AN EXPANDING NURSING SPECIALTY HAD ITS BIRTHPLACE AT THE CLEVELAND CLINIC

The nursing specialty of Enterostomal Therapy (ET) has undergone substantive change since its beginnings in the 1950s, expanding its focus from management of people with ostomies and fistulas to include caring for people with incontinence, pressure ulcers and all types of wounds. Director of the Enterostomal Therapy program Paula Erwin-Toth, RN, sees it as a logical evolution. From its beginnings to its current role in health care, the specialty has achieved a unique role in patient-centered care.

THE BEGINNINGS

The world’s first enterostomal therapist was a patient — Ohio native Norma Gill — who had an ostomy performed by Cleveland Clinic colorectal surgeon, Rupert B. Turnbull Jr., M.D. in the early 1950s. After she recovered, Gill expressed interest in caring for patients with ostomies and fistulae. Working with Turnbull, she laid the foundation for enterostomal nursing and set her goals to provide empathic care to patients with stomas and fistulae, to develop ideas for more effective and efficient ostomy products and to educate patients and other health care professionals on

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We are pleased to bring you the fall 2004 edition of Notable Nursing.

As you read the articles in this issue of our newsletter, you will see how Cleveland Clinic nurses work in an environment that is shaped by research and education, as well as clinical care.

The cover article tells one of the great stories of modern nursing: how the innovative leadership of two Cleveland Clinic nurses helped to create a new specialty and established the nation’s first enterostomal therapy school.

Nursing research reflects our passion to improve patient care. It is the foundation of our nursing practice. Our research is highlighted in an article that seeks to find more effective ways of assessing pain in nonverbal patients in the intensive care unit.

Coverage of our orthopaedic conference reflects the partnership that exists between physicians and nurses and their mutual commitment to education.

Finally, don’t miss the article about Advanced Practice Nursing, a growing area of clinical nursing practice that has been part of patient care at The Cleveland Clinic for nearly 30 years.

It is exciting to work in a major academic medical center that has a solid commitment to deliver optimal patient care, to improve outcomes and to keep learning — it is a commitment that has made The Cleveland Clinic a leading destination for nursing practice.

We hope you enjoy this issue of our newsletter. Please share it with your colleagues and let us hear from you.

Email comments to youngc@ccf.org
managing ostomies and fistulas. Most of all, she wanted to assure patients that they could live fully with an ostomy.

Erwin-Toth, who calls herself “one of Norma’s kids,” is carrying on Gill’s legacy. Born with multiple birth defects, Erwin-Toth became a patient of Gill’s following an ostomy when she was 10. “I remember the profound difference Norma Gill made in my life,” Erwin-Toth says. “I wanted to be like her.”

Erwin-Toth began her career at The Cleveland Clinic in 1990. She has taught self care to patients with ostomies as young as 4 to as old as 110. “Patients can look at me and know that they can live a full life with an ostomy,” she says.

THE FIRST SCHOOL OF ENTEROSTOMAL THERAPY

ET didn’t last long as a lay specialty. In 1961, Dr. Turnbull Jr., with Norma Gill’s help, established the first School of Enterostomal Therapy at The Cleveland Clinic. Of the 3,700 nurse professionals in ET/WOC (wound, ostomy and continence) practicing worldwide, 1,044 have graduated from the Clinic’s school, which offers an intensive eight-week course that combines 320 hours of classroom education and clinical bedside care.

Early applicants to the school were those who had an ostomy or a family member with an ostomy. Nursing experience was not required. Today, ET/WOC nurses are RNs with a BSN and a minimum of one year of current, full-time medical/surgical experience, who must re-certify every five years. Good communication, excellent clinical skills, self-direction, flexibility and a good dose of patience are additional requirements.

Physically managing a stoma is only a small part of ET/WOC nursing. “The Turnbull School curriculum also educates nurses on the psychological and developmental issues that each person with an ostomy may be experiencing,” Erwin-Toth says.

Students have the option of dividing the course into four weeks of didactic instruction at the Turnbull School followed by four weeks in their own home facility under the guidance of a pre-determined ET/WOC preceptor.

The Turnbull School, one of only seven ET/WOC schools in the United States, remains the specialty’s birthplace and has become a model for ET/WOC nursing programs worldwide. Erwin-Toth and others have helped establish ET schools in Japan, Malaysia, Thailand, and Hong Kong, among others, and serve as resources to physicians and nurses.

SPEARHEADING IMPROVEMENTS AND PATIENT ADVOCACY

The ostomy equipment Erwin-Toth used as a child was “archaic, inefficient and horrible,” she says. Norma Gill spearheaded product development in the industry, and there has been a “quantum” improvement in equipment for people with ostomies over the years. Erwin-Toth and other ET/WOCs advise product development companies on new products to manage the care of people with these problems.

After years of poor insurance coverage in the U.S. for ostomy equipment, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, have increased the amount for equipment. This has relieved the fear of many people with stomas who worried their ostomy pouches would leak, or they would run out of them. The improvement was due, at least in part, to Erwin-Toth’s testimony before the CMS board.

FUTURE ROLES FOR ET/WOC NURSES

The number of permanent ostomy surgeries has decreased in the past 25 years due to earlier diagnosis and advances in surgery, but Erwin-Toth believes the need for ET/WOC nurses will only increase. “The need in the future will be in the areas of wound and skin care and continence care,” says Erwin-Toth. “As the baby boomers age, we will need more specialists in long-term care facilities and home health care. Through evidence-based practice, specialists in ET/WOC will play a pivotal role in improving the quality of life for patients and controlling health care costs.”

Research is also expected to play an expanded role in the future of ET/WOC nursing. In 1998, The Cleveland Clinic established a stoma registry database that may be the largest prospective gathering of data in the world on people undergoing ostomy surgery. The database will be used to research and establish predictive values on decreasing post-operative complications through preparation and stoma site marking; identifying common types of skin complications to prevent them from occurring; and dealing with psychological issues.

“We have so many opportunities for advancing nursing and nursing practice and improving patient care that I can’t imagine doing anything else,” Erwin-Toth says. “Our mission goes on.”

WHAT NURSING IS ALL ABOUT

Following long-term positions in critical care nursing and cardiac rehab, Denise Groh, BSN, RN, completed training in the Turnbull School of Enterostomal Therapy.

Groh explains the appeal of ET/WOC nursing. “You are one on one with the patient. They need and rely on you. They see you as the one person who is going to turn their life around and make it worthwhile to live again. If that isn’t what nursing is about, I don’t know what is.”

E-mail comments to grohd@ccf.org.
In the spring 2003 issue of Notable Nursing, we reported on the establishment of a Nonverbal Pain Assessment Tool (NPAT) to help assess and treat pain in nonverbal adult patients. The development of the tool was based on the FLACC (Merkel et al, 1997) pain assessment tool used to assess infant’s pain through observation of various behaviors. The NPAT was designed by nurses in the Intensive Care Unit at The Cleveland Clinic and incorporates five categories of behavioral indicators: emotion, movement, verbal cues, facial cues and positioning/guarding. This article describes two trials of the NPAT designed to measure its validity and reliability.

Teams of two nurses were used to measure the validity and reliability of the NPAT in five Cleveland Clinic intensive care units: Coronary Intensive Care, Medical Intensive Care, Surgical Intensive Care and two Cardiothoracic Surgical Intensive Care units. The nurses were trained using case study presentations. The nurses were given the NPAT indicator definitions and worked through the case examples.

When data collection began, it was apparent that the Medical Intensive Care Unit (MICU) patient population would have to be dropped from the study because of their sedated state. Excluding the MICU patients, a total of sixty-eight patients were rated on the NPAT.

Validity, the ability of a tool to quantify what it intends, was measured by comparing the results of the NPAT with the gold standard for pain assessment: the visual analog scale (VAS). One team member assessed a communicative patient using the NPAT, while the second member asked the patient to indicate his pain score on a scale of 1 to 10. From these pairings, a concordance correlation of .31 was calculated, indicating the NPAT had low validity.

Reliability, the repeat consistent performance of a tool, was measured by comparing the independent scores of each team member on a nonverbal patient. The interrater reliability was .69 (concordance correlation coefficient) indicating a moderate reliability.

In a meeting to discuss their experience with the NPAT, the nurses voiced overwhelming agreement that the tool provided consistency in assessing patient pain. However, the verbal cue indicator was seldom used. There was consensus that the indicators of movement and positioning/guarding needed to be weighed more heavily. With these comments, the verbal cue indicator was dropped and a second pilot of the NPAT was implemented.

Analysis was conducted by the same method. Forty-two patients were assessed via the NPAT and VAS. The NPAT validity was .21 (concordance correlation). Interrater reliability, calculated on thirty-nine pairs of scores, was .72.

Our conclusions regarding the NPAT are mixed. The staff nurses’ experience with the NPAT revealed satisfaction and a continued desire to have a consistent approach to measure pain in the nonverbal population, confirmed by moderate interrater reliability scores. However, because pain assessments are done to guide treatment, a valid measure of pain must be used.

As the literature continues to support the hypothesis that behaviors can be studied to assess pain in a nonverbal patient population, we are continuing our research study. The research team is now assessing the validity of the NPAT in a population of patients known to have pain — the post-surgical patient. A team of two nurses will assess patients’ pain using the VAS and the NPAT, as described previously in the ICU patient population. We will report our findings in a future issue of Notable Nursing.

E-mail comments to dumpem@ccf.org, lewicki@ccf.org or klein@ccf.org

Michelle L. Dumpe, PhD, MS, RN; Linda Lewicki, PhD, RN; and Deborah Klein, MSN, RN, CCRN, CS
Making the transition from nursing school to staff nurse or from experienced nurse at a smaller hospital to one the size of The Cleveland Clinic can be daunting. To ease the transition for newcomers, the Clinic’s Department of Nursing Education offers support groups.

The voluntary weekly get-togethers grew out of a request in 2001 from clinical instructor Carol Ann Brooks, RN, CT-ICU to Kirste Carlson, ND, RN, CS, clinical nurse specialist in behavioral services. Brooks asked Carlson for guidance in transitioning 30 new graduates from many different nursing schools into the CT-ICU staff. “In addition to the sudden influx, we considered that the variety of shift options meant that nurses would have multiple preceptors, which would make establishing relationships and continuity more difficult,” Carlson says.

The answer seemed to be a support group format where new arrivals could bring up concerns in a confidential environment of peers and group leaders. Brooks and the unit’s management team encouraged nurses to attend the voluntary support groups following centralized orientation. The groups were well received.

Fast forward to Spring 2004. Carlson says because of the positive response in the CT-ICUs, groups are now offered for all newly-hired nurses. Group leaders rotate and include many of the Clinic’s clinical nurse specialists and clinical instructors. Still, the groups are fluid and may include as few as two people or as many as three groups of eight to 10 people each. A lot depends on the time of year, with new grads making summer the busiest time.

Whatever the season, Carlson says that communication skills and self-confidence are the most frequently discussed subjects. “We found that some nurses lacked skills in assertiveness and did not feel comfortable communicating their need for more training or assistance,” says Carlson, describing the range of topics that a session could cover. As an example, she recounts a nurse who was reluctant to tell her preceptor that she was not comfortable starting IVs. The support group gave her the encouragement she needed to formulate how she might state her concern and request IV training for a full day to improve her skill.

“We discuss balance in one’s life, not being too hard on oneself and how to learn from small mistakes.”

“My battle was with myself. I wanted to do the best even though I was new. It was challenging.”

In addition to adjusting to the size of The Cleveland Clinic, some nurses who come from outside the area may find it difficult to adjust to a new city. The support group is a place where individuals can discuss these challenges. Andrea Sandalakis, RN, joined the stepdown cardiology unit in 2003 as a new graduate of Youngstown State University. She was not intimidated by her job or a new city. “My battle was with myself,” she says. “I wanted to do the best even though I was new. It was challenging.”

“We developed the groups to support new nurses, because we want them to know that their feelings are important and that we value their professional contributions.”

Kirste Carlson has been with The Cleveland Clinic for 18 years. She received her master’s degree in psychiatric and mental health nursing from Kent State University and her nursing doctorate from Case Western Reserve University. E-mail comments to carlsonk@ccf.org
Advanced practice nursing has a long history at The Cleveland Clinic. In 1967, Registered Nurse Joanne Khatib studied under two physicians in gynecology and learned advanced assessment skills. In 1982, she successfully took the NACOG exam and was certified as a Nurse Practitioner based upon her knowledge and skill. Five years earlier, The Clinic had hired its first graduate nurse at the request of Gil Lowenthal, MD, an internal medicine physician who had worked with advanced practice nurses (APNs) in Minnesota. Lowenthal recognized their value in managing internal medicine patients and encouraged the use of APNs at The Cleveland Clinic.

The education of APNs has changed markedly. In the early days, registered nurses participated in a three-month primary care program at Case Western Reserve University's Frances Payne Bolton School of Nursing, followed by a nine-month internship under the supervision of a physician. Upon completion, they were certified as Nurse Practitioners.

Today, APN education resides in colleges and universities at the graduate level. Upon completion of their graduate education, nurses must successfully complete a certification exam in their specialty prior to being granted a certificate of authority as an APN. Certified nurse practitioners (CNP), clinical nurse specialists (CNS) and clinical nurse midwives (CNM) also may take graduate level pharmacology courses and be granted a certificate to prescribe. There are now approximately 7,000 APNs in the State of Ohio, working as nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists (CRNAs). APNs assist in the management of patients, focusing on health and the prevention of illness and the management of acute and chronic illnesses. Core responsibilities include providing comprehensive patient assessments, identification of health-related problems and working with the patient and the healthcare team to develop a plan of care.

At The Cleveland Clinic, over 300 APNs function in almost every clinical specialty from the inpatient arena to the outpatient clinics and operating rooms. Approximately 130 CRNAs work in the Clinic's 60 operating rooms as well as at the Clinic's ambulatory surgery centers spread across northeast Ohio.

Advanced practice nurses are privileged as affiliated clinical practitioners at The Cleveland Clinic and are granted privileges consistent with their education and training. The privileging process was modeled after the one utilized for physician staff and incorporates primary source verification, peer references and a review of quality and competency. An APN Privileging Committee comprised of APNs, nursing administration, credentialers and a physician, reviews applications for privileging that includes education, assessment of competency and quality monitoring.

“I think what makes the Clinic unique,” says Director of Advanced Practice Nursing Jan Fuchs, MSN, RN, “is not only the number of APNs we have but how we utilize them in our inpatient and outpatient areas. APNs are being increasingly utilized in a variety of areas to help with throughput, continuity of care and patient access. For example, the use of acute care nurse practitioners has been shown to decrease the length of stay and the cost per case in our coronary artery bypass patients and cardiovascular surgery patients,” says Fuchs.

Marie Namey, MSN, RN, clinical nurse specialist at the Cleveland Clinic Mellon Center for Multiple Sclerosis Treatment and Research, says there has always been a shared responsibility between doctors and nurses. “But the advanced practice nursing certification gives me a bit more autonomy in my role and increased responsibility for patient care, which has great appeal.”

“When I began in nursing, advanced practice degrees were not part of the basic offering for nurses,” says Bertha “Bert” Lovelace CRNA. (See sidebar.) “Now, I really believe advanced practice is where nurses need to be.”
Bertha "Bert" Lovelace, CRNA, BA, chief nurse anesthetist in the Cleveland Clinic Department of General Anesthesiology says she has two main goals and challenges. The first is to ensure that people understand the role of the nurse anesthetist as a vigilant and safe provider of anesthesia.

“People in the most remote rural areas do not have to delay a surgical procedure requiring anesthesia because a vigilant safe provider is available — CRNAs are everywhere,” Ms. Lovelace says. Her second goal/challenge is to ensure that the nurse anesthetists she supervises have what they need to be safe vigilant providers of anesthesia. This includes the completion of 40 hours of CEUs needed for recertification every two years and a work environment where nurse anesthetists feel encouraged and supported in their responsibilities.

Like many nurses, Lovelace began her career in the hospital working as a nurse in med/surg. Although she found the position rewarding, she had an intense desire to work one-on-one with patients and to expand her nursing practice through a more challenging specialty. A suggestion by a physician friend steered her into the nursing anesthesia program at Mercy Hospital in Pittsburgh. She was smitten. “I enjoyed the challenge of the critical care piece of administering anesthesia. It came to be my love.”

Lovelace came to the Cleveland Clinic in 1973 as one of about 25 CRNAs in the Department of General Anesthesiology. She was appointed Chief Nurse Anesthetist in 1984 and currently supervises 34 CRNAs. In 1997, when the state of Ohio first recognized the special role of advanced practice nurses, CRNAs were already working full force at the Clinic. “When I began in nursing, advanced practice degrees were not part of the basic offering for nurses,” Ms. Lovelace says. “Now, I really believe advanced practice is where nurses need to be.”

Ms. Lovelace is a Clinical Instructor in the 26-month-long Cleveland Clinic certification program for CRNAs, held in conjunction with the Frances Payne Bolton School of Nursing at Case Western Reserve University (CWRU).

In 1999, Ohio Governor Bob Taft appointed Lovelace to the Ohio Board of Nursing to fill an unfilled term. She is the first CRNA to sit on the 13-member board that, in 1999, represented 180,000 registered nurses in Ohio, of which only 1,000 were CRNAs. She considers her role on the board to be different from her role at The Cleveland Clinic. “On the board, I’m a nurse first, and a nurse anesthetist second,” Lovelace says. “I bring in my specialty only when needed.” She was re-appointed to the board in 2000.

She spends four hours a day in the OR, administering and monitoring anesthesia — her first love.

The administration of anesthesia has changed with the advent of new, shorter-acting drugs that help patients awaken from anesthesia more quickly. But, says Ms. Lovelace, “the concept of giving anesthesia has not changed. The process is the same, the vigilance remains the same — and will never change.”

E-mail comments to lovelab@ccf.org
The Fourth Annual Orthopaedic Conference was held this past spring at the InterContinental Hotel and MBNA Conference Center, located on the main campus of The Cleveland Clinic. About 160 nurses as well as physician assistants attended the one-day conference, which focused this year on cutting edge technology in orthopaedics.

The first portion of the conference was devoted to a live video feed of a total knee replacement surgery as it was being performed by Cleveland Clinic orthopaedic surgeon Mark Froimson, M.D., who explained the surgery as it progressed. Following the surgery, Dr. Froimson stopped by the conference for a question and answer session that included questions on complications of surgery.

“Nurses on the floor rarely get to see an actual total knee operation,” says Dawn Gerz, BSN, RN, ONC, RNFA, Department of Orthopaedics, Upper Extremity Section, “The conference gave them the opportunity to see the surgeon saw the bone and dislocate the patella. They got a better understanding of why patients have pain and how to provide comfort. They also learned first hand why moving the leg in certain ways is important after surgery and how to prevent blood clots from forming.”

About 460,000 total knee replacements are performed annually. Patients in need of a total knee replacement are generally debilitated when they first come in to be seen, says Gerz. Nurses provide pre- and postoperative education critical to successful outcomes. Hospital stays are generally three days followed by seven days on a subacute floor for rehabilitation. “When they come back in for their post-operative checkup, they are a different person,” says Gerz. “They are no longer debilitated and their quality of life has improved. It’s wonderful to see.”

The conference topic then turned to bone grafting and stem cell research with a presentation from Cleveland Clinic orthopaedic surgeon and researcher George Muschler, M.D., one of the country’s leading stem cell researchers. Dr. Muschler spoke to participants about using stem cells to discover what causes bone to grow and what kind of environment is conducive to successful bone grafts.

Bedside nurses frequently see “non-union” of bone grafts, says Gerz, especially in patients who smoke or have osteoporosis. Gerz also noted that learning about what’s new on the horizon with bone grafts and what environment best suits successful bone grafting will affect the quality of care nurses provide as well as how they educate patients. “Nurses at the conference learned something new about these surgical procedures — knowledge they can integrate into what they already know and then apply to the care of their patient,” says Gerz.

First offered locally to Cleveland area nurses and orthopaedic professionals in 2000, the Clinic’s orthopaedic conference has been expanding annually. In addition to local and Ohio-based nurses, participants attended from North Carolina, New Hampshire, Pennsylvania, Indiana, New York and Illinois.
Ankle fusion and tibiotalocalcaneal fusion (ankle and subtalar fusion) are two of the numerous foot and ankle surgeries performed in Orthopaedics at The Cleveland Clinic. These surgeries are usually performed in patients who are 45 years or older and who have a diagnosis of rheumatoid arthritis, osteoarthritis or post-traumatic arthritis. The goals of the surgery are to reduce pain and correct malalignment deformities. Surgical screws, staples or rods may be used to accomplish the 2-3 hour surgery. A one- to two-day hospital stay followed, in some cases, by a short recovery at a rehabilitation facility ensures patient comfort and safety.

Prior to scheduling surgery, most patients are unaware of the lengthy recuperation process. One of the most critical roles of the nurse clinician is to educate the patient prior to surgery on what to expect postoperatively. Patients must be prepared for the physical changes they will encounter with daily living activities. Because they will have to use crutches or a walker postoperatively, patients should be advised to work on upper body strength prior to surgery.

Following both ankle fusion and tibiotalocalcaneal surgeries, patients should expect to either be on crutches, use a walker and or a wheelchair as needed for nine to 12 weeks. Patients will be unable to bear weight on the lower extremity for six weeks or more, which dramatically impacts activities of daily living such as cooking, cleaning, stair climbing, pet care and driving. The patient’s spouse or significant other will need to assume a vital role during the recovery process. A single person must call on a family member or close friend to assist in the home. When patients don’t have help, they may risk injury, the surgical wound may not heal or a non-union or unnecessary pain may occur. Many of these conditions are the result of excessive swelling.

While educating patients, the importance of elevating the foot above heart level is stressed for the first 3 weeks during initial recovery. This regimen of care reduces dependent edema, promotes wound healing and improves pain.

After three weeks, patients continue to elevate the lower extremity consistently on a footstool when sitting. Most patients are encouraged not to return to work for at least three weeks, if not longer, depending on their occupation. Elevation is especially important when a compromising condition such as diabetes or rheumatoid arthritis is present. If patients smoke, they should be encouraged to stop since smoking can impede healing.

Since patients are in a cast following fusion surgery and cannot see their wound, nurses must provide education about the signs of wound problems or infection: For example, do they have a burning sensation or an increase in temperature? Is there a sensation of wetness, which indicates the wound may be draining? Is there pain in the calf, which may be indicative of a blood clot? Patients are encouraged to communicate any of these issues to their surgeons’ office so appropriate actions may be taken.

Once the patient is home, physical therapy may be arranged to ensure patient safety while using assistive devices. Skilled nursing is not usually necessary. But if a physical therapist is seeing the patient, a home health aide may be arranged to assist the patient for a few hours a week. Patients who have undergone ankle fusion or tibiotalocalcaneal fusion are seen in follow-up by the surgeon the first, third, sixth, ninth and twelfth weeks post-op. X-rays are taken and checked at six and 12 weeks post-op to assess bone healing. By following instructions of the health care team, patients can experience a smooth postoperative course.

Ankle and tibiotalocalcaneal fusions are excellent pain relieving surgeries. A patient’s full recovery may take from six to 12 months, but it can be a very gratifying surgery allowing the patient to return to an active lifestyle.

Donna Morgan has spent her 25-year nursing career in Orthopedics at the Cleveland Clinic. She is a graduate of Cleveland Metro Health School of Nursing and obtained her First Assist status in 1998. Email comments to morgand@ccf.org
National Appointments
Patricia Weiss RN, BSN, OCN
Nancy Kelly RN, MSN, AOCN
National Fellow, Oncology Nursing Society Leadership
Development Institute

Nancy Albert, Ph.D. (c), RN, CCNS
President, American Association of Heart Failure Nurses
American Heart Association
Member at Large, Steering Committee
Council of Cardiovascular Nurses

Advanced Certification
The following nurses from the Cleveland Clinic Taussig Cancer Center received a Certificate in Evidence based Practice from Case Western Reserve University:
Nancy Kelly RN, MSN, AOCN
Patti Akins RN, BSN
Catherine Lawrence BA, RNC, CHPN
Maudie Murray RN, BSN, OCN

Presentations
Emergency Nurses Association
2004 Scientific Assembly in San Diego, CA
September 30-October 2
Nina M. Fielden, MSN, RN, CEN:
Integration of the Emergency Severity Index System into an Existing Five-Category Triage System
Mary Sokolowski, BSN, RN:
Defibrillation Competency

National Gerontological Nursing Association
October 15-17, Las Vegas
Program: Gerontological Nursing — Aging is a Work of Art
Poster presentation: Geriatric Ambulation and Care
Partners Program
Michele Thoman, RN, MBA
Marge Schreiner, RN
Anne Vanderbilt, MSN, RN, CNS
Sarah Carraquillo, BSN, RN
Ruth Rivera, RN

Publications
Accepted for publication:
MEDSURG Nursing: The Journal of Adult Health
“When Families Complicate Patient Care: Guidelines for Handling Resultant Ethical Dilemmas”, Katrina A. Bramstedt, PhD and co-authored by Kirste Carlson, ND, RN, CS; Marci Molnar, RN, BSPA; and Susan Bilyeu

Upcoming Events

6th Annual Update in Neuroscience Nursing
November 11-12, 2004
InterContinental Hotel and MBNA Conference Center
Cleveland Clinic, Cleveland, Ohio
For more information, contact tobinm@ccf.org.

24th Annual Dimensions in Cardiac Care Nursing Symposium
November 14-16, 2004
InterContinental Hotel and MBNA Conference Center
Located on The Cleveland Clinic Campus, Cleveland, Ohio
For more information, contact the Center for Continuing Education:
216/444-5696 (local)
800/762-8173
www.clevelandclinicmeded.com/registration.htm

The Cleveland Clinic will host the
Greater Cleveland Post Anesthesia Nurse Association meeting.
January 2005
PACU nurse Rene Doubrava, RN will serve as coordinator.
For more information, email halunr@ccf.org.
The Cleveland Clinic is a not-for-profit multispecialty academic medical center located in Cleveland, Ohio. When you make The Cleveland Clinic your career choice, you will be working at one of the nation’s premier medical centers.

Our physicians recognize that much of the Clinic’s success lies in the strength and commitment of our nursing staff. Here, nurses and physicians work as partners exchanging ideas and knowledge with a shared goal — delivering the highest quality patient care and improving patient outcomes.

For more than a dozen years U.S. News & World Report has ranked The Cleveland Clinic among the “Best of the Best” hospitals in the country. In 2004, the magazine ranked the Clinic among the top four hospitals in the nation. Our Heart Center has been ranked number one in the United States for 10 consecutive years and many other specialties, including digestive disorders, urology, rheumatology, kidney disease, orthopaedics, neurology and neurosurgery, ear, nose and throat, gynecology and hormonal disorders are ranked among the top 10.

With more than 900 beds, The Cleveland Clinic is one of the world’s largest and busiest medical centers, serving patients from every state in the nation and around the world. Our staff includes more than 1,400 physicians and scientists representing 120 specialties and subspecialties. Annually, the Clinic records nearly two million outpatient visits and more than 50,000 hospital admissions.

It doesn’t matter where you are in your nursing career — from new graduate to seasoned professional, you’ll find what you’re looking for here. There is no better place to learn, see and do. Make The Cleveland Clinic your destination for nursing practice.

Unlimited Career Opportunities

Make The Cleveland Clinic your destination for nursing practice. The Cleveland Clinic Division of Nursing offers a range of career paths in nursing that provides diversification and specialization. Nursing specialties include:

- Advanced Practice Nursing
- Behavioral Health
- The Children’s Hospital & Birthing Services
- Nursing Education
- The Heart Center
- Medicine/Women’s Health
- Emergency Department
- Cancer Center
- Regional Medical Practice
- Surgery/Post Acute Care/Radiology
- Nursing Quality
- Nursing Research
- Surgical Services
- Nursing Information Systems

The Cleveland Clinic Cancer Center currently has a variety of RN positions available in the following areas:
- Adult Bone Marrow Transplant Program
- Adult Solid Tumor and Leukemia Service
- Harry S. Horvitz Center for Palliative Medicine
- Outpatient Chemotherapy Treatment Center
- Oncology Advanced Practice Nurse

Visit our web site at www.clevelandclinic.org/nursing or call 216/297-7700 for more information about all available nursing opportunities.
This feature focuses on families — husbands and wives, mothers and daughters and mothers and sons — who have made nursing a family tradition.

When Chris Orlando switched his career plans from pre-med to nursing, his mother, Leann, was not surprised. “Part of it may have been because he shadowed me during summer breaks when he was attending the Medical College of Ohio in Toledo,” she recollects. Leann works in the Cleveland Clinic Heart Center, caring for patients who have had open heart surgery.

Chris says that once he got into the hospital environment and shadowed both doctors and nurses (including his mom) and asked a lot of questions, he knew nursing was where he wanted to be. After receiving his BS degree in biology, Chris completed a BSN degree and joined his mother at The Cleveland Clinic in 1998. Chris, who works part time on the cardiothoracic unit, says nursing is a perfect fit for him.

“You can tailor your schedule to your personal needs and at the same time work in a dynamic, ever changing profession,” says the married father of a young son with a new baby on the way. Chris says he enjoys the variety and challenges of working in a major medical center like The Cleveland Clinic, where he also assists patients in their recovery following heart surgery.

“The reputation of the Clinic was a big draw for me,” he says. “You can say with pride that you are an integral component of the finest cardiac institution in the nation. When you come into work, you know your day is not going to be what it was like the day before. It is never stagnant.”

While Chris followed in his mother’s footsteps, Leann’s interest in nursing began as a child, when she would pour through books about nurses and use her plastic nurse’s kit to “fix” her dolls. Leann’s route to a nursing career was interrupted when her husband received transfer orders from the Navy. But in 1989, Leann enrolled at Lakeland Community College and obtained her nursing degree in 1993.

“By that time, my youngest child was in middle school,” says Leann, who says she appreciated the flexibility of structuring her schedule so she could be home with her children as much as possible. “Nursing is a tough job, but you have options, flexibility and rewards that a lot of other careers don’t offer,” says Leann. “I like the contact with people and being able to teach patients, to explain what they can expect during their recovery so they know what is normal and what isn’t.”

When mother and son share a nursing profession, it is inevitable that conversation at family functions will turn to their work. “Chris and I usually hear, ’stop talking in abbreviations,” chuckles Leann, with obvious pride for her son. “Chris is an excellent nurse. He is smart and intuitive and does a great job taking care of his patients. I am very proud of him.”

Although men make up about 6 percent of the more than 2 million nurses nationwide, the number of men enrolling in nursing schools is on the rise according to the National Sample Survey of Registered Nurses.

Story written by: Mary Beth Modic, MSN, RN, CS, clinical nurse specialist in Patient Education. Modic has worked at The Cleveland Clinic for 29 years. She received her master’s degree in nursing from Kent State University in 1987. E-mail comments to modicm@ccf.org.