Feature Story

Taking Shared Governance to New Heights

One team at a time, empowered nurses rise to the challenge of tackling the issues they face every day. – pg 1

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On the cover, from left to right: Rosemarie Pierson, RN, BA, Retention and Recognition Council; Karen Saidel, RN, BSN, Shared Governance Team; Chief Nursing Officer Claire Young, RN, MBA; Anderson Waldon, CT, Model of Care Team; and Nicholas Angelis, RN, BSN, Intergenerational Nursing Team.
During the past four years, the Division of Nursing has been focused on empowering nurses, encouraging their voices, enhancing their careers and championing their autonomy. At the same time, our nurse leaders have been challenged to solve issues that are faced universally by hospitals across the country – staffing, nurse retention, throughput, model of care and shared governance.

Last year, in an effort to answer questions up front and dispel rumors, I set up a public forum on an intranet site and invited nurses to post their questions anonymously. I answered more than 600 questions over a three-month period. Clearly, nurses had a lot to say about nursing practice, job quality and patient care. What would happen, I wondered, if I put the ball in their court and asked front-line nurses to evaluate issues, brainstorm strategies and develop recommendations for improving processes? It made sense to ask those who are on the frontlines to assist in developing solutions to our issues.

I was not surprised when they rose to the challenge and created and convened nine teams across all disciplines and representing all skill and experience levels. Teams met for nine weeks facilitated by representatives from the Nurse Executive Council and from human resources and finance. They talked about barriers and roadblocks to nursing practice, about better ways to practice nursing care, and about strategic directions to enhance job quality. The teams presented their preliminary recommendations to nursing employees at Town Hall meetings last July, and final recommendations were released in November 2005.

We are proud to present some of the results of the discussions and recommendations from these teams.
Notable Nursing

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– Dana Wade, MSN, RN

Shared Governance

Cleveland Clinic has had a shared governance structure in place for several years that includes nurse councils on management, quality and nursing practice, as well as hospital-unit-based councils. “What we had was working well for us, but it was time to take a look at our structure and see how we could improve it,” says Dana Wade, MSN, RN, Nursing Accreditation Specialist and a team facilitator.

The Shared Governance Team decided to expand the council structure to the hospital unit level and include ambulatory care clinics in the structure as a means of improving decision-making and enhancing nurse autonomy. As a result, every nursing unit now is responsible for developing a council comprised of nurses and other multidisciplinary professional and support staff as determined by each unit’s/clinic’s unique needs.

The team also recommended adding three new councils to the division-wide councils: Education and Research; Retention and Recognition and a Coordinating Council that would oversee all the councils and be a direct liaison with the NEC.

“Nurses are approaching this in a positive way. They are excited about the opportunity to implement programs, policies, procedures and projects that will improve their work environments and nursing practice.” Wade says.

Team member Karen Saidel, RN, BSN, Quality Accreditation Nurse for PACU/SDS, says that direct-care nurses are enthusiastic about the councils because they now have a voice in decisions all the way up to the NEC. “This is an exciting opportunity for employee involvement in decision making at all levels of nursing.”

Hospital units and ambulatory clinics throughout Cleveland Clinic are now organizing their councils or building on existing councils.

The NEC approved the team’s recommendation to elect a president of the nursing staff to serve as a representative to the executive administrator of nursing. Applications for the position are available internally and voting will be done online by nursing staff.

Model of Care

“The team’s goal was to take the decision regarding care delivery to the providers at the patient’s bedside,” explains Kelly Hancock, RN, Clinical Nursing Director for the Cleveland Clinic Heart and Vascular Institute. She and Michelle Dumpe, PhD, RN, Director of Nursing Education and Professional Practice, were the NEC facilitators for the team.

“In the face of the nursing shortage, the challenge is how to deliver quality care with the providers we have,” Dumpe adds.

The team recommended changing the model of care from primary nursing to team nursing. They developed the solution of patient care teams that were assigned to care for nine patients on the regular nursing floors and step-down units. The teams would consist of two licensed providers and one unlicensed provider. An additional unlicensed provider would provide additional support for two care teams.

For ICU, the Model of Care Team recommended that teams include one RN per patient if high acuity is a factor or one RN for two patients. A PCNA and CT would be dedicated to every four patients around the clock.
Teams would be scheduled in 24-hour blocks and work only 8 to 12 hour shifts or weekend shifts. The team also surveyed nurses on the floors, asking what they wanted in their jobs. The top three answers were respect, education and upward mobility.

“It was clear that accountability was one of the main issues on the floors preventing nurses from achieving these three things,” explains team member Anderson Waldon, Clinical Technician.

The team focused on developing better job descriptions that would clarify accountability and include incentives for performance and education. Over the nine-week period, the team reduced the number of job descriptions in patient care from eight to four and expanded the key job responsibilities within each description.

Waldon expects both nurses and patients to benefit from the new model. It includes clearly defined pay-for-performance standards and incentives for education and places nurses in a leadership role on their units. “Nurses now know who to ask to get a specific job done, and everyone on the team has a clear idea of their job expectations.”

“With this kind of accountability, people are approaching their performance reviews with a new enthusiasm,” he adds. “Instead of listening to a supervisor tell you about your job, you can bring to the meeting anything that you have done to enhance your job.”

The NEC has selected four pilot units, representative of the continuum of care at Cleveland Clinic, to reconfigure into the new model.

**Intergenerational Nursing**

To begin to understand generational differences that impact job performance and satisfaction, the team created an age profile of the Cleveland Clinic nursing staff. It revealed that Cleveland Clinic has a higher than usual number of nurses in their 20s and early 30s – about 53 percent. And 41 percent are baby boomers (early 40s to early 60s). This generational breakdown is typical of teaching hospitals. Yet, it can create interpersonal challenges, says Luann Capone, MPH, MSN, RN, Director of Nursing Quality.

“With several generations of nursing personnel working together in patient care, generational differences in values, job expectations and problem-solving styles can create barriers that impact communications,” she explains. “And communications impact quality of care and employee satisfaction.”

The team determined that improving communications requires recognition of differences, commitment to improving communication within a team or unit, and working out a solution at the small group level.

Although nurses may understand this in the abstract, the hands-on work of improving communications can be daunting. To facilitate the process, the team developed the “Generations Working Together” tool kit. Posted on the nursing intranet, it includes a variety of activities and discussion-starters that units or work groups can use as a starting point for understanding and improving intergenerational communications.

**Senior Nurse Retention**

Faced with a national nursing shortage, how does an institution like Cleveland Clinic promote retention of senior nurses to meet personnel needs now and in the future? That was the core question addressed by the Senior Nurse Retention Team.
Jan Fuchs, MSN, RN, Director of Advanced Practice Nursing, cites the statistics that underscore the importance of addressing the needs of senior nurses: nearly 20 percent of Cleveland Clinic’s 3,400 hospital and ambulatory care nurses have more than 15 years of service; the average age of inpatient nurses at Cleveland Clinic is 39.2 and of ambulatory care nurses is 46.1; according to U.S. statistics, 40 percent of all RNs nationwide will be over age 50 by 2010.

“As a senior nurse, I feel that I understand the issues and challenges related to keeping our most experienced nurses in patient care,” says team member Bea Krajnak, RNC “One of the basic issues is recognition, not just for years of service, but also for the expertise that comes with long-term service.”

When the team reviewed the literature and surveyed senior nurses at Cleveland Clinic, they found that recognition was among their top concerns.

The team addressed this issue with six recommendations for improving recognition for senior nurses. Three of these ideas will be implemented in the first half of 2006:

- The first Senior Nurse Reception will be held during National Nurses Week in May to recognize these nurses for their contributions and provide a social occasion for networking and renewing old friendships.

- A Nursing Hall of Fame will be displayed in the major pedestrian bridge at Cleveland Clinic during National Nurses Week, featuring large photographs of Cleveland Clinic’s 200 nurses with 25 years or more experience and listing their names, years of service and professional accomplishments.

- To give senior nurses a forum to express their specific concerns, the Retention and Recognition Council now will include two senior nurses. Their task will be to bring senior nurses’ issues to the table and generate ideas that enhance the work experience of professional nurses.

All of these actions taken together will encourage Cleveland Clinic senior nurses that “their concerns are being heard,” Krajnak says. “Having senior nurses on the council will help ensure that the momentum continues.”

She is assisting Cleveland Clinic Regional Medical Practice in incorporating similar ideas at the 13 Cleveland Clinic Family Health and Surgery Centers. The NEC also is evaluating other benefits such as preferred scheduling linked to years of service as part of a Senior Nurse Advantage package.

**Unit Secretaries**

Professionalism and recognition for unit secretaries at Cleveland Clinic are taking a leap forward, starting with revising the job title to health unit coordinator.

This is only one of the dramatic changes introduced by the team to improve recruitment, retention and job satisfaction in this position.

Establishing a chapter of the National Association of Health Unit Coordinators (NAHUC) on campus was another major step that the team initiated. NAHUC, the well-respected national association for health unit coordinators, provides opportunities for professional growth and recognition for members.

Also in the works is a new career program that will support recruitment and provide job recognition for the position, now being implemented on Cleveland Clinic’s main campus. “Under this structure, health unit coordinators will start their career path as secretaries and have the opportunity to progress through three more levels with increasing responsibility,” says team facilitator Michelle McAfee, MHA, RN, Assistant Administrator of Nursing.

Advancing through the career program requires unit secretaries to become preceptors and eventually obtain certification from NAHUC. When the career program is fully implemented, promotion to the third level will require a health unit coordinator to be certified, have five years of experience and be enrolled in an associate’s degree program.

**Renewed pride in nursing**

In less than three months after the teams’ final recommendations were presented, 20 percent of them have been implemented, and about half are under serious consideration. In addition to the five teams highlighted here, the teams’ initiative also addressed staffing, technology, throughput and unit aesthetics.

The process has paid off in intangible, as much as tangible, accomplishments, with a renewed sense of pride and accomplishment prevalent through all levels of nursing at Cleveland Clinic.

The Model of Care Team and the Staffing Team will continue their work. The Technology Team will convene again in a slightly different form. By analyzing data from a variety of sources we will form new teams as new issues arise. This has been a very successful experiment and we want to continue it. We called our front-line nurses to action—and they came up with solutions.

E-mail comments to youngc@ccf.org.
PACU Prizing expertise in caring for high acuity patients

Once out of the OR and into the PACU (Post Anesthesia Care Unit), surgical patients—especially the high acuity patients seen at Cleveland Clinic—face additional risks that require highly skilled and experienced nurses.

“Nursing care in the PACU is as state-of-the-art as it is in our OR,” says Lori DeWitt, RN, BSN, CAPA, CPAN, Nurse Manager of PACU and Same Day Surgery. “Because we do surgeries you will not see elsewhere, our PACU nurses must have a higher skill level.”

So critical and unique is the skill required to become a PACU nurse that the orientation with a preceptor is 12 weeks. This orientation includes training in critical care medicine, anesthetic agents, airway management and advanced cardiac life support. PACU nursing care also requires knowledge and skills necessary for every surgical specialty.

After patients are moved from the OR to the PACU, the first phase is helping them recover from anesthesia. Under the preceptor, nurses begin by caring for less complex post-surgical patients and move up to more complex cases, such as patients who have been under anesthesia for 12 hours. Skill level is so highly prized that nurses must work one year in PACU before they can become a charge nurse or work with pediatric patients.

“Healthy patients usually go to the outpatient centers for surgery,” DeWitt observes, “but on the main campus we operate on many patients who are considered high risk for surgical interventions with many co-morbidities. So knowledge, experience and acute observation are keys to the care we provide in the PACU.”

24/7 anesthesia coverage if a situation arises where a patient in PACU needs immediate intervention” she says. Our nurses are prepared to handle the high volume and acuity of patients arriving from the 47 ORs, which averages approximately 150 patients a day,” says DeWitt.

One unique program recently cited in OR Manager is that of our orthopaedic QUEST program. Called QUEST for Quality, Efficiency, Satisfaction and Teamwork, the process has helped reduce turnaround times for total orthopaedic joint replacements. Under QUEST, a PACU nurse assumes care of the patient in the OR from the anesthesiologist at the end of the surgical procedure. She then accompanies the patient from the OR to the PACU and gives a report on the patient to the PACU staff. This allows the anesthesiologist to move more quickly to the next case. “It’s an efficient use of time and resources,” DeWitt says.

Barbara Wilson, MSN, RN, CNAA, CNOR, Clinical Director of Surgical Services adds, “Nurses in the PACU must be as highly skilled and specialized as nurses in the OR and without them, nurses in the OR would be unable to do their jobs.”

E-mail comments to dewittl@ccf.org.
Patients who undergo breast reduction surgery are generally very happy following surgery, reports Roberta Woodman, RNFA, RN, BSN. But she wanted to know exactly why.

Woodman, a Cleveland Clinic nurse for the past 30 years, transferred from OB/GYN to Plastic Surgery in 2002 and will complete an MSN degree this year. Her graduate requirements include a research study. With the help of Nancy Albert, PhD, RN, CNS, Director of Cleveland Clinic Nursing Research and Innovation, and with the support of Sharon Radzyminski, PhD, JD, RN, Woodman’s graduate instructor at Cleveland State University, Woodman knew just the population she wanted to study.

“The literature on breast reduction surgery focused on surgical techniques and physical symptoms, not quality of life issues, not why patients were so happy after surgery,” Woodman said. To find the answer, Woodman developed a phenomenological study, a type of qualitative research study that focuses on lived experiences.

Woodman asked a single question of nine patients between 20 and 60 years of age who had breast reduction surgery: What has your life been like following breast reduction surgery?

“Every patient reported that physical symptoms—back, neck and shoulder pain—were much improved or gone altogether,” Woodman said. “They said they felt better about their bodies, had improved self-image, confidence and self-esteem. They said their clothes fit and they could exercise comfortably. They said they felt fantastic.”

Breast reduction surgery is a three- to four-hour procedure with a two-week recovery period. Patients can return home the same day or opt for the 23-hour stay. Patients are back to work in two weeks but are restricted to lifting no more than 20 pounds for four weeks following surgery. Since surgery can affect breastfeeding, some women delay surgery until they complete childbearing.

Although the parameters of the study limited Woodman to a single question during the patients’ postoperative visit, patients also reported that the decision to have breast reduction surgery was extremely difficult and many women took years to decide, often without spousal support. Despite this difficulty, each patient reported she would do it again and would recommend surgery to other women with large breasts, poor body image and painful physical symptoms.

Unexpectedly, however, the study yielded issues needing further study. Patients reported that their postoperative period was less optimal than they would have liked, marred by minor infections, increased pain or unexpected scarring.

“We learned that we needed to look at whether our preoperative patient preparation and education was adequate,” Woodman said.

“Health care professionals must learn about patient quality of life after breast reduction surgery,” Albert said, “especially since this surgery is meant to improve image and quality of life. This qualitative study provides new knowledge in the field and can become the basis for further research on preoperative patient communication.”

E-mail comments to woodmar@ccf.org or albertn@ccf.org.
Cleveland Clinic to Partner with Local College to Educate Nurses of the Future

Cleveland-based Cuyahoga Community College (Tri-C) has received a $1.86 million community-based job training grant from the U.S. Department of Labor to implement creative solutions that will significantly increase the number of registered nurses for Cleveland Clinic.

The Employer Driven Approaches for Alleviating Health Care Worker Shortages initiative was collaboratively developed by Tri-C and Cleveland Clinic, the Cleveland Municipal School District and the region’s Workforce Investment Boards.

“Cleveland Clinic is excited about creating and increasing nursing job opportunities both for our existing employees and for people throughout Northeast Ohio,” says Claire Young, RN, MBA, and Chief Nursing Officer for Cleveland Clinic. “This partnership also will help ensure the continuation of quality nursing at the Cleveland Clinic.”

Grant funds will be used to educate an additional 64 registered nurses each year who will work for Cleveland Clinic. The College will accomplish this by providing education to the Cleveland Clinic’s existing workers (who are not currently registered nurses) who are interested in moving into these high-demand positions. The College will work with the regional Workforce Investment Boards and “One-Stop” system to provide education and identify new workers who can “backfill” jobs vacated by employees moving into the new positions.

Tri-C will bring the registered nurse coursework on-site at Cleveland Clinic and provide distance learning for Cleveland Clinic’s incumbent workers at other facilities who want to become registered nurses. In order to further expand educational opportunities, Tri-C will create a new Clinical Simulation Center at its East Campus in Highland Hills and another Simulation Center at Corporate College in Westlake.

Cleveland Clinic will support its incumbent workers by assisting with tuition and has committed to advancing them into new positions when they complete their education. Cleveland Clinic will build a new nursing lab and learning environment at an existing Cleveland Clinic facility. The lab and classrooms will be used by Tri-C to provide on-site education for Cleveland Clinic employees.

E-mail comments to youngc@ccf.org.

Academic Partnership Trains Advanced Practice Nurses in Acute Cardiovascular Care

In fall 2005, Cleveland Clinic began a partnership with Case Western Reserve University Francis Payne Bolton School of Nursing to train advanced practice nurses to assume an expanded role in caring for and managing patients with cardiac disorders.

“This will be a world-class cardiovascular acute care nurse practitioner program,” said Janet Fuchs, MSN, RN, director of advanced practice nursing at Cleveland Clinic. “Graduates of the program will be prepared to function in a state-of-the-art acute care cardiac environment” in collaboration with cardiologists and cardiovascular and thoracic surgeons, Fuchs said. APN graduates will have key advantages in seeking advanced nursing positions in cardiology and cardiac surgery as Acute Care Nurse Practitioners (ACNP).

The program curriculum was developed jointly by nursing faculty at Case and advanced practice nurses and members of the medical staff at Cleveland Clinic. Faculty for the program will come from both institutions.

“What better institution for the Bolton School to collaborate with on acute cardiovascular patient care than the nation’s No. 1 heart hospital?” asked May L. Wykle, dean and Florence Cellar Professor of Nursing at the Bolton School.

Research has consistently demonstrated that APNs have dramatically improved the quality of care to patients suffering from a wide range of chronic disorders; decreased length of patient stays; and improved patient and family satisfaction. Currently, 300 APNs now practice in four specialty areas at Cleveland Clinic as Nurse Practitioners, Nurse Midwives, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists. Historically functioning primarily in an outpatient setting, graduates of the new ACNP Program will assume an expanded role in acute cardiovascular patient care and increase the presence of APNs in the hospital setting.

E-mail comments to fuchsj@ccf.org.
Keeping a Closer Eye on Blood Glucose Levels
New national guidelines on diabetes management are changing nursing practice

Modic says that additional studies confirm that inpatients who have just one blood glucose level higher than 220 mg have a 5.8 times higher risk of contracting nosocomial infection (2). Another study demonstrates that for every 50 mg/dl rise in glucose, hospital costs increase by $1,769 and length of stay increases by .76 days (3).

At Cleveland Clinic, where approximately 30 percent of inpatients have diabetes—an average of 10 patients per unit—a comprehensive three-step process was initiated in 2004 to bring the new guidelines and their implementation into better focus.

As a first step, a committee representing diverse perspectives was assembled. Comprised of endocrinologists, an intensivist, hospitalist, cardiologist, pharmacist, nurse manager,
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certified diabetic educator, nutritionists, and five advanced practice nurses, the committee "was a bit unusual," Modic notes. "Most national meetings convened to discuss implementation strategies do not usually include nurses on the faculty. It is ironic since the nurse is the one who must implement the protocols. This committee has championed the implementation of the protocols at Cleveland Clinic. The group meets regularly to discuss obstacles and successes. Everyone’s viewpoint is solicited and valued."

Staff education was the next step. Cleveland Clinic’s Division of Nursing created a 16-hour course for staff nurses, which was presented four times with physicians, advanced practice nurses, nutritionists and pharmacists serving as faculty.

“The course was really well done,” says Marge Schreiner, RN, Quality and Magnet Accreditation Nurse on an Internal Medicine / Telemetry unit. “It invigorated us to improve how we manage and treat patients with diabetes, which are about one-half of our patients.”

Other units responded similarly as nursing staff became energized to educate the bedside nurses about the changes in nursing practice regarding diabetes management. Taking three major points from the 16-hour course, assistant nurse managers and staff nurses began teaching their peers on the following:

- Why it’s important that physicians and nurses be educated to better manage and treat high blood glucose levels.
- Why hypoglycemia is a concern with tight glycemic control and the actions that can be taken to prevent it from occurring.
- Why patients with diabetes must learn survival skills before leaving the hospital.

Cheryl Rovniak, RN, BSN, a bedside nurse on the Internal Medicine/Telemetry units, was a member of the education team on her units. “It used to be that patients thought their blood sugar would be messed up while they were in the hospital. But now we ensure that patients are in much tighter control. We check their blood glucose more often, we ensure stricter control over their levels and we educate them about the new management guidelines so they can better care for themselves.”

Schreiner said the new protocols have changed nursing practice in several important ways. For example, rather than give a patient with hypoglycemia (>70) a large glass of orange juice, nurses now know to provide 15 grams of carbohydrates, check glucose levels again in 15 minutes and repeat the first step as needed.

The third step involved taking patient education to a new level. Staff nurses on the Internal Medicine/Telemetry units developed a new assessment sheet to determine the level of patient knowledge about self-care management of their disease. “We put the assessment sheet at the front of the patient’s chart,” Schreiner says, “so we know what patients still may need to learn about the best self-care practices. Now staff nurses are educators.”

“As an advanced practice nurse, I get excited by education,” Modic says “What is even more exciting is to witness bedside nurses becoming empowered to educate their peers and change nursing practice based upon science. They are taking ownership and driving the implementation of these protocols. This behavior is one of the many illustrations of outstanding nursing practice. It demonstrates why Cleveland Clinic has Magnet Status recognition.”

Cleveland Clinic also has set up referrals for inpatients to the Self-Management Education Program, recognized by the American Diabetes Association. Run on an outpatient basis by a nurse practitioner, referrals give patients with diabetes an opportunity to continue their education on managing their disease.

On the medical units, as part of the physician-nurse partnership program, hospitalists and nursing staff meet monthly to discuss and solve clinical issues. Diabetes management has been a topic of much discussion. The medical units set an ambitious target goal: keep blood glucose levels below 140 mg/dl. “Diabetes is becoming more and more prevalent,” Schreiner says, “so we need to continue to improve assessment, management and education.”

E-mail comments to modicm@ccf.org, schreim1@ccf.org or rovniac@ccf.org.

Neuro-Oncologic Emergencies:
When time is of the essence, rapid recognition and intervention save lives

Lisa Sorenson, MSN, CNP

Nurses play an important role in the timely evaluation of patients in a neuro-oncologic emergency. Neuro-oncologic complications can arise from brain tumors or from the procedures used to treat brain tumors. Rapid recognition of the signs and symptoms of a neurological crisis, coupled with timely intervention, saves lives.

In addition to the standard ABCs of treatment—airway, breathing, circulation—neuro-oncologic emergencies require patient-specific and condition-specific interventions.

**Intracranial Pressure**
A potential neurological emergency is related to a rise in intracranial pressure. Normal intracranial pressure (ICP) is 10-15 mmHg (14-16 cm H2O). Increased ICP occurs when the cranium cannot accommodate additional masses, such as tumors, space-occupying lesions, abscesses, increased spinal fluid or blood because the capacity for compensation within the skull is finite. Increased ICP results when there is a disparity in the volume and the contents. As ICP increases greater than 15 mmHg, there is decreased global cerebral perfusion and ischemia, inflammation and swelling. Since the skull is finite and the edema takes up valuable space, the brain begins to shift or herniate in order to accommodate the edema.

**Signs of Increasing ICP**
Patients with raised ICP typically present with headaches, altered mental status, ataxia, nausea and vomiting, focal weakness, speech and sensory changes. Typical clinical signs include motor weakness, ataxia, papilledema, cranial nerve palsies, visual deficits, and speech deficits. If uncontrolled, increasing ICP leads to death.

**Causes of Increased ICP**
The most common causes of increased ICP are:

- localized masses including neoplasms, hematomas and abscesses
- obstruction of the CSF pathways by a brain tumor causing hydrocephalus
- diffuse brain edema, diffuse head injury and subarachnoid hemorrhage
- obstruction of the major venous sinuses.
Blood Brain Barrier Disruption: Getting Chemo to the Brain

Blood brain barrier (BBB) disruption given in conjunction with intra-arterial chemotherapy is provided for patients with primary central nervous system lymphoma. An intra-arterial infusion of a hypertonic solution such as Mannitol creates an osmotic opening of the blood brain barrier, enabling chemotherapy to more easily enter the brain. The opening is transient and reversible and disruption usually lasts two to four hours.

BBB disruption allows for enhanced chemotherapy delivery up to 100-fold. Radiation can cause damage to the brain tissue and results in long-term cognitive defects, but BBB disruption does not damage the brain tissue, so cognitive function is maintained, along with quality of life.

At Cleveland Clinic, the BBB disruption procedure requires a 4-day stay. Patients are admitted once every four to six weeks for approximately 12 months.

- Day One: Pre-op physical, MRI of the brain and lab tests; patient admitted to neuro stepdown unit.
- Day Two: Patient is intubated. The BBB is disrupted by delivery of intra-arterial Mannitol administered via a catheter inserted into the femoral artery and then advanced into the posterior or anterior cerebral circulation. Once the Mannitol has opened the barrier, intra-arterial chemotherapy is given and the angiocatheter withdrawn. The patient is simultaneously given intravenous chemotherapy. When the procedure is completed, the patient is taken to PACU, extubated, recovered and taken back to the neuro stepdown unit.
- Day Three: The same procedure is repeated as on day two using a different cerebral artery, either in the anterior or posterior circulation.
- Day Four: Patient is discharged.

Patients receive 24 BBB disruption treatments a year.

Risks of Treatment

Generally, the BBB disruption procedure is well-tolerated. Risks of the BBB disruption treatment include neuro deficits that are usually transient and will resolve within 24 hours. Seizures occur in 7 percent of patients and stroke is also a risk. Monitor patients for increased ICP as chemotherapy can irritate the brain and cause swelling and herniation. Chemotherapy-related issues can occur seven to 14 days post-procedure when the patient’s immune system is most vulnerable. However, despite the risks of treatment, studies have revealed a 42-percent five-year survival rate with no loss of cognitive function.

Brain Herniation

Nurses will likely be the first health care professionals to see patients with symptoms of raised ICP and potential brain herniation. Be aware of these types of herniation and their signs and symptoms:

- Subfalcine herniation causes a very dramatic shift of the brain tissue from under the falx (dural fold) to the opposite side of the brain. Patients may be asymptomatic or present with headache.
- Transtentorial/uncal herniation is the most common type of herniation, pushing the brain downward. Patients slowly lose consciousness. Watch for early signs of a severely dilated pupil or contralateral hemiparesis.
- Tonsillar herniation is subtle and scary. Patients present with a tingling when they flex their neck forward, which is similar to presenting with multiple sclerosis. But these patients suffer cardiorespiratory impairment as the medulla is compressed by the cerebellar tonsils as they exit the skull. Patients can progress rapidly to coma.

Brain Tumors

Increased ICP and herniation may occur due to a brain tumor or the sequela associated with a brain tumor. Brain tumors are the second most common pediatric cancer after hematological cancers, and they are the leading cause of death from pediatric cancers up to 19 years, according to the American Cancer Society. Among males 20 to 30 years old, brain tumors are the second leading cause of cancer-related deaths.

Primary brain tumors arise from the brain tissue and can be benign or malignant. A pituitary adenoma is one type of primary brain tumor. Metastatic brain tumors occur due to a cancer elsewhere in the body that secondarily spreads to the brain where they are always malignant. At least 25 percent of patients diagnosed with systemic cancer will develop a brain metastasis at some point during their overall disease course.

Brain Metastases

The percentage of patients with systemic cancer who develop brain metastases:

- 40 percent to 68 percent of patients with melanoma
- 21 percent to 36 percent of patients with lung cancer
- 30 percent of patients with breast cancer
- 3 to 6 percent of patients with gastrointestinal cancer

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- 3 to 6 percent of patients with gastrointestinal cancer
Melanoma, renal and testicular cancers have the highest tendency to metastasize to the brain. Up to 85 percent of metastatic brain tumors are located in the supratentorial region; up to 15 percent are in the cerebellum. Metastases to the brain stem or the spinal cord are rare.

Sixty percent of all brain metastases occur in patients between 50 and 70 years of age. Over half of patients who present with brain metastasis will have multiple lesions.

**Clinical Signs of a Metastatic Brain Tumor**
Patients will typically present with one or more symptoms including progressively worsening headache, personality change, new onset of seizures, nausea and vomiting, loss of visual acuity, difficulty with speech and memory, and progressive weakness.

**Treatment, Goals and Outcomes for Brain Tumors**
Treatment modalities for primary and metastatic brain tumors include surgery, whole brain radiation therapy, gamma knife radiosurgery, chemotherapy, and intra-arterial chemotherapy in conjunction with blood brain barrier disruption.

Treatments are intended to restore neurological function and prevent complications for the duration of cancer treatment. If patients live long enough to succumb to their systemic disease because we have controlled their intracranial metastases, we consider treatment successful. Good treatment outcomes occur more often in patients under 60 years with no more than three malignant brain lesions. Regardless of whether a tumor is primary or metastatic, neuro-oncolgic emergencies can occur requiring urgent treatment.

**Pituitary Emergencies**
Though infrequent, it is important to know the warning signs of pituitary apoplexy, a condition that occurs when a pituitary tumor (adenoma) rapidly grows and hemorrhages, and / or causes an infarction to the pituitary gland. Symptoms include headache, nausea and vomiting, ptosis, diplopia or visual loss. Nearly 15 percent of patients are asymptomatic when they first present. Only about 5 percent of patients may complain of severe headache and fear they are going blind. Hemorrhage of the pituitary is a severe emergency.

Watch out for apoplexy of the pituitary, not infrequently associated with pregnancy or delivery, where it is called Sheehan’s Syndrome.

Be aware that when patients present with double vision, visual complaints, visual paralysis, visual loss, ptosis and mental status change, these symptoms may represent very urgent conditions.
**Brain Hemorrhage**
Many tumors hemorrhage. Neurosurgeon Lilyana Angelov, M.D., of the Department of Neurosurgery and the Brain Tumor Institute, noted that a retrospective study of 761 patients with tumors found that 3.5 percent of the tumors hemorrhaged, often causing neurological deterioration.

Management of brain hemorrhage is very patient- and condition-specific and includes both non-surgical and surgical options. Excellent functional recovery is possible in patients with tumor-associated hemorrhage, but early detection and rapid intervention are key.

**Seizures**
Seizures are transitory, abnormal motor, sensory, autonomic or psychic phenomena that result from transient dysfunction of a part or all of the brain. They usually occur suddenly and are related to abnormal electrical activity. Though rarely life-threatening, seizures are often the first sign of a brain tumor. About 50 percent of patients with a primary or metastatic brain tumor will have seizures during the course of their disease.

The ABCs of treatment apply. Then, stop the seizure with an anxiolytic (such as Ativan) and administer an anti-convulsant (such as Dilantin). Neuro-imaging should be considered, especially since 10 percent of newly diagnosed brain tumors present with a seizure.

**Hyponatremia**
The average normal range for serum sodium is between 134 and 148. Patients may become hyponatremic due to the abnormal persistent release of antidiuretic hormone. In this condition, patients do not lose salt, but rather retain water. Mild hyponatremia begins at 133 mmol/L, is severe at 125 mmol/L, and is life-threatening at 120 mmol/L. The osmotic water shift that occurs causes an increase in intracellular fluid volume in the brain’s cells. Nausea, malaise and headache progress to lethargy as the sodium level drops. Seizures, stupor and coma quickly follow.

**Treatment**
It is important to correct hyponatremia by gently raising the plasma sodium level and replacing any sodium or potassium deficits, while restricting water.

**Summary**
Although earlier diagnosis has reduced the frequency of neuro-oncologic emergencies, patients rely on the surveillance skills of nurses who will be the first to notice that something is wrong. Careful assessment, timely intervention, and thorough evaluation are three necessary skills that nurses must demonstrate when caring for brain tumor patients. Although nausea and vomiting are common and could indicate the flu, nurses should also be watching the patient for a dilated pupil, change in mental status or severe headache. This careful attention to these subtle signs makes all the difference.

E-mail comments to sorensl@ccf.org.

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**The Contents of the Cranium**
The brain, with its two hemispheres and multiple lobes is enclosed and protected within the cranium, a rigid structure with eight bones. The brain is further supported by two major dural folds — tough fibrous membranes that form the outer envelope of the brain and spinal cord. The dura helps prevent excessive movement of the brain within the cranial cavity. Multiple cerebral arteries supply blood and venous drainage. The brain occupies 80 percent of the intracranial contents, with blood and CSF taking up the rest of the space. If a tumor or abscess is added, intracranial pressure rises.
Caring Conversations

Nurses learn to explore end-of-life issues for themselves and with their patients

Studies reveal that more than 2.5 million people die each year, and that many who die in hospitals have no decision-making capacity.

To help nurses and health care professionals gain clarity about their own preferences and values for end-of-life care, converse with critically ill patients and their families about end-of-life issues, and become better advocates for the rights of terminally ill hospital patients, the Division of Nursing has initiated an advance directives workshop called Caring Conversations.

Originally developed as a community-based program by the Center for Practical Bioethics, trained facilitators have revised the original program to better meet the needs of Cleveland Clinic nurses who care for critically ill patients.

Caring Conversations was developed when results were released in 1995 from the SUPPORT Study—the largest study ever undertaken to understand prognosis and preferences for outcomes and risks of treatment. Funded by the Robert Woods Johnson Foundation, the eight-year study of 10,000 critically ill patients in five leading hospitals gave poor marks to end-of-life care in hospitals.

The study revealed that all too often efforts to prolong life merely prolong pain and suffering. For many patients, dying became an arduous process made worse by the medical care they received. Half the time, the study found, physicians never discussed the possibility of death with dying patients and only 47 percent of physicians knew that patients did not want CPR. Family members reported that conscious patients who died at the hospital suffered moderate to severe pain at least half the time. Families also reported they were financially devastated by the cost of end-of-life care.
The Caring Conversations Program at Cleveland Clinic addresses both the personal and professional needs of nurses. On a personal level, the program helps nurses communicate with the most important people in their lives about their own goals, values and preferences for their end-of-life care. Professionally, it gives them tools for listening to patients and initiating caring conversations with patients (and their family members) who face life-limiting choices. The program provides guidance in how to document important information about patient and family preferences and choices.

Documentation is an important part of the Patient Self-Determination Act, which was released by the federal government 15 years ago, changing nursing practice. The act provided guidelines to ensure patients have the right to participate in making decisions about their own health care in the event they are unable to make those decisions for themselves. It established policies and procedures whereby patients had to be informed about their rights in writing. Institutions had to document in the patient's record what patients were or were not told about their rights and what information patients were given about advance directives.

Each state is allowed to interpret the federal guidelines in a way conducive to state politics and citizen practice. Institutions within each state must specify the program that will best fulfill the mission and vision of the institution within the context of the state regulations backed up by the federal guidelines.

At Cleveland Clinic, guidelines for advance directives are based in part on Ohio statutes that guide institutions’ policies and procedures about how to fulfill a patient’s right and ability to participate in advance directives.

Typically, less than 25 percent of people have advance directives, and even fewer bring the papers to the hospital with them. Even if advance directives are available, providers don’t always follow them, in part because the patient never spoke with family members about their end-of-life preferences, and anguished family members often become unwilling to agree to follow the directives. Many advanced directives are incomplete, contain contradictory or inconsistent directives, or directives that are medically inappropriate, illegal or unethical.

Caring Conversations is offered to Cleveland Clinic nurses and health care professionals to clarify federal and state guidelines on end-of-life care and provide information on available forms of directives and their limitations. The customized two-hour workshop begins by exploring personal goals and values around end-of-life issues before moving into applying information to clinical practice. Caring Conversations teaches nurses how to shift the emphasis from documents to conversations and trains them to help patients explore the many end-of-life choices available. Nurses are guided in how to speak with family members about the patient’s choices and how to help families respect the patient’s wishes. Caring Conversations also empowers the health care team to honor patient preferences. Caring Conversations are important because the absence of a living dialogue weakens the written word.

E-mail comments to wociall@ccf.org.
One of the highlights of the 2006 Orthopaedic Conference was the video feed of a live reverse total shoulder arthroplasty (RTSR), performed by Joseph Iannotti, M.D., Ph.D. at Cleveland Clinic. This new type of shoulder replacement surgery has been available in the United States for two years. The RTSR surgery differs significantly from conventional shoulder replacement surgery, but the care of the post-operative patient is the same for both types of surgery. “Since most nurses are not exposed to surgery, seeing a live surgery helps them better understand why the patient has pain and why the arm needs such total care after surgery,” said conference co-director Dawn Gerz, RN, RNFA, ONC.

Conventional shoulder replacement recognizes nature’s design, which means the glenoid remains the “socket” and the humeral head remains the “ball.” In RTSR—commonly known as Delta shoulder replacement—the socket becomes the ball and the ball becomes the socket. RTSR improves leverage and helps strengthen the deltoid muscle.

Reverse total shoulder arthroplasty is new. Because the design of the shoulder is changed, RTSR is rarely, if at all, performed on people younger than 70. In addition to age, patients must have a massive rotator cuff tear and secondary glenohumeral arthritis. Patients must be in pain and unable to lift their arm.

Reports indicate that the complication rate with RTSR is high and, in some series, as high as 30 percent when taking into account both major and minor complications, which is substantially more than the 10-percent complication rate found...
in conventional shoulder replacement. Yet, RTSR provides almost immediate pain relief and improved functional use of the ADL in patients who would otherwise have poor functional outcome with conventional TSA. The $9,000 cost of RTSR is twice that of a normal shoulder replacement. Studies, including cost analyses, are needed to assess impact of RTSR on quality of life. In our own clinical experience with the RTSA, the functional outcome and quality of life indicators show better functional improvement and relief of pain for patients with rotator cuff tear arthroplasty when compared to conventional hemiarthroplasty at one-year follow-up.

**Pre-Op Education**

Total shoulder replacement surgery usually lasts two to three hours and patients are hospitalized two to three days. Pre-op education is important in preparing patients for the procedure, the aftercare and the physical exercises that begin immediately following surgery and continue for six weeks. Pain medication and cold therapy are used initially.

**Immediate Post-Op**

Wound care ensures the incision is well approximated and the dressing is dry and changed after the first 24 hours. Encourage patients to get out of bed. Discuss the limits of activity and the importance of continuing the exercises at home. Explain the signs of potential complications and provide a full overview of when to use cold or heat therapy.

Bedside nurses can initiate simple range of motion and stretching exercises following surgery, such as ball squeeze and elbow flexion extension—all done at waist level with the elbow at the side of the body. Supine passive elevation is usually started in the first 24 hours after surgery. After the first week post-op, heat may be applied for 10 to 20 minutes prior to exercising; apply ice afterward. Increased pain lasting more than one to two hours after exercising indicates that the arm was exercised too much.

Pendulum exercises are also good to start in the first few days after surgery. The patient stands with the good arm supported on a stable surface, bends forward and allows the affected arm to hang loosely. Slowly, the patient swings the arm forward and backward. Squeezing a rubber ball or gauze roll for five seconds and releasing and repeating 10 times will help. Throughout the rehabilitation process, patients make the greatest progress when each of the exercises is done 10 times each, five times a day.

**Post-op education on recovery and rehabilitation includes these instructions:**

- no sudden movements
- no lifting and carrying with that arm except for lightweight items such as a coffee cup
- no pushing or pulling above waist level
- use of ice as needed
- avoidance of alcohol while taking pain medication

Physical therapy will initiate Phase I exercises (as noted above) while the patient is in the hospital and continue them on an outpatient basis. Phase I exercises permit healing, reduce shoulder stiffness, facilitate collagen healing, control pain and inflammation and enable simple range of motion.

**Education for Going Home**

The patient is sent home with the affected arm immobilized in a sling or small abduction pillow sling for comfort. Assure the patient that the sling can be removed at home and while exercising. Wear the sling out in public to protect the arm from unintended sudden movement or bumping.

Be sure that patients understand the importance of continuing their exercises at home. Prior to leaving the hospital, patients must be able to do their exercises independently or with the help of a family member who knows how to correctly perform them. Failing to continue the exercises at home puts the patient at increased risk for shoulder stiffness.

Therapy will advance the patient to Phase II exercises at three weeks post-op to improve the shoulder’s full range of motion, increase neuromuscular control and strength and normalize scapulohumeral rhythm. How fast the patient progresses in healing depends on the size of the rotator cuff tear, tendon involvement and overall quality of the tissue. A full six weeks of healing is essential before a patient can progress to more active exercises.

*James Ciccone, RN, BSN, is a nurse clinician in the Department of Orthopaedic Surgery at Cleveland Clinic. He was elected to the Cleveland Clinic Nursing Hall of Fame in 2004.*

E-mail comments to ciconj@ccf.org.
Treating Developmental Dysplasia of the Hip

Scott A. Arkwright, RNFA, BSN, CNOR

Developmental Dysplasia of the Hip (DDH) is defined as an abnormal acetabulum or shallow hip socket. A dysplastic hip typically does not last a lifetime. DDH is more commonly seen in females than in males at a ratio of 6:1 and is slightly more prevalent in the Native American population, probably due to cultural swaddling.

Risk Factors
A genetic predisposition through a family history plays a large role in DDH. DDH is thought to begin in utero as a result of a crowded uterine environment. DDH most commonly affects the left hip, most likely because most babies lie in the left occipital anterior position. About 25 percent of babies with DDH assumed a breech lie in utero. Conditions such as torticollis or metatarsus adductus often accompany DDH and are likely also to be the result of intrauterine crowding. Infants with these findings should be carefully checked for DDH.

The natural course of the disease, if left untreated, is that of ultimate degenerative arthritis of the hip joint. Residual dysplasia is the most common cause of early adult osteoarthritis.

Nurse’s Role
One of the nurse’s roles is to notice and to help assess the presence of risk factors. Although counterintuitive, children with DDH are typically pain-free, even with a dislocated hip, so it is easy to miss the diagnosis. Thigh and gluteal skin fold asymmetry and unequal leg lengths are potential clues to the diagnosis. Ensure that appropriate screenings are scheduled when indicated. Parental education is critical because, in the absence of pain, most parents will not notice a dysplastic hip.

Early Diagnosis and Treatment
Early and ongoing screenings are critical, especially if risk factors are present. Treatment is initiated based on physical exam findings, specifically the presence of instability. At birth, many children have unstable hips during the neonatal period, but these will ultimately stabilize without treatment. When in doubt, an ultrasound at 4 to 6 weeks is recommended if risk factors are present, followed by an X-ray at 6 months. Ultrasound is preferred for infants under 4 months, and X-ray is preferred for infants over 4 months.
The main principle of treatment is to center the femoral head in the acetabulum or hip socket. The presence of the femoral head in the socket is what induces normal acetabular development. As long as the femoral head is in contact with the socket and is moving in the socket, the acetabulum has the capacity to remodel and normalize. The sooner this is accomplished in the child’s life, the better. Best results occur in patients when this is accomplished by age 4.

Harnesses, Bracing and Casting
The femoral head is best reduced into the acetabulum by abducting the hips. There are many ways to accomplish this, including double diapering, bracing, casting and surgery. Historically, children were hospitalized and kept in bed with traction prior to treatment. Pre-treatment traction does not appear to be cost-effective and is no longer the standard of care.

Unstable hips in the neonatal period often respond well to abduction bracing with a Pavlik harness. The brace is inexpensive and has a low risk of complications. The Pavlik harness maintains reduction while allowing the child to move. An additional benefit of the Pavlik harness is that an ultrasound can be done while the child is in the harness. Since the acetabulum seems to remodel better when hip motion is allowed, the Pavlik harness is an excellent choice for treatment, as it allows children to kick and move their legs while wearing the device. Children typically outgrow the harness by the time they are 6 months old and can be transitioned into a plastic ‘cruiser’ brace that accomplishes the same thing while allowing the child to crawl and walk.

In fitting the Pavlik harness, the nurse plays another important role in ensuring that it is properly fitted and that parents are adept at putting on the brace properly. The harness should be fitted to maintain 90 to 100 degrees of flexion. At each visit, talk with the parents, ask questions and ensure they understand the importance of proper fitting to avoid future pitfalls.

DDH in Older Children
Children older than 18 months with developmental dislocation of the hip may require a closed reduction of the dislocated hip in the operating room with application of a hip spica cast. Surgery is often required for children diagnosed with DDH at 18 months and older. We must be more aggressive in treating children older than two years at initial diagnosis because it usually requires more than bracing to get the femoral head back into the acetabulum. Frequently, these operations consist of releasing soft tissue structures that block reduction of the hip, as well as bony procedures (osteotomies) which reorient the proximal femur, acetabulum or both. The combination of these surgical methods allows for a stable reduction of a dislocated hip in an older child. Typically, these children are maintained in a cast for six to eight weeks or more as the bones and soft tissues heal.

DDH is a treatable condition. Early diagnosis and treatment facilitate excellent outcomes with minimal morbidity. Fortunately, most cases are identified early in the child’s life and are nicely treated with minimally invasive methods. Unfortunately, late cases often require more aggressive surgical treatment. The nurse plays a critical role in both identifying the presence of an unstable hip in the pediatric patient and in educating parents about treatment modalities.

Scott A. Arkwright is a nurse clinician in the Pediatric Orthopaedics section in the Department of Orthopaedic Surgery.

Special thanks to Ryan C. Goodwin, M.D., for his assistance.

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

PRESENTATIONS

Academy of Medical Surgical Nurses Convention
October 2005 | Las Vegas, Nevada
Surgical Treatment of Atrial Fibrillation and Chest Pain
Kathy Hill, MSN, CCNS

National Gerontological Nursing Association
October 2005 | Myrtle Beach, South Carolina
Poster presentation: Physical, Functional, Cognitive and Social Interventions by the Geriatric Advanced Practice Nurse in a Geriatric Center
Mary Hujer, CNS

Great Lakes Cancer Nursing Conference/American Cancer Society
October 2005 | Detroit, Michigan
Making “Head” way: Advances in Brain Tumor Treatment
Kathy Lupica, CNP

National Cooperative Growth Study Coordinators Meeting
November 2005 | San Francisco, California
A Program for Transitioning Growth-Hormone-Deficient Adolescents to Adult Endocrine Care
Cheryl Switzer, CNP

OAAPN Statewide Annual Meeting and Conference
November 2005 | Columbus, Ohio
Poster presentation: Collaboration of Nurse Practitioners and Clinical Nurse Specialists in the Care of Interventional Radiology Patients
Barbara Kurent, CNP

American Psychiatric Nurses Association Conference
November 2005 | Nashville, Tennessee
Cognitive Behavioral Therapy, Gestalt Therapy, and Self Psychology Applications in Clinical Practice
Kirste L. Carlson, ND, CNS

13th Annual Scientific Assembly, International Association of Forensic Nurses
September 2005 | Arlington, Virginia
Domestic Violence: A Workplace Issue
Nina Fielden, RN, CNS

Kidney Foundation of Ohio’s 30th Annual Renal Symposium
September 2005 | Cleveland, Ohio
Domestic Violence: Identification and Intervention
Nina Fielden, RN, CNS

Oncology Nursing Society
November 2005 | Webcast
Control of CINV: Sparking a Change in Your Practice
Diana Karius, RN, CNS

APPOINTMENTS

Nina Fielden, RN, CNS
2006 President
Greater Cleveland Emergency Nurses Association

Jeff Arnovitz, RN, CNP
President
Buckeye Chapter of the International Transplant Nurses Society

PUBLISHED

Pericarditis: Inflammation or Infarction?
Journal of Cardiovascular Nursing 20(4), 2005, 239-244
Taletha Carter RN, MS, CCRN
Carrol Ann Brooks, RN, BSN, CCRN

The Quest Project
O.R. Manager, January 2006
Robert Lovequist, RN
Nurse Manager, Orthopedics Operating Room

BOOK CHAPTERS

Triage Nursing Secrets
St. Louis, Mosby Elsevier, 2006
Depression and Suicide; Violence and Security Issues
Nina Fielden, RN, CNS

UPCOMING CONFERENCES

2nd Annual Cleveland Clinic Nursing Research Conference
May 11, 2006, 8am to 4pm
Bunts Auditorium, Cleveland Clinic main campus
For more information: clevelandclinic.org/nursingresearch

For more information, e-mail Connie Ciamacco at ciamacc@ccf.org.
Save the Date: May 11, 2006

Nursing Research Conference

Cleveland Clinic’s Department of Nursing Research & Innovation is hosting the 2nd Annual Nursing Research Conference, on May 11, 2006. The Making Nursing Research a Reality conference provides an opportunity for nurses and students to discuss clinical nursing research, to network and to share research with colleagues. The conference brochure is available at clevelandclinic.org/nursingresearch.

Cultivating the Nursing Workforce of the Future

Cleveland Clinic Office of Civic Education Initiatives is launching a high school summer internship program for high school students interested in pursuing careers in nursing. The Nurses of the Future Program begins in June and is open to students who will be entering the 11th and 12th grade next fall. The paid internship will give qualified students the opportunity to work alongside nurses at Cleveland Clinic in the areas of nursing research and patient care. The program provides an opportunity for students to learn firsthand about careers in nursing. It also clarifies potential misconceptions and motivates students to pursue careers in this critical field. For more information, contact Rosalind Strickland, Senior Director, Office of Civic Education Initiatives, Cleveland Clinic, at 216.445.6600. Or visit clevelandclinic.org/civiceducation and click on “Nursing Internships.”

Coming Soon...

Notable Nursing soon will be available for distribution via e-mail. If you’d like to be added to our e-mail distribution list, please subscribe at clevelandclinic.org/nursing.
Nurse of Note

Nancy Albert, PhD, RN, CCNS, director of the Cleveland Clinic Department of Nursing Research and Innovation, knew as a teenager that she wanted to be a nurse. “In biology,” she recalls, “I was intrigued with exploring the body and learning how it ticked. I have always wanted to know more about it.”

Albert received her nursing diploma from Huron Road Hospital in 1977. After becoming an assistant nurse manager, she realized she needed to go back to school for a bachelor’s degree. She received her BSN from Cleveland State University in 1985.

In her 14th year of working for Huron Road Hospital, she thought about making a change. At the Cleveland Clinic annual cardiac care nursing conference she had heard news about research and how it affected patients. “I wanted to be on the cutting edge of what was going on in research,” Albert says. So she went to work for Cleveland Clinic as a nurse manager in the coronary care ICU. “There, I saw research firsthand because at any one time five or six CCU patients were involved in research studies. I began to think about nursing from a research perspective.”

In 1991 she received a MSN from Kent State University and she became a CNS in 1996. “As a CNS, I had more opportunities to do research and to help staff nurses think about what they were doing at the bedside.” She realized that research was her true passion. Albert was appointed director of Nursing Research and Innovation in 2004. She received her PhD this past summer from Kent State University.

Since her appointment to director, Albert has been building the infrastructure of her research department. She is one of four PhD nurses on staff and has about 90 research projects in various stages of development. This year, she plans to add a part-time nurse ethicist to her team. Albert also wants to build a repository of current and past research that would give nurse researchers access to studies.

Her department is gaining national recognition as a model for building a nursing research program and she often is asked how to get staff nurses involved in research.

“Nurses are excited to do research when it involves patients on their unit,” Albert says. “It is exciting to see nursing research teams moving forward with project work while juggling their busy work schedules. They are making it happen.”

Albert is currently studying why patients with heart failure adhere or not to self-care directives in their treatment plan. She has designed a research tool to measure patient knowledge and she already has applied this tool to several studies. Next, she plans to develop an intervention study that will help patients understand more about heart failure and how their actions impact their health.

Albert enjoys spending time with her husband and three children. She is an avid bicyclist and gardener and enjoys winter skiing. She creates stained glass windows and lamps and, for relaxation, reads “good, juicy novels.”

Albert is struck by how her decisions have led her to her passion. “I am glad for a curious mind; wanting to know how we can do things better, both for patients and for nursing peers.”

Albert has more than 100 articles published in nursing journals. Her most recent article is about the revised guidelines on managing patients with chronic heart failure. In the article, Albert encourages nurses to measure and monitor how the guidelines are working in a clinical setting so that they can adjust their practice based on the evidence. “Evidence-based practices will ensure patients are getting the best care possible,” she says. Albert submitted the article to the American Association of Critical Care Nurses’ Advances in Critical Care journal.

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