a triad of care: DEFINING NURSING PRACTICE

Cleveland Clinic Division of Nursing Develops a New Practice Model

As hospitals across the nation struggle with the nursing shortage, nursing leadership at The Cleveland Clinic embraced the crisis as an opportunity to assess, refocus and redefine what nursing practice is at the Clinic.

“Although nurses are highly respected by the public, confusion remains about the essence of nursing practice,” notes Michelle Dumpe, Ph.D., RN, director of Nursing Education, Research and Quality Management at The Cleveland Clinic. Nurses themselves often have difficulty defining the unique role they play in patient care, she says. “They talk about their work as it relates to medical interventions or medical diagnoses. But, often, they feel frustrated because they do not believe they are valued for the contributions they make to patient care or to attaining positive patient care outcomes.”

At The Cleveland Clinic, the time was right to introduce a new practice model for nursing. Dr. Dumpe explains that a conceptual model was developed that includes three essential and measurable domains of nursing practice: comfort, safety and education. Comfort interventions address the alleviation of physical, psychological, social and spiritual distress. Safety interventions focus on patient protection from injury or harm. Educational interventions assist patients and their families in making decisions, acquiring skills or learning self-care strategies.

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Welcome to the spring 2003 edition of Notable Nursing, a newsletter produced by the Cleveland Clinic Division of Nursing. Now in its second year, we are pleased to broaden the distribution of this newsletter to our colleagues in the community and the nation. We also wish to welcome nursing faculty and students to our readership.

In this issue, you’ll read about our new nursing practice model that is based on a collaborative team approach. The model has been designed to elevate the stature of nursing at the Clinic by giving a voice to nursing practice — demonstrating that nurses provide care that is complex, skilled and essential.

You’ll also learn about a new nonverbal pain assessment tool that we developed for use in our intensive care units. An update on feeding tube practices is provided, as well as a review of ventricular assist devices. Those interested in neuroscience nursing will want to read the highlights from our 5th Annual Neuroscience Nursing Conference. From a personal perspective, read how one couple, who met and fell in love in nursing school 20 years ago, continue to find their nursing careers professionally and personally fulfilling.

Notable Nursing reflects the commitment that Cleveland Clinic nurses share to deliver the highest quality patient care — a commitment that is responsible for the Clinic’s ongoing ranking as one of the nation’s top-rated hospitals.

We hope you enjoy this issue of Notable Nursing. Please share it with your colleagues, and let us hear from you. We would love to cover topics that interest you.

Shawn M. Ulreich, MSN, RN
Chief Nursing Officer, Division of Nursing
Shawn M. Ulreich was appointed Chief Nursing Officer for the Cleveland Clinic Division of Nursing in April 1998. Ms. Ulreich received her master’s degree at Kent State University in 1990 and also serves on their adjunct faculty. She began her nursing career at The Cleveland Clinic in 1984 as a clinical instructor for the oncology and bone marrow transplant units. She later served in various clinical, supervisory and administrative roles prior to being named chief nursing officer.

I am pleased to serve as Executive Editor of Notable Nursing and hope you find our articles and stories interesting and helpful in your career. We hope to hear from you and trust you will share your thoughts and comments with us. If you have questions or topics you would like us to cover, please e-mail me at dumpem@ccf.org.

Michelle Dumpe, Ph.D., RN

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A conceptual model of nursing practice gives voice to the many facets of patient care provided by nurses. The Cleveland Clinic Nursing Practice Model facilitates articulation of nursing practice among nurses, other health care providers and the public. By developing this model, Cleveland Clinic nurses now can speak to their unique contributions to patient outcomes. It provides a visual depiction for the work and practice of nurses. It serves as a foundation for decision making in the Division of Nursing by differentiating nursing practice from non-nursing activities. It has assisted in the development of a team model of care utilizing nurses and nonlicensed personnel to provide daily care for Clinic patients. It is the focus of educational presentations to high schools and community groups about the practice of nurses.

“We used a chunking methodology to organize common nursing interventions into the three domains of practice,” says Dr. Dumpe. The patient is at the center of the model, which reinforces that patients are the focus of nursing care. The model and philosophy of practice are incorporated into the Clinic’s nursing orientation program for all new staff, which provides a clinical focus for each of the nursing practice domains.

To measure the influence of the practice model on patient outcomes, quality indicators were selected to evaluate patient care in the three domains of practice. The practice model is reinforced through a graphic identity that is on all written materials from the Division of Nursing.

“We believe this practice model can be helpful in elevating the stature of nursing practice at the Clinic,” says Mary Beth Modic, MSN, RN, CNS, clinical nurse specialist for Patient Education, who was instrumental in working with Dr. Dumpe and the nursing leadership group in developing the new practice model. “We are trying to demonstrate and communicate that nurses provide care that is complex, skilled and essential” says Ms. Modic.

Recognizing that the shortage of nurses presents an opportunity to reevaluate the processes and workloads of patient care, the Division of Nursing also embarked on a pilot project on three patient care units; medical, surgical and birthing services, explains Dr. Dumpe. The objective of the pilot was to evaluate the work of all patient care providers, with the goal of developing a care partnership between licensed and nonlicensed care providers.

Initially, staff nurses were uncomfortable delegating the care of patients to patient care nursing assistants, as they had limited experience in the team approach to care.

The new nursing practice model was used to facilitate discussions on working together as partners in patient care. Instead of focusing on what to delegate, the members of the pilot units were asked to think of ways nurses could safely share their practice with other patient care providers. This focus moved nursing unit members from a stance of hierarchy to one of team thinking. For example:

- What tasks of the comfort domain could be shared with unlicensed providers?
- How could patient care nursing assistants help with safety needs of patients?
- How could the unit secretaries assist in the flow of patient care?

Once the discussion and planning were underway, all members of the patient care nursing units recognized that their communication skills needed improvement. Reporting between shifts and among the team providers was restructured to improve the flow of patient care information.

Because Cleveland Clinic patients require complex patient care, the nursing leadership team decided to strengthen the training of nursing assistants to enhance their skills and increase their confidence in providing care. In addition, classes in teamwork and building trust among care providers also were provided.

“We were very gratified with the results from the pilot project,” says Dr. Dumpe. “In a very short period of time, we were able to implement changes that improved nursing practice.”

Adds Ms. Modic, “The Cleveland Clinic’s model of care is based on collaboration. We now have in place in the nursing division a dynamic team approach that recognizes and quantifies the excellent care our nurses deliver.”

Michelle Dumpe joined The Cleveland Clinic in May 2001 as director of Nursing Education, Research and Quality Management. She received her doctorate degree in nursing science and economics from the University of South Carolina in 1999. E-mail comments to dumpem@ccf.org

Mary Beth Modic, clinical nurse specialist for Patient Education, has been at The Cleveland Clinic for 26 years. She received her master’s degree in nursing from Kent State University in 1987. E-mail comments to modicm@ccf.org
Enteral nutrition is an important aspect in the care of the critically ill patient, but it is not without risks. Tube insertion can result in misplacement or perforation. Patients may experience gastrointestinal complications from the formula, such as diarrhea, flatulence and abdominal bloating. Contrary to popular belief, patients are at risk of aspiration if they are not positioned properly. And the use of tinted feeding solutions to detect aspiration has been shown to pose serious problems for critically ill patients.

Since nurses have primary responsibility for providing enteral nutrition and for monitoring the patient during treatment, their practice should be based on evidence, not tradition. This article provides a review of the facts and myths about nursing care for patients with tube feedings.

**CHECKING NASOGASTRIC OR NASOINTESTINAL TUBE PLACEMENT WITH AIR BOLUS**

Traditionally, nurses auscultated over the patient’s epigastric area while instilling a small amount of air through the tube to determine if the tube was in the gastric region. Research has shown that auscultation is an unreliable method of determining placement. In one retrospective review of tubes that had been inadvertently placed in the respiratory tract, nurses described hearing sounds in the epigastric area in eight of nine cases.

Unfortunately, there is no gold standard bedside test to determine correct tube placement. Definitive methods include a chest X-ray or KUB. Assessing aspirate for color, PH or glucose is useful but not definitive.

**BLUE DYE NO LONGER USED**

Beginning in the 1980s, enteral feeding solutions were tinted blue to determine if patients were aspirating tube feedings. The belief was if suctioned respiratory secretions were tinted blue, the patient must be aspirating the tube feeding. Recent evidence shows that this test is insensitive (Maloney et al, 2002).

In addition, blue dye may pose serious risks in the acutely ill patient (Seidner, 2002). When research found that methylene blue dye can be absorbed enterally and is linked to hemolytic anemia, it was replaced with FD&C blue dye #1. Although it is not absorbed in healthy people, blue dye #1 can be absorbed in the acutely ill patient, causing intense discoloration of skin, urine and even internal organs. Nine cases have been reported to the Food and Drug Administration in recent years, and several of these resulted in death. Because of the insensitivity and risks associated with blue food coloring, it is no longer used at The Cleveland Clinic.

**PREVENTING ASPIRATION**

If blue dye food coloring and auscultation do not detect or prevent aspiration, what does? The old adage: “An ounce of prevention is worth a pound of cure.” has never been more applicable.

The American Society for Parenteral and Enteral Nutrition recently issued a consensus statement on aspiration (McClave et al, 2002). In it, they recommend diligence, precaution and the following guidelines:

- Place the feeding tube in the small bowel instead of the stomach.
- Minimize sedation. Reassess need, level and choice of agents often.
- Minimize narcotic use. Reassess need and choice of agents often.
- Infuse enteral formula continuously instead of intermittent or bolus.
- Use Prokinetic agents (i.e., Reglan).
- Keep head of the bed elevated to 30-45 degrees – ensure that the bend of the bed is at the patient’s lower back.
- If the patient is unable to bend at the lower back, place the bed in reverse trendelenberg.
- Perform good oral hygiene regularly.

**REFERENCES**


This is the first part of a two-part article, describing the development of the Nonverbal Pain Assessment Tool (NPAT). Part two will describe the research on its validity and reliability and will be in the next issue of Notable Nursing.

When patients are admitted to the hospital, one of their greatest fears is that they will be in pain, and it will not be controlled. Also, family members do not want their loved one to experience pain that cannot be controlled.

The Cleveland Clinic Patient Bill of Rights states that all patients have the right to appropriate assessment and management of pain. Nurses within the Division of Nursing assess pain as the 5th vital sign and use a visual analog scale (VAS), which allows the patient to assign a numeric score of 0 to 10 to their pain level.

Patients in the intensive care unit (ICU) are frequently unable to report physical discomfort and pain intensity due to treatment interventions. Therefore, assessment of these patients depends upon the observations of the registered nurse. At the urging of the intensive care nurses, members of the Adult ICU committee decided to create a nonverbal pain assessment tool for adult patients.

A review of the extensive literature about pain assessment included discussion related to behaviors, reports from patients’ significant other(s) and physiologic parameters. Noted behaviors identified in the literature that may potentially indicate pain include the following:

- facial expressions - frown, grimace, fearful, sad, muscle contraction around mouth and eyes.
- physical movements - restlessness, fidgeting, absence of movement, slow movements, cautious movements, guarding, rigidity, generalized tension (not relaxed), trying to get attention (calling out for someone).
- vocalizations - groaning, crying, moaning, and noisy breathing.

It was determined that the pediatric approach for assessment of pain, which uses the FLACC scale to assign a number to observed behaviors that have been identified as clues to pain, had validity in adult patients who are unable to communicate a pain level. Using this framework, an adult behavioral pain tool was developed.

The Nonverbal Pain Assessment Tool (NPAT) created by members of the Adult ICU committee incorporates the following five categories of behavioral indicators:

- emotion
- movement
- verbal clues
- facial cues
- positioning/guarding

Each category is scored on a 0-2 scale, which can result in a total score between 0-10, the same range utilized by the VAS. To determine the behavioral score for each category, the nurse must observe and interact with the patient. For example, to assess the category positioning/guarding, the nurse observer must observe not only how the patient lies in bed but also touch the patient to assess a response to tactile stimuli.

To establish the reliability and validity of this new assessment tool, it was determined that the following research questions should be answered:

- Does the NPAT measure pain (validity)?
- What is the consistency of the pain scores obtained by the NPAT as assessed by two different nurses (reliability)?

Five intensive care units were selected to test the NPAT, representing cardiac surgical, medical coronary and surgery intensive care units. Teams of two nurses collected the data on each unit during November and December 2002 and January 2003. Anecdotal comments from the data collection teams indicate the tool was easy to use and offered direction and consistency in their pain evaluation of a nonverbal patient. The final results of the reliability and validity testing will be included in the next edition of Notable Nursing.

Senior Nurse Researcher Linda Lewicki has been at The Cleveland Clinic for more than 20 years, serving as staff nurse and clinical director prior to her current position. She received her MSN from Frances Payne Bolton School of Nursing, Case Western Reserve University (CWRU) in 1978 and completed her doctorate degree at CWRU in 1997. E-mail comments to lewickl@ccf.org

For biographical information on Michelle Dumpe, see page 3. E-mail comments to dumpem@ccf.org
All of the current ventricular assist devices (VADs) have their roots in the invention of Cleveland Clinic physician Willem J. Kolff, who invented the first artificial heart in the 1950s. After the first recipient of the Jarvik-7 total artificial heart died in the 1980s, attention shifted from perfecting a total artificial heart to heart transplantation. With a limited number of donor hearts available, concern focused on developing VADs to sustain end-stage heart failure patients prior to cardiac transplantation.

Cleveland Clinic heart surgeon Leonard Golding and other national leaders including Robert Jarvik, Christian Barnard, Michael DeBakey and William DeVries shaped the modern ventricular assist device. The first VADs were pneumatically driven by air compressors with large external monitoring consoles that weighed several hundred pounds. Internally implanted blood pumps were approximately five inches in diameter and weighed three pounds.

In 1994, when the Food and Drug Administration approved VAD therapy for clinical use, the monitoring consoles were smaller and portable. But recipients were unable to leave the inpatient setting. Second-generation VADs made use of portable battery systems that allowed patients to leave the acute care setting and await their heart transplant at home. The current generation of VADs assume the full burden of contraction and circulation, relieving the failing heart of its overwhelming workload.

**NATION’S LARGEST EXPERIENCE**

The Cleveland Clinic Heart Center has the most extensive experience in VAD therapy. The HeartMate, the most frequently used device at the Clinic, is strictly a left ventricular assist device. Candidates for this device must have a large enough body size to accommodate the 2.5-pound blood pump, which is implanted in the abdomen. A newer 1998 model, the HeartMate VE (vented electric) model (fig.1), can be powered by two portable batteries that are worn in a lightweight holster vest. Newer revisions in 2001 include more extensive monitoring and alarm features.

The Thoratec VAD system also is used at the Clinic. The Thoratec is ideal for patients with smaller body sizes because the blood pumps lie outside the body (fig. 2). This device has left, right and bi-ventricular assist capabilities and can be used for individuals who have failed other VAD therapy.

**OUR NURSING EXPERIENCE**

Cleveland Clinic nurses have been highly successful in achieving positive patient outcomes in the management of patients with VADs. Because the quality of nursing care influences patient outcomes, nurses must maintain a level of technical expertise as the technology evolves. Elements of unique nursing care for patients with a VAD include assessment/treatment, psychosocial issues and medical emergencies.
Nurses educated to care for patients requiring VAD therapy must have an advanced understanding of the assessment and treatment of end-stage heart disease. Nurses must diagnose and treat assessment findings related to disease pathology as well as potential mechanical problems posed by the VAD equipment. For example, typical nursing management of a heart failure patient might include adding inotropic therapy for decreased cardiac output. However, patients with VADs exhibiting decreased cardiac output syndromes might be well managed with a manipulation of VAD settings. Experienced nurses who care for this exceptional patient population rely on their advanced knowledge to differentiate the most appropriate nursing management. Therefore the age-old adage of “treat the patient, not the monitor” is the paramount nursing guideline.

Nurses also must manage complex psychosocial issues when caring for patients with VAD therapy. In general, nurses who care for individuals with cardiac disease are familiar with the psychological conditions that affect patients with chronic illness. Cardiac patients are prone to develop depressive symptoms as their disease progresses. This situation becomes even more complex when VAD therapy is the only option. Following implantation, the physical symptoms of heart failure are rapidly alleviated. However, it is a harsh reality when patients realize they are completely dependent upon electromechanical support. Patients who are aware of their illness and the possibility of VAD therapy tend to cope with less anxiety. Conversely, those who experience massive myocardial infarction (MI) and wake following emergency VAD implantation will face major changes in lifestyle with difficult psychosocial adaptations. Nursing management includes support of the patient and family through education that covers patient comfort, safety and disease management.

A vital component of patient safety involves actions that are necessary in the event of VAD mechanical failure or rapid medical decompensation. The nurse must integrate knowledge of the VAD with the appropriate clinical skills to manage emergent situations. For example, electrical power to the HeartMate device must be interrupted prior to defibrillation whereas the Thoratec device can remain in the pumping mode during defibrillation. Additionally, chest compressions are contraindicated for both VADs, however, each device has its own “hand-pump” procedure for emergencies. Nurses play a crucial role in educating those individuals with VAD therapy and their families on emergency measures. Comfort and independence in providing self-care enables patients to progress beyond the acute care setting.

WHAT THE FUTURE HOLDS

Clinical trials are revealing the mechanical principles of future ventricular assist devices. In contrast to the current pulsatile VADs, the newer devices will provide continuous flow, which are now known as “axial flow pumps.” These are designed with features similar to jet propulsion technology. A rotating set of impellers draws blood into the pump housing and then thrusts the blood out at approximately five liters per minute. Approximately the size of a lipstick case, the pump housing can be positioned within the native left ventricle or in the pre-peritoneal space. Axial flow pumps currently being evaluated in clinical trials at The Cleveland Clinic include the DeBakey and the Jarvik (fig. 3). The early artificial heart pioneers, Michael DeBakey and Robert Jarvik, remain on the cutting edge of VAD clinical research.

Clinical Nurse Specialist Deborah Hanes has worked at The Cleveland Clinic for 12 years as a staff nurse, case manager and utilization review coordinator. She received her master’s degree in nursing from the University of Akron in 2000. E-mail comments to hanesd@ccf.org

Clinical Nurse Specialist Ross Swanson joined The Cleveland Clinic two years ago. His clinical experience includes working as the VAD coordinator at University Hospitals of Cleveland. He received his master’s degree from Case Western Reserve University in 2001. E-mail comments to swansor@ccf.org
More than 120 nurses gathered in Cleveland in mid-November, 2002, to attend The Cleveland Clinic’s Fifth Annual Updates in Neuroscience Nursing conference. The two-day conference included comprehensive presentations from Cleveland Clinic neuroscience nurses and physicians. Keynote speakers included Reg Green, author of The Nicholas Effect.

Mr. Green told the tragic story of how his son, Nicholas, was killed during a family vacation in Italy. The family’s decision to donate their son’s organs thrust the family into the world spotlight, making Mr. Green an advocate for organ donation. “Nicholas’s death saved seven people, one of whom was within two days of dying,” said Mr. Green. “It helped us in our loss to see that someone we loved was able to save others.”

Allen J. Holl, EMT-P, CPTC, senior procurement coordinator for LifeBanc, discussed the role the neuroscience nurse plays in providing medical support in the management of the organ donor as well as comfort and care to the family. Andrea Wasdovich, BSN, RN, nursing director for surgery and post acute care at The Cleveland Clinic, offered tips on positive thinking and keeping a sense of humor. Other speakers included renowned neuroscience nurse educator, Linda Littlejohns, MSN, RN. Highlights of Ms. Littlejohns’ presentation and those of Cleveland Clinic neuroscience nurses Kathleen Lupica, MSN, RN, CNP, Rebecca Mitchell, MSN, RN, and Joann Palmer, RN, BS, are summarized here.

The conference was organized by Cleveland Clinic neuroscience nurses Sharon Dorsey, RN, CNS, and Lisa Jahan, RN, Nurse Manager of the NICU. Other nurses involved in the effort included Angie Hamm, RN, ANM of the Epilepsy Monitoring Unit, Cheryl Smith, RN, Donor Awareness Coordinator, and Sharon Talkar, RN, ANM of the NICU. Administrative support was provided by Janice Brown and Tonya Ronsko.

For information about the 2003 conference, please contact Lisa Jahan at jahanl@ccf.org or Jane Miller at millerj@ccf.com

“Nicholas’s death saved seven people, one of whom was within two days of dying,” said Mr. Green. “It helped us in our loss to see that someone we loved was able to save others.”

Keynote Speaker Reg Green (l.), author of The Nicholas Effect

**a review of presentations from cleveland clinic neuroscience nurses**

**STAY UP TO DATE**

Kathleen M. Lupica, MSN, RN, CNP, a nurse practitioner in the Cleveland Clinic Brain Tumor Institute, stated that the genetic analysis of brain tumors, new surgical treatments and advances in delivering radiation have improved the odds for patients. “Everything is changing constantly,” said Ms. Lupica. “It is a very exciting and challenging area to work in.” Ms. Lupica noted that nurses must stay up to date. She said that a distinct advantage at the Brain Tumor Institute is the team approach to managing patients. But she insisted, “If you have questions, get on the phone and use your connections. You have to stay up to date on new treatment protocols and clinical studies so you can be a resource for patients.” Ms. Lupica also runs a support group for brain tumor patients and their families. “It is intense,” she said. “They are people just like you and me who have all the normal stresses of life, but now they have to deal with a life-threatening illness.” Ms. Lupica acknowledged that she can’t fully understand what they are experiencing, but she takes heart in being a facilitator of the group. “They help each other and that is very gratifying.”

**ASK THE OBVIOUS**

Advance Practice Nurse Rebecca Mitchell, MSN, RN, who works in the Department of Pediatric and Adolescent Neurology, discussed current treatment modalities for headaches in adolescents. “Chronic non-progressive headaches in adolescents are common and may be difficult to treat,” she said. “We ask a lot of questions about the child’s headache, such as how often it occurs and how it feels. But we need to be sure to ask the obvious and sometimes overlooked questions about school, friends and family. She stressed that overuse of over-the-counter pain medications can cause rebound headaches. Ms. Mitchell stated that a lot of time is spent on educating adolescents and their families about headaches and treatment options. Ms. Mitchell stressed that in evaluating children, the physical exam is expected to be normal. If the physical exam is abnormal, there may be another underlying condition that needs further investigation. Children and adolescents who are diagnosed with chronic non-progressive headache can be helped with a combination of emotional and psychological support and medical interventions.
Linda Littlejohns, MSN, RN, an internationally renowned neuroscience nurse educator stood before the nurses gathered at the Fifth Annual Updates in Neuroscience Nursing conference and urged them to “keep learning.”

“There is nothing more rewarding or more challenging than neuroscience nursing,” said Ms. Littlejohns, whose love for the specialty developed more than 20 years ago when she was a trauma nurse. “CT scans didn’t exist then, so the only way to educate myself was to go down to the pathology department and study the human brain.”

Throughout her review of vascular anatomy, Ms. Littlejohns stressed the need for nurses to think critically and ask questions. Why did the doctor order this? Why am I doing this? “You have to own your practice,” she said.

“Knowing the nuances of what happens to patients when the blood supply is altered or diverted can help you understand why your patient is behaving in a certain way,” she stated. For example, a patient who has a fracture, undergoes surgery or sustains trauma to the bony prominence of the anterior/posterior skull may have sequellae two years out. Damage to these blood vessels can result in cognitive damage. An example is the teenager who suffered a head injury in sports, who may now be acting up in class.

A thorough understanding of vascular anatomy enables nurses to make critical assessments. Since minutes matter in the neuro-intensive care unit and on the floor, nurses must pay immaculate attention to detail, noted Ms. Littlejohns. “Remember, bleeding will find the path of least resistance. If you notice bruising behind the ear on the mastoid bone, this may be a ‘battle sign’ but it may mean there is skull-based vessel bleeding. The patient needs immediate attention.”

Don’t minimize symptoms, she stressed. If your patient says, “This is the worst headache I’ve ever had. I feel like I’m dying,” pay attention. Look at your patient’s coordination. All of your initial assessments may be normal until you ask the patient to touch your finger and you find that their bleed is occurring in the posterior circulation of the cerebellum and is life threatening.

“It all gets down to you and me,” Ms. Littlejohns said. “The bedside nurse is the patient’s advocate. Do your assessments. Know vascular anatomy. Question the orders. Pay attention to the details. At the end of the day, you want to be able to say, ‘I did everything I needed to do for my patient.’”

Don’t assume anything

Joann Palmer, RN, BS, Department of Neurological Surgery, reviewed anatomic and physiologic features of Chiari I malformations in one of the breakout sessions. A thorough discussion of diagnosis, surgical intervention and nursing issues was presented. Ms. Palmer noted that the advent of MRI “opened a window” on the diagnosis of Chiari malformation, providing four times as much information as CT. “Be aware that the symptoms of Chiari malformation, which include headache, sensory changes, balance problems and arm weakness, may mimic other diseases such as multiple sclerosis,” said Ms. Palmer. “Assume nothing,” she stressed. “Take the time to listen to your patient’s symptoms and learn everything you can.” For some patients, Chiari I malformation is self-limiting. She mentioned that nurses should educate patients about the risks and benefits of surgery and indicate that they can expect a minimum six-week postoperative recovery. “Look at the patient as a whole, not just a single diagnosis.”
PRESENTATIONS AT NATIONAL AND LOCAL NURSING ASSOCIATIONS

American Organization of Nurse Executives  
March 29-April 2, 2003, New Orleans  
Poster Session: A Triad of Care: 
The Essence of Nursing Practice at The Cleveland Clinic  
Michelle Dumpe, Ph.D., RN and Mary Beth Modic, MSN, RN, CNS

National Association of Clinical Nurse Specialists  
March 26-29, 2003, Pittsburgh  
Poster Sessions  
The CNS Role in Product Evaluation  
Deborah Hanes, MSN, RN, NP, CNS and Diane Palec, MSN, RN, CNS

Malice in the Workplace  
Kirstie Carlson, MSN, RN, ND; Mary Beth Modic, MSN, RN, CNS;  
Carol Ann Brooks, BSN, RN, CCRN and Debbie Solomon, BSN, RN

Development of a Conceptual Model for Nursing  
Michelle Dumpe, Ph.D., RN; Mary Beth Modic, MSN, RN, CNS;  
Kirstie Carlson, MSN, RN, ND and Diane Palec, MSN, RN, CNS

Implementation of a New Directive for  
Acute Myocardial Infarction Patients  
Deborah Kelin, MSN, RN, CCRN, CS; Nina M. Fielden, MSN, RN, CEN

Treatment of Community-Aquired Pneumonia  
Nina M. Fielden, MSN, RN, CEN

Presentations  
The Nurse Manager and Clinical Nurse Specialist:  
Partners in Research for Care of Colorectal Surgery Patients  
Diane Palec, MSN, RN, CNS and Bruce Robinson, RN, Nurse Manager

Leave them Laughing: The Use of Humor to Promote Change  
Mary Beth Modic, MSN, RN, CNS and Diane Palec, MSN, RN, CNS

3rd Annual Orthopaedics Excellence through Education  
April 4, 2003, Independence, Ohio  
Presentation: Ha! Ha! It’s Off to Work We Go  
Cleveland Clinic Department of Orthopaedic Surgery  
Mary Beth Modic, MSN, RN, CNS

Research Symposium  
sponsored by Sigma Theta Tau, Rho Xi chapter  
April 9-11, 2003, Savannah, Georgia  
Nursing Practice: A Conceptual Model of Care.  
Michelle Dumpe, Ph.D., RN, Keynote speaker

Northeast Ohio Clinical Nurse Specialists  
April 9, 2003, Independence, Ohio  
Real Life Experiences of Dealing with Sepsis-Related Delirium  
Deborah Hanes, MSN, RN, CNP, CNS

UPCOMING NURSING CONFERENCE

23rd Annual Dimensions in Cardiac Care  
Sunday, September 7 through Tuesday, September 9, 2003  
This year the symposium will be held in the new Intercontinental Hotel and Conference Center on The Cleveland Clinic campus. The conference is intended for nurses caring for adult and pediatric cardiac patients in the ICU, cardiac catheterization setting, stepdown, telemetry, and emergency department. The conference features presentations on 12 lead ECG interpretation, hemodynamic monitoring, pacemakers, EPS studies, myocardial infarction, thoracic surgery, heart failure, transplantation, cardiac surgery and many others.

For more information, go to www.clevelandclinicmeded.com
The future of nursing is here

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 2002, 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 the past eight years by U.S. News and many other specialties, including urology, neurology and neurosurgery, orthopaedics, otolaryngology, gynecology, gastroenterology, geriatrics, endocrinology, nephrology, respiratory disorders and rheumatology are ranked among the top ten.

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 at The Cleveland Clinic. There is no better place to learn, see and do. Join us and be a part of the future of nursing.

Visit our web site at www.clevelandclinic.org/nursing or call 800/223-2273, ext. 44000.
Amidst the gloom and doom in articles and media stories about the nursing shortage, which often portray an inaccurate image of the nursing profession, are untold stories that focus on individuals who find incredible personal and professional fulfillment as nurses.

This special feature will provide an up-close look at families—husbands and wives, mothers and daughters and mothers and sons—who have made nursing a family tradition. We hope you’ll find their stories inspiring and uplifting.

Some people believe nursing is a calling. For many people who may have been headed toward another career, someone comes along and directs them into the nursing profession.

Such was the case with Gerard and Kathy Beattie. Gerard was pursuing an elementary education degree at Salve Regina College in Rhode Island when family concerns required his return to Cleveland. Determined to get his degree, Gerard saved money while he worked in a factory in Cleveland. When he was financially able, he enrolled at Kent State's Ashtabula Campus. “My interest in science and the wonderful mentor I had in Kent’s Dean of Nursing, Estelle Stofko, led me to a career in nursing,” says Gerard, who graduated with his ADN in 1981.

Meanwhile, Kathy Zupcsan, who had graduated from The Ohio State University (OSU) with a BS degree in physical education, was working as an assistant coach at OSU. Kathy was a talented field hockey player who was hoping to make the U.S. Olympic team when she suffered a serious hand injury. “The orthopaedic surgeon who took care of my hand knew my athletic career was over and steered me to the Kent State nursing program,” says Kathy. GERARD

Kathy and Gerard met while at Kent State’s nursing school. Romance blossomed, and they were married in 1982 after completing nursing school. Commuting from Ashtabula, they began working at the Clinic. Kathy worked as a staff nurse on 4 North, ENT Surgical Unit. She also served as a clinical instructor for the unit. Gerard was assigned to 5U, an Infectious Disease Unit. In 1987, Kathy and Gerard left the Clinic to work closer to home while their children, Elizabeth, Gerard, Eric and Katherine, were young.

The Beatties returned to the Clinic in 1994, where they worked as staff nurses and preceptors, mentoring both nursing students and new staff. Their careers and passion for nursing are flourishing at the Clinic.

Gerard mentors students and new staff on G61, Surgical ICU. He is a dynamic teacher who effortlessly guides new nurses as they refine their skills and knowledge. His wisdom and expertise are evident, whether he is explaining a patient’s condition or titrating vasoactive drugs. “The working environment on G61 is especially professional and collaborative,” says Gerard. “It allows me to thrive. I love being at the bedside. This is clearly where I belong.”

Kathy loves the challenge of nursing and says she has never stopped learning and finds great satisfaction in nursing. “Patients depend on nurses to care, to comfort and to give them hope,” she says. “I work with nurses who do this quietly and effortlessly. I am in awe, and I am inspired. Nursing is hard work, but I know of no other profession that is as gratifying.”

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Kathy and Gerard Beattie

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