During that time, the nurses showed that they had an extraordinary increase in their workload. They changed practice settings. Many retired because of COVID-19. More, even more alarming are the fact that 45% to 56% of the nurses in our study said they are

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- Well, when everyone does the analysis of the workforce issues, they come up with two basic reasons for it. One is not enough nurse educators, and the second is not enough clinical placements. And so that, if we go to the root of the problem, I think that's where we'll find it in terms of, in my area, nurse education and having access to clinical placements is a huge issue.

In addition, we've introduced the virtual nursing platform to layer on a registered nurse with experience

- Yeah. Well, you know, I've got so much in my mind and my heart about this that I will get to diversity, but I want to start with some topic that people cringe at, especially nurses, pay in terms of nurse educators, an acknowledgment that in the university systems and college programs, community colleges, other places, nursing is not valued the same way that other departments are, and yet, frequently, they're bringing in more money into those programs, into those universities than any other program.

And if not the most, they're right up there with the top in terms of the number of students, and they take biology, they take chemistry. I mean, they are like the material of the university and yet not acknowledged in the same way our physician colleagues or even the legal colleagues that we have, professional programs are.

So that's one issue that we've got to face. And I say cringe because nurses, we're so good. We're so angelic. We don't need money. But the truth is money makes a difference in terms of this whole thing. Secondly, there just aren't enough nurse educators of color. The diversity is not there.

I always say that some people are praying that that educator of color will turn up the next day because if that person doesn't, there's no one there. It's like I got one or I got two. We've got to work on that pipeline, and I don't know if people have some aversion to pipeline, but I still see it as something that runs through, that's prepared, that's leveled, that you don't wait till the last minute to say, "Do we have enough?"

And so we've got...and I think one of the things that we did...I used to be Dean of Nursing at North Carolina A&T p3(7rcsing at North

as opposed to the RN workforce. So that seems to me that we need more of a pipeline to get those nurses that are LPNs into the RN workforce and keep advancing careers of nurses.

- I just want to mention that we had a program called LPN to BSN 20 years ago, and it was about getting LPNs to the baccalaureate. And we were funded for that program at A&T, $6 million to do that. It was a nine-year program.

We got a lot of nurses that way. That's not an outdated idea.

- Thank you. Well, I want to turn to some other statistics. We have not only issues with experienced nurses, as I said, but 24% of RNs say they plan on leaving the profession in the next 5 years. They have less than 10 years of experience.

They're our future. In that study, one of the main reasons younger nurses are stressed is because they feel ill-prepared to enter the workforce. Clearly, we need to address the needs of this group. So, Eileen, I'm going to begin with you. Talk about how educators...

And, Karen, I want you also to talk about the need for transition to practice. But, Eileen.

- Yes, thank you so much, Maryann. I think one of the things that we're really focusing on at the education level is really ensuring that we're graduating practice-ready nurses. So, at the University of San Francisco right now, we're revising our nursing curriculum, and we're doing this in conjunction with our clinical agencies in our region to really make sure that what we're teaching in the classroom reflects the needs of health systems today.

You know, health care and the work of health systems evolves so quickly, and academia doesn't quite move that fast. And so we're really trying to make sure that what we're teaching in the classroom really prepares the students. And that goes back to that c

- And it shows how each of these issues are all interconnected.

- They are. Lavonia, what's going on at MD Anderson with your new graduates?

- So we are, and we've heard the feedback as far as entry and taking care of our existing workforce. We do have year-long residencies but also, then, looking at how long do we go beyond that. To be honest with you, we all need a form of safety net as we move through our careers, because we make transitions, we take new jobs, and we all need that backup and safety net.

So we're going to be partnering so that we teach them across that screen and they can participate with us for that piece of it. So we're hoping to grow that expert advice piece, but virtual nursing absolutely does have a place in our future to maintain the health and wellness of our existing workforce, create new career paths for nurses, create opportunities for nurses who need to work modified work schedules.

There's lots of opportunities around it.

- Bev, did you?

- Yeah. Listening to my colleagues, a thought came to me that it's really operationalizing Pat Benner's "Novice to Expert," that the virtual nursing can do that. So you have your expert there with your novice in a different way. And I think that taking existing theories and applying, that's the kind of problem-solving we're going to need to do.

The other thought that came to my mind is that there's concentrated effort on the clinical setting about making sure that the culture there is supportive of growth not just for new nurses but for those who are already there. I'm not sure there's that concentration of effort on university faculties and community college faculties, that there's that effort to make sure that it is a welcoming, warm, cuddly environment there for faculty.

There's the assumption that these are grownups and they should know how to behave. And that just doesn't prove to be true all the time. There is a need to focus on, and I know our dean at UCSF is thinking about this, to focus on, how does that faculty work together?

How does the faculty treat students? Does the faculty actually have biases? Oh, my goodness, they're a

- You know, I think staffing ratios do make a difference, obviously, and the data shows that. But I do agree with Lavonia that it really does need to be in the hands of the nurse leaders, you know, that can assess the patients on a minute-by-minute basis to be able to ensure that staffing is meeting the needs at that particular time.

I think the challenge with staffing ratios is that, you know, it's a double-edged sword. You can say that we're going to provide you with this ratio, but is that all that we're going to provide instead of allowing that flex that needs to be considered throughout a shift? So I think, as long as it still remains in the hands of those who are caring for the patients, that final decision needs to rest there.

- Karen or Bev, any thoughts?

- Yeah. Staffing ratios, I think there needs to be some level of assurance that patients are getting care, right, the numbers that are needed. But I, and like my colleagues here, believe that leadership should be providing that guidance. And the thing that I heard Lavonia saying was that it's at MD Anderson that they have their staffing ratios. It's not some state legislature that has made a decision about, boom, "For all of you, this is going to be it, colleagues."

And that's pretty far away from the clinical area to be making that decision. So I'm thinking that there's a place for them, but it's not just the only thing, that it has to be within the context of the system you're working in, and it has to be with the leadership of those who are providing and saying on a day-to-day basis, "Hey, this is an emergency. We need more than anything you can tell."

But, no, the state or the federal system says, "We only need this much. So you're only going to get this much." To me, that endangers the patient, and it is all about quality patient care, that we start there. And I know that those who are proponents of staff ratios are saying it's about quality patient care. But I'm thinking that we still need the leadership of on-site people who are making decisions on a day-to-day basis about, what is the situation here?

So if you're going to put them in, have your escape clause in there somewhere that says that it really is up to those who are monitoring the day-to-day situation that goes on.

- Well, what I would add is, spending a lot of my time in front of legislative committees, giving testimony to legislators, the last people on earth I want doing staffing ratios for nurs

- Go on, girl.

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- Thank you. Karen?

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