Project: Nursing America's Veterans

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Nursing, health care administration, theology, licensed practical nurse, minister, pastor, anthropology, tonsillectomy, church, destiny, Chi Eta Phi Sorority Incorporated, nurse union, wellness, self-care, Veterans' Medical Center, VA, agency nursing, medical advice, home-based primary care, drug wars, war, COVID-19, abuse, empathy, caregiver, case management, wraparound services, respite, advocacy, technology, polypharmacy, self-governance

Abstract

In this interview, Carmen discusses her mother's influence on her career and how she ended up becoming a nurse. She theorizes about the interplay between anthropology and nursing, the importance of the wellness and self-care models of nursing, and role of empathy in the nursing profession. Carmen also shares some of her most powerful memories from all of the experiences that she's had working as a nurse over the past 30 years. In addition, she talks about the role religion plays in her life and her work as a nurse, the importance of patient advocacy. Carmen closes by describing the impact that COVID-19 has had on the Veterans Administration (VA) hospital system and on nursing in the United States in general.

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[0:00] Carmen gives an overview of her background, her family, her schooling, the post-secondary degrees she holds, and her role as a pastor, Carmen's journey into anthropology, what her parents did for a living

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[7:14] Carmen lists the extracurricular interests and activities she was involved in growing up, Carmen's most significant childhood memory, growing up with her maternal grandmother, Carmen's first job, her nursing education, extracurricular activities she participated in during college

[13:47] Carmen discusses her role as a pastor and her Doctorate degree, her membership in Chi Eta Phi Sorority Incorporated

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[25:51] Carmen explains how long she has been a nurse and what her current role is, Carmen's early nursing career, the wellness model of care, the theorist Dorothea Orem, Carmen's work at the National Rehab Hospital and DC General and her agency experience

[34:57] Carmen recounts some of the most powerful memories from all of the experiences that she's had working as a nurse over the past 30 years, the importance of having empathy and engaging in self-case as a nurse

[40:01] Carmen describes her coping strategy for dealing with trauma, the role religion has plays in her self-care, Carmen's husband and children, the importance of having an optimistic outlook on life and manifesting what you want in your life, the importance of self-care, respite care

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[1:05:17] Carmen lists the equipment provided to her by the VA so she can do her job, her love of working with technology, the importance of outpatient nurses having the same pre-written templates as

on the inpatient side, developing care plans, polypharmacy, remote meetings and visits during the COVID-19 pandemic

[1:12:09] Carmen discusses the effect of COVID-19 on the VA system, the effect of COVID-19 on nurses and the nursing profession in the United States, the impact of family support on patient recovery, the lessons Carmen is taking forward from the COVID-19 pandemic, universal precaution,

[1:17:15] Carmen expresses her opinion about the role of nurses in advocating for their patients, her role in empowering patients and helping them navigate the VA system, educating patients, how advocacy has changed for nurses, the working environment at the VA

[1:22:55] Carmen shares the best part of working at the VA and expresses her gratitude for being asked to participate in this project, prioritizing and partnering with veterans and their caregivers on their wellness journey

[0:00] AG: Hi Carmen. Thank you for being our first interview for the Library of Congress oral histories. Can I ask you to introduce yourself, please?

CH: I am Dr. Carmen Vaughn-Hewitt, RN. I am the eldest of four children. My parents were the late Reverend Harold Vaughn and [unintelligible] Jordan. With that union there were two of us, myself and my brother. I have two other sisters, one who is deceased, and that is the youngest one. I was born in Flint, Michigan. My parents divorced when I was about five years old, and because of that, I got to travel quite a bit, because I lived with both parents separately and both sets of grandparents, maternal and paternal. Because of that travel, I've lived in Flint, Michigan, Erie, Pennsylvania and Chicago, Illinois, which was very exciting. I went to elementary school in those three states. I went to middle school in Pennsylvania and Michigan, and the same with high school. I graduated high school in 1974, Erie East High School, Erie, Pennsylvania. I went to Virginia Union University in Richmond, Virginia first. I transferred to Marymount University. In those days, in the 70s, it was Marymount University for women, even though there were a few men attending. I was not successful in nursing when I was at Marymount, and I changed my major to Healthcare Administration. I received an Associate's Degree there in 1978. I never got a job in healthcare administration, and I went to Licensed Practical Nursing school in the 80s. When I completed that, I said, "Well, I might as well keep going. Nursing is nursing," and I then enrolled at the University of the District of Columbia, in Washington DC. I received the Associate Degree in Nursing in 1989. I went to Bowie State University in Bowie, Maryland, where I received the Bachelor of Science in Nursing in 1999. I am also an ordained minister in our fellowship. We ordain as elders, so I am an elder, and I'm also a side pastor at a senior apartment building. I have a Master's in Biblical Studies from Calvary Christian College, Waldorf, Maryland in 2011, and from the same institution, I have a Doctorate of Ministry in 2017. Let me just go back a second. I forgot to mention something that's important because, you know, now certificates matter. I started on this wonderful anthropology journey which is so exciting to me and I don't want to leave it out, because it's so important. I have certificates of Health Inequality and Care, and also Global Women's Health Leadership at Rutgers University, and I just completed that, so I didn't want to leave that out.

AG: Carmen, I'm wondering what your parents did for work when you were growing up.

CH: My parents did work. My father worked at Fisher Body in Michigan, and he worked there primarily his whole working life. He didn't retire from there. My mother held various positions. She was an administrative assistant for many years, and then she went and became a Licensed Practical Nurse, and that's where she retired.

AG: Did your mother's example, both in her marriage and in her career, affect you or influence you growing up?

[3:39] CH: I would say I was kind of affected by it, I think. When my mother was readjusting to being divorced from my father, a lot of things happened. I remember I had to get my tonsils out. In those days, you stayed in the hospital for quite a little while. Tonsillectomy now is in and out. My mother said I was not mature enough to advance to the second grade, and so she held me back and that really affected me. However, when I did advance, I was always in the top of the class, so I don't know what that immature stuff was all about [chuckles]. I enjoyed going to school. I loved doing science projects. I think my favorite subjects were-- I liked mythology. I did like science, and I really loved geography. I loved to travel. Those were some of my favorite subjects. As I mentioned to you, I am a minister, and I firmly

believe that our destinies and our purposes are predetermined. From the fact that I was not successful in the beginning with nursing, and the fact that I was unable to get a job in health care administration, and then I was rerouted back to nursing, I just believe that I was predestined to be a nurse. When I originally went to Virginia Union, which is very renowned for producing African American doctors, I knew I wanted to be a doctor. I thought it was a medical doctor [chuckles], but I told myself, "You don't want to do that, but you could be a nurse". But if you could be a nurse, you could be a doctor, actually. So, it was predestined for me to be a nurse and a doctor, but not a medical doctor. I don't know, I guess I love people. I can remember as a little girl growing up there in Erie, Pennsylvania. Erie is right on Lake Erie, and my grandparents lived round the corner from the lake. When I would be with my friends, and we would ride bicycles by a little park there and I'd see a dead bird, I'd have us bury the bird. I don't know. Maybe that was leading me towards being a nurse. But, I just decided that I'd go into nursing and here I am. It's very rewarding and I love it. It's been great.

AG: Growing up, did you have any extracurricular interests or activities that you were involved in?

[7:14] CH: I did a lot. Back to me and my spiritual roots. I went to church a lot and I would sing in the choir. I was involved with the youth ministry; I taught Sunday school. In Erie, they have quite a few community centers, so I would go to the activities at the community center. In particular, I remember I took karate, I was a cheerleader, and then in middle school, I was a candy striper. Maybe that was part of that nursing thing too, but I was a candy striper and helped to work with those who were less fortunate when in my childhood years. The most significant childhood memory was being hospitalized for having my tonsils out. That is the most significant thing. I was not a sickly child at all, so those routine visits, but the event that is just indelibly etched in my mind is that of having my tonsils out. My grandparents, both sets, came from the south. They migrated north from the south. My maternal grandmother, who I spent most of my time with, she made sure that we had nutritious meals. We didn't eat fast food. We did eat cold cuts. She'd fix us a formal, four-course or five-course meal for each meal. In those days, in the winter time, you took castor oil and St John's and orange juice every morning [chuckles]. I don't remember having colds or anything like that. With the tonsillectomy, I vividly remember the anesthesia. They used to give you this ether and they'd put this mask over your face and then they would kind of spray something in it. I remember having dreams about Mickey Mouse in technicolor. I remember that. Then I remember the nursing staff having an argument over what I could eat. They brought me ice cream, sherbet and custard. One nurse said to the other nurse, "She can't have blah, blah, blah". While they were arguing, I just took a bite out of each one. That was really funny. Then from the anesthesia, I remember, I threw up quite a bit of blood. That was really remarkable to me as a child. I'm primarily a healthy person and I'm so thankful for that, but that memory really sticks with me today. I'm 65 and I can still remember it like it was yesterday. It was traumatic, I guess I would say.

AG: Can you recall your first job?

CH: Oh my God. What was my first job? I think I had a summer job when I was going from a junior to a senior in high school. They had these summer programs, and I worked at a junior high school as a library assistant. I helped to catalog the books when new books came in. I helped to catalog those in, and in the summer there are no children around, so it was pretty easy [laughs].

AG: Where did you attend college-- education for nursing?

CH: I started at Marymount University. I then went to the University of the District of Columbia in Washington DC, where I received the Associate's of Applied Science in Nursing. That was in 1989. Then I completed the Bachelor's of Science in Nursing at Bowie State University in Bowie, Maryland in 1999.

AG: Did you enjoy college? Did you have extracurricular activities then that you participated in? What was that like for you at that time?

CH: Again, most of my activity was around church, and whatever activity we would be involved in, in working with homeless persons or impoverished persons. What else did I do? Oh, dancing. I am a dancer, and I would go to different community dance theaters and dance. I like ballet. I like tap. I like jazz. I like African. I think I like ballroom dancing too. I haven't done that much. I just really have an appreciation for dance. I love it.

AG: Carmen, before we talk a bit more about your nursing career, I'm so curious to hear more about your role as a pastor and your Doctorate in Religion.

[13:47] CH: I am a site pastor, and that means that my church has different sites where we offer church membership and church activities. I am the servant leader for a senior apartment building. I have a staff of ministerial persons who support me and I have leadership over them. My congregation is small. The building has about 26 apartments in it. I think there are 28 people living there, and about five are actual members of my church. They come with different activities that we have. Because of COVID, right now we are doing everything virtual. Tomorrow, as a matter of fact, my senior pastor said we have to go from teleconference to Zoom [laughs]. I will be trying my first hand tomorrow at being the actual manager of a Zoom conference. I'm looking forward to that. What we provide, of course, is for the spiritual well being of the seniors in the building. We also provide food; we do a food delivery there. We provide them with clothing if they need. We have a mobile boutique. We provide clothing and food again. By the nature of me being a registered nurse, if they have any medical questions or concerns about their medication. I do blood pressure screens. I do some teaching on diabetes. Those are some of the activities that I have with them. I am also a member of Chi Eta Phi Sorority Incorporated, which is a professional nurse organization, and we are community-oriented. We provide education on health issues. We conduct blood pressure screens, information sessions and we mentor and encourage persons who might be interested in the health care field as well. One more thing, too, I forgot. It's very important. I am the national liaison with my sorority to St. Jude Children's Hospital. I'm very excited to be involved with that. What St. Jude's focuses primarily on children with cancer and sickle cell anemia. I help to raise funds. Our biggest fundraiser with St. Jude is through their annual walk/run. Just encourage the different chapters. Chi Eta Phi Sorority Incorporated is international, so that means that we are national, primarily. We just get the different chapters throughout the country to participate and raise funds.

[17:38] AG: And besides your civic and religious participation, do you also participate in the Union?

CH: I am also a member of National Nurses United, which is a nurse union. I [unintelligible] educational offering that they had, and they mentioned that they had scholarships for us to attend, at that time, it was American University. I said, "Well, that's free. That's a prestigious school. I might as well take advantage of it". I was selected. I didn't know that it was anthropology. After I found out, I just really kind of fell in love with it. But, I'm telling you, that program stretched me. You probably know

that [chuckles]. It stretches you but it's so rewarding. It really is kind of in line with nursing. Anthropology, like nursing, has different divisions. They do have a specialty for medicine. I just fell in love with it. My instructor at American, she-- just the interactions that I've had with her as an anthropologist and then the director of the anthropology department at American, the interaction I've had with them it's just been wonderful, phenomenal. And the different readings and the podcasts and the videos that I have had to view. It's about people and I love it. I was getting anthropology archaeology mixed up but I think they're kind of related, thinking about just antiquity, but anthropology really has their finger on the pulse of humanity and the problems that we face as the human race and our race relations and interactions. In the two programs that I've participated in, the focus was about the injustices of inequality, the injustices of capitalism and globalization, and neoliberal ideas. See, I'm talking like an anthropologist now [laughs]. I really love anthropology. I think that goes with my love of geography and people as well. But, like I said, I was really stretched. I loved it. I think the anthropologists have to be the intellects of society. I don't have the tenacity anymore to pursue that degree, but I am very thankful that I had the opportunity. I've made some wonderful relationships that I think are going to be life relationships, and I will continue some kind of way to be associated with anthropology. It's great.

[21:58] AG: Do you think that there is a lot of overlap between anthropology and nursing, in your experience?

CH: I think, like I mentioned earlier, anthropology and nursing, anthropology and medicine are very closely related in the fact that we are involved with the human experience. In nursing training, in our education, we are guided by a theorist. The theorist that I was guided by in my baccalaureate of studies was Betty Newman. Her concept is of the total person, meaning that health is on a continuum. That continuum includes your spiritual, your psychological, your physical, your social being, and if any of those are off balance, you have illness. If any one of those is affected and it is not addressed, that it is not taken care of, you will have eventual death. I feel in anthropology they go that deep as well. They are very much intertwined. We don't call nursing anthropology. We don't call anthropology nursing, but it is still the concern with the whole human experience and wellness, I may add. Very much so wellness.

AG: Do you recall when you decided to become a nurse?

CH: When I was at Virginia Union and I decided that I didn't want to be a medical doctor, but I wanted to be a nurse. When I was a senior in high school, after taking the SAT, the colleges and universities start to recruit you. I remember I had a lot of schools recruiting me. One day, I sat down at the table with my mother and I said, "Okay, mom. Help me select a school". She picked up Marymount's brochure, oddly enough [laughs], and she said, "That's the school I want you to go to". I'm like, "Mom, that's an all girls school. I don't want to go to an all girls school". When I did make the decision that I wanted to go to nursing school, I remember I talked to the Dean of Students. I think his last name was Miller, Dean Miller, at Virginia Union. He said to me, "We can make a dual major for you that you would go to Virginia Commonwealth and do studies here. We'll make you a Resident Assistant so you don't have to pay room and board". And [unintelligible] now I want to go to an international city, and I just applied to Marymount and I got accepted.

[25:51] AG: How long have you been a nurse now, and what is your current role?

CH: 33 years. I work at the Washington, DC Veterans' Medical Center. I have worked in the building for 23 years, I think. I originally started working there as an agency nurse, and the staff would always say, "You need to become permanent with us". I don't know if you know about agency nursing. The money is good and you get paid every day [laughs]. One can become quite accustomed to having a certain amount of money in your pocket every day [laughs]. Eventually, as I got older-- and then the freedom too, the flexibility. I fixed my own schedule. But, the day did come when I decided I wanted to be on regular staff at the VA. I worked in the ICU. I worked in surgical and medical ICU at the VA, there, agency, and then I went into the in-house pool. Now, the thing with the in-house pool is you could only make a certain amount of money each year, and then once you met that maximum, they wouldn't assign you any more work. I remember I primarily worked night shift because I liked to avoid politics and I liked to be able to practice nursing uninterrupted. This one particular morning, when I got off, the phone just kept ringing. I think two or three nurse managers called and asked if I wanted to be on their staff. The ICU was full. Their staffing capacity was at the max. I said, "Yes," to the nurse manager from the call center, medical advice. I worked on medical advice, probably about five years. Right now, I work in home-based primary care. I love it. I go out in the field to the homebound veterans' homes. I do case management. You are able to build a special relationship and bond with the veteran and the caregiver and the families. I also like it because you are really able to have the veteran and caregiver participate actively in wellness. In the wellness model, it's, "What are your goals for your health? What is it you want to achieve?" Another theorist that I was taught under in the Associate Program was Dorthea Orem. Her model says that you have to want to participate in your care. Her model was self-care model. It goes right along with wellness. I have some real good foundational theoretical thinking as far as my practice as a nurse. That's one of the things that I love about working at home-based primary care. And, of course, the freedom of not being confined to the hospital [laughs], because we travel. You asked me how many other places have I worked. I have worked at the National Rehab Hospital in Washington, DC. I've worked primarily on the traumatic brain injury and stroke. They also have a unit for spinal cord injuries. I had the privilege of going on staff at National Rehab when it first opened, so I've seen that place evolve quite a bit. That was a very impactful experience for me personally, because I heard so many stories from the patient saying, "I was able to get in the bathtub but I could not get out". I was riding on the Beltway, and so that made me kind of [laughs] paranoid about riding on the Beltway for a while. I am in Washington, DC and we have a Beltway. They had a car accident and they sustained terrible injuries from that. It was so wonderful to see persons who had a traumatic brain injury advance to the point where they could give a complete sentence. They were able to wash their face. National Rehab is a wonderful place. I've worked at-- it's now closed, the Washington DC public hospital, DC General. I was there during the height of the drug wars in DC in the 1990s. I've worked in the trauma, surgical ICU. I could often tell what kind of night I was gonna have if I came and I saw a trail of blood on the floor. Okay, where did I go from there? I'm trying to think. Agency. My agency experience. Oh my gosh, that was wonderful. That was another wonderful thing, too. We used to have real weekend alternative as an option to work, where you worked on the weekend, 12 hours, Saturday and Sunday. Some place it was either Friday, Saturday, or Sunday, Monday or Friday, Sunday, some kind of combination like that, and you worked 24 hours. If you've worked at night, you got paid for 40 hours. What do you do the rest of the week? You work, agency [laughs]. I had assignments as occupational health nurse, contracts with the federal government, and I had the wonderful opportunity of working in different government buildings and agencies. The architecture, and a lot of those buildings was just awesome. I did school nursing in a middle school, elementary school. I did research with insurance companies. And, let me see, occupational and the ICUs, did a little bit of med surg. I think that's it.

[34:57] AG: What are some of the most powerful memories from all of the experiences that you've had working as a nurse over the past 30 or so years?

CH: Working at DC General during that bad drug war was really something. DC General expanded and they had a new wing built on to the hospital. The old trauma ICU was right above the emergency room. When I got to work, we were told that the persons who had shot one of the patients didn't kill, and they came to the hospital to kill the person. They came with their shotguns. They told everybody in the emergency room to get on the floor, and they were looking for the person. Well, guess where the person was. We were right above the emergency room. Thank God nobody told them where they were, because that could have been the end of my life, because they didn't care. They didn't care. That was one very traumatic incident. We had cases. I don't want to just single it out, but we've had cases where young women who came from different places in the United States to work in the DC area were sexually abused, and just some of the horrendous acts that people can imagine to do to another human being. Some of them died. Some of them were the only child that their parents had. It was hard, but one thing I have to say, as a nurse you really have to develop the skill of empathy. You have to care. You have to care. I don't see how you can be in this profession and not really care about humanity, not really care about some of the abuse that people experience. Abuse to themselves, abuse from other people. Some of the experiences that people have from going through different types of diseases, the conditions that people live in. I say you have to have empathy because you can get stuck on what has happened to people, and it will really affect you as a human being because we are human beings and we do have feelings. You really have to engage in self-care. You really have to when you are going through that traumatic phase because it's traumatic for us as well. You have to be able to de-stress that. Right now, I'm not at the bedside, so I can only imagine from, I call it wartime experience, that I had in the 90s, what the nurses are experiencing with this COVID-19 pandemic. I see them on television. I hear some of my colleagues talk about how it is affecting them. Self-care is important as a nurse, and it does affect us, the things that are happening to other people.

[40:01] AG: Do you have a coping strategy for dealing with, you know, so much trauma?

CH: I developed something that I call the elevator mentality. This applied to if I was having a situation at home, when I walked from the parking lot to the building, to the elevator, when I got on the elevator, whatever I was dealing with at home stayed downstairs when I got upstairs, got on my unit. When I got back on that elevator, whatever was going on in that unit, I left it there. I was able to function. Of course, you still kind of think about things, but you don't let that become your focus anymore. Well, you already know, as a minister, I have my prayer. Just even going to church service and hearing the Word of God, singing the hymns and the songs. We call them songs of Zion. They all help with my self-care. Being around my family. I didn't talk about this, but I was married for 34 years to a wonderful man. He passed away. I have three wonderful daughters. Just having that other responsibility helped me a lot, in the same way as when they were babies, going to work helped me to get a break, believe it or not. Then I have four step sons. I think for me, just having an optimistic outlook on life period. I'm not a person who likes to hold grudges. I don't like being depressed. Of course, you get depressed sometimes, but I think if you have an uplifting outlook on life and all of this comes from within. I really believe this, that you have to order what your life is gonna be like. If you don't, you gonna be a mess, because things are happening all the time. I really believe that you gotta take care of yourself. My mother used to say to me, " I can't buy myself a pair of pantyhose because of spending my money on you children". I determined right then when my mother said that, when I have children and I get paid, I'm gonna make

sure I buy myself a pair of pantyhose. I'm gonna make sure that I take me a bubble bath. I mean, something as simple as that - a bubble bath with the candles, and if you drink wine, your little glass of wine and your little music going. I don't know if I'm allowed to say this part, but I like lingerie. I buy lingerie for myself. I like perfume. I buy the perfume for me. You really have to do things for yourself and not always be the martyr or sacrifice yourself to that extent for other people that you're not paying attention to yourself. You're no good to anybody if you're not good to yourself. I really believe that. Now, I don't know if I done went off on a tangent or not, but I really, really believe in self-care. When I was in nursing school, I used to hear that other nursing students say they couldn't have a social life. I was like, “What kinda business is that?” When I was working on the floor, nurses would say, "I can't go to the bathroom or take a lunch break". I was like, “What kind of business is that? You better learn how to do this. Take 10 minutes: five minutes to drink somethin, five minutes to eat somethin - oh, 15 minutes - and five minutes to go to the bathroom”. You have to, otherwise what are you doing to your own health? That's one thing that I stress to the caregivers, is that you have to take care of yourself, because if you don't take care of yourself, who's gonna take care of this person that you love so much? Nobody's gonna do it like you. Self-care is very important. Even as a college student, you have to do positive things. I'm talking about positive things, not things that are gonna harm you, and be around positive people. I can't tolerate people who are negative all the time. I have girlfriends who are like that. I could be with them for a little bit, but then they start getting negative, adios [chuckles]. Self-care, self-care.

AG: And you mean the primary care doctors at the VA that you're working with in the patient care?

CH: Yes, whoever is the person that is the primary caregiver. I really stress that the home-based primary care program in the Veterans' Hospital system is tremendous in that we do offer wraparound services. One of the benefits that's offered is what's known as respite. It's a respite so that the caregiver can get a break. I always make sure the caregivers know about the respite benefit and remind them of it, because self-care is extremely important.

AG: What is your schedule like day to day? What is it like to be a home-based nurse at the VA?

[46:54] CH: My day to day varies. Every day I don't go out in the field, because I have to have some administrative time, and I have to have time to make appointments. This is pre-COVID that I'm talking about. COVID is a different situation. Pre-COVID, I call and make the appointments or confirm appointments that I've had previously. We are equipped with pretty much a home office, except we cannot print federal documents at home, so we have to go either up to the hospital. But in my case, I am so blessed that I've worked between two community clinics where I can print, so I have to go there and pick up the documents that I need to take with me on the visit. We give immunizations, draw blood. Some of the veterans who have dementia, and the caregiver has dementia, or they have dementia and they don't have anybody who can assist them with planning their medications. I do pre-filling of med boxes, and that's primarily done while I'm in the visit. When I go to the veteran's home-- well, they already know me, but if I'm going to enroll a person into our program, identify who I am, identify them and the caregiver, explain what we're going to do. Primarily what I do when I'm in the home, I do a general physical assessment. That means I'm lookin at you to see if you're lookin like your normal self. Then take the vital signs, and that includes the temperature, blood pressure, heart rate, respirations. Listen to the breath sounds, listen to the heart sounds with a stethoscope. If it is indicated, I will get an oxygenation reading with what's called pulse oximeter on the veteran. Then I ask some questions like,

"How are you doing? Are you having any pain?" Safety is one of the major forces of the plan of care, so we want to make sure that the home environment is safe. We assess the veteran for falls, make sure that they are taking their medication properly, that they know how to store their medication, that they are paying attention to expiration dates of the medication and prescription, that they know what medications they're taking, the correct dose, the correct times, and the correct method of taking. If you're supposed to put it in your eye, you're not supposed to be swallowing it or puttin it in your nose, those types of instructions. Checking them for any type of allergic reactions they may have, assessing whether or not they're gettin the proper amount of sleep, if they're gettin adequate nutrition. Home-based primary care is a regular clinic. It's the regular primary clinic. The only thing is the clinic is coming to you. We are multidisciplinary. We have a social worker, dietician, a dedicated pharmacist, occupational therapists, recreation, a social worker. I have learned that I don't have to do everything, and that each discipline practices their specialty, so it works very well. All of the disciplines are very dedicated in making sure that the veteran gets what they're supposed to get. When I go in, if I notice, for instance, the veteran is having some problems holding objects or their blood pressure is so extremely high, then I will make a recommendation to the primary care provider. I work with the primary care provider as well as the leader of the team, and we would collaborate and make referrals to specialty clinics. Specialty clinics would be like neurology, cardiology. I forgot, we have a psychologist too. Again, though we would refer them to psychology, podiatry, audiology, endocrine, pulmonary. Every system that you have in your body has a specialist. If we determine you need to be followed by a specialist, we send the referrals for that. We advocate for the veteran and the caregiver to get the proper care and services that they need. I'm very big on advocacy. I'm big on advocacy and self-care. For the caregiver, we answer any questions they have. Anything that they see that the veteran needs, we work with them to make sure that the veteran gets it. If the veteran has extensive wounds that need attention, we contract out with the outside nursing agency to go in and manage the wounds. We provide resources for home health aides for veterans who need help with dressing and bathing, light housework, cooking. We provide that service as well for the veterans who qualify. The VA provides transportation. Our clients vary in age. Primarily, we are a part of the geriatric clinic, but we also have some veterans who are younger because they are homebound. Ideally, the veteran is a homebound person. Some of them are bed-bound. Some of them are wheelchair-bound. Panel now, I think I have people from the age range of 47 to 95. I think my 99 year old passed away a couple of months ago. As far as conditions that they may have, we have those who have had cardiovascular accidents, known as stroke. My panel load is up to 35 persons. Right now, I have 32. We have some veterans who received their primary care in the community, and they are utilizing the VA for certain portions of their benefits. Those who are managed actively by a community primary care provider, we will see them twice a year. We see some every three months or twice a year. Some of them, though, may require a monthly visit. If we have veterans who are on anticoagulation therapy, for example, and their coagulation is not therapeutic, that will require a more frequent visit, but most definitely every month because of the need to obtain the blood samples to go to the lab to monitor anticoagulation.

[57:29] AG: Carmen, what is your weekly schedule like? What is a typical week's schedule like for you?

CH: It varies, because, keep in mind, we cannot have our schedules so packed that we are unable to address the needs, because I get emergency phone calls that I have to stop what I'm doing and coordinate the emergency. There are other crises that may happen that I have to coordinate. One of the things that is very challenging about my job is having to depend on other departments to get the job done. There may be problems, like, you have to wait a little while before you could talk to somebody on the phone, or I

may have to get in my car and actually go to the hospital and then go to the department, and so all of that is factored into what our typical day can be. Every day is not like that, but again, I cannot say I'm going to see eight patients in a day. Typically, we don't see any more than four because also we have to build in the travel time. Getting home, you may be faced with a crisis or an emergency. Say you plan to be there for an hour, the crisis may take you three to four hours. What happens to the other people? A telephone conversation to help coordinate something or manage a situation can be quite extensive. I really commend the persons that put the thought into what our day should look like in home-based primary care. When we are doing an admission, an admission can take anywhere from an hour to a couple of hours. When we get in the home, before we get to the home. Some of the areas that we go to, you see a lot of suspicious characters around, suspicious activity. You don't get out your car. You circle the block to assess whether or not it's safe for you. I have a situation where myself and the provider went to admit a veteran and it was a shootout. We couldn't leave; we had to stay put for our safety until it was clear. I had another situation. I was going to the veteran's home and the police stopped me and wanted to search my car because they were looking for somebody. Then when I left the veteran's home, another set of police were there who didn't see me the first time. They searched my car again. Then, if you're driving somebody may hit your car. I remember somebody hit the back of my car in rush hour. That's another thing. If you're in rush hour traffic. I do different things. It's not just going to do a regular clinic visit. Case management, and we happen to have a primary care component to that. We do quite a bit.

AG: What are some of the challenges and rewards of your current position with the VA?

[1:01:35] CH: The reward is having the expertise of the different disciplines. That's so rewarding. Everybody does their job. Everybody is excited about coordinating the care of the veteran and servicing and serving our nation's veterans. That is so very rewarding. I work with a wonderful group of professionals, and we all have a very common goal in mind, and that is for the wellness and the care of the veteran and their families. What would be the challenging part? The challenging part is delay sometimes in gettin communication from each other. That's about the biggest challenge, because I work with a very wonderful group of professionals. I love it. I'm gonna stay there ‘til I retire, I think, long as my health allows it, because some of the homes that we go to, you have to park a distance from the apartment building. Some of the houses have a lot of steps, and it's challenging, even now. As long as my health holds up, I'll stay on this job. I have the same supervisor. She's wonderful as well [laughs]. I see myself having this job until I retire. The VA Hospital system is a teaching institution, so if we have students and students from different disciplines who need to have a mentor, I do that. I sometimes help to orient new nurses coming on.

AG: What is it like for you to go into these different neighborhoods and these different homes to care for the veterans?

CH: Sometimes the family members are interesting [chuckles]. Sometimes, the home environment is interesting. I remember one home I went in, the roof was starting to cave in, and eventually it did. We've had some family members who have been violent towards us verbally and attempt to physically. Some of the environments that we go into, there's various kinds of illegal activity going on. I will add that if those situations occur, we do discharge that veteran back to the primary clinic at the hospital, because we have to be safe as well.

AG: And do you have all the remote equipment that you need for this kind of job?

[1:05:17] CH: We have hospital-issued cell phones. We have iPads, where we are able to access the veteran's medical record. In my home, besides the telephone and iPad, I have a laptop. In the 90s, when I started working at the VA, they were ahead of the curve in that we used automated systems for our patient records, for getting physician's orders, which was heaven, because trying to read some people's handwriting was a real big challenge. You work at night. A part of my job is to make sure I am practicing safely, and that includes if I have to transcribe your handwriting and I cannot tell what is going on. I have to call you. Working at night, some people get a little salty, and I just tell them, "Hey, you need to print. You want me to get this right, I need to be able to understand your communication, so print and scribble your signature". That was really great to be able to have the doctor's orders printed, and being able to pull up pertinent information, like their lab reports, their x-ray reports, havin a ready list of the medications. Then also, when I worked at the bedside, the dispensary for the medications to help cut down on mistakes was also automated. You had to get the medications in the right amount of time. You had to have the right code. You had to scan everything to make-- those were just safety checks. I love working with technology. I-- That's a part of what's built into my routine, doing the charting. We do have pre-written templates. When I first came to my department, they were doing that narrative stuff, and I had come to them from bedside, and I was like, "Look, we are in the same institution. We need to have the templates that we have on the inpatient side. This is ridiculous. You want me to type all that stuff out?" We already have, “alert, confused, anxious”. Now all you gotta do is click click click [laughs]. That's much better. Part of the charting as well is developing the care plan, and that is an interdisciplinary exercise. The different teams meet monthly on a different set of patients. We do quarterly on any group of our patients, and we discuss what's currently going on with the veteran, any concerns that the veteran or other family has, any changes that need to be made in the medications, because the pharmacist is wonderful and the veteran may be on a medication regimen that needs to be adjusted because of the interactions of the different drugs together, polypharmacy. There is really an effort now to decrease the amount of medications that any one person is taking. I forgot to talk about that. That's the whole day with the interdisciplinary meeting, and we do come together. Something that I told my boss we should do a long time ago, because of parking and the space that we have at the hospital, that we should have our meetings remotely. Now because of COVID, we do. They are done on Microsoft Teams. Our medical director has mandated that we do not do in-person visits unless it is absolutely necessary. The other day, I had to go out and draw someone's blood for management of his diabetes with the endocrine department. But if it's not absolutely necessary, like, for the person whose pillboxes I have to fill, I go and get the medications, pill boxes, take them to the office and fill 'em up and take them back. Outside of that, we are not doing any in-person, but we are doing virtual. We have the different video means to do video visit with the veteran and the caregiver.

AG: Does the VA make sure that veterans are able to access, like, a computer for these remote online visits during the pandemic?

CH: Since the pandemic, they're supplying them with the iPad if they need it. But other than that, you do it on your phone, or if they have an iPad, but a lot of them have the phone capability and we're able to contact them that way.

AG: How do you think COVID has affected the VA system?

[1:12:09] CH: The amount of inpatient services has been restricted. Whenever there's an attempt to increase the percentage of inpatients-- of in-person activity, it's had to be decreased again. I think that's the biggest impact. Those other clinics and specialties and services that the veteran would go into the hospital for, they are also using virtual means of communication and examination and evaluation. Then the other thing is, for those who are inpatient, visitation has been restricted. Those who are able, the employees who are able to work remotely, are also encouraged to do so.

AG: What do you think the effect of COVID-19 has been on nurses and the nursing profession in the United States?

CH: I think it has really had a devastating effect. When you look at the availability of PPE, which is personal protective equipment, when you look at-- in terms of those health care workers who have actually contracted COVID-19, you know. I spoke earlier about self-care. When you think about the psychological impact on persons who are in that traumatic stress environment, of seeing the deaths, of seeing the patient being isolated from their family and suffering without their loved one actually at the bedside, even though you do have a compassionate healthcare worker, it's still something different about your own support system being present. I just like to add to that-- that I have seen in my nursing practice, I have seen that people get well faster. They have the will to live better when their own support person or persons are able to actively be there with them. Even if they just come once a week, I've seen a big difference. I feel like that has impacted our overall health care system. And then just the nature of this virus, so many of the unknowns and how it affects our bodies, how it is transmitted. I think that really has had an impact on our health care system. Then those who are overworked, because there's not enough staff, because the staff is ill, that has really impacted us as well.

AG: Carmen, what lessons are you taking forward from the COVID-19 pandemic?

CH: You can't take anything for granted. Universal precaution, we've already been practicing that, but you have to be vigilant with it. What is universal precaution? Washing your hands [chuckles]. We just have to still be vigilant with that. I also think, I might have just said it, but you can't take anything for granted. You must appreciate your loved ones. We as a profession must appreciate and support each other. We have to be there for each other. We have to be more empathetic for each other and for those who are entrusted in our care.

AG: Carmen, what do you think the role of nurses is in advocating for their patients or maybe advocating for changes at the societal level?

[1:17:15] CH: It has always been something that I feel you should do as a nurse. You should advocate for those who are trusted in your care. Advocacy goes for if the physician is doing something that's not right, you have to speak up. If your colleagues are engaging in behaviors and activities that are injurious, you have to speak up. If I see that a patient is being abused by family members, by staff, you have to speak up. You have to advocate. You have to empower people. That's another part of my advocacy is empowerment. I have to help persons navigate the VA system. I have to tell them, "If you're not getting what you feel you should get, we have a patient advocate department. Get in touch with them. If you're not getting any results, go to the director's office". We have to empower people so that they don't feel helpless and hopeless. I forgot to talk about this as part what I do, is education. We have to educate people, educate them about their disease process so they're not fearful, so that some of the folk stuff that

they learned, not to discredit it, but that you just have a little more knowledge about what's going on with you so that you are able to, without fear, say to your provider, "What you're doing is not working for me. Can we try it this way?" If you're uncomfortable with me, your provider, say so. Go to somebody else you feel more comfortable with. This is not a punitive thing. We want you to be well. Empowering people goes along with advocacy. Maybe how advocacy has changed for nurses is that we're better able now to speak up and speak to-- Providers are different now, but it used to be the doctor, the physician to speak up, not be afraid to say to the physician, "No, I'm not giving you my chair. Go get your own chair". That's just how nursing has progressed. There was a time that's what nurses did. When the doctor came, you got up and gave a man your seat. I don't mean to sound sexist or anything, but I'm still from the old school. I'm the lady. I should be sitting down. In that way, nurses are not afraid to speak up and advocate for the patient and the caregivers. We stand up now, stand up and speak out.

AG: How have you seen the VA change?

CH: The VA is a wonderful work environment. I have always felt like they really cared about the workers' wellbeing, the workers' development and advancement, if you want to advance. Having the atmosphere of self-governance, that's very important to me. Self-governance, the open dialogue that they encourage the worker with management. They really encourage that. They really encourage surveys, that we participate in surveys about, "How is management treating you? How can we make this a better place for you to work?" I applaud that. They have programs for wellness for the employees. They encourage you to use the workout facility in the building. They have the wellness classes, yoga, acupuncture, massage. They have all of those wellness-type of activities for the employees. I really see that they are intentional on making the work environment at the VA a place of wellness and a place where you would want to continue and retire from in your career.

AG: What do you think is the best part of working as a nurse for the VA?

[1:22:55] CH: Just having the privilege of being able to give back to a group of people who sacrificed so much so that we as a nation could be safe. The other most rewarding thing is empowering them. When they have come from such a traumatic theatre, that's what they call war, when they're involved in war theater, that I, in some way, help to make their assimilation back to whatever normalcy is, that I some way am a positive entity in their journey in wellness.

AG: Thank you so much, Carmen, for joining these oral histories. Is there anything that you would like to add before we say goodbye?

CH: And thank you, and I wish you the best of luck in your studies and your career aspirations. Dr. Latta knows how I feel about her. I thank her so much for being a part of my journey, and also for asking me to take part in this very important conversation about the Veterans' Administration hospital system. As you can tell, I like to talk, and this has just been wonderful for me. I like to share about what I do and the wonderful organization that I find the VA to be. It's not perfect. I hear disappointments and it hurts me, actually, because I feel like my department is there, you know, that we really make you a priority. That's what I would say about home-based primary care. We make the veteran and their caregiver family a priority, and partnering with them on their wellness journey, because it's a partnership. We can't do it alone. You have to want it. And so, wonderful partnership.

[1:25:45] End of recording.