Feature Story

Making Strides in the Practice of Nursing

One year after stepping into new roles as problem-solvers, nurses reap the benefits of their contributions. – pg 1

Also Inside

For aspiring nurses as well as experienced nurses, Cleveland Clinic offers new educational opportunities – pg 8

Hundreds of nurses turned out for the 25th annual cardiac care conference – pg 12

Meet two nurses who shine in the field of cardiovascular care – pg 24
Welcome to the fall 2006 issue of Notable Nursing. We hope you find the articles interesting, informative and inspirational.

We appreciate your feedback and comments, so please send them to any of the e-mail addresses listed throughout the publication.

Thank you for taking the time to read Notable Nursing.

Sincerely,

Claire Young, RN, MSN, MBA
CHIEF NURSING OFFICER
Yet, as shared governance councils began to form on virtually every Cleveland Clinic nursing unit, a gradual but definite paradigm shift could be felt.

One year later, as the second group of teams prepare to meet, the skepticism is largely gone. Nurses have seen for themselves the incredible difference they have made by speaking up.

On the units and at the bedside, positive changes in practice, processes and people are happening everywhere. Here is a sampling of what is happening in some of the divisions.

**Emergency Services and Critical Care**

“Today’s clinical environment encourages problem solving on the front line of patient care,” says Barbara Morgan, RN, MSN, Clinical Nursing Director for Emergency Services and Critical Care. “The greatest ideas come from the people who work at the bedside every day.”

Senior nurses in the Surgical ICU developed a mentorship program for nurses who completed the 90-day nursing orientation. They provided a luncheon program that included additional training on emergency medications, role playing and hands-on scenarios.

As patient complaints about long waits in Emergency Rooms increase nationwide, Cleveland Clinic Emergency Department nurses developed Triage Plus—a secondary triage area where patients begin to receive care and don’t return to the waiting room.

“Enhancing the patient experience is a high priority,” Morgan said. “Sharing patient perceptions of care and service with the clinical team is the key to improvement.”

**Heart and Vascular Institute**

“Nursing needs to be at the same table as the physicians when it comes to quality measures in the department,” said Kelly Hancock, RN, BSN, Clinical Nursing Director of the Heart and Vascular Institute.

To elevate nursing, unit staff now elects a Quality Accreditation Nurse (QAN) who serves in much the same way as the physician staff quality review officer.

QANs from each of the cardiothoracic intensive care units meet with staff physicians monthly to discuss quality patient care measures. Physicians have been positive about the change, Hancock says.
George Rouse, RN, BSN, was elected as the QAN on the Medical Cardiology Step-Down Unit. “It’s an interesting leadership position,” Rouse says. “I have to expect from myself exactly what I expect from my co-workers. People ask me questions about how things should be done and it gives me an opportunity to lead by example.”

Nurses and nursing assistants on the unit also have developed a communication report sheet that covers patient care issues, educational needs and problems, says Heart and Vascular Institute Nurse Manager Debbie Brosovich, RN.

And, for the first time, nursing assistants have developed their own communication report sheet, making them less dependent on busy nurses. “Communication with the PCNAs used to be person-dependent,” Brosovich said, “but now we have made communication on our unit consistent between nurses and between nurses and nursing assistants. It’s a win for everyone because gaps in care have disappeared.”

Elsewhere in the division, changes have been made for the better.

“I have seen a change in morale,” Hancock said. “The nurses at the bedside doing the work roll up their sleeves every day and help make the decisions. They have elevated nursing to a higher level.”

**Medicine and Behavioral Health**

Some of the nurse managers in the Medicine and Behavioral Health units have been in the position for a year or less. “I want to help them become great managers so they can develop their staff to be the best they can be so the patients get the best of care,” says Barbara Reece, RN, MSN, Clinical Nursing Director of Medicine and Behavioral Health. She meets weekly with her nurse managers.

Patty Hibbitt, RN, Nurse Manager of Internal Medicine, Renal Hypertension, Gastroenterology and Telemetry, noticed that her patient care nursing assistants never spoke up at shared governance council meetings. “They told me they felt left out of discussions and didn’t feel their issues were important enough to bring up,” Hibbitt said.

She began to meet weekly with her PCNAs. She taught them how to quietly confront a co-worker who was being disrespectful and invited them to share important issues in their workday. As a result, they began to hold each other accountable for mistakes and praise each other for good work.

“Disgruntled employees have a habit of taking their negativity into the patient rooms and that interferes with patient satisfaction,” Hibbitt says. “Now my staff is a team. Empowerment and holding people accountable has vastly improved our patient satisfaction scores.”

Julie Simon, RN, BSN, CMS, a staff nurse and the unit’s QAN is active on the shared governance council. Simon contacts every staff member on each shift for feedback, distributes meeting minutes and surveys staff members on all shifts for ideas for council discussion. “I don’t want staff to feel ‘what’s the point?’” Simon said. “I want them to say ‘People go to the unit-based council meetings and things happen.’”

Ruth Rivera, RN, nurse manager of General Medicine and Telemetry knows shared governance works. Her unit’s team nursing model pairs together one RN, one LPN and one PCNA to care for nine patients on days and 12 patients on nights. “It is a whole new mindset for the nurses,” Rivera says, “but my PCNAs love it.”

Nurses on the Medicine staff have made great progress on many issues, Reece says, and more remains to be done. “We are looking at enhancing continuity of care, enhancing discharge planning and removing barriers to effective communication,” she says. “But I believe everyone is happier.”

**Surgical Services**

“High patient acuity and the urgency of care in the surgical areas on a consistent basis are not conducive to a friendly environment,” said Barbara Wilson, RN, MSN, CNOR, CNAA-BC, Clinical Nursing Director of Surgical Services. “Last year, we recognized that we were not being civil to each other. We needed help.”

For nine months, professionals from nursing, anesthesia and surgery met twice monthly to develop a process to introduce the RESPECT program into the OR, PACU, Same Day Surgery, Sterile Processing, and Support Services. This initiative was originally led by Armin Schubert, M.D., Chairman of General Anesthesia, and Barbara Wilson, who jointly have a commitment to their co-workers for trying to provide a more civil environment. (See sidebar for more on the RESPECT program.)

Dovetailing the RESPECT initiative is the shared governance council in the OR, comprised of staff nurses, OR technicians,
representatives from surgical support and sterile processing services, weekend staff and a representative from the outpatient surgery unit. “We have input from all areas, not just nursing,” said Valerie Kovacic, RN, CNOR, Nurse Manager of ENT and Plastic Surgery. “That’s good because we are a team and we have to work out our issues together.” The council has several initiatives under way, Kovacic said, including welcoming and mentoring programs for new hires and upgrading the staff lounge.

The 20-member unit-based council is chaired by Helen Merrick, RN, BSN, CNOR, a staff nurse in the OR. At one meeting, the council decided to completely revise the OR Nursing Record, which is annually evaluated by JCAHO.

“The Nursing Record was out of date,” Merrick said. “The Record was near and dear to nurses — we use it every day — and we wanted to take it on as our project. We did not want leadership to hand us a new form and tell us to use it. We felt we knew best what it should contain and what would be most relevant to our practice.”

The project is nearly completed. “We’re excited because never before—at least in my 26 years—have OR nurses had input in any of our documentation,” Merrick said.

Another shared governance council, formed late last year in PACU and Same Day Surgery, took on employee dissatisfaction and low morale. “Employees weren’t receiving the recognition and praise they deserved and needed,” said Lori DeWitt, RN, BSN, CPAN, CAPA, Nurse Manager of PACU and Same Day Surgery.

The council came up with the Stand Together and be Recognized (STAR) program that gave unit staff an opportunity to recognize co-workers for excellence. (See sidebar for more information on the STAR program.)

“Shared governance is a huge improvement,” Kovacic says. “Now staff nurses, clinical technicians and unit secretaries feel free enough to improve their environment and take ownership of where they work—and that has made a huge difference in morale.”

E-mail comments to youngc@ccf.org.

RESPECT
A New Initiative in Surgical Services is Changing Old Patterns in Relationships

In November 2005, a core group of staff from the departments of nursing, anesthesia and surgery held a series of meetings with staff to get feedback on the level of respect in the culture.

Based on feedback, the core group developed a “Respect Reaffirmation” initiative that kicked off in June. “We reintroduced components of how we treat each other,” says Barbara Wilson, RN, MSN, CNOR, CNAA-BC, Clinical Nursing Director of Surgical Services, “such as being respectful in our speech, engaging each other by name and not role (calling someone John instead of “anesthesia” for example) and remembering our four cornerstones of teamwork, quality, service and innovation.”

S.T.A.R.
Stand Together And Be Recognized

There are six criteria for being recognized as a S.T.A.R.

• Working as a team
• Helping others without hesitation
• Leading by example
• Being positive and supportive of workers and others
• Anticipating the needs of other workers and patients
• Being professional and courteous at all times

Staff members fill out a S.T.A.R. card on a co-worker and drop it in boxes located in all three staff lounges. All nominees submitted monthly receive a small token of appreciation. One name is drawn monthly for the STAR of the Month award, which brings more recognition and a small gift.
Nursing is a Family Tradition for Some at Cleveland Clinic

When three generations of O’Donnell get together every August for their family reunion – a long-standing tradition – there’s never any worry about someone jamming a finger playing volleyball or scraping a knee sliding into first base. That’s because another family tradition is nursing - with nine RNs in the family, this group is equipped for almost anything.

Not only do these nine family members share the same career, seven of them have chosen to pursue it at the same place — Cleveland Clinic.

Linda Skolaris, RN, a Nurse Manager in the PACE (Preoperative Anesthesia Consultation and Evaluation) clinic, started this family tradition when she began working for Cleveland Clinic 27 years ago. Over the years she has been joined by her husband, Fred Skolaris, RN; brother Ken Lors, RN; and cousins Janet Adams, RN; and Jeanne Ryan, RN (who are sisters); MaryAnn Russo, RN; and Kathy Laffey, RN.

“I never thought about it until other people started noticing how many of us there are,” Skolaris says. “It’s a lot of fun when I hear from a patient or a staff member that they have met another member of my family here.” The effect is multiplied by even more family members working at Cleveland Clinic in non-medical capacities, such as Janet and Jeanne’s sister, Jackie Donovan, and Jeanne’s 19-year-old daughter Jamie.

Although they have chosen the same profession, the nurses in the family have chosen to pursue it in a range of different specialty areas. Aside from Linda in anesthesia assessment, Fred is an OR nurse in urology; Ken is in the orthopaedics OR; and Kathy works in the cardiology and pediatrics ORs. Janet and MaryAnn work in PACU, and Jeanne is Nurse Practice Manager for Cleveland Clinic CEO Delos Cosgrove, M.D.

“There’s something special about knowing I have family here who will support me if I need them,” says MaryAnn Russo, Skolaris says she often hears from patients and other staff members about her relatives. “The two things I hear the most are that all of them go above and beyond, and that my husband likes to make people laugh to help them relax before surgery,” she says.

Beyond their familial relationships, what binds this multi-nurse family together is a shared interest in caring for people, Skolaris says. “We’re the kind of extended family that would go anywhere we had to, to take care of another family member.”

Whether their tenure at Cleveland Clinic is long or short, they all have discovered that a similar philosophy underlies patient care at Cleveland Clinic, she says. “This is a place where that personal touch is so important. ‘Patients first’ says it all. When we see Cleveland Clinic rated third [best hospital] in the country, it makes us all so proud to be part of it.”

In fact, Skolaris says, they all promote Cleveland Clinic to friends and family as not only a great place to work but also a great place for medical care. Recently, an aunt came to Cleveland Clinic from New Hampshire for specialty care. Another cousin is in nursing school now, and Skolaris says, “We’re already getting her prepped to come here.”

For anyone who’s keeping track - yes, she would be the eighth.
A Study of **Nurse Uniform Color** and Perceptions of Professionalism

Cleveland Clinic Department of Nursing Research and Innovation wanted to know: Does the color of a nurse’s uniform affect patients’ and visitors’ perceptions of nurse professionalism?

And the answer is: Yes, it does.

Adult participants in a study of 509 patients and their families unequivocally chose a white uniform — white tunic top and white pressed pants — and rated it the most professional in terms of nursing image.

Participants chose the winning white uniform out of a series of eight photographs of the same nurse in the same pose wearing various uniform color and style combinations. Participants were asked to rate each uniform for its ability to communicate 10 nursing traits, such as attentive, approachable, efficient, and empathic.

The study confirms a long-held implicit belief that white best communicates nursing professionalism — a belief that in June 2005 influenced Cleveland Clinic Chief Nursing Officer Claire Young, RN, MSN, MBA, and the Nurse Executive Council to make white the uniform color of choice for Cleveland Clinic nurses who care for adult patients. White uniforms also helped patients and visitors more easily identify nurses.

Patients also gave the white uniform high nurse-image scores for communicating a nurse’s confidence, competence, reliability, and efficiency, said Nancy Albert, RN, PhD, CCNS, Director of the Department of Nursing Research and Innovation, which conducted the study. Yet, the white uniform scored lower than others in communicating nurse approachability and empathy. “Seems like people do not perceive warm fuzzies from white uniforms,” Albert said.

A solid blue uniform was rated highest by participants for communicating nurse attentiveness. A print top with white pressed pants seemed to communicate, more than the other uniforms, a nurse’s spirit of cooperation.

**Patients in Cleveland Clinic Children’s Hospital**

Children overwhelmingly chose a bright bold pattern print top and solid color pant as their favorite nurse uniform. “It was their preference,” Albert said, “but their choice had nothing to do with the perception of professionalism, which was the purpose of our study.” Children, ages 7 to 17, did not prefer the handprint (yellow handprint on a white background with small amounts of blue and green) uniform currently worn by nurses at Cleveland Clinic Children’s Hospital. The handprint uniform was the children’s lowest-rated choice in preference and also in nurse image.

Adults over 44 years old, who were either patients or family members of patients, chose white uniforms (both fitted pant and tunic top and scrub pant set) as the color and styles most closely associated with nurse image traits and as their personal preference. As the age of respondents increased, their view of professional nurse image based on uniform became stronger for the fitted white pant and tunic top, rather than the scrub pant set.

Albert and her team will present the study’s outcomes at a national nursing conference. She expects to launch a Phase II study in the future. For now, the Uniform Study is being replicated in a Detroit hospital and in a small community hospital in Michigan. “We will be able to see if this outcome is unique to Cleveland Clinic or if the results are widely applicable in general,” Albert said. Nursing Research and Innovation will do the analysis of the study results from these hospitals. “If the results from this multi-site study are similar, it would send a very strong message,” Albert said.

E-mail comments to albertn@ccf.org.
Ninety-five Cleveland Clinic nurses, managers and directors attended the first Nursing Innovation Summit in April on Cleveland Clinic’s main campus. The summit consisted of two four-hour sessions; with different nurses attending each session.

“Nurses on the front line are the perfect people to develop innovative solutions to processes, structures or patient care systems,” says Nancy Albert, RN, Ph.D., CCNS, Director of Nursing Research and Innovation.

Albert, Dawn Gubanc, RN, MSN, CNAA, BC, Nursing Director, Taussig Cancer Center, Michelle Dumpe, RN, Ph.D., Director of Nursing Education, and Terri Wimms, RN, Director of Nursing Informatics, planned and facilitated the one-day brainstorming event.

Nurses who had never worked together but who faced similar issues on their units watched a brief slide show about a fictional patient. Participants were asked to take a new look at a post-op surgical scenario and a model of care scenario.

Quickly, nurses wrote down themes from the scenarios and began brainstorming solutions.

“It was a really unique opportunity for nurses to step away from the routine of delivering patient care,” Gubanc said.

Most nurses are often so busy that they don’t get much time to think critically about innovative solutions to problems, Gubanc and Albert said. “Giving them time to meet with collaborative peers helped to jump-start their creative juices.”
innovation

“The process of brainstorming solutions to problems without limitations is foreign to nurses. We are masters of creating solutions with the resources that we have. We had to continually coach the group to dream big and not filter their ideas.” – Dawn Gubanc

Participants began to refine concepts on improving work flow, patient safety and patient outcomes. “People began to feel they could come up with a new solution to an everyday problem,” Gubanc said.

Nurses created several prototypes. Finally, in a grand Show and Tell, a representative from each group shared the group’s innovative solution with the assembly.

The team presented several ideas to the Nurse Executive Council (NEC). Most of the innovations relate to processes and some suggest improvements on a device currently used by nurses; suggestions were made to make the device more user-friendly and give the patient more control.

“Nurses were surprised that so many new ideas were generated. It was a very synergistic group effort,” Gubanc said.

Next step is a meeting with Cleveland Clinic Innovations for advice about patents and commercialization.

Chris Coburn, Executive Director of Cleveland Clinic Innovations, was not surprised at the nurses’ ideas. “The insight that drives innovation starts at the actual point of delivery, where the nurses are,” Coburn said. “They are a very important element in the innovation cycle.”

Innovations from the summit fell into five broad categories: communications; patient education and patient knowledge; efficiency; patient comfort and control; and team member recognition.

Planning is under way for the 2nd Annual Nursing Innovation Summit in spring 2007.

E-mail comments to gubancd@ccf.org, albertn@ccf.org or wimmst@ccf.org.
Educational Programs Help Both Current and Future Nurses

Cleveland Clinic Division of Nursing has a longstanding commitment to nursing education. This emphasis upon education has resulted in improved patient outcomes, the expansion of nursing knowledge and enhancement of professional nurse satisfaction.

Two new initiatives in the Division of Nursing, the CNS internship and increased support for the RN-BSN degree, continue this commitment to offering career advancement opportunities for nurses at various levels. A third initiative from the Division of Nursing and the Cleveland Clinic Office of Civic Education Initiatives, the Nurses of the Future program, encourages young people to choose a career in nursing by exposing them to the diverse opportunities available in the field of nursing.

Clinical Nurse Specialist Internship
Cleveland Clinic experienced firsthand the challenges in the current nursing job market in 2003 and 2004 when multiple clinical nurse specialist positions remained vacant for longer than a year.

In response, the Department of Nursing Education and Professional Practice Development created the Clinical Nurse Specialist Internship. “This unique program allows the nurse to work full-time while completing master’s degree coursework combined with clinical, education and research experience over a two-year period,” explains Michelle Dumpe, RN, PhD, Director of Nursing Education.

Each nurse accepted into the program is paired with a CNS preceptor. Didactic content is provided through the Kent State University School of Nursing, primarily online. Kent State accelerated the usual curriculum to meet Cleveland Clinic’s need for a faster paced program.

“The internship is open to nurses with at least five years of bedside nursing experience who possess strong clinical skills and a desire to develop their research and education skills,” Dumpe says. Participants must make a work commitment to Cleveland Clinic upon graduation.

The first five Clinical Nurse Specialists graduated from the program this spring. One additional CNS will graduate in 2007, and two will graduate in 2008.
RN to BSN

“There is solid evidence that patient care outcomes are improved in an environment where the nurses have at least a BSN,” Dumpe reports.

However, in today’s market many are educated at the associate degree level. To balance these two realities, the Division of Nursing has increased its support to obtain a BSN degree. Through arrangements with local universities, classes are now available daytime and evening on-site as well as online. “The support was deliberately planned to combine convenience with quality,” Dumpe says. The result is a blended experience that allows nurses to create a schedule that fits their needs. More than 200 nurses have met with college counselors to discuss options for returning to school.

Nurses of the Future

New in 2006, The Nurses of the Future program targets high school students who may be considering a career in nursing. “The goal is to inspire participants to choose nursing as a rewarding career choice,” explains Kathleen Oliphant, RN, BSN, Nursing Special Projects Coordinator.

The nine-week summer session assigned 29 high school juniors and seniors to patient care areas at Cleveland Clinic’s main campus and hospitals within the Cleveland Clinic Health System. “They had the opportunity to work 40 hours a week in patient care areas to gain a firsthand understanding of the practice of nursing,” Oliphant explains.

The students – 27 girls and two boys – gathered each Wednesday for a presentation on some aspect of the practice of nursing delivered by Cleveland Clinic faculty. Topics included collaboration between nurses and physicians, nursing research and how to make a research presentation.

The students put this information to good use in their assigned clinical areas. They conducted nursing research projects under the direction of their clinical mentors, created posters and prepared PowerPoint presentations of their results prior to a graduation ceremony on August 11th.

The Nurses of the Future program is open to all high schools in a seven-county area. More than 100 applications were received for this first session, and the final selection was based on the students’ applications and personal interviews.

“By fostering an interest in nursing and nursing research and emphasizing the importance of science and math in school, we hope to be able to make an impact on the nursing shortage,” Oliphant says. “This program is unique because it offers students a chance to get hands-on experience and not just observe the activity on a nursing unit. Students discover that the nursing profession offers a wide range of exciting opportunities.”

Email comments to dumpeem@ccf.org or oliphak@ccf.org.
Foley Catheter Study Helps Define Protocols for Use

Educating nurses about the appropriate use of indwelling Foley catheters can reduce the overuse of these devices in the geriatric patient population. This was a significant finding of the Nurse Driven Protocol for Removal of Indwelling Catheters study recently completed at Cleveland Clinic, reports Anne Vanderbilt, RN, MSN, Clinical Nurse Specialist in Geriatrics and Medicine.

"Due to adverse consequences related to the long-term use of Foley catheters, we realized the need to ensure that the use of these catheters is restricted to defined protocols that specify appropriate uses and duration for this use," she says. Adverse effects in a geriatric population include increased risk of urinary tract infections and psychological trauma in confused patients.

The protocol was based upon criteria identified for catheter use defined by the Agency for Heath Care Policy and Research. This included: acute fluid status monitoring; management during the perioperative period (24 to 48 hours); patient comfort at end of life; the presence of a pressure ulcer greater than Stage 2; or bladder outlet obstruction.

In phase one of the protocol defining process, geriatric resource nurses on a single inpatient unit at Cleveland Clinic measured the frequency of catheter use in a population of 30 patients for one month. "Evaluation included: the unit where the catheter was inserted, such as the ER, ICU or the patient floor, reason for insertion, duration of use and reasons for removal," Vanderbilt explains. Nurses found that fluid monitoring was the primary reason for an indwelling catheter in 80 percent of patients on the floor.

The second phase was an educational intervention that required all nurses on the unit to participate in several sessions on the appropriate use of Foley catheters, including the defined uses, the importance of removing the catheter prior to discharge and management of incontinent patients without the use of a catheter. "We wanted to educate nurses to the risks of long-term use and stress that most catheters should remain in place for a maximum of two days," Vanderbilt says.

During a one-month intervention phase, nurses identified and removed catheters from those patients who did not meet the criteria for continued catheter use. If a patient's family requested that the catheter remain, this request was honored. No adverse events occurred that required re-insertion of the catheter in patients from whom it was removed.

The number of catheters removed during this intervention phase was small. Vanderbilt stated that some nurses were hesitant to act without a physician's order. However, she notes, progress toward the goal of minimizing catheter use was successful. "Overall, fewer catheters were inserted on the floor, the duration of use was shortened, and more catheters were removed prior to discharge." Additionally, fluid status monitoring criteria were tightened as a measure to reduce catheter use. She attributes these improvements in patient care to the education process that increased the nurses' awareness of appropriate use and duration and influenced nurses to discuss patient voiding issues with physicians.

Vanderbilt and colleagues will present the protocol in a poster session at the 2007 Nurses Improving Care for Healthsystem Elders (NICHE) in February.

E-mail comments to vandera@ccf.org.
Flexibility is Key to Parent Shift Program

“Flexibility is the No. 1 reason nurses who want to return to work choose Cleveland Clinic’s Parent Shift program,” says Nancy Albert, RN, PhD, CCNS, Director of the Cleveland Clinic Department of Nursing Research and Innovation.

A year-long study of the Parent Shift program by Nursing Research and Innovation surveyed nurse managers to learn if Parent Shift improved patient satisfaction scores and nurse vacancy rates; how nursing practice was affected by nurses who do not work full shifts; and if Parent Shift nurses were adequately prepared for work on the units.

As well, 89 returning nurses who joined Parent Shift were surveyed about why they joined Parent Shift; what incentives motivated them to remain in the program; and if the program met their expectations about what kind of nursing roles they would fulfill. Responses were collected when the nurses were first hired and after four months in the program.

The program welcomes all registered nurses who need flexible hours in order to return to work. “Nurses don’t have to tell us why they want Parent Shift,” said Albert. “They just choose Parent Shift rather than PRN.”

Overwhelmingly, former nurses chose Parent Shift because of its flexible work schedule. Parent Shift nurses work less than eight hours a day, have flexible start/stop hours with 9 a.m. to 2 p.m. being the most popular shift. There are no mandatory weekend and holiday shifts.

Due to partial shifts, their nursing roles on the units are not centered on a patient assignment. Rather, Parent Shift nurses are more likely to admit new patients, pass medications, cover lunch, change dressings or start IVs.

There are few such programs in the country and very little data on them, Albert said. Specifics on the study’s results will be announced at a national nursing conference or in a nursing journal, but Albert shared some general results.

The majority of nurse managers reported these observations:
• The program was a good match for needs on their floor and was well-liked by the staff
• Parent Shift nurses relieved other staff of stress, improving teamwork
• Parent Shift nurses had been adequately prepared to return to duties on the units

The overwhelming majority of Parent Shift nurses surveyed reported:
• They had joined the program because they preferred to make their own hours while caring for children at home
• They were satisfied that their roles and tasks on the units were what they expected them to be

“We discovered that these nurses were not using Parent Shift as a second job and that most were not caring for older parents,” Albert said.

The study also revealed that Cleveland Clinic’s preparation and orientation for nurses returning to work after a significant absence had met its goals.

E-mail comments to albertn@ccf.org.

Parent Shift was started in August 2004. “Our purpose in establishing Parent Shift was to meet Cleveland Clinic’s need for additional nurses on the floors and to find a way for nurses to work, if they want to, even if they can’t work traditional shifts,” said Susan Paschke, RN, MSN, BC, CNA, Associate Chief Nurse, who, with Chief Nursing Officer Claire Young, RN, MSN, MBA, came up with the idea.

PRN Nurse
• Works a standard full shift of at least eight hours
• Works only on an as-needed basis
• Has mandatory weekend and holiday shifts
• Has a full-shift assignment in terms of patient load
• Works as part of the unit team

Parent Shift Nurse
• Does not work a standard shift
• Has flexible start/stop times
• Has no mandatory weekend or holiday shifts
• Does not have full-shift assignments in terms of patient load
• Undertakes care groupings (admits, covers lunch, passes medications, etc.) but has assignments only during the shift
• Works as part of a unit team
Marianne Chulay, RN, DNSc, a nationally known consultant in critical care nursing, advocated the integration of evidence-based practice into the bedside clinician’s daily routines. Although implementing these types of changes requires commitment and time, ultimately, the result is better quality patient care, Chulay said.

Chulay’s perspective on creating an environment of evidence-based care coincided with the philosophy presented by the second keynote speaker, Debbie Brinker, RN, MSN, CCNS, CCRN, president of the American Association of Critical Care Nurses (AACN).

She encouraged nurses to participate in AACN’s Healthy Work Environment Initiative, a multi-year effort to engage nurses, their employers and the nursing profession in working collaboratively to improve the environments in which nurses work.

“The AACN’s call to engagement and transformation is a bold call to action,” Brinker said. “We must pledge to stay engaged until we have transformed our work environments.”

The Cleveland Clinic Division of Nursing hosted more than 500 nurses from around the country at the 25th annual Dimensions in Cardiac Care symposium March 19 to 21 on Cleveland Clinic’s main campus. The participants gathered at the InterContinental Hotel and MBNA Conference Center for this milestone event. Symposium Co-Directors were Nancy Albert, RN, PhD, CCNS, CCRN; Kelly Hancock, RN, BSN; and Kathy Tripepi-Bova, RN, MSN, CCNS, CCRN.
Heart Failure Team Management
EPS-HF Services Collaborate to Improve Patient Care

Elizabeth Ching, RN, FHRP, and Linda Kelly, RN, MSN, CC, NPC.

Cleveland Clinic electrophysiology and heart failure nursing services recently implemented a collaborative team approach to caring for heart failure patients with devices.

The result is better patient care, improved outcomes and higher patient satisfaction, report Elizabeth Ching, RN, FHRP, Nurse Manager, Device Clinic; and Linda Kelly, RN, MSN, CC, NPC, Nurse Manager, Cardiovascular Medicine.

“There was a definite need for greater collaboration and team work,” Kelly said. “We have many patients with new devices that yield new types of data. It was essential for us to determine together how it can best be utilized to improve patient care.”

Recognizing this void between available data and its application to patient care, the two nursing services decided to work toward closer collaboration. They started with monthly meetings involving representatives of both services.

Key to the success of the team approach were the device manufacturer’s cooperation and assistance, she added. “We worked with the company to be able to obtain the data we need, and then went through a training program to learn how to read the device reports. The manufacturer now has the system configured so that the heart failure team has access to the same information as the EP team.”

This allows the heart failure nurses to access each patient’s diagnosis, arrhythmia status, lifestyle and overall device performance. The report includes detailed, comprehensive information such as ventricular and atrial events, quality of life indicators, patient activity, heart rate variability, details of VT/VF and AT/AF episodes and pacing history.

Collaboration between the two teams also has led to the establishment of the Electrotechnology for Heart Failure Center, which serves as a liaison among the heart failure, electrophysiology and pacing and echocardiography teams.

E-mail comments to chinge@ccf.org and kellyl@ccf.org.
Managing Congestion to Reduce Hospitalization

Nancy Albert, RN, PhD, CCNS, CCRN, CNA

Congestion related to heart failure, once considered merely a nuisance problem, is now recognized as a risk factor for increased mortality in this population. Nancy Albert, RN, PhD, CCNS, CCRN, CNA, Director of Nursing Research and Innovation, and Clinical Nurse Specialist at the Kaufman Center for Heart Failure, advocates a proactive approach to assessing and managing these patients to improve survival and reduce hospitalization.

Ultimately, she said, “heart failure is a chronic condition and, like other chronic conditions, should be treated on an outpatient basis.” Current data suggest that as many as 83 percent of hospitalizations for heart failure are avoidable, she said. Reasons for hospitalization are often due to issues that lead to congestion. For example, about 24 percent of hospitalizations are due to noncompliance with diet; 24 percent are due to noncompliance with medications; and 19 percent are due to the patient’s failure to seek medical care, even when signs or symptoms of fluid overload are observable.

“More effective congestion management through better adherence to dietary modifications and medications could significantly reduce heart failure hospitalizations due to congestion,” Albert said. “Additionally, research suggests that aggressive management coupled with adherence to the treatment plan not only improves quality of life and reduces hospitalization but may also confer a survival benefit.”

“Another important aspect of heart failure management, that ultimately stabilizes congestion, is ensuring that patients are on the right drugs, including an ACE inhibitor and a beta blocker,” Albert said.

Although diuretics historically have been a mainstay of treatment for congestion, Albert cited multiple retrospective studies that found diuretics increased mortality. As a result, she said, “we are trying to place less emphasis on overusing diuretics and more on self-care behaviors and self-monitoring.”

The newest generation of implantable defibrillators opens up additional strategies for fluid monitoring in patients with advanced heart failure who require a device for cardioversion/defibrillation. These devices monitor thoracic bioimpedance, an indirect measure of thoracic fluid volume. Although this monitoring technique is reserved for the sickest patients and has limitations, it adds useful information to the total diagnostic picture, Albert said.

E-mail comments to albertn@ccf.org.
The Pursuit of Optimal Diets

Walter Willett, M.D., Professor, Department of Nutrition, Harvard School of Public Health, and author of Eat, Drink and Be Healthy: The Harvard Medical School Guide to Healthy Eating, gave one of the keynote addresses on the last day of the conference.

There has been enormous progress in understanding the relationship between diet and disease throughout the 20th century. Nutrients that promote health have been identified as having non-beneficial compounds such as saturated fats, trans-fats and refined starches. The U.S. Department of Agriculture (USDA) published its first dietary recommendations in 1894 and its first Food Guide Pyramid in 1992. The pyramid, still recognized today, offered a graphic display of both type and quantity of foods that would promote health. The pyramid was refined in 2005 although it has yet to be determined if the refinement expanded the public’s understanding of beneficial and detrimental foods.

One of the problems with the initial pyramid and one that may have been carried into the new pyramid is a failure to distinguish beneficial fats from detrimental fats in the Western diet. During the last decade, large epidemiologic studies have shown that all fats are not equal. Trans-fatty acids increase the risks of coronary heart disease and diabetes, whereas unsaturated fats reduce these risks, especially when compared to carbohydrates. High intake of refined sugars and starch are associated with increased risks of these diseases whereas high-fiber cereals appear to reduce the risks.

The Nurses’ Health Study, started in 1976, provided 14 years of follow-up on 84,129 participating women. The study showed that adherence to the USDA food pyramid was not associated with lower risks of chronic disease. We designed an alternative diet index emphasizing healthy forms of fat and whole grains with fish, poultry, nuts and legumes providing primary sources of protein. Our studies of the population in the Nurses Health Study show that adherence to this diet is associated with a 30 to 40 percent lower probability of cardiovascular disease risk. When combined with smoking abstinence, weight maintenance and routine physical activity, the diet may reduce the risks of heart disease by 80 percent, the risk of stroke by 70 percent, type 2 diabetes by 90 percent and colon cancer by 70 percent. Details of the diet are available in: Eat, Drink and Be Healthy: The Harvard Medical School Guide to Healthy Eating, 2nd ed. New York, NY: Simon & Schuster; 2005.
Evidence-Based Practice in Cardiac Care

Suzette Cardin, RN, DNSc, FAAN, Assistant Dean of Student Affairs at the UCLA School of Nursing, gave one of the keynote addresses on the last day of the conference.

There is no universally accepted definition of evidence-based practice (EBP); however, the one advanced in 2002 by Sigma Theta Tau, the national nursing honor society, is more than sufficient. It termed EBP as “an integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families and communities who are served.”

The concept of EBP began during the last decades of the 20th century. It continues to be driven forward by a number of factors, some of which include a drive for efficiency in care delivery with the resultant cost-effectiveness, the Magnet hospital movement, increasing emphasis on quality at all levels, and the expansion of data-driven knowledge that can be readily accessed by healthcare providers, patients and the public.

The path to implementing EBP in nursing begins with not only questioning established practice and traditional methods of delivering care, but framing the questions scientifically so that the answers that result rest on hard data and can stand unchallenged.

The first questions asked usually target established practices, which often remain in place because no one has thought to ask if there is a more effective, efficient and less expensive means of delivering care. Articles and practice guidelines can be the start of research but should not be considered the end because all evidence gathered must be evaluated.

Nurses should establish a culture of inquiry in their institutions and challenge rituals and traditions where appropriate. Those nurses who are educators must base their instruction on their experience and the most current data. They should encourage students to question and challenge.

Leadership in Nursing

An excerpt of closing remarks made by Suzette Cardin, RN, DNSc, FAAN, on the last day of the conference.

Nurses today live and practice in an environment that has been called “permanent whitewater,” an arena of constant change and challenge. Effective leadership rests on recognizing this continuing change and taking advantage of it to acquire and retain staff and to move them forward to providing better, more efficient and more cost-effective care.

Concepts of leadership in health care have been evolving since the end of the 20th century. It may be said that there are four types of leaders who are effective today and will remain so well into the future: the interactive leader, the caring leader, the transformational leader and the sharing leader.

The interactive leader, as described in 1990 by Peter Senge in his book *The Fifth Discipline*, encourages participation by all staff members in working toward goals. Individuals are valued and a team approach is taken to meeting challenges.

The caring leader emphasizes interaction as the key to success. Communication is open, learning is valued and everyone is recognized for the work they do. Younger nurses – those just coming into the profession – want to be in an environment where people value and care about them. They do their best work in this environment.

In the book *The Leadership Challenge*, authors James M. Kouzes and Barry Z. Posner describe the transformational leader as an individual who is a role model, who inspires a shared vision, who challenges existing processes and enables those around him or her to act in a meaningful manner.

In studying leadership styles, I developed a shared leadership model which draws on the qualities of the interactive, caring and transformational models. This leader strives to build a consensus and sees conflict and change as opportunities, and accepts the roles of a manager, which are to facilitate, integrate and coach young professionals.

We are up to our necks in whitewater. The way to cope is to recognize that change is a way of life. Leaders must learn to lead, to create change rather than to simply react to it.
Cardiovascular Disease in Athletes

The most common cause of sudden cardiac death (SCD) in young athletes is hypertrophic cardiomyopathy, which is responsible for about a third of such deaths.

It is an autosomal dominant genetic disorder that is characterized by an asymmetric, hypertrophied, non-dilated left ventricle. The combination of the genetic defect and physical exertion may cause persistent ventricular tachycardia or ventricular fibrillation leading to the fatal event. The physical symptoms of hypertrophic cardiomyopathy include chest pain, exertional dyspnea, lightheadedness and syncope. Other less frequent causes of SCD include congenital coronary artery anomalies, myocarditis, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy and commotio cordis, which is a sudden, non-penetrating blow to the chest that triggers ventricular fibrillation.

The American Heart Association recommends that screening should be mandatory for all youths preparing to participate in organized high school and college sports. The screening should include a family history noting any premature sudden cardiac deaths or heart disease in relatives younger than 50. The youth’s personal history should include inquiries about a heart murmur, systemic hypertension, unexplained or excessive fatigue, syncope or near syncope, excessive and unexplained dyspnea and chest pain that appears on exertion. The physical exam should include listening for a heart murmur, assessing femoral arterial pulses, assessing for signs of Marfan Syndrome and measuring brachial blood pressure.

Some institutions and countries, notably Italy, have incorporated electrocardiograms into their screening programs and, though the issue has been raised in the United States, it is felt that they would be prohibitively expensive for most youth athletic programs. There is also the concern that the false positives a massive screening program would engender could constitute a burden on athletes, their families and the healthcare system. More extensive testing such as ECGs, echocardiograms, and MRIs are called for only when the youth is positive for one or more of the physical symptoms. Currently the best means of reducing SCD is vigilance on behalf of family and healthcare workers, those involved in screening athletes and those involved in supervising the sports.

E-mail comments to kleind@ccf.org.
Optimal Nursing Care of Carotid Stent Patients
Combines Clinical and Patient Education

Deborah Brosovich, RN, CCRN

Improvements in technology and techniques for the treatment of carotid stenosis over the last decade have brought stent-supported carotid angioplasty to the forefront as primary and secondary stroke prevention in patients with carotid atherosclerosis, according to Deborah Brosovich, RN, CCRN, Nurse Manager, Interventional Cardiology/Heart Failure.

Despite, or possibly because of, these advances, “pre- and post-procedural patient education has become one of the most important aspects of treatment,” she said.

Pre-procedural management
Prior to the procedure, the patient undergoes a comprehensive physical exam to detect carotid bruits and a neurologic exam to determine possible neurologic deficits. The degree of stenosis may be assessed by carotid duplex ultrasound, MRA, carotid angiography or a combination.

When the diagnosis is confirmed and the procedure is scheduled, the nurse must advise the patient of the preparations required. “Many patients undergoing carotid angioplasty are elderly, and the nurse needs to ensure that they heard or read and understood the preparations and can comply,” Brosovich added.

Post-procedural management
Intensive blood pressure monitoring during the immediate post-procedural period is critical in these patients.

Also during this period the nurse should check the patient for any reported symptoms of headache, which may signal hyperperfusion syndrome. This condition typically occurs in patients with long-standing hypoperfusion due to high-grade stenosis. Loss of the brain’s ability to regulate vasoconstriction causes increased cerebral blood flow, potentially resulting in increased intracranial pressure, hypertensive events and intercranial hemorrhage.

Systemic hypotension occurs in about 5 percent of patients up to 36 hours after the procedure, resulting from stimulation of the carotid baroreceptors during angioplasty and stenting.

Management of post-procedural hypotension includes IV fluids, IV dopamine and Sudafed. “The level of IV fluids to be administered depends on the degree of left ventricular impairment and ranges from 150 ml per hour for normal LV to 75 cc per hour in the case of severe LV impairment,” Brosovich said.

Routine post-procedural laboratory work includes a CBC to monitor bleeding and effects of antiplatelet therapy; a chemistry profile for evaluation of renal function; CK or CK-MB to assess for peri-procedural MI; and an AC/HS.

Discharge instructions
The nurse conducts a pre-discharge assessment the day after the procedure to check the patient’s symptoms, vital signs and the groin entry site. At Cleveland Clinic, patients also undergo an ultrasound to assess stent patency and a neurologic exam by a neurologist.

“The nurse continues to be the primary patient educator at this stage, providing comprehensive home-going instructions,” Brosovich said. Discharge instructions also should include activity limitations, diet, groin care, blood pressure monitoring, signs and symptoms of stroke and plans for follow up with the patient’s physician.

E-mail comments to brosovd@ccf.org.
Psycho-Social Issues in Transplantation
Giving and Living

Susan M. Paschke, RN, MSN, CNA

Six nurse specialists representing a variety of disciplines came together on the first evening of the cardiac care symposium to informally share the insights they have gained from working in one of Cleveland Clinic’s several solid organ transplant units.

The speakers were Cheryl Smith, CRTT, BA, Donor Awareness Coordinator; Kay Kendall, MSW, LISW, Social Worker; Lucia Wocial, RNC, PhD, Neonatal ICU; Shawn Paschal, RN, BSN, Assistant Nurse Manager, Transplant and Special Care Unit; Tracy Evans-Walker, RN, BSN, CCTC, Lung Transplant Coordinator, Transplant Center; Rosemarie Pierson, RN, BA, Communication Nurse Cardiothoracic Intensive Care Units.

Cheryl Smith, CRTT, BA, said that when clinicians, nurses and the procurement team work together with a family and display the appropriate sensitivity and understanding, consent rates can rise above 70 percent.

Kay Kendall, MSW, LISW, said a social worker can improve clinical and psycho-social outcomes. A social worker specialist can interface with families to increase the number of advance directives, evaluate candidates for transplant procedures quickly and efficiently to insure they will be responsible caretakers of the organ, and assess the strength and extent of the candidate’s support group.

Lucia Wocial, RNC, PhD, observed that a significant percentage of organ-transplant candidates will not get the organ they hope for and, because of this, it is essential that someone discuss this possibility with the family and urge them to discuss the possibility with the candidate. Simply asking the question indicates the discussion is a permissible topic. She said nurses and other specialists must teach themselves to be comfortable talking about death.

Shawn Paschal, RN, BSN, said depression is common among hospitalized candidates waiting for an organ and should be anticipated. It can be minimized by giving patients some self-control, such as making them responsible for monitoring their weight, fluid intake and other aspects of their health. Weekly educational classes on diet, immunologic responses, and psychological responses can help them cope and maintain psychological balance.

Tracy Evans-Walker, RN, BSN, CCTC, advised to keep making communication with home-bound candidates for organ transplant a weekly to bi-weekly routine.

Rosemarie Pierson, RN, BA, described how the entire cardio-thoracic transplant team meets with candidates and their families to educate them and walk them through every aspect of the procedure. Specialists in transplant must learn to deal with circumstances that arise when an organ is found to be unsuitable. This is not unusual. Some candidates have been called to the hospital three to four times before an organ is determined to be suitable.

E-mail comments to paschks@ccf.org.
Cleveland Clinic Nursing News

PRESENTATIONS

National Organization of Nurse Practitioner Faculties
April 2006 | Orlando, Florida
The Attending Nurse Practitioner: A Model Practice Analysis in Acute Care
Christopher Manacci, MSN, ACNP, CCRN

Cardiac Care Symposium
April 2006 | Cleveland, Ohio
Practice Profile of the Acute Care Nurse Practitioner in Cardiothoracic Surgery
Christopher Manacci, MSN, ACNP, CCRN

38th Annual American Association of Neuroscience Nursing Conference
April 2006 | San Diego, California
Increased ICP and Herniation: What Every Nurse Needs to Know
Michael Anderson, RN, BA, CCRN

International Society for Heart and Lung Transplantation
April 2006 | Madrid, Spain
Outcomes of Patients Removed from a Cardiac Transplant Waiting List
Katherine Hoercher, RN

Society of Healthcare Consumer Advocacy
April 2006 | Atlanta, Georgia
Ask the Experts: Regulatory Guidelines
Carol Santalucia, MBA

American Association of Critical Care Nurses National Teaching Institute
May 2006 | Anaheim, California
Piecing It Together: Ethics, Nurses, ICU and Advance Directives and Ethics, Nurses and Planning Ahead: The Role of the Nurse
Lucia Wocial, CNS, Kathy Hill, CNS

Beyond the Basics Conference
May 2006 | Beachwood, Ohio
Celiac Disease and Type 1 Diabetes
Cheryl Switzer, CNP

The Healing Power of Music-Radio Interview
May/June 2006 | San Francisco, California/ Eugene, Oregon
KCBS San Francisco and KOPT Eugene
Sandra L. Sidlecki, RN, PhD, CNS

25th Annual Scientific Meeting of the American Pain Society
May 2006 | San Antonio, Texas
Self-rated Health: Pattern Variations in Power, Pain, Depression and Disability
Sandra L. Sidlecki, RN, PhD, CNS

9th Annual Society of Chest Pain Centers
May 2006 | Boston, Massachusetts
They’re Watching You! Performance Management
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

18th Annual Trends in Critical Care Symposium
American Association of Critical Care Nurses Greater Cincinnati Chapter
May 2006 | Cincinnati, Ohio
Race, Drugs and Heart Failure
Nancy Albert, RN, PhD, CCNS, CCRN, CNA
National Congress of the Oncology Nursing Society
May 2006 | Boston, Massachusetts
Renal Cancer: Understanding the Disease and Maximizing Outcomes and Molecular Target Therapies for Renal Cell Carcinoma
Laura Wood, RN, MSN, OCN

31st Annual ONS Congress
May 2006 | Boston, Massachusetts
Using ELNEC to Enhance Nurses Comfort Levels in Providing Quality End-of-Life Care
Dawn Gubanc, RN, MSN, CNAA, BC
Catherine Lawrence, RNC, BA, CHPN
Christina Shane, BSN, OCN

31st Annual ONS Congress
May 2006 | Boston, Massachusetts
Improving Safety: Implementation of a Falls Assessment Tool and Interventions Specific to Hospitalized Oncology Patients
Diana Karius, RN, MS, AOCN
Marge Hubman, RN, BSN, ANM
Christina Shane, RN, BSN, OCN

31st Annual ONS Congress
May 2006 | Boston, Massachusetts
Turning Discharge Deficiencies into Throughput Efficiency
Dawn Gubanc, RN, MSN, CNAA, BC

Heart Rhythm Society Conference
May 2006 | Boston, Massachusetts
When Confidence in Therapies is Jeopardized: Addressing Patient Issues
Carol Santalucia, MBA

Association for Professionals in Infection Control and Epidemiology
June 2006 | Tampa, Florida
Using the Intranet to Document Healthcare Worker Declination and Participation in a Mandatory Influenza Vaccination Program / Surgical Site Infections Following Laparoscopic Bariatric Surgery
Mary Bertin, RN, BSN, CIC
Michele Scarpelli, RN, BSN, CIC
Joan Vinski, RN, MSN

Annual Heart Failure Association of the European Society of Cardiology
June 2006 | Helsinki, Finland
How to Educate and Counsel Patients about Cardiac Resynchronization Therapy
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

2nd Annual Meeting of the American Association of Heart Failure Nurses
June 2006 | Miami, Florida
Patients are the Heart of What We Do
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

Latin American Committee for Treatment & Research in Multiple Sclerosis
July 2006 | Isla de Margarita, Venezuela
Treatments Administration and Immunosuppressant Therapy
Marie Namey, CNS

Advanced Practice Nursing Conference-Mayo Clinic
July 2006 | Rochester, Minnesota
Ethics, Nurses and the ICU: Changing the Status Quo
Kathy Hill, CNS

16th Annual Summer Institute of Nursing Informatics
July 2006 | Baltimore, Maryland
The Nursing Unit of the Future: Imagine if You Will...
Kate Sibilia, RN, BSN
Mary Kenney, RN, BSN

American Academy of Nurse Practitioners Annual Conference
July 2006 | Gaylord, Texas
Geriatric Spine Pain Management
Jackie Golden, CRNP
Joann Schneider, CCNS, CRNP

International Society of Nurses in Cancer September 2006 | Toronto, Canada
Healing Rituals
Dawn Gubanc, RN, MSN, CNAA, BC

Heart Failure Society of America September 2006 | Seattle, Washington
Heart Failure Case Discussion Panel
Katherine Hoercher, RN

International Transplant Nurses Society Annual Conference October 2006 | Rotterdam, Netherlands
Privileging, Credentialing in APN Practice
Jeffrey Arnovitz, MSN, CNP, CCTC

APPOINTMENTS
Paul Blakeley, Program Director
American Association of Nurse Anesthetists

Jeff Arnovitz, MSN, CNP, CCTC
Judiciary Chair
American Board for Transplant Certification

Nina Fielden, RN, MSN, CEN
Editorial Board
Advanced Emergency Nursing Journal
Claire Young, RN, MSN, MBA
Editorial Board
Nursing Spectrum (Midwest Edition)

Jackie Golden, CRNP
Chair of the State Formulary Committee
Ohio Board of Nursing Committee on Prescriptive Authority

Candace Rufo-Smith, RN, BSN
Course Chair
Seventh Annual CCF Nurses Course

Katherine Hoercher, RN
Chair of Endorsement Committee
Heart Failure Society of America

Katherine Hoercher, RN
Program Chair of Allied Health Satellite Symposium
American Transplant Congress 2007

Transcutaneous Carbon Dioxide Monitoring
Critical Care Nursing Clinics of North America 18(2), 2006, 211-215
Kathy Hill, MSN, CCNS
Deborah Klein RN, MSN, CCRN, CS

Outbreak of Methicillin-Resistant Staphylococcus Aureus in a Neonatal Intensive Care Unit Associated with a Healthcare Worker with Chronic Otitis
Infect Control Hosp Epidemiol (27), 2006, 581-585

Effect of Music on Power, Pain, Depression, and Disability
Journal of Advanced Nursing 54(4), 2006, 553-562
Sandra L. Siedlecki, RN, PhD, CNS

Self-Rated Health: Pattern Variations in Power, Pain, Depression, and Disability
Sandra L. Sidlecki, RN, PhD, CNS

Evidence-Based Nursing Care for Patients with Heart Failure
AACN Advances in Critical Care, 17(2), 2006, 170-185
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

Bioimpedance Cardiography Measurements of Cardiac Output and Other Cardiovascular Parameters
Critical Care Nursing Clinics of North America, 18, 2006, 195-202
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

They're Watching You! Performance Measurement, Staffing and Facilities Requirements
Critical Pathways Cardiol-Consensus Guidelines for HF Management in the Chest Pain Center, 5, 2006, 18-24
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

The Use of Tai Chi to Improve Health in Older Adults
Orthopaedic Nursing, 25(2), 2006, 122-126
Patricia Adler, RN, PhD(c), CS

I Was a Triage Nurse for Plaquemines Parish
International Transplant Nurses Society Newsletter
Barbara E. May, RN

Telehealth Divide
Mary Schmeida PhD, MSN, MA

State Government Policy Initiatives: Improving Access for the Medically Underserved
Mary Schmeida PhD, MSN, MA

Short Stay Management of Heart Failure
Philadelphia, Lippincott Williams and Wilkins, 2006
Performance Measurement, Staffing and Facilities Requirements for Observation Unit Heart Failure Management
Nancy Albert, RN, PhD, CCNS, CCRN, CNA

Evidence-Based Nursing Care for Patients with Heart Failure
AACN Advances in Critical Care, 17(2), 2006, 170-185
Nancy Albert, RN, PhD, CCNS, CCRN, CNA
Your Destination for Nursing Practice

Student Shift

Cleveland Clinic understands that nursing students have hectic schedules. Balancing work and school is no easy task. In response, we have designed a new Student Shift program to address the needs of nursing students.

Through this innovative program, young professionals are able to experience one of America's top three hospitals at their convenience. We offer flexible scheduling, no required start/end times, no minimum hours or weekends and compensation for students’ work. As a Student Shift nurse, students will enhance their vital occupational skills, build a strong understanding of high-quality patient care and work with some of the nation’s top professionals — all while practicing at a Magnet Status hospital, the highest national ranking for nursing excellence.

Create your own schedule, work on your terms and experience the world-renown Cleveland Clinic — your destination for nursing practice. Sign up for the Student Shift today!

For more information, please visit clevelandclinic.org/nursing. To apply for a Student Shift position, visit clevelandclinic.org/jobs.

Unlimited Career Opportunities

Cleveland Clinic’s Division of Nursing offers a wide range of nursing career paths that allow for diversification and specialization. Nursing specialties include:

- Advanced Practice Nursing
- Cancer Center/Subacute Services
- Behavioral Health
- Regional Medical Practice
- The Children’s Hospital
- Surgical Acute Care
- Nursing Education
- Professional Practice Development
- Nursing Quality Management
- Heart and Vascular Institute
- Nursing Research and Innovation
- Medicine/Women’s Health
- Surgical Services
- Emergency Department/Critical Care
- Nursing Informatics
- Nursing World Class Service

The Cleveland Clinic Heart & Vascular Institute currently has a variety of RN positions available.

Visit our Web site at clevelandclinic.org/nursing or call 216.297.7700 for more information about available nursing opportunities.

Explore Cleveland Clinic Nursing on Our Web Site

The Division of Nursing Web site reflects the strength and diversity of nursing practice at Cleveland Clinic, where nurses have achieved Magnet status – the highest national ranking for nursing excellence.

Log on to clevelandclinic.org/nursing, and while you’re there be sure to read the overviews of our departments, peruse the comments of Cleveland Clinic nurses and review job openings. Then decide if this is the right career choice for you. Call 216.297.7700 for more information.
Kathy Ridella, RN, MSN, CNP (Cardiothoracic Anesthesia) and Jackie Smith, RN, MSN, CRNP (Cardiovascular ICU) have taken different paths to becoming advanced practice nurses. Their exemplary skills, patient care interventions and collaborative practice with physicians have drawn attention.

Kathy, a Cleveland native, married and had three daughters before she decided at age 25 to become a nurse. She received her nursing degree from Ursuline College and joined Cleveland Clinic’s Cardiothoracic ICU as a staff nurse in 1990. She returned to school in 1996 for her advanced practice degree at Case Western Reserve University while continuing to work in the ICU. As a CNP, Kathy set up an outpatient clinic for post-operative cardiothoracic patients, using her new skills to deliver care. “I had a big impact on patient care during those four years,” she said, “because I could work very independently in helping patients through the post-op period.”

Jackie Smith, also a Cleveland native, knew she wanted to be a nurse since she was 7 years old. Her first job after nursing school was as a staff nurse in Cleveland Clinic’s Cardiovascular ICU. She earned a MSN from Northwestern University. When she and her husband moved to Phoenix, she entered the new program for nurse practitioners offered at Arizona State University and was in one of the first graduating classes. She worked for five years in the Arizona Heart Institute in Phoenix as a NP before she returned to Cleveland in 2002. “I made a full 360-degree return to Cleveland Clinic,” she says.

As CNPs, she and Kathy can intervene quickly and provide patients with timely therapeutic care. “Our knowledge and skills enable us to have a more in-depth understanding of exactly what is going on with the patient, physiologically and pathophysiologically,” Jackie says.

“Being a CNP allows me to process information and make decisions independently,” Kathy says. “I’m no longer powerless to make a change without a physician’s order.”

They are trained in invasive techniques, including placing central lines, chest tubes and dialysis catheters. “We are the physicians’ eyes and ears when they are not on the floor,” Jackie says. “We keep physicians updated and collaborate with them on behalf of the patient and also seek out their wisdom and expertise.”

Kathy adds that she enjoys the meetings focused on patient needs that occur regularly between CNPs and physicians. “That collaboration is a wonderful change I have seen develop over the past 16 years,” she says.

Both Kathy and Jackie praise ICU staff nurses. “ICU nurses are by nature rather aggressive caregivers,” Jackie says. “They are very strong about voicing their concern for the patient,” Kathy agrees. “They aren’t easily intimidated.”

Kathy and Jackie say that one of their most important roles is communicating with family members and helping them through crises. “Families want to be informed — whether it is good news or bad news — they just want to know,” Jackie says.

Jackie and her 12-year-old son, Bryan, live in Shaker Heights. She is an avid golfer and skier. Kathy relishes her role as grandmother, and enjoys hiking, biking and gardening.

“There aren’t many of us around,” both nurses lament, hoping that more of their colleagues will take the plunge into advanced practice nursing.

Email comments to riddellk@ccf.org and smithj9@ccf.org.
Outcomes Data Available

The latest edition of Cleveland Clinic outcomes data is available. Our outcomes booklets offer summary reviews of medical and surgical trends and approaches. Charts, graphs and data illustrate the scope and volume of procedures performed in each department each year. To view outcomes booklets for many Cleveland Clinic medical and surgical disciplines, visit clevelandclinic.org/quality.