueprint of Navy Nursing. It depicted five or so areas in which I could specialize as a Navy Nurse. As a new grad, newly married and newly commissioned, I was more focused on getting myself adjusted to life as a nurse and in the Navy. At that point, I didn't look to the Blueprint for career guidance; I looked to my

immediate supervisor. She told me to concentrate on my clinical skills as a nurse and leadership opportunities would present themselves. During those first twelve to eighteen months, I became proficient in my clinical skills, anticipated my patients' needs, and became a resource for my Department. I helped develop the Newborn Nursery's procedure on vaccination, (no big deal by today's standards, but this was before the Internet). I was a Neonatal Advanced Life Support (NALS) and Advanced Cardiac Life Support (ACLS) Instructor, and was selected to serve on a newly formed "Process Action Team" for Maternal-Child Nursing. Little did I know then, but my supervisor was right. As a junior officer, my scope of influence and responsibility centered around my role as a clinician. As my competence and confidence grew, so did my awareness of how I could contribute to the organization. By the end of my first tour of duty, I had become proficient in two clinical areas, and was selected to be one of the first Navy Nurses to serve in an outpatient clinic.



holding me accountable to be the best officer and nurse I could be. Sometimes it was hard to hear, but she did that to spur me on to success, and not to fail.

Sometimes, the difficult questions are not even centered on what you want. Sometimes, they are centered on what your family's needs are or the state of the nation. Ensigns today are not given the choice, I was, where I could specialize as an Operational Nurse or Administration. Rather, they are operational nurses by virtue of their choice to join the Navy. Their difficult questions include: "How will deployment affect my family and me?" "How can I use this deployment experience to further my skills as a Clinical Leader or to expand my nursing practice?" "How can I make these soldiers, sailors, airmen or Marines' lives better, even though they may have a life changing injury?"

Navy Nurses today can assess themselves along the three domains of the Clinical Leadership Model: Clinical, Operational and Leadership,

as they move nimbly between the roles in a hospital, aboard ship or in forward deployed settings. It is no longer an "either or" question to be considered when setting goals or evaluating one's own performance." These three components are not a singular choice. Rather, they combine to develop you into a Clinical Leader no matter what role you take on a Navy Nurse.

Whatever the question, and however difficult it may be to answer, I urge you to take the time to assess your goals every year. Promotions, moves, the births of children and the deaths of loved ones can forever change your perspective and your life goals. Similarly, there is a balance between individual goals and interests, command goals and the needs of the Navy.

At one stage of your career, you may receive everything you thought you wanted. At other times, an opportunity arises that you may have not considered or which may make you apprehensive. These are the times to ask the difficult question, "By taking this opportu-

nity, how can I positively influence my patients, the Nurse Corps, and the Navy?" or "Am I ready for this next rank?" You may be surprised at the results. Countless nurses with whom I have spoken with say it was in these unexpected opportunities that they experienced the most growth. They are today's Clinical Leaders because of the opportunities that stretched them beyond what they could have ever imagined.

Not getting selected for DUINS the first time was a blessing. What I learned most about myself was that while I had my own personal and professional goals, I needed to ensure that I didn't beat myself up or have such a rigid timeframe to meet those goals. By being flexible, I had some amazing experiences and opportunities that I would have missed. I did take PCS orders to a large teaching hospital where I found my clinical passion, and where I stretched so much I thought I would break. This ended up forever changing my entire career trajectory."



near my duty station to set up a clinical orientation. I ensured that I regained my clinical skills, as well as completing all my deployment checklists in case I was needed. Likewise, my colleagues were engaged in the same process. One Captain who was “re-oriented” by an Ensign told me it was the most exhilarating thing he had done in years and said, “The clinical skills are like riding a bike, but the opportunity I had to be taught by the next generation of Navy Nurses was thrilling to me.”

The beauty of the Nurse Corps is that the Corps also adapted to changing external forces to meet the needs of nurses reentering after years away from the bedside. Today, every nurse, whether they have served for two or twenty two years, is prepared to deploy safely and competently.

This experience showed me the importance of continued learning, re-assessment and questioning the status quo. Throughout your career you will conduct a series of self-assessments. These assessments involve future job oppor-

tunities, applications to school, what assignment you will choose, or where you will live. These “small” reassessments involve asking yourself, “where do I go from here; MEDCEN versus DUINS, East coast, or West coast?” “Do I take RN-ISP or explore a new clinical area?” However, the “huge” reassessments, like the changing operational landscape took me by surprise. For me, if my goal was to make Captain, how do I gain the clinical competence I will need? You never know when external forces will suddenly change your entire thinking and practice. Stay nimble and be ready to change when it does.

## Self-Assessment

### Theme #4:

### Am I a Navy Nurse for a Tour or a Career?

June 2008

A mentor asked me today where I was planning on going next. I told her I’m thinking about retiring .... she told me

whatever I decided just to be sure I could look back without regret.

The Navy Nurse Corps, as with all military careers, is a very rewarding, and sometimes difficult life filled with many decision points. One of the most difficult decisions to assess is when to close the chapter as a Navy Nurse and begin a new chapter outside the Navy. I have seen nurses who joined the Navy in their teens and have led successful careers for thirty plus years. I have seen others who join the Nurse Corps for a tour length and left the Navy enriched by their experiences. No matter the context or the experience, I believe each nurse asked themselves three very difficult questions to discern when it was time to go or stay longer.

The first question pertains to one’s current circumstance. “Is your current situation influencing your decision to stay in or leave the Navy?” Work can be hard and personalities can be difficult, but making an important life decision based on the influence of a cur-

rent circumstance should be taken with caution, as many times they are influenced more by emotion than fact. Remember those are the opportunities that cause you to grow and stretch, and will leave you feeling grateful to live and tell about it to future Navy Nurses.

Instead of giving up, try asking yourself how this challenging circumstance will strengthen you for your next position. Seek out a mentor and advocate to help you navigate through difficult periods. If you can see the reason for the current situation and how it is building your resilience in achieving your goals, stay the course.

The next question, "have you achieved the professional goals you set out to achieve when you joined the Navy?" This one may be more difficult to answer. On the one hand, we are Navy Nurses with a professional portfolio unlike our civilian counterparts. The Navy offers autonomy, collegiality and variety of experiences, few find anywhere in the world. On the other hand, as a Nurse, we have the ability to influence the science of nursing practice,

wherever we practice in the Navy, or in the community. Yet, the question remains, have you achieved the professional goals you set out to achieve when you joined the Navy? You joined the Navy for a reason, and your goals were influenced by your Navy experiences. I joined the Navy to practice nursing where I would increase in seniority and

not lose it every time I moved duty stations. I wanted to be deployed on USNS COMFORT (T-AH 20), and I wanted to practice at the National Naval Medical Center Bethesda. Along the way, I added the goals of developing my ICU nursing skills, being the kind of nurse others wanted to emulate, influencing health care policy, and making work easier for



those who practiced at the bedside. I thought I wanted to stay in the Navy as a career, but I was not sure where that career would take me. Instead, I continually reassessed where I was at in relation to the short and long term goals I set out before me, and kept moving forward. I encourage you to do the same.

The third question, I believe, is one many consider most when deciding to resign or retire. "Are there external forces "pulling" you out of the Navy?" These "pulling" forces most predominantly come from changing family needs. In making these decisions, family influence and inclusion are vital in the success of any Navy Nurse's career. Examples include dual active duty families, where there may be competing priorities in each respective career. It is important to recognize and discuss this characterization relative to any career decision. Are there aging family members? This could be school aged children en-

tering middle and high school or aging parents with failing health. Both extremes weigh heavy on one's decision. It is important to note that research has shown that deployments are not an external pulling force; they are actually a job satisfier. However, balancing deployments with family developmental needs can influence one's decision to stay or leave the Navy.

I married a wonderful man who was a widower. He had lost his first wife to a long term illness. He found the thought of my deployment into harm's way unnerving. I had children in both middle school and high school and while my career did not project me to move anywhere, I felt like I had lost many opportunities to spend quality time with them. I made the decision, after serving twenty years, to retire. It was the pulling forces that ultimately helped me make the decision. I loved being a Navy Nurse; my last position was very fulfilling, and I looked

forward to continuing to achieve the professional goals that I set out to accomplish. But for me personally, it was a matter of work-life balance.

Abraham Lincoln was asked once why he was confident about what he did. He answered, "I desire to conduct the affairs of this administration that if at the end, when I come to lay down the reins of power, I have lost every other friend on earth, I shall at least have one friend left, and that friend shall be down inside me" (1864).

Your career as a Navy Nurse is yours to own and cherish. Whether you stay in for a tour or for a lifetime, you have the opportunity to see and do amazing things for yourself, your profession and your nation. Take time out to conduct regular self-assessments that consider your professional, personal and family goals. Consider what your passion is and set goals to attain it. You will never regret it.



## Chapter 9

### Professional Growth and Resilience

**“A** path will be placed before you. The choice is yours alone. Do what you think you cannot do. It will be a hard life ... but you will find out who you are.”

— (McCallum, 1999)

Clinical Leadership is painted on a canvas of joy, sorrow, pain, and recovery in the lives of our patients, our colleagues and ourselves. Becoming a Clinical Leader requires a journey from novice to competent nurse with focused expertise that is to be balanced in the three domains of clinical proficiency, leadership development, and operational readiness. The essential nursing characteristic that is both a strength and vulnerability is our capacity to connect with empathy, while maintaining professional clarity in our critical thinking and actions.

Professional nursing has always been known to be demanding and requires strategies for conserving ourselves as we care for others. The Text-Book of Nursing (Weeks-Shaw, 1892) used by the Navy Hospital Corps School for male nurses in 1902 admonished, "Even a nurse is but human; you cannot retain your vigor and consequent usefulness without a due allowance of rest, food, and exercise" (p. 4). Nurses have been used as the models for researchers to understand the

impact of occupational stress in the caring professions (McVicar, 2003). As a career, professional nursing fully embodies the complexity needed for understanding occupational stress as organizational demands and rewards, personal coping resources, and the existential meaning of caring for others play out against each other. One context for understanding occupational stress in nursing is to know the influence of burnout, compassion fatigue, and compassion satisfaction (Table 9.1).

Occupational stress is expected and predictable within nursing. The capacity to connect with people on an emotional and intellectual level and then use those connections to promote healing is an essential nursing trait. Burnout is a sign that we are using the capacity to care without adequate replenishment. The experience of burnout can be a source of growth and professional development. Early in our careers, we actually experience burnout quite frequently. This is how we

	Burnout <sup>1</sup>	Compassion Fatigue <sup>2</sup>	Compassion Satisfaction <sup>3</sup>
Definition	A state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations	The experience of short-term exhaustion and traumatic stress reactions associated with exposure to the suffering one's clients	The perceived joys derived from experiencing the suffering of others and succeeding in helping to relieve their suffering in some way
Characteristics	<ul style="list-style-type: none"> <li>• Emerges slowly overtime with gradual exposure</li> <li>• Erosion of idealism</li> <li>• Void of achievement</li> <li>• Accumulation of intensive caregiver contacts</li> </ul>	<ul style="list-style-type: none"> <li>• Prolonged Exposure to suffering</li> <li>• Traumatic recollections and memories</li> <li>• Disruptions in daily life</li> </ul>	<ul style="list-style-type: none"> <li>• Meaningful caregiver experiences</li> <li>• Sense of contributing to a greater good</li> <li>• Increased competence and confidence</li> </ul>

Table 9.1 — Burnout, Compassion Fatigue and Compassion Satisfaction

<sup>1</sup>Stamm, 1999, <sup>2</sup>Boscarino, Figley & Adams, 2004, <sup>3</sup>Figley, 2002; Stamm, 2002

learn our limits and what resources are needed to sustain us during times of stress. A burnout risk for experienced nurses is that we learn to ride the edge of exhaustion and wait too long before we do things that restore our energy and capacity to care.

A Navy Nurse who started as a Hospital Corpsman shares:

I have always known that the lives of my fellow Sailors and patients counted on my training, dedication, and vigilance; but most of all, they needed me to be able to connect in mind and spirit with them; to understand their suffering, and to ease their suffering. This ability to connect the therapeutic use of self has been a great source of challenge and satisfaction as a Navy Nurse. For me, burnout is when I go past tired and remain clinically proficient but emotionally numb. Satisfaction comes when I make a meaningful connection while giving competent care; when I know I made a difference.

Unlike burnout, compassion fatigue is an intrusive form of vicarious trauma that takes a near immediate toll on the nurse. Compassion fatigue is directly related to working with physically and psychologically traumatized patients. Ironically, mindful use of empathy is a very powerful intervention for supporting post-trauma recovery and a necessary risk for the nurse. Compassion satisfaction is the ability to draw meaning and purpose from the provision of care. It is compassion satisfaction that buffers the strain of fatigue and trauma exposure. Throughout human history, those with purpose and meaning in life can withstand almost any deprivation while those without meaning cannot tolerate even minor inconveniences.

Evaluating the sources of burnout, compassion fatigue, and compassion satisfaction provide meaningful insight for clinical leaders about maintaining operational readiness. The source of burnout is inherent within the care giving work environment. The need for twenty-four-hour services, healthcare

emergencies, high workloads with insufficient staff, sufficient staff with insufficient space, and balancing personal life with professional demands are examples of external strains to the individual nurse which are often not amenable to the external actions of leaders. The sources of compassion fatigue are the traumatic injuries and experiences that our patients bring into the nurse-patient relationship. Potentially traumatic events increase dramatically during times of war and even routine non-trauma services can have traumatic exposures. Patient-based vicarious trauma or direct trauma exposure of caregivers is not under the control or influence of the individual nurse or the healthcare organization. Since the sources of burnout and compassion fatigue are largely outside of our influence, you may ask, "How and why do nurses not only survive but continue to flourish in the face of such challenges?" The sources of compassion satisfaction include effective training and skills, confidence that you are making a positive difference, teamwork, and

personal satisfaction. Most of the sources of compassion satisfaction are very amenable to influence of the individual nurse, his or her coworkers, clinical leaders, and the environment of care. Fortunately, that which has the strongest influence on occupational stress is largely open to personal and leader intervention.

### Transitions

All nurses must continue to grow and develop their clinical competencies throughout their professional lives. Navy Nurses also must continue to develop clinical leadership skills and maintain their operational readiness. Chapter 2 presented a brief discussion of the application of Benner's Novice to Expert as it applies to the Navy Nurse Corps Clinical Leadership Model. The transition points in professional nursing development are not static. A nurse can be an expert in one nursing domain and an advanced beginner in another. It is rare for a nurse to truly return to the novice stage in any aspect of nursing due to the broad foun-

dation of baccalaureate nursing knowledge. Early chapters have outlined that the path from novice to competent nurse in the areas of clinical practice, leadership, and operational readiness is structured to support the transitions. The transitions to proficient and expert nurses vary by interests, personal strengths, specialty, resources, and opportunities. These later developmental transitions are largely semi-structured and thus open to greater challenges and rewards.

The military lifestyle contributes additional challenges to professional nursing demands. One of the mainstays of Navy Nursing is the opportunity to learn how to master transitions. New Navy Nurses gain an appreciation for the scope of change that occurs in their lives when reporting to their first duty station. The majority of new accessions have limited clinical and nursing experience outside of their nursing school and student employment as experienced by a LTJG:

My decision to become a nurse emerged at the end of my

first year as a biology major. My student job was as a campus bus driver and I often had the shift that transported nurses from the parking lots to the university hospital. The nurses' caring and dedication intrigued me. I decided that a nursing career was right for me through interviews and career searches. The Navy Nurse Candidate program provided a way to pay for college. By the time I graduated and was preparing to report for duty my only clinical experience was from my nursing courses. The first few months in the Navy was a blur of training, acronyms that sounded like a foreign language, and learning to wait for a Chief Petty Officer to salute me first. The nurse internship program at my first duty station was awesome. The time and structure spent on internship felt like a clinical rotation in nursing school but everyone was very aware that this was for real. My first assignment was on a general surgery unit where I developed confidence in my nursing skills,

my role as an officer, and started critical care cross-training. With my promotion to Lieutenant Junior Grade, I was ready to be the assistant division officer on the unit. My orders to deploy as part of a surgical team to Iraq came before I started my new role. I knew we were going to war and I was anxious that I was not ready to provide the care that would be needed. The first month at Al Taqqadum, Iraq was a lifetime of experience. It was during that first month where I absolutely knew that I was ready to meet the challenge and that Navy Nursing had prepared me to provide nursing care anywhere, at anytime, for anyone.

The Navy Nurse Corps has a long and rich relationship with the Hospital Corps. Many corpsmen develop personally and professionally with the mentorship of a Navy Nurse. Many Navy Nurses develop their clinical and leadership competencies by working with corpsmen as teachers and students. The skills of many corpsmen surpass

those of the novice or advanced beginner nurse. Many of our technicians have college degrees and focused training that is unparalleled in the civilian healthcare workplace. Recognizing the wealth of knowledge, skills, and dedication of Navy Hospital Corpsmen and other non-medical enlisted personnel, the Nurse Corps actively identifies and mentors Sailors and others who are good Navy Nurse Corps candidates. Even with their Navy experience, most former enlisted nurses find their first tour a transition unlike any other they have experienced.

I started in the Navy as a Hospital Corpsmen working in a large hospital ICU and then with the Marines. The Medical Enlisted Commissioning Program supported my nursing education and transition to become a Nurse Corps officer. At my first command, I fully expected to work in critical care. I was a bit dismayed with my assignment to the post-partum unit, however, I accepted the assignment and figured I would “pay my dues”

for six-to-nine months and then transfer to critical care. The frustration mounted after nine months and numerous requests, I was told my services were still needed on post-partum. I thought my clinical skills were not being challenged. I called one of my nurse mentors from when I was a corpsmen to vent and seek guidance. He helped me to understand something he called the “sphere of influence”. The sphere of influence is where you strive to maximize your clinical, leadership, and administrative skills within the role you have at the moment and that it expands with each role. He also helped me understand that job titles and assignments were not the same as nursing roles. I re-focused my energies beyond my own clinical skills to make sure that the patient care and corpsmen training were the best I could influence on my shift and ward. Ironically, four months later when I was transferred to critical care I was reluctant to leave post-partum because

I have not accomplished all I wanted to, especially in corpsmen training.

The structure and support of the Navy Nurse Corps Clinical Leadership Model is based on the assumption that most Navy Nurses will be transitioning from nursing schools into their first career employment. This is a valid assumption for most, but not all, nurses. Nurses who have significant professional experience have additional transition challenges. Most are older than their peers and have different professional goals and family relations than new accessions. The Nurse Corps also grants promotion credit for professional experience. The professional acknowledgement and pay is a plus for the experienced nurse, however, it also creates a dilemma. The assumption is that all Lieutenant Junior Grade nurses have at least two years of Navy experience and they have mastered all the core skills which are part of the Ensign experience. Lieutenants are expected

to have at least four years of Navy Nursing experience which includes mastery of fundamental military leadership skills and operational training.

After graduating from nursing school in the Midwest, I worked for seven years in a variety of hospitals and was the charge nurse of an inpatient mental health unit. Cold winters and longevity pay increases would be my future and Navy Nursing provided a potential alternative for my family and professional growth. The Nurse Corps gave me promotion credit for my nursing experience and I was commissioned a Lieutenant Junior Grade. My first assignment was to the Mental Health Department at Portsmouth, Virginia, the largest in Navy Medicine at that time. Because of a shortage of mental health nurses, I was assigned as the Division Officer of the locked diagnostic unit. I was experienced and competent, how different could this be from what I had been doing before joining the Navy? It was a world of dif-

ference. There were three main challenges. First, because of my rank, the staff and supervisors thought I had two years of Navy Nursing experience and knew how things really worked. Second, I needed to recalibrate my clinical skills to crisis intervention, rapid assessment, and medical/administrative dispositions versus long-term care. Third, I rapidly learned that “collateral duties” were like a second full time job. The quality of the corpsmen and professionalism of the nurses helped my transition. A new department head arrived during my second year; apparently it was time to grow. For the next two years, it seemed like everything I did was scrutinized, critiqued, and returned for revision. I eagerly negotiated for orders to my next assignment. It was not until I reported to my next duty station, as a department head for mental health nursing, that I realized how four years of mentorship, guidance, and growth was crammed into those last two years.

The transitions of the first duty

station are critically important to the career decisions of the first-term Navy Nurse. If the first-term is experienced as a process of professional and personal growth, teamwork, and the knowledge that in this career the nurse can make a difference, then the decision is most often for retention and to strike out on the next adventure. However, continued service is unlikely if the first-term is characterized by an unbalanced burnout or compassion fatigue to compassion satisfaction ratio. The experience and transitions of the first-term nurse is where effective clinical leadership can make a lasting impact on the life of the nurse and the Navy Nurse Corps. Subsequent experiences require a balance between demands and satisfaction in all career domains as well. The advantage of a Navy career is that experiences and organizational savvy increase the ability to influence the sources of compassion satisfaction.

### Find Your Passion

There is a professional and personal restlessness that occurs at the career intersection of advanced

clinical proficiency and compassion satisfaction. Often the nurse knows that it is time to commit to a more dedicated clinical or leadership role. Either path requires a commitment to focused training, often a Master's degree, and the knowledge that future assignments and duty stations will be significantly influenced by that choice. Some look to a mentor and follow the mentor's path. Some identify what they do not want to do and choose the polar opposite. Still others are comfortable where they are in their current assignment and simply follow the next logical step. Each of the previous methods for a career choice lacks a crucial step. That step is to identify your passion. Personal and professional passion does not get much recognition during the first four to six years of a Navy Nurse career. Those early years are about the transition from novice to competent nurse and developing an identity as a Navy Nurse Corps Officer. Clinical leaders mentor to a common core of knowledge and skills that form the essence of every Navy Nurse. Now,

there is a need to find your passion, your unique professional voice, to discover the essence of that which sustains you as a nurse.

I knew I wanted to be a Psychiatric Mental Health Nurse Practitioner. I truly enjoyed going to work every day as a staff nurse and knew this was the next logical step. For the first semester in my Master's program my academic advisor and most of the faculty asked repeatedly, "What is your passion, why are you here?" At first I replied, "To meet the needs of the Navy." It was not until I was struggled to write a paper on a topic that I chose because it fit a need in the Navy, and not my own, did I understand the question. My passion is to ease the suffering of those with combat and stress injuries before they became mentally ill. All my studies and career decisions are now linked to that passion.

The process to identify your professional passion requires a trusted other who knows you

well and can challenge your logic and assumptions. Ideally, that trusted other is a mentor. The next step is to ask a series of questions.

- 1) Why did I choose nursing? Be as specific as possible and do not self-censor because some of the reasons may now seem frivolous or naïve.
- 2) What are my greatest hassles, challenges, and frustrations as a nurse and as a Navy Nurse?
- 3) What are my greatest triumphs, rewards, or successes? Once again, do not self-censor items that may seem frivolous or self-congratulatory.
- 4) What does it mean to me to be a Navy Nurse Corps Officer?
- 5) Read and talk through items 1-4 with your trusted other.
- 6) Start to write your passion statements with the goal to refine one into a concise single sentence.

Knowing your passion makes

choosing an advanced degree, military training program, or your next assignment a logical extension of your compassion satisfaction. When you are working in your passion every day, even in arduous conditions, there is a great deal of satisfaction and meaning. There are many more advantages to knowing your passion. Nurses may look for duties and opportunities that their passion such as volunteering, teaching, reaching-out, and making career decisions that are ultimately linked to a source of strength and resilience in their lives.

### Blending Roles

Navy Nursing requires a blending of personal, clinical, and military roles. The roles we play are dynamic and not always congruent. Actors have a much easier job than any Navy Nurse; they have scripts, directors, supporting staff, and retakes. Navy Nurses are always on a stage of sorts where the decisions we make and the actions we take are bound by the rules and requirement of the dominant role in the moment. Understanding what role

you are in is important for managing its daily demands and role strain. For example, as a clinical leader your dominant style may be to teach and coach while avoiding interpersonal conflict. When a senior staff member's behavior is disruptive to unit cohesion the role requires that you constructively engage in conflict communication to ensure that behavior expectations are unambiguous and have clear consequences. In your role as a spouse or parent, those same behaviors may require a different strategy. The key here is self-awareness of role specific expectations and the flexibility to adapt communication styles.

### Navy Medicine Caregiver Occupational Stress Control

Preserving the psychological health of nurses and corpsmen is one of the greatest challenges facing nursing leaders. Modern psychological, medical, and spiritual frameworks offer nursing leaders the understanding and tools to help meet this challenge. The Navy and

Marine Corps Stress Continuum Model (Figure 9.1) is fundamental to the Navy Operational Stress Control (OSC) and Marine Corps Combat and Operational Stress Control (COSC) programs. These programs are described in the Maritime COSC Doctrine (MCRP 6-11C/NTTP 1-15M) and are also the foundation of the Navy Medicine Caregiver Occupational Stress Control (CgOSC) program.

Occupational, operational, and humanitarian missions have many identifiable stressors ranging from daily hassles to extreme trauma. In the Stress Continuum Model, nursing leaders are responsible for ensuring their units and personnel are mission-ready (green zone). A key strategy that nursing leaders use to promote readiness is realistic training which results in units with high cohesion and staff members that are competent and confident to achieve their unit’s goals. Everyone reacts to a stressor (yellow zone). Stress reactions are usually transient and do not need intervention unless the stress reaction creates a safety risk to patients or staff.

About one-third of the people that have a significant stressor experience will develop signs of a stress injury (orange zone). Stress injuries produce more severe or persistent distress and are caused by one or more of four sources: Life threat/trauma exposure, loss, inner conflict, and fatigue. Life threat/trauma exposure is a trauma injury due

to an experience of death provoking terror, horror, or helplessness. Loss is a grief injury due to the loss of cherished people, things, or parts of oneself. Inner conflict is a moral injury due to behaviors or the witnessing of behaviors that violate moral values. A fatigue injury is due to the accumulation of stress from all sources over time without

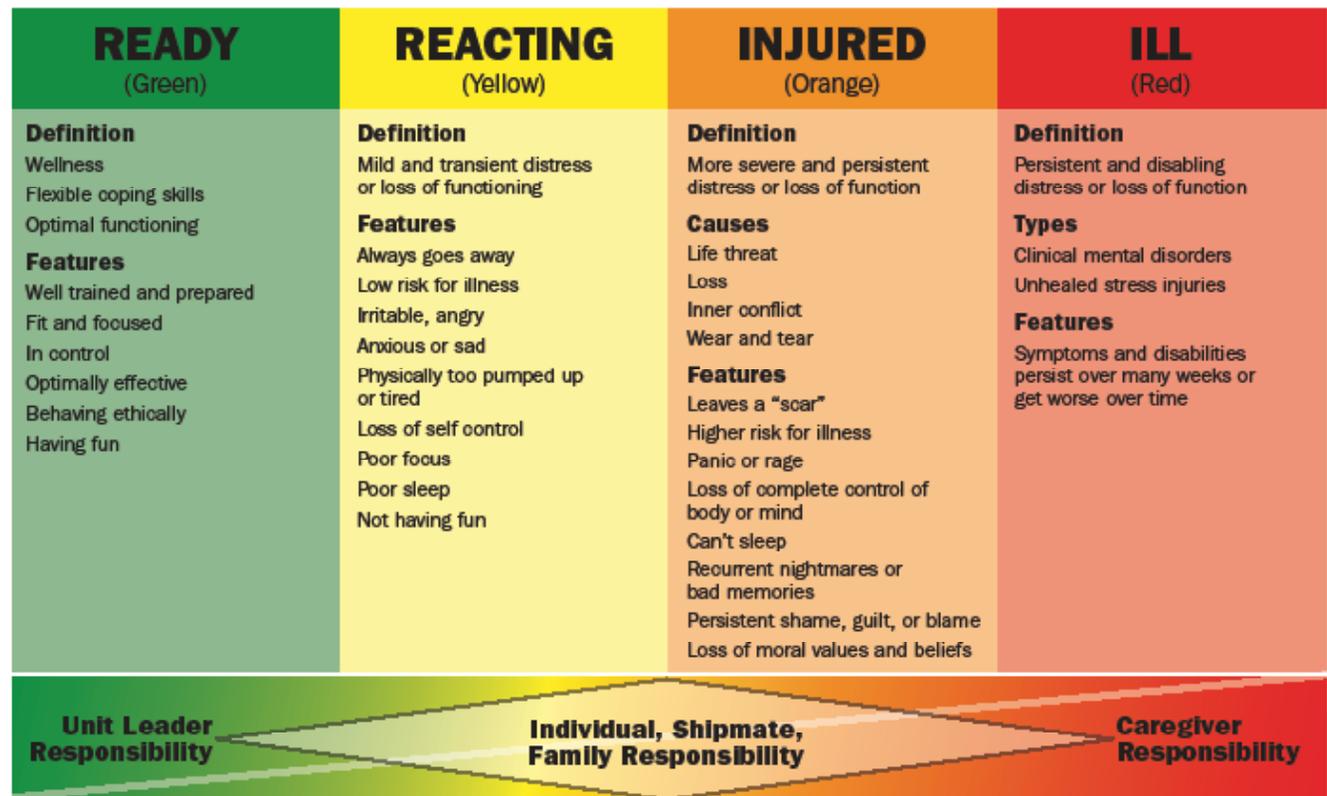


Figure 9.1 — Stress Continuum Model

sufficient rest and recovery. Burnout and compassion fatigue are examples of stress injuries. Stress illnesses (red zone) are persistent and disabling losses of function and need clinical intervention to promote recovery.

### Maritime COSC Doctrine

In terms of the Stress Continuum, the goal of CgOSC is to promote:

- 1) Early recognition — Helping caregivers by creating awareness of occupational and compassion fatigue, stress and burnout and the potential negative impact on an individual's professional and personal life.
- 2) Peer intervention — Building networks of supportive colleagues and friends who provide unconditional acceptance and support, can help with complicated situations, act as mentors, and provide referrals to support resources.
- 3) Early access to mental health services — Providing timely and proactive support for caregivers to cope with working in a unique and high stress healthcare environment.

Occupational and operational

stress injuries will occur and are expected. Clinical leaders can use their knowledge about their staff and clinical environments to anticipate and respond to them. A stress first-aid model was developed to guide the actions of peers, leaders and caregivers when a stress injury is identified. Stress injuries are recognizable as a change in function, statements of distress, or exposure to significant events. Following significant stress events or trauma all people have five essential needs (Hobfall, Watson, Bell, et al., 2007).

- 1) Need for safety
- 2) Need for calming
- 3) Connectedness
- 4) Competence in coping
- 5) Hope for the future

Knowledge about the five essential needs can be used by nursing leaders to shape work environments that reduce unnecessary stressors and build resilience resources. The five essential needs were used to develop the foundation of the combat and operational stress first-aid (COSFA) model.

The COSFA framework of the five C's — cover, calm, connect, compe-

tence, and confidence — forms the basis of systematically understanding core issues that impact individuals and units or work centers as a whole. The stress continuum and COSFA models are used as assessment and intervention tools for leaders and CgOSC training teams.

### Nursing Leadership Skills for Caregiver Stress

Leader competencies in addressing caregiver stress are based in applying foundational principles versus making lists of symptoms and behaviors that require specific actions. The Stress Continuum Model encourages clinical leaders to be mindful of the four sources of stress injury that impact individuals or whole units. As nurses, we are often drawn into the details of our patients' experiences so that we may fully understand their strengths and vulnerabilities. This attention to detail can work against the clinical leader when they get lost in descriptions of the stressor versus looking at the source of stress injury. Once the sources of stress injury are identified, the clinical leader

can then assess the strengths and vulnerabilities in each of the five essential needs.

Using sound nursing principles, assessment forms the basis of intervention. There are five core leader functions in the Maritime COSC Doctrine: strengthen, identify, mitigate, treat, and reintegrate. These leader functions are essential for the prevention, identification, and care of adverse stress outcomes across the stress continuum. Clinical leaders need to consider the following adaptations of the five core COSC leader functions to maintain the mission readiness of nurses and corpsmen.

**Strengthen.** Caregiver training typically will focus on the “just in time” elements of the mission or the clinical environment. The warrior-healer duality of the caregiver role needs to be acknowledged and practiced in the training. Training evolutions need to include after action reviews that incorporate the usual who, what, where, how of the exercise and a discussion of the meaning of that event to the caregiver’s role or expectations. Pay particular attention to building cohesion.

**Mitigate.** Caregivers are often considered “containers of resources” in the leaky bucket stress metaphor. As a “resource,” there is a risk that they may not be meeting their own physical, social, mental, and spiritual needs. Include caregivers in the practices to conserve health and well-being. Consider having caregivers from other units engage each other in a process of mutual assessment and support.

**Identify.** Caregivers are very adept at avoiding or minimizing responses to screening questionnaires and other early warning assessment tools. As a clinical leader, you need to trust your gut instinct when you think a caregiver has a stress injury. Use the OSCAR approach to address your concerns.

Observe the behavior.

State your observation clearly.

Clarify your role and why you are concerned.

Ask for clarification to understand their point of view.

Respond with guided options to get the caregiver to engage with available resources.

**Treat.** The stress first aid strategies are as effective for caregivers as they are for other Sailors and Marines. The caveat is that caregivers are usually engaged in their roles and may not show symptoms of stress injury until after the last patient has been treated or they have turned over their responsibilities to the next shift. Watch for stress injury signs during the period of quiet and solitude following intense caregiver activity or during prolonged and fatiguing care experiences. Connectedness and competence are critical interventions to support caregivers.

**Reintegrate.** Post-deployment reintegration is particularly challenging for caregivers. Caregivers deploy as individual augmentees from their parent commands and become part of a cohesive unit. They must leave the cohesive unit and return to their parent command where they then must become part of a new unit. The caregivers in the parent command who did not deploy have had their own stressors and may place more emphasis on getting “back to work”

rather than a purposeful reintegration. Operational deployment experiences in particular change a caregiver's tolerance for "unimportant issues". Administrative processes or rules that do not appear to improve patient care are generally not well tolerated. Consider phased in work schedules and delaying collateral duty assignments as part of a caregiver post-deployment or post-stress injury reintegration.

### Impacting Future Generations

In 1902, the textbook used to teach Hospital Corpsmen to perform nursing duties identified nursing as demanding and that nurses needed to take care of themselves and each other in or-

der to provide quality professional nursing care. Currently, we have a body of knowledge providing a framework for nurses and clinical leaders to understand and assess the dynamic balance between the capacity, skills, duty, and desire to care. From the current framework we can see that occupational stress, like burnout and compassion fatigue, are expected and predictable. Just as in patient care, if we can predict a potential adverse event we can develop early assessments and nursing interventions to reduce severity of the functional impairment and shorten the recovery time. The early assessments that we have are shaped by the knowledge that there are vulnerabilities and op-

portunities during times of transition, prolonged fatigue, or acute stress exposure. Understanding the source of stress injuries and the essential needs that people have allow clinical leaders to reduce the hundreds of variables and permutations of individual stressors into an economical model of actionable processes. The actions required to conserve those nurses with potential stress injuries are derived from the five core leader functions that all military leaders use to enhance the psychological resources of their personnel. Embracing the trials and tribulations while simultaneously celebrating our triumphs strengthens the individual nurse, the cohesiveness of our clinical units, and the Nurse Corps.

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**W**e often read that a book has been written as a “labor of love”. Truly, the completion of this book fits that bill. Many of our colleagues, active, junior and senior, of all specialties and experiences, labored to ensure we created a document that encompasses the essence of what it means to be a Navy Nurse of the Twenty-first Century. This book could never have been completed without their unwavering commitment. All volunteered their time, as precious as that is, during a period of unprecedented deployments and changes in our healthcare systems throughout the Navy. They did it voluntarily and with amazing passion and enthusiasm. I could not be more proud, and humbled, to have worked with these fine men and women who epitomize the leaders we have in our

Corps today. To say thank you seems so pale in light of the monumental task they performed. That said, I wish to single out those who deserve our gratitude for their contributions.

My goal was to create a model representative of the dynamic path of development offered to today's Navy Nurses. From its earliest inception, CAPT Kathleen Pierce, NC, USN (Ret) was the spearhead for creating this timeless model. Inspired by a master's thesis completed by LCDR Christine Palarca, NC, USN, it became apparent that the Nurse Corps was in need of a model that was reflective of our day-to-day work and would not simply become a manual collecting dust on our bookshelves. CAPT Pierce began creating the concepts literally on the back of an envelope with the help of her staff, CAPT Regina Mercado, NC, USN, CAPT Kathy Thorp, NC, USN and CDR Valerie Morrison, NC, USN. Mr. Shane Stiefel lent his graphic arts skills to design the model as it is represented in this book. It was imperative that our nurses be able

to "see" themselves in this writing as they perform all their duties throughout the world. I believe we were extremely successful in achieving that goal.

Each chapter was written by one or more Navy Nurses who demonstrated the experience or subject matter expertise in that subject. More importantly, they were willing to give of their precious time to see the project through to completion. A daunting task for which I will forever be grateful.

So a huge Thank You goes to all of you! Starting with our chapter authors who bore the brunt of our endless nagging to complete their assignments on time (or at least as close to the deadline as possible!): RDML Cynthia Dullea, CAPT Karen Biggs, CAPT Anne Bloom, CAPT Cathy Cox, CAPT Lori Laraway, CAPT Regina Mercado, CAPT Kathleen Pierce, CAPT Lisa Raimondo, CAPT Andrew Spencer, CAPT Richard Westphal, CDR Julie Hendrickson, CDR Lisa Lewis, CDR Brian McCann, CDR Valerie Morrison, CDR Kenneth Page, and LCDR Christine Palarca; all superb Navy Nurses with an

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We certainly could never have completed this project were it not for the patience of our superb contractors from Alion Science and Technology, Barbara Mendoza, program manager/editor, Sarah Meharg, editor, and Jeffrey Kendrick, graphic designer. Thank you for hanging in there with us and providing just enough nudging to ensure we got the job done. Your professionalism and support were the lifelines we needed to venture into this

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Yes, this has been a labor of love. But, more importantly, it has been our way of saying thank you.

Thank you to all Navy Nurses, past and present, who helped build the model of today. And for those nurses yet to come, this model is in your very capable hands. I have no doubt you will move it, and us, even further in the future. It has

been our privilege and honor to contribute to the history about to be made.

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