



# Nurse Corps News

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## Certification: A Mark of High Velocity Learning



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Achieve high velocity learning at every level. That is a Line of Effort on the Chief of Naval Operations (CNO) [Design for Maintaining Maritime Superiority](#), to which the [Nurse Corps Professional Practice Model](#) (PPM) aligns nicely. The Nurse Corps emphasis on advanced education and full scope of practice is in keeping with all of our PPM tenants; Professional Development, Transformational Leadership, and Operational Readiness. We must remember that as Navy Nurses we are both nurses and naval officers. As we learn, grow, and become experts in our field, we are better informed to lead and we are better able to prepare ourselves and others for the mission.

Some time ago, the Nurse Corps Flag Officers from all three military services made a united decision to make the BSN the standardized entry into the Nurse Corps. While the Nurse Corps recognizes the value and talent of an ADN or LPN/LVN, the requirement of a BSN spoke to the value recognized in the level of expertise and professionalism that comes with the BSN. Higher education at the Masters, Doctoral, and PhD level is not only rewarding, but expands your knowledge base to make you one of the best in the field of nursing, thereby earning respect in your field.

Certification in both healthcare specialties and operational realms is just as important. Certification in a healthcare specialty demonstrates advanced knowledge and understanding of the field, and represents your contributions to our patients, the Navy Nurse Corps, and overall Navy Medicine. It is in direct support of High Reliability Organization (HRO) principles and improves practice across the Nurse Corps. I am pleased to say that so many of you have already earned certification in your communities, such as MedSurg, Critical Care, OR, etc., just to name a few. In addition, our junior nurses who are leaders can easily earn Nurse Executive-Board Certification (NE-BC),



Tina Davidson, RDML, NC, USN

Director, Navy Nurse Corps

while our senior nurses may be eligible for the Nurses Executive Advanced-Board Certification (NEA-BC) or Certified in Executive Nursing Practice (CENP).

Pick up a nursing journal and you will notice certifications held by many of the authors, often annotated behind their name. Ask yourself what those certifications mean and whether you are eligible for that same certification. Your certifications and organizational affiliations reflect your professional experience and growth and demonstrate your motivation and initiative, and thereby make you more "marketable," whether you continue in the Navy Nurse Corps or decide to enter the civilian workforce.

Certification or qualification in an operational arena is equally important. Devices such as Surface Warfare Medical Department Officer (SWMDO) and USMC Fleet Marine Force (FMF) validates that our nurses are motivated to learn about the operational environment. Many of you have heard me talk about "relevance" and why we need uniformed NC officers. Our ability to "fight tonight" and to not only understand but excel in operational environments is essential to our long term

Cont. on page 2

## Certification: A Mark of High Velocity Learning (cont.)

value to the Navy, and, most importantly, to those we serve. A warfare device worn on the uniform demonstrates to our line counterparts that “we get it,” “we’ve been there,” lending credibility to our contributions and roles.

It is not enough to simply obtain a certification/qualification; you must then use what you learned to inform practice, decisions, and the organization,

regardless of where you practice. It is not just to showcase your knowledge and ability, but an opportunity to propel the organization further along. It is my expectation that you will seek certification and qualifications where you are eligible and that you will continue to seek additional certifications throughout your career. Don’t stop at just one!

Thank you for what you do everyday; I am so proud of you!~

Save the Date!

MONDAY  
09 April

Join us for the next  
Nurse Corps VTC!

### ***Operational Readiness/Jointness***

We are able to function and succeed across a complex spectrum of environments, considering and honoring the personal views of all those we serve. Our operational readiness and jointness are the versatility of our mission across all theaters.



### ***Excerpts from the Professional Practice Model, Chapter 2: Operational Readiness*** [Read the full content here!](#)

Operational readiness is the reason Navy Medicine exists and the cornerstone of a Navy nurse’s career development. In the operational arena, Navy nurses are entrusted with providing the highest quality care across the continuum of military engagements, from kinetic operations to global health engagement. They are expert *clinicians*, *highly trained professionals*, and strategically-focused leaders who are ready to deploy to any environment at any time. Successful deployments require Navy nurses to perform as clinicians and leaders, and there is an increasing need for them to effectively engage with the sister services, host and partner nations, and nongovernmental organizations.

Interoperability is on the rise in both operational settings and medical military treatment facilities (MTFs). Deployments to multinational medical facilities like Camp Bastion and Kandahar in Afghanistan, and joint tours within the enhanced multi-service markets, provide unique challenges and diverse clinical experiences. The establishment of the Defense Health Agency (DHA) on October 1, 2013, set the framework for joint partnerships and created increased opportunities for Navy nurses to work within the joint healthcare team. As part of a globally integrated health system, Navy nurses must maintain their relevance and uniqueness. At the same time, they must adapt and thrive in the joint medical environment.

The operational readiness and jointness domain is only one component of the Professional Practice Model. As its prominent location on the upper left corner illustrates, it is a cornerstone of the Model and a vital component of a Navy nurse’s career. In the future, Navy nurses will continue to answer the call to service. Preparing Navy nurses as joint military professionals early in their career, using the same vigor that goes into preparing them to be *clinical professionals*, ensures that Navy nurses will meet the expectation of the Nurse Corps to support joint initiatives, meet Navy Medicine’s mission, and improve Navy Medicine interoperability (Nathan, 2015).~

## Reserve Corner: A Medically Ready Force



**Mary Riggs, RDML, NC**  
**Deputy Director,**  
**Reserve Component**

As we launch into the New Year, resolutions are made to better ourselves, our families, and our community. As integral members of Navy Medicine, let us take the time to reflect on the pillars of our Navy Nurse Corps Professional Practice Model (PPM) in setting professional and personal goals for this year. Operational Readiness/Jointness, Professional Development, and Transformational Leadership activities provide us with tools to “always be ready” and are the foundation of our PPM. More importantly, focusing on the Surgeon General’s goal of readiness and relevance to the warfighter is our number one priority this year.

There are many tenets of readiness. Clinical readiness is at the core of our commitment to the Navy. Clinical sustainment and having a current credential from CCPD for your primary subspecialty code (SSC) is just the baseline. Demonstrating current com-

petency is our obligation. Platform readiness is having courses like TNCC, ACLS, and TCCC, or those required for your subspecialty code and for some mobilization sites like GTMO, Djibouti, or other locations.

Many New Year resolutions also align with being physically ready, such as going to the gym regularly, eating healthier, or walking more, which is measured every six months with the Physical Fitness Assessment (PFA). Medical readiness of a member is an ongoing requirement, noted by annual Periodic Health Assessments of individuals and units. While overall readiness is necessary in order to respond at a moment’s notice, one aspect that is often overlooked is our own personal medical readiness. Disclosing personal medical issues in a timely fashion to the NOSC and provider is essential and required. If you start a new medication or have an elective or needed surgery or treatment, keeping the NOSC up to date is necessary. Waiting to disclose a new medical condition upon receiving mobilization orders is not acceptable and can lead to separation of a member. As professional healthcare providers, we know communication and disclosure of medical conditions is necessary in being medically and clinically ready.

CDR J. Skelton, Strategic Plans and Operations Officer, M10, provided an excellent presentation on being ready to deploy in his presentation entitled, “It’s Time to Go: Your Readiness for Deployment” at the December 13 virtual JO Symposium TelCon. CDR Skelton

shared this presentation to all AC and RC NC and it is a comprehensive go-by for being ready for a deployment on all levels. The four-hour TelCon included presentations on professional and clinical development, transformational leadership, and operational readiness, with expert and nationally known speakers, and was developed for both AC and RC NC junior officers in all commands. This session was recorded and is accessible via milSuite along with all the speakers’ PowerPoints, so RC nurses can listen to it on DWEs. The PowerPoint handouts are available at <https://www.milsuite.mil/book/docs/DOC-428526>

In closing, I want to thank each of you for all you do to maintain your readiness year round so we can care for our warfighters at a moment’s notice. I challenge you to ask that not only are you ready, but as VADM McCollum states, are you “Ready to Win”! ~

*Reserve Component: The [Navy Nurse Corps milSuite site](#) is meant for you, too! But did you know there’s a milSuite page built with you in mind? Find information on Reserve-specific education opportunities, career management, and meet your Specialty Leaders. Click on any of the Naval Reserve icons throughout the News to check it out!*

**NAVAL  
RESERVE**  
STAY STRONG





## Billets and Bodies: The Manpower Mystery



**Deborah Roy, CAPT**  
**NC Deputy Director**

Greetings leaders! I often get asked why our Nurse Corps (NC) manpower numbers show us as “overmanned” in a specialty, while at the bedside, it feels like more staff is needed. Manpower management is truly an art form, and I have great respect for those who understand the many variables. It is important for our NC to have a basic understanding of manpower principles, so I will try to give you the “down and dirty” in hopes that it might answer the “why” of our staffing as it is.

Manpower for Navy Medicine needs to be thought of in two “buckets:” “Readiness” and “Benefit.” In the buckets, we have four categories of workers; Active Duty (AD), Reserve Component (RC), Government Service (GS) and Contract. The AD and RC directly support the “Readiness” bucket, while the GS and contract support the “Benefit” bucket. This is a great oversimplification, but for this discussion think AD/RC = Readiness and GS/Contract = Benefit.

The NC must optimize the uti-

lization of all of our members to support both the readiness and benefit missions in providing quality care and being prepared to deploy. A balance of the personnel types is required for success. As we continue to explore our manpower footprint, it is important to define some terms:

**Manpower Requirement:** The type of position and skill required to perform a function (we “require” # number of ICU nurses to meet operational needs on our platforms, # = manpower requirement).

**Authorized Billet:** A position or Full Time Equivalent (FTE) to be filled. An authorized billet has funding attached to it. (Ex: There are 10 AD billets and 10 GS FTEs on this Labor and Delivery Unit).

**Body:** Individual filling the position. (You!)

**Readiness:** Our operational mission, the people in uniform that directly support our military efforts across the globe; includes Military Treatment Facilities (MTF), Fleet, and Marine Corps roles.

**Benefit:** Care provided to beneficiaries in various locations **in support** of the readiness mission. Typically provided in MTFs otherwise known as the “Direct Care System.”

**Readiness Bucket:** Our AD and RC billets are based on the operational needs for each specialty; this drives our AD **Manpower Requirements**. Said another way, the number of specialty billets is based on the Operational requirements. If you counted up the NC billets in all of our operational platforms, this gives you the number of AD personnel

needed in each specialty if ALL platforms were deployed simultaneously; let’s call this **X**. Now, you actually need more bodies than **X** in order to rotate bodies, i.e. one person in the billet, one person coming out of the billet, one person ready to fill the billet on a regular rotation (applies to some duty stations but not others). The number of **bodies** needed to satisfy **X** is more than **X** its self. Therefore our **Manpower Requirements** are based on the number of **bodies** needed to support the operational mission with personnel rotating in and out of the operational billets. This translates to the number of billets needed to support those bodies. We are not funded for all of the billets needed to meet all of the body requirements. This is a level of risk that DoD accepts to control costs. For NC, we are funded for 2970 AC bodies. Bodies not currently deployed or in operational roles are utilized at the MTFs. To ensure we are sustaining our skills and are employed, the MTFs support the **benefit** mission using the **readiness** labor force.

The RC billets are based on the AC billets, and is an overall percentage of the AD billets. Everything we do to shape the AC will impact the RC.

So what does this mean? Let’s take L&D (1920) as an example. The current L&D AC billet authorization is 150 billets; we have 159 1920 nurses (bodies), so we are overmanned. “How can this be?” you might ask, “I need more 1920 nurses on my unit to provide care.” Remember, the AD billet authorization is based on

*Cont. on page 5*

## Billets and Bodies: The Manpower Mystery (cont.)

operational requirements (Readiness), NOT facility manning requirements (Benefit). So Navy Medicine uses GS and Contract hires to fill the gap. Our 1920 specialty requirement is based on providing maternal child care to the **overseas commands** and some **humanitarian missions ONLY**.

So let's complicate things: the actual operational billet requirement for 1920 (what is needed) is 90, but I just said we had 150 billets. This is because Navy Medicine has grown 1920 billets (and bodies) to meet the benefit mission. Said another way, there was a gap of the number of bodies (AD/GS/Contract) needed to staff the L&D areas; to increase staffing on L&D (without increasing GS/Contract positions) we moved billets from other areas like Med/Surg. As a result, instead of being 101% overmanned, we are actually 169% overmanned in this specialty. Since we have a finite number of bodies the NC can have, when we moved AD positions from Med/Surg to L&D, we lost Med/Surg billets; it's a zero sum game. If we plus up on one specialty, we have to take from another. **\*\*This shifting of AD billets (in many specialties) to meet benefit mission has, over time, resulted in a misalignment of NC billets to meet our readiness mission.\*\***

**Benefit Bucket:** Navy Medicine has the benefit mission in order to train and sustain our specialties (Note: NDAA17 changes this, the benefit mission will now be owned by the Defense Health Agency). The MTF/benefit mission is a means by which we sustain those AD persons not currently performing in an opera-

tional capacity (still true under NDAA17). The Benefit bucket is essential to our specialty educational pipelines, such as training new specialty nurses or the Medical Corps GME programs. This also provides essential medical care for our families and retirees who our government has committed to supporting. The benefit mission also supports the readiness mission as the care we provide to both AD and beneficiary populations provides a healthy force and family, able to adapt to the rigors of military life.

Each command is afforded a certain amount of money to support GS and Contract employees to meet staffing requirements for the benefit mission (filling the gap between AD staff and total staff needed to provide care at the MTF). How these positions are distributed and utilized is up to the command. There are caps to the number of GS billets a command can have; there are not personnel caps to contracts, but a funding cap of sorts.

I'm often asked to increase a specialty, or add a new specialty to our inventory. For example the Family Nurse Practitioners would like to have opportunities in the Fleet which currently do not exist; the critical care and emergency nurse specialties would like to add Acute Care Nurse Practitioners (ACNP) to the inventory. To do this, there first must be an operational requirement for the specialty (i.e. Fleet and Marine Corps desire to have and buy the specialty billets). NC must be able to support our current readiness requirements AND meet the new requirements. This gets back to the fact that NC has a set number

of bodies we can maintain. If I want to build a new specialty, I have to take from another. The work to increase or establish a new specialty is quite involved and can take years. NC currently is moving on several fronts to see how we can add opportunities while being able to maintain our current operational responsibilities.

If you're still with me, one more thing you should know. Above I mentioned how we have shifted billets to support the benefit mission; as a result we are now misaligned with the readiness requirements. Navy Medicine (all Corps) is undergoing a re-alignment process, moving billets and specialties within our system to better match our readiness mission and the ability to sustain the operational specialties more effectively. This will look differently at each command, and will be implemented over 3-5 years, resulting in increased billets in some specialties and a decrease in others. As a result, this will also result in a shift of AD and GS and Contract billets within each MTF to balance the addition or loss of AD specialty nurses in any given area. Do not be afraid! We will continue to have opportunities for AD, RC, and civilians in the various specialties we have now, the numbers just may change. Information will be forthcoming as we undergo this adjustment. Again this will happen over time, so you should not see/feel big changes.

So, do you have a headache? If yes, thank a Manpower Analyst for doing the work that they do so well!

I hope this was helpful.~

## Career Planner

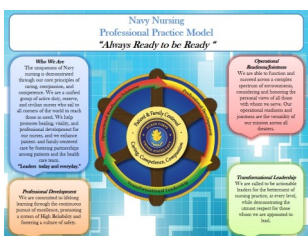


**Carolyn McGee, CAPT**

### Nurse Corps Career Planner

Happy 2018!

As we begin a new year, I'd like to review some programs and projects that have evolved since my article last year (<https://www.milsuite.mil/book/docs/DOC-351006>). One initiative that is moving forward is our Navy Nursing Professional Practice Model (PPM) Toolkit. The Toolkit includes various marketing items for use by Senior Nurse Executives and all leaders. The Toolkit was pilot tested in 2017 by four military treatment facilities, two operational sites, and one reserve unit. A team of officers is currently compiling the pilot results. The final Toolkit will help bring the PPM to life across all Navy nursing sites. In the meantime, you can learn more about the PPM at <https://www.milsuite.mil/book/groups/professional-practice-model>.



[professional-practice-model](https://www.milsuite.mil/book/groups/professional-practice-model).

Another program with new developments is the Career Development Board (CDB) Program. Since it was initiated in 2012, this Program has grown and evolved, and now serves as a model for similar programs in other officer communities. The policy for this program was just signed by **RDML Davidson** and is located at <https://www.milsuite.mil/book/docs/DOC-436700>. You can learn more about on-going CDB initiatives by reading **CDR Coby Croft's** excellent article in the Year in Review Newsletter at <https://www.milsuite.mil/book/docs/DOC-433531>. Contact your command CDB Coordinator to schedule your Board, or to serve as a Board Member!

The Nurse Resident Program (NRP) is a pivotal transition program for new Nurse Corps officers. Many of you graduated from a NRP, and countless other military and civilian nurses have run command programs and served as preceptors for new nurses. In 2017, the NRP at Naval Medical Center Portsmouth was accredited by the American Nurses Credentialing Center as meeting Practice Transition Accreditation Program criteria. This is a true honor and a testament to the nursing leaders at Portsmouth who made this happen. In the upcoming year, **CDR Cynthia Hutchinson**, the Nurse Resident Program Manager, will lead a group to identify and leverage best NRP practices to assist our new nurses as they transition into our Corps.

There are a wide variety of leadership courses that are available to Nurse Corps officers. These courses are summarized in

the Navy Medicine Leadership Course Catalog (<https://www.milsuite.mil/book/docs/DOC-408957>). From the Combat Casualty Care Course to the Navy Senior Leader Seminar, there is a course for every rank. If you are interested in attending one of the courses, speak with your chain of command and follow the application instructions. If you don't get selected the first, second, or even third time, keep trying! The courses are in high demand, and are well worth the time, effort, and persistence.

Finally, I hope many of you were able to participate in the Junior Officer Leadership Symposium, either during the Live Event or by listening to the recording. I understand the teleconference format isn't ideal, but it is a cost-effective way to reach a global audience. The briefs and recording are available on the Navy Nurse Corps Career Development site (<https://www.milsuite.mil/book/groups/navy-nurse-corps-career-development>). I hope to schedule similar events in the future, and I welcome suggestions for topics.

If you have any questions about the programs I've listed or would like to discuss your career, please contact me via milSuite or [contact me by email](#).

### [The FY18 Navy Medicine Leadership Course Catalog](#)

is on milSuite!

This catalog contains information about available courses and dates, how to register, funding, & eligibility requirements.



## Additional Qualification Designation (AQD) Codes



**John Eckenrode, CAPT**  
Personnel Planner

### *What is an AQD and how do I get one?*

Additional Qualification Designation, or AQD, codes provide supplementary information regarding the qualifications, skills and knowledge a Nurse Corps Officer retains, or those that may be required to perform the duties and/or functions of a billet beyond those implicit in the billet, designator, grade, subspecialty, or naval officer billet code (NOBC). Per the Manual of Navy Officer Manpower and Personnel Classifications ([NOOCS Manual, Updated October 2017](#)), “Additional Qualification Designation (AQD) codes enhance billet and officer designator codes by identifying more specifically the qualifications required by a billet or a unique qualification awarded to an incumbent through service in the coded billet.” The AQD generally indicates a requirement for an officer who has attained special qualifications through training and/or experience. Similar to Subspecialty Codes, AQDs serve as an ac-

counting tool, not a personal recognition tool.

The AQD codes consist of three characters, either alphanumeric or all-numeric. The first character identifies a broad occupational area closely related to the designator. The second character specifies the type of qualification within the occupational area. The third character further defines the qualification. AQDs beginning with the number “6” pertain exclusively to health care. For Nurse Corps officers the AQD may be used during assignment and selection procedures. For instance, a command representative may ask the detailers to assign an officer who carries a specific AQD; e.g., a 1910R officer who carries the 690 AQD for an ambulatory clinic billet. Additionally, during selection boards, the individual’s AQDs are visible and provide descriptive information about the officer’s skillset and experience.

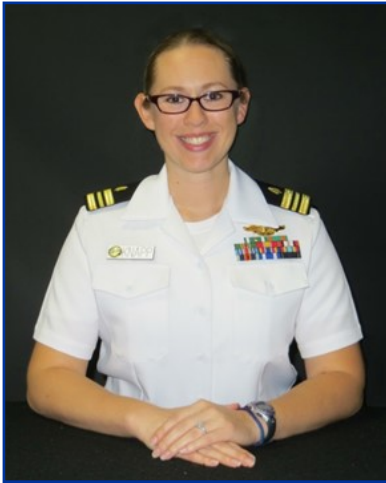
The most common AQD codes validated and assigned by the Nurse Corps Personnel Planner are as follows (other AQDs exist but are granted through different processes, such as Joint Specialty AQDs for deployments,

which are approved by PERS-4): Further information regarding AQD descriptions and awarding criteria can be found in the [NOOCS Manual Volume I, Part D](#). The forms for requesting AQDs can be found in the [Navy Nurse Corps Subspecialty Code Management Guidance](#), located on the Nurse Corps milSuite site. For questions regarding specific AQDs, please [contact the Nurse Corps Personnel Plans Analyst or Assistant](#) via email or milSuite.~



<b>BX2</b>	FLEET MARINE FORCE (FMF) QUALIFIED OFFICER
<b>HB3</b>	OFFICER RECRUITER
<b>HG1</b>	OFFICER RECRUITER, HEADQUARTERS STAFF OFFICER
<b>LA7</b>	SURFACE WARFARE MEDICAL DEPARTMENT OFFICER
<b>6FA</b>	FLEET MARINE FORCE EXPERIENCE
<b>6OB</b>	SHIPBOARD ASSIGNMENT
<b>6OC</b>	HOSPITAL SHIP ASSIGNMENT
<b>6OE</b>	EN-ROUTE CARE
<b>6OU</b>	FLEET HOSPITAL EXPERIENCE
<b>6OW</b>	TRAUMA TRAINED OFFICER
<b>6AJ</b>	FLIGHT NURSE
<b>67G</b>	MANAGED CARE COORDINATOR
<b>68I</b>	HEALTH CARE MANAGEMENT
<b>69K</b>	PEDIATRIC INTENSIVE CARE
<b>68L</b>	INFORMATICS NURSING
<b>69O</b>	AMBULATORY CARE NURSING
<b>69P</b>	PRIMARY CARE NURSE PRACTITIONER
<b>69L</b>	LABOR & DELIVERY NURSE EXPERIENCED

## MHS GENESIS: The Biggest Lesson Learned



**Monica Knapp, LCDR**  
**NC Informatics Fellow,**  
**BUMED M36**



MHS GENESIS. The new EHR of the future. The first four facilities have gone live (transitioned from legacy systems [CHCS, AHLTA, Essentris] to MHS GENESIS) in what is called the Initial Operating Capability (IOC). Fairchild Air Force Base transitioned in February 2017, in Spokane, Washington. Naval Health Clinic Oak Harbor went live in July 2017 and Naval Hospital Bremerton went live in September 2017. The final site in the IOC to go live in October 2017 was Madigan Army Medical Center in Tacoma, Washington. These sites also overlay something called a Med-COI. A Medical-Community of Interest is basically a geographically centralized area that provides Virtual Private Networks for encrypting, securing, and seamlessly exchanging health care data. The next Med-COI area to go live will be in California. Over the next few years, all of the DoD MTFs

will both transition to the Med-COI and the new EHR.

Now that IOC is completed, the new focus will be lessons learned from the IOC and on preparing for the next wave of deployment. The biggest common area that the EHR implementation team has identified as a root cause for a lot of the trouble tickets is TRAINING TRAINING TRAINING. End-users need to focus more on workflow than on "button-ology" (basic training on the use of the software). MHS GENESIS now has drastically different workflows that the end user must understand in order for everything to function as designed.

Remember in Essentris, when the provider had to initiate the H&P so that the information flowed and prepopulated information into other notes? ...And if this first step didn't happen, a lot "broke?" Well, there are more complex pathways in MHS GENESIS that require sequential documentation workflows to occur. Learning this prior to go-live is CRITICAL in easing your transition and avoiding mistakes.

There are two types of mistakes made in an EHR: Knowledge-based or Rule-based. Knowledge-based mistakes result from incomplete knowledge of the rules or key concepts. This can happen when a clinician performs a workaround in the EHR because he/she doesn't think the current workflow is effective (there is human bias involved). In Rule-based mistakes, the clinician knows the rules, but ignores them in part or in whole. Both mistakes can cause angst on the part of the clinician because the

system is not performing like it should. It can also prime situations to have the holes line up (the Swiss cheese effect) and a potential patient safety event to occur. In order to mitigate this, you need to be well trained on the nuances of MHS GENESIS.

There are challenges with Computer Based Training (CBT). We have a tendency to click "next" over and over to "get through" the training as fast as possible, and not actually study the material. It's hard to learn without being able to do hands-on within the program. Adults learn better through "doing" and CBT is not conducive to this. But... it is very important to take this training seriously in preparation for Instructor-Led Training (ILT). That way you can come to the ILT with better questions regarding workflows. Maximizing your training and truly taking advantage of it is very important. We can master the button-ology in time, through practice. But we can create bad habits that cause failure of the solution to work if we don't follow the correct way of documenting that we need to.

Have you started your CBT? Everyone can access the 100 levels through [JKO](#) now. Once your account is requested, you will be assigned levels 200 and 300, as needed. ILT will happen strategically prior to your site going live. The bottom line is to take this training seriously, and to prepare yourself for no longer doing things the way we've always done them. ~

*"Leadership is about coping with change."*

John P. Kotter



## Specialty Leader Update: Perioperative (1950)



**Richard Lawrence, CDR**  
**1950 Specialty Leader**

**John Broom, CDR**  
**Assistant Specialty Leader**

Happy New Year from the Perioperative Nurses! It comes with mixed emotions as this article represents the last one I will be writing as the Perioperative Nurse Specialty Leader. During my tenure, I had the pleasure of representing all things perioperative nursing from BUMED to the Fleet, and I could not have been more proud and humbled by the amazing team of perioperative nurses, both military and civilian.

If you are an active duty/reserve nurse and interested in joining our perioperative team, please see the [Perioperative Nurse Training Guidelines](#) on milSuite. Deadlines for command-endorsed packages are due to CAPT Meyerhuber by the 15th of February, May, and September. Please seek out your local perioperative nurses for assistance. The West Coast training site is NMC San Diego and the new East Coast training site will be moving from NH Jacksonville to NMC

Portsmouth in September 2018.

In addition to their primary responsibilities, perioperative nurses continue to be engaged in numerous activities in support of BUMED, quality, and readiness initiatives that will directly impact the quality of care for our beneficiaries, in and out of the operating room, while ensuring we have a fully trained and deployable specialty. There is a large team of subject matter experts, led by Operational Medicine and Capabilities (M9), to develop a BSO-18 Unit Deployment Process (UDP) and support system that would align us with the organizational modernization priorities. What this means for everyone, not just critical war-time specialties, is BSO-18 would have the Type Command, infrastructure and capacity, to deploy and sustain Navy Medicine units in support of operational requirements.

The specialty subject matter experts worked alongside the stakeholders in the development of distinct courses of action to man, train, equip, and ensure the logistical and administrative support was in place throughout all phases of the deployment cycle. In conjunction with those efforts, a readiness checklist was created to support those needs of the specialty and what it will require to train perioperative nurses for deployment. This checklist was then worked on in collaboration with the Army and the Air Force Consultants to establish one tool that could also be utilized to

### *\*What's BSO-18?*

"BSO" stands for "Budget Submitting Office; all medical treatment facilities and clinics funded by Navy Medicine fall under "line 18" of the BSO; hence, BSO-18.

support future missions. Perioperative nurses continue to support readiness and local mission objectives, at the Military Treatment Facility (MTF) level as well in a multitude of activities from process improvement to Surgical Services Clinical Community sub-communities and working groups.

Other projects being further developed are the high-level disinfection and sterilization process and associated training, with easy access to updated, centrally purchased reference materials for all commands performing these tasks. We also have numerous safety and practice initiatives to ease transitions as a result of constant turnover by standardizing our techniques. For additional information about perioperative nursing accomplishments, activities, and areas of influence and impact, see our quarterly [Perioperative Newsletter on our milSuite page](#).~

### **CNOR Strong**

*Research shows that nurses who earn the CNOR credential have greater confidence in their clinical practice. A team of CNOR certified nurses can improve outcomes in surgical patients. If 50% of eligible perioperative nursing staff is CNOR certified, and the facility consistently recognizes nurses who become CNOR certified, they can earn the title of CNOR Strong!*

*See Page 16 for our newest CNOR Strong teams!*

Meet your Reserve  
Perioperative Specialty  
Leaders!!



**Cynthia Schwartz, CDR**

**Specialty Leader**

**Cynthia Jones, CDR**

**Assistant Specialty Leader**



## EMF BEAUFORT: Operationally Ready!

**George “Lew” Dyer, CAPT**  
**EMF GOLF Senior Nurse**

What do you call a cadre of 28 Navy nurses who gather together for a week of Expeditionary Medical Facility (EMF) Training at the Naval Expeditionary Medical Training Institute? I call them **MOTIVATED!**

From December 10-16, 2017, 28 Navy Nurse Corps Officers came from six different commands to join approximately 118 active duty physicians, corpsmen, allied health professionals, and administrators to form EMF GOLF at the Naval Expeditionary Medical Training Institute, Camp Pendleton, for the Phase II Operational Readiness Exercise (ORE). The purpose of this exercise was to obtain certification as a “ready to deploy” unit. Certification as a Tier 1 Organization indicates to the combatant commander their readiness to deploy within 30 days of notification. EMF GOLF was led by their Commanding Officer, **CAPT Donna Bradley, NC**, serving as the current Executive Officer at Naval Hospital Beaufort.

The EMF Platform is a Role III facility. These nurses and other staff received training in a mock 50-bed tent hospital which included two operating rooms, an Intensive Care Unit, Post-Anesthesia Care Unit, Medical/Surgical area, and Mental Health area. Additionally, the hospital had an ambulatory clinic and full ancillary service capabilities.

The exercise consisted of didactic, hands-on, and practical field wartime scenarios, to include mass casualty and command and control situations. The training was excellent and included equipment familiarization, integrated medical patient throughput, functional area operations, scenario and mission training, and emergency operation procedures. Additional scenarios included mass casualty measures, surgical triage, and how to evacuate and transport patients in the event of fire.

The group of nurses was a vital component to the overall success of the certification process. **CDR Tracy Vincent**, Senior Nurse at Marine Corps Recruit Depot Parris Island, who served

as the Functional Leader (Department Head) for the Triage, Casualty and Receiving area, stated, “I think this is some of the best training that I have had in my Navy career. The teamwork among the various Sailors was amazing, the scenarios were realistic from my experience in the past, and we even had the opportunity to care for a simulated injured military working dog. It was a great opportunity to learn.”~



CAMP PENDLETON (Dec. 14, 2017) — Active Duty and Reserve Navy medical Sailors participate in a joint Expeditionary Medical Facility (EMF) and Navy Role 2 Light Maneuver (R2LM) training exercise. The weeklong training began on Dec. 10 and simulated casualties in several combat environment scenarios. (U.S. Navy Photo by HM1 Corey Nasfell/Released)

## Our Journey to High Reliability: Leadership from the Deckplate

**Andrea Petrovanic, CAPT**  
**Jose Flores, CDR**

One of the principles of a High Reliability Organization (HRO) is the recognition that the deckplate staff - frontline clerks, Hospital Corpsmen, medical assistants, health technicians, nurses, and physicians - are the subject matter experts when it comes to

improving the delivery of safe quality care. Aligning with this HRO concept, we instituted a Continuous Improvement Board at Naval Branch Health Clinic Miramar to solicit their ideas. The board consist of four headings: IDEAS, TO DO, DOING, and DONE. Ideas are submitted using a suggestion card, which are discussed during our weekly Clinic Management Team meet-

ing, then the cards are moved along the board based on actions taken. One of the first suggestions came from a junior Hospital Corpsman who identified that a patient didn't have a place for their belongings when being measured for their height and weight. Based on the suggestion card, we assessed the clinic's patient flow, and moved our scale

*Cont. on page 12*

## Our Journey to High Reliability (cont.)

to a new centrally located area and improved the workflow.

An article from the Journal of Healthcare Management discussed improving the safety culture of an organization, “An HRO must commit to the understanding that leadership drives the values, values drive behaviors, and behaviors create the culture that produces the desired outcomes” (Hendrich & Ziad, 2017). We found that providing the staff with a method to communicate improvement ideas is an essential item as we strive to become an HRO, and many other suggestions have been submitted. Our

board is also in alignment with the principles of TeamSTEPPS, as it promotes teamwork and encourages staff to Speak-Up. By initiating a process improvement board in your area, you can actively engage and empower your staff. Visible results will help promote team buy-in and improve unit morale. Nurses in ambulatory settings are front and center in this all-hands effort to positively impact our culture of robust process improvement, and a Continuous Improvement Board is a great start in leveraging the talents of our deckplate staff. ~



*Hendrich, A. & Ziad, H. (2017). Building a High-Reliability Organization: One System's Patient Safety Journey. Journal of Healthcare Management, 62 (1), 13-17.*

## Unique Clinical Rotation—American Samoa



**Christopher Johnson, LT**

Waiting in the airport for the once-a-week flight to American Samoa, which is located halfway between Hawaii and Australia, I was already surrounded by the very people I would soon be taking care of. Very large, with even bigger hearts, American Samoans are among the friendliest and most inviting people I have ever met. I spent three weeks as a Family and Women's Health Nurse Practitioner student working under the supervision of Mrs. Tele Hill, a Family Nurse Practitioner with over thirty years

of experience in an area with limited practitioners and resources. Currently, the healthcare available in American Samoa consists of one local hospital, three Department of Health clinics, and a Veterans Affairs clinic.

The first of two students from the Uniformed Services University to be invited to perform clinical rotations in American Samoa, I found that this experience reinforced that I was ready. Each day was rewarding and educational, seeing patients with conditions ranging from diabetes and hypertension to elephantiasis and Zika. I would see four to five newborns, five to six obstetrical patients, perform six to eight well-woman exams, and complete the clinic day with routine family care or performing home visits.

The home visits were extremely different than anything I had done before. Armed with a blood pressure cuff, a stetho-



scope, a portable oxygen sensor, and a prescription pad, I would travel through different districts or take a boat to an outlying island to diagnose and deliver care. I confirmed the skills to begin working as an advanced practice nurse wherever the Navy might send me. The opportunity will continue with more students who will meet similar smiling faces looking forward to being cared for by the American military's finest advanced practice nursing students.~

Major Taylor and LT Johnson, FNP students in Samoa; traveling with Mrs. Tele Hill to outer islands for home visits. (Photos by LT Johnson)



## OB Emergency Drill Conducted At US Naval Hospital Yokosuka

**Katie Schulz, LCDR**  
**Certified Nurse Midwife**

**Why does the U.S. have such a high maternal mortality rate, and how does that relate to postpartum hemorrhage?** The U.S. maternal mortality rate is very complicated and multi-factorial. There are not one or two specific things that can be identified as a cause. However, the U.S. health care system is working to develop ways to address the morbidity and mortality rate. Implementing standardized evidence-based protocols and safety bundles (like a postpartum hemorrhage bundle) are ways in which we are trying to address perinatal morbidity and mortality.

**What is a postpartum hemorrhage?** A postpartum hemorrhage is when a woman has excessive bleeding after childbirth, specifically one liter of blood or more. There are risk factors that help us to identify women at increased risk of hemorrhage, but women without risk factors can also hemorrhage. In a small facility with limited blood supply, it is critical that we identify and respond to a hemorrhage quickly. Navy Medicine West

recently released a very robust hemorrhage protocol that is used throughout Navy Medicine to help identify and respond to postpartum hemorrhage.

**What is a Code Purple?** A Code Purple can be initiated for a range of obstetric and neonatal emergencies. Examples include, but are not limited to, shoulder dystocia, umbilical cord prolapse, fetal distress, antepartum hemorrhage, postpartum hemorrhage, eclampsia, or delivery outside the Labor & Delivery Unit. Training for a Code Purple requires multi-disciplinary participation across many departments.

**How do we conduct Code Purple training?** Having a robust simulation program is critical to our readiness to respond to OB emergencies. Twice a year, we conduct command-wide drills, played out as realistically as possible. Our new state-of-the-art simulators make the training realistic and allows the greatest amount of hands-on training and practice with emergency equipment. Drills and simulation provide the team a chance to practice some of the low-volume, high-risk emergencies that can occur in any facility. They also help us to identify areas for ongoing improvement and future training needs. ~



CODE PURPLE - OB EMERGENCY DRILL  
U.S. NAVAL HOSPITAL YOKOSUKA  
DECEMBER 13, 2017



YOKOSUKA, Japan (Dec. 13, 2017) - Doctors, nurse and corpsman assigned to USNH Yokosuka's emergency room, labor and delivery and surgical suite conduct a drill to hone their obstetric care skill sets. The simulation involves saving the lives of a simulated mother and baby with a postpartum hemorrhage, excessive bleeding during childbirth, wherein the staff had to combine their effort in order to save the lives of the patients under a short timetable. (U.S. Navy photo by Tim Jensen/Released)

# Nurse Corps News

Volume 12, Issue 1 ~ January/February 2018

## You Can Help Support the Navy Recruiting Mission!

### Kristen Edgar, CDR NC Program Manager

In my role as the Program Manager, I serve as the main conduit between Navy Recruiting, the Nurse Corps Officer Community Manager (OCM), Nurse Corps Detailers, BUMED, 26 Navy Recruiting Districts (NRD), and 180 Medical Officer recruiters across the nation to recruit, screen, select, and commission the best and the brightest to serve as future Navy Nurse Corps Officers. I maintain comprehensive knowledge of the Nurse Corps Program Authorization, professional Nurse Corps qualifications, incentive pays, Officer Recruiting Manual and the recruiting application process. I also review, compile, and forward Nurse Corps applications

to the Professional Review Board. I coordinate Medical VIP Tours and collaborate with NRDs to ensure appropriate recruiting presence at National Medical Recruiting Events. Best of all, I get to play a role in providing mentorship and guidance to our future and new Nurse Corps Officers and support Navy Medical Officer Recruiters in supplying the lifeblood to the next generation of Navy Nurses, ultimately shaping the future of the Nurse Corps. This non-traditional nursing role at Navy Recruiting Command, Headquarters, Millington, Tennessee, allows me the opportunity to provide a line of communication between

Navy Nursing Leaders and Navy Recruiting Leadership, while also allowing me to provide mentorship and guidance to potential new Nurse Corps Officers.~

All NC Officers have the opportunity to support our Medical Recruiting Mission!

#### *We could use your knowledge to:*

- Provide NC interviews (O-4 and above; Active Duty, Reserve, Retired)
- Support Navy Recruiting booths at National Events
- Support Navy Recruiting events in your local area
- Speak with Navy Nurse Corps applicants regarding what you do in the Navy!

*Contact your SNE for more information on how you can get involved.*



SAN ANTONIO, TX. (1 December 2017). Forty-two Navy Junior Reserve Officer Training Corps (NJROTC) cadets from George Bush High School near Houston, Texas, receive a Navy Medicine overview presentation from LCDR Sarah Gentry, a Navy nurse serving as NMTSC's Hospital Corpsman Basic Course department head and public affairs officer at Navy Medicine Training Support Center (NMTSC). (U.S. Navy photo by Mass Communication Specialist 2nd Class Gary Ward/Released)

## Your News Team in 2018

### Melani L Harding, LCDR Editor in Chief, NC News

It's a New Year, and we're excited to share another year of the Nurse Corps News with you. [Find us on milSuite](#) to get the latest News or upcoming due dates; you can also [email the team](#). We want to hear from you!

I'd like to give a shout-out to **LCDR Nikki Pritchard**; as a Layout Editor for the last year and a half, she made significant contributions to this format. She's also responsible for much of the layout of the [Year in Review](#), including the *By the Numbers* page! As she has started DUINS, we've welcomed a new team member in her place. **LT Randi Acheson** is joining us

from NMC Portsmouth and is quickly learning the ropes. We're excited to see the ideas she's bringing with her. She joins **LCDR Eric Banker** as a Layout Editor; LCDR Banker is the veteran of our News team, and is also the Editor of the Perioperative Newsletter. He'll be moving back stateside this Spring, meaning the entire team will be in one country—for the first time in two years!

We are eagerly anticipating adding liaisons from the Reserve Community. We want to include all of the great things being done by our RC, and this is a great way to stay involved. [See the announcement here](#); packages are due March 26. We can't wait to work with you!~





### Certifications

**LCDR Jessica Dalrymple**, USNH Guam, achieved her certification in Neonatal and Pediatric Transport certification (C-NPT) by the National Certification Corporation (NCC). She also passed her Neonatal CNS exam (ACCNS-N).

**LCDR Christine Higgins**, currently in DUINS for a DNP in Midwifery, received her ANCC Certification in Advanced Forensic Nursing.

**LCDR Katherine Gelenter, LT Gary Laccay, LT Gissele Zeldorf, LT Amanda Partner, LT Lucy Stephan, LT Ananda Craft, and LT Marissa Hesse** of NMC San Diego recently attained their Operating Room Nurse Certification (CNOR).

**LT Resel Deppen**, NH Camp Pendleton, earned her Certification in Perianesthesia Nursing (CPAN).

**LT Angelica Fink**, NH Camp Pendleton, earned her Ambulatory Care Nursing Certification.

**LT Nita Flores**, USNH Naples, just earned her Certification in Ambulatory Care.

**LT Lawrence Johnson** of NH Camp Pendleton attained his Certification in Medical-Surgical Nursing (CMSRN).

**LT Tiffany Lerch**, USNH Rota, earned her certification in Ambulatory Care.

**LT Alison M. Upton**, NH Camp Pendleton, attained her Inpatient Obstetrics Certification (RNC-OB).

**LT Ann Vanegas** of Walter Reed NMMC recently attained her Operating Room Nurse Certification (CNOR).

**LT Sabrina Watson**, USNH Yokosuka, achieved certification in RN-BC in Ambulatory Care Nursing.

**LTJG Jay Clancy**, NH Camp Pendleton, earned his Certification in Emergency Nursing (CEN).

**LTJG Rhea C. Drake**, BHC MCRD Parris Island, earned her Medical-Surgical Certification.

**LTJG Maria Jarrett**, USNH Guam, achieved her certification as a Critical Care Registered Nurse.

**LTJG Alexandra Hansen** of USNH Guam achieved her certification as a Critical Care Registered Nurse (CCRN).

**LTJG Lauren Martin**, from NMC San Diego, earned her Medical-Surgical Certification, CMSRN.

**LTJG Ira J. Wilkie**, NH Camp Pendleton, achieved his Inpatient Obstetrics Certification.

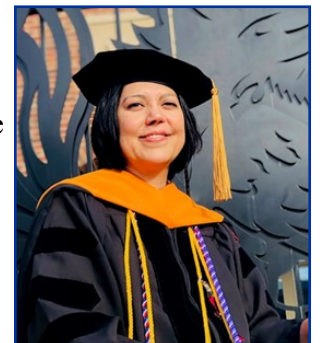
### Education

**CDR Kim P. Shaughnessy**, currently assigned to BUMED M32, Office of Women's Health, graduated from the Villanova University Doctor of Nursing Practice program on 12 December 2017.

**LCDR Connie Braybrook**, recently of NH Guam and now at NBHC Fallon, received her DNP from Gonzaga University and successfully defended her project "Improving Nursing Competence and Comfort in Caring for Suicidal Patients on Medical Wards by Implementing a Suicide Management Protocol in a Military Hospital."

**LCDR Penny Jimenez**, NMC San Diego, earned an MBA from Liberty University in December, 2017.

**CAPT Kimberly Taylor**, NHC Corpus Christi's SNE, graduated Summa Cum Laude with her DNP from the University of South Carolina in December 2017. CAPT Taylor is a Jonas Veteran Healthcare Scholar and Certified Nurse Executive-Advanced.







### Education

**LT Razika Baksh**, NH Pensacola, earned her MSN in Education.

**LT Dayna E. Stevens**, of NH Pensacola, completed her MS-CAM (Masters of Science in Complimentary Alternative Medicine) and a Healing Touch Level I Practitioner Certification.

### Recognition

**CAPT Andrea Petrovanie** was elected to the American Academy of Ambulatory Care Nursing Nominating Committee for a 2-year appointment.

The Surgical Tech Program of Medical Education Training Campus at Fort Sam Houston has just received the certificate for **CNOR Strong** amongst the Tri-Service nurses. A consolidated program, the perioperative nursing leadership consists of two Army, one Air Force, and two Navy nurses; **LCDR Annissa Cromer** and **LCDR Kirby Jahnke**.

Bravo-Zulu for the Operating Room nurses at NHC Lemoore. All four of the Perioperative Nurses have obtained CNOR Certification, showing their commitment to the highest standards of patient care. Due to the high percentage of CNOR Certified Nurses, the Competency & Credentialing Institute (CCI) has recognized NHCL as **CNOR Strong**.



(2 February 2018) **CDR Edith (Glanton) Asante**, a midwife and Department Head for Labor and Delivery at NH Pensacola, plays with **Gracelynn Page** at NHP while her mother **Mirielle Page** and father **Electronics Technician 2nd Class Jacob Paige** watches. Because of the care Asante provided **Mirielle** during the delivery of **Gracelynn**, she was nominated and won a **DAISY Award for Extraordinary Nurses**. **DAISY** is an acronym for **Diseases Attacking the Immune System** and award is a national program to recognize exceptional nurses. This was the first time NH Pensacola has granted the award; they also expanded the award to include corpsmen.

(Photo by Jason Bortz/Released)

### *Final Call!*

### **Need Money For Graduate School? 2018 Graduate Degree Nursing Scholarship Opportunity!**

A Washington Metro Area Navy Nurse Corps Association (WMANNCA) Chapter Nursing Scholarship will be offered to three Navy Nurses to continue their studies for an advanced graduate degree in Nursing. Active duty (non-DUINS), Reserve Component, retired and former Navy Nurses are eligible.

A \$1,000 scholarship will be awarded to each winner. The applicant must live or work in the WMANNCA AOR (Maryland, Northern Virginia, West Virginia, Pennsylvania, New Jersey, Delaware or the District of Columbia).

Deadline for submission is April 2, 2018!

Download the guidelines and application materials here:

<http://nnca.org/join-nnca-2/local-chapters/wmannca/>



NH Camp Lejeune Perioperative Nurses, Pictured left to right: **LCDR Timothy Benjamin**, **LT Jaslyn Bushong**, and **LCDR Francisco Rodriguez-Sosa**. **LT Mark Soriano** (far left) is currently deployed.

