

# Caring

HEADLINES

November 1, 2001

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# Perioperative Nurse Week

November 11-17, 2001

*This issue of Caring Headlines spotlights the perioperative services at MGH, supporting the theme of this year's Perioperative Nurse Week celebration: "Caring Today—Preparing for Tomorrow!"*



Kathy O'Brien, surgical tech



Diana Telfort, RN



Lisa Carr, RN

**MGH** Patient Care Services  
Working together to shape the future

## Knowledge is empowering

We're all familiar with Franklin Roosevelt's famous words, "The only thing we have to fear is fear itself." While the events of September 11th may indicate otherwise, there is still truth to these words. Fear can be triggered by unrealistic or exaggerated concerns. I've found that knowledge can go a long way toward allaying fear, even when there's legitimate reason to be afraid.

In my interactions with staff and leadership, I'm hearing messages of concern. This is completely normal and understandable. We are all concerned. To help allay my own fears, I have sought out facts and information, for I truly believe that armed with knowledge and reason, calmer heads will prevail.

On October 17th, I attended the quarterly meeting of the MGPO and heard a presentation by Drs. David Hooper, director of Infection Control, and Stephen Calderwood, chief of Infectious Disease. They provided a very concise and realistic overview of bio-terrorism, specifically, the threat of the spread of anthrax. Their presentation was thoughtful and factual, with none of the 'hysteria' that tends to accompany television newscasts. By the end of the presentation, I felt

informed and less fearful. Because this presentation was so well done, we are scheduling similar educational sessions for employees. I will keep you informed of dates and times, and I hope as many of you as possible will plan to attend.

I have also sought information about our own safety and security here at MGH. Bonnie Michelman, director of Police and Security, assures me that effective security is the result of:

- A well-trained security team, which we surely have at MGH.
- State-of-the-art integrated security technology, prudently responding to the needs of the institution. Over the last few years integrated security systems have been installed at MGH; work on this new technology continues as we speak.
- Informed and aware staff. Every member of the MGH community has a responsibility to be aware of his or her work environment. We must all be vigilant about identifying and addressing quality and safety issues.
- Effective policies and procedures. We have taken great care in crafting our policies and procedures to ensure the highest level of security for MGH staff, patients

and families. One of the simplest, most important steps every member of the MGH community can take is to wear your ID badge.

As senior vice president for Patient Care, I'm proud to say that we have created a strong and durable infrastructure. I have complete confidence that MGH is a safe and secure environment. Yes, our nation is facing serious and unprecedented challenges, but I ask you not to give in to fear of the unknown. Temper your fear with information; temper your con-

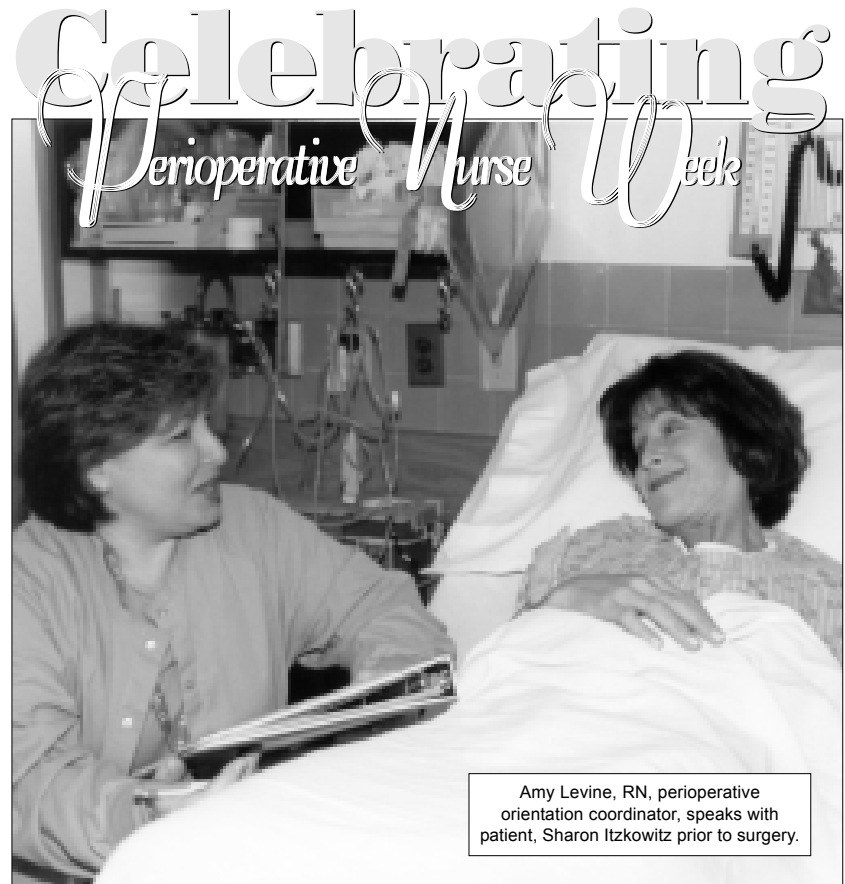
cern with knowledge. Where unfocused fear can paralyze... knowledge can empower you.

Franklin Roosevelt's words are still meaningful. And so are the words

of Howard Koh, MD, commissioner of Public Health for the State of Massachusetts, who says, "Anthrax is not contagious; only the fear of anthrax is."



Jeanette Ives Erickson, RN, MS,  
senior vice president for Patient Care  
and chief nurse



Amy Levine, RN, perioperative orientation coordinator, speaks with patient, Sharon Itzkowitz prior to surgery.

## Ensuring the safety, security and spiritual well-being of staff

The *Fielding the Issues* section of *Caring Headlines* is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions or concerns presented by staff at various meetings and venues throughout the hospital.

**Question:** What is the MGH doing in response to bio-terrorism threats?

**Jeanette:** The chiefs of Infection Control and the division of Infectious Diseases are coordinating the dissemination of information for health-care workers and patients. Regular updates are posted in All-User e-mails and on the MGH Primary Care website: ([http://oi.mgh.harvard.edu/pcoi/frontpage\\_frames.asp](http://oi.mgh.harvard.edu/pcoi/frontpage_frames.asp)). Open-forum information sessions will continue to be held as necessary to provide up-to-date information. If you have any concerns, please contact your manager.

.edu/pcoi/frontpage\_frames.asp). Open-forum information sessions will continue to be held as necessary to provide up-to-date information. If you have any concerns, please contact your manager.

**Question:** What actions have we taken to increase security on the MGH campus?

**Jeanette:** There is an increased presence of Police and Security on all shifts (both inside the hospital and on hospital grounds). Mail room staff are trained to be watchful for suspicious mail or packages; and in light of recent events, training to identify and manage suspicious packages has been augmented.

**Question:** What can I do to help?

**Jeanette:** The most important thing you can do is be aware of what's happening around you and report anything you feel is suspicious. You should wear your MGH ID badge at all times, and question anyone who comes to your unit without proper identification.

MGH is committed to keeping you informed about issues of safety and security, and we ask you to partner with us in maintaining a safe work environment.

**Question:** How can we learn more about the Muslim faith? After hearing the Qur'an read at the interfaith vigil, and knowing that so many of our staff and patients are Muslim, I'd really like to know more about Muslim traditions.

**Jeanette:** We are fortunate to have a number of resources at MGH. Imam Talal Eid, in our Chaplaincy, is an excellent resource, and we've asked him to expand his hours of availability. We are planning forums, panel discussions, and increased consultation time, and we will be disseminating information we think will be helpful in caring for patients.

**Question:** Where can I find information about anthrax and biological warfare?

**Jeanette:** The Patient and Family Learning Center currently has a

display of information on anthrax and other chemical and biological agents. The information is free to staff and the public.

**Question:** I think that being able to come together as a community was very important following the terrorist attacks. Are there plans to do that again in the future?

**Jeanette:** When we feel threatened and uncertain, it is important to come together to talk—in small groups, big groups, and one-to-one. Sharing our fears, worries, concerns and questions is necessary as we adjust to a different way of living. We need to explore new ways to cope. I encourage everyone to take time in meetings to share how you're doing. Contact the Employee Assistance Program, a social worker, or chaplain if you feel the need.

The Chaplaincy is coordinating an interfaith service for Tuesday, November 13th, at noon. I have convened a task force to develop and conduct forums on topics such as, "Coping Strategies," "Disaster Planning," "Safety and Security," and "Bio-terrorism." Watch for upcoming announcements.

Please don't be shy in seeking each other out, helping each other, and getting the help you need. We're stronger when we are together.



### Rewarding excellence in the Same Day Surgery Unit

Above, senior vice president and CMO, Britain W. Nicholson, MD, presents Same Day Surgery Unit staff nurses, Mary Jane Komich, RN (left), and Pat Kane, RN, with certificates of Excellence in Action; nurse manager, Janet Dauphinee Quigley, RN (right), looks on. This recognition came about as a result of a letter sent by a patient, which stated in part: "I want you to know how fortunate I felt to have Pat and Mary Jane as my nurses, and what truly special people they are. I have worked at MGH for 25 years. Neither Pat nor Mary Jane knew that, which leads me to believe they must treat all their patients with the same respect and care. If I ever require surgery again, I'll be calling to make sure I can have them as my nurses."

## Pre-Admission Testing Area: collaboration at its best!

Pre-operative assessment at MGH has evolved substantially over the last few years to promote optimal patient preparedness for surgical procedures and continuity of care across a variety of settings. In 1990, MGH created the Pre-Admission Testing Area (PATA) to better meet the demands of a changing healthcare environment. This shift to an outpatient admission process was driven by advances in technology and a hospital-wide effort to control costs.

The Pre-Admission Testing Area provides patients and families with a comprehensive outpatient program for pre-operative care. Originally, an anesthesiologist, surgical resident, and nurse evaluated each patient. But in July of 2000 after a series of operations improvements, the PATA Nurse Practitioner (NP) program was developed and implemented. Now, a nurse practitioner takes histories and performs physical exams, eliminating the need for separate interviews with an anesthesiologist and a surgeon. The NP program has increased patient satisfaction while contributing to a more comprehensive approach to pre-operative care.

Under the new program, a nurse practitioner gathers all necessary health information and has an anesthesiologist available for medical direction and support.

—by Jennifer Neves, RN,  
and Jane Flanagan, RN

NPs provide patients and families with general education about, and explain options for, anesthesia. Vascular Surgery, General Surgery and Neuro-surgery are three surgical services successfully using the NP program for pre-operative patient evaluations.

In the future, the Pre-Admission Testing Area hopes to expand the NP program to include all surgical patients.

The staff nurse's role in the PATA is to assess the patient and develop an individualized plan of care based on each patient's needs, which may include consultation to other departments. Patient- and family-education and discharge planning are keys parts of this interview. Together, nurse practitioners and

relaxation techniques and follow-up visits on the inpatient unit. The nurse practitioner ensured further follow-up care by notifying the primary care physician.

Within Partner's Healthcare System, continuity is enhanced by the availability of nurse practitioners' assessment data on the longitudinal medical record (LMR) in the CAS system. Nurses and other providers throughout the system report that the LMR pro-



Pre-Admission Testing Area nursing team (back row, l-r): Jane Flanagan, RN; Joan Braccio, RN; Donna Slicis, RN; Regis MacDonald, RN; and Brenda Smith, RN. (In front): Jennifer Neves, RN; and Catherine Grams, RN.



Peter J. Hayes, RN, BSN, staff nurse, Pre-Admission Testing Area, with patient, Mary Gunzelmann

staff nurses collaborate to provide seamless care, making patients known to all providers throughout the system. For example, one nurse practitioner recently interviewed a patient who had both psycho-social and anxiety issues related to surgery. Recognizing that continuity of care throughout the perioperative experience was crucial, she referred the patient to a nurse in the PATA who provided

vides them with quick access to essential information. To access the LMR from any Partners workstation, log on to CAS, select the patient name and look under the heading, "Notes." Double click "Notes" to bring up the list of patient notes.

The Pre-Admission Testing Area is located on Jackson 1 and evaluates approximately 65–85 patients each day for surgery and other interventional procedures.

## Nursing care extends to family waiting area

A family member accompanies a patient to the operating room. As the elevator doors open, she sees a big red sign that reads: "Authorized Personnel Only." At this point, she leaves her family member and goes to sit in the Gray Family Waiting Area. She could be there for hours and will not see her loved one again until he arrives on the patient care unit.

This is a very stressful time for families. Obviously, they can't be part of the surgical care team, and they're separated from their loved one for an indeterminate amount of time.

In 1995, a group of nurses came up with a

—by Sandra E. Silvestri, RN, MSN, CNOR  
surgical nurse liaison

plan to keep concerned family members in the Gray Family Waiting Area informed about the condition of their loved ones. Nurses decided to expand their practice into the waiting area, and the idea of a surgical nurse liaison was born.

Pat Rowell, director of Volunteer and Interpreter Services, was contacted and presented with a proposal whereby nurses would work in concert with volunteers to keep family members informed of the status of their loved ones. Volunteers embraced the idea with enthusiasm, and in February of 1998, the surgical nurse liaison

role became a reality.

Since inception of the program, surgical nurse liaisons have interacted with an average of 1,300 family members a month. The nurse liaison talks to patients in the operating room and finds out the names of individuals waiting for them in the family waiting area; this helps give a personal touch to interactions with family members. The nurse liaison makes rounds throughout the operating rooms all day and provides timely information and updates to families.

Family-satisfaction surveys are available in the waiting area and the

results of these surveys are compiled and presented annually. Some of the feedback received includes comments like, "Having a nurse liaison made a huge difference in the long waiting period for my husband's surgery. Talking with her and knowing she had been in the room where the surgery was in progress made my wait much easier. I didn't feel so shut out of the whole process."

Another person wrote, "Our time in the waiting area was very comfortable (four visits in eight weeks). The volunteers were very helpful and friendly. The nurse liaison on each occasion was so reassur-

ing and helpful to all of us."

And someone else wrote, "The nurse involvement has really been wonderful and has changed the whole waiting experience."

This expanded nursing role has provided an opportunity for perioperative nurses to become more involved with families; it has opened up a once-frightening environment to families and made them feel part of the surgical experience.

Currently, surgical nurse liaisons are available during the day shift only, but there are plans to expand this role to include off-shifts and weekends.



Surgical nurse liaison, Sandra Silvestri, RN, with Gray Family Waiting Area volunteers, Caroline Blake (left) and Katherine Baker

### EAP Work-Life Seminars

#### "Raising Emotionally Healthy Boys"

Opening avenues for communication can facilitate emotional health in pre-adolescent boys. This seminar will provide tools for enhanced communication.

November 8, 2001

12:00-1:00pm

Wellman Conference Room

For more information, call the Employee Assistance Program at 726-6976

### Rewards for PCS employees who recruit or refer clinical staff for hire within Patient Care Services

- PCS Referral Program rewards PCS employees who refer individuals for hire into specific roles between now and December 31, 2001
- All current PCS employees are eligible (excluding directors, leadership and HR staff)
- \$1,000 will be given to employees whose referrals are hired into PCS clinical positions of 20 hours per week or more

For more information, contact Steve Taranto at 724-1567

## Meet your team in the Same Day Surgery Unit

— by Ruth J. Bryan, RN;  
Janet Dauphinee Quigley, RN;  
and Kelley Grealish, RN

It's 6:30am Tuesday, and you've just arrived in the Same Day Surgery Unit to have your surgical procedure, a knee arthroscopy. Jeanette Valverde, operations associate, greets you warmly at the front desk. As the operations associate, Jeanette is one of the first people you meet in the Same Day Surgery Unit. She works hard to make the admission process a smooth entry into the surgical experience. Jeanette asks your name and asks you to have a seat to complete the nursing assessment form. Jeanette has worked in the Same Day Surgery Unit (SDSU) for approximately a year. She loves working with the diverse team in the SDSU. Her Spanish background is a great asset to the unit. She is an ambassador to patients and families of all cultures, a resource to her colleagues, and a great support to Spanish-speaking patients.

After you complete the nursing assessment form, your name is called by one of the patient care associates (PCAs), Claudette Altamarino. Claudette escorts you to the changing room, where she gives you a hospital gown and a bag to hold your street clothes. She is kind, gentle and comforting. Clau-

dette escorts you to the pre-operative area and assists you onto a stretcher. She asks if there's anything you need. Claudette has been a PCA at MGH for 30 years (the last 10 in the SDSU). She is known for her infinite patience and a smile that never quits. She truly enjoys working with patients. Claudette offers reassurance and comfort as you prepare for surgery.

In the pre-operative area, Paul Craigie, RN, introduces himself. He reviews the nursing assessment form with you. He explains what will happen between now and the time you're discharged, and he briefly discusses your discharge instructions. Most importantly, Paul answers any questions you may have and attends to any present needs. He is a great source of knowledge and comfort. Paul values this pre-operative time as an opportunity to relieve anxiety and educate patients about the perioperative experience. Paul has been an MGH nurse for 24 years (a nurse in the SDSU for five years).

During your time in the pre-operative area, you meet a whole group of healthcare providers. The anesthesiologist

introduces him- or herself to you, conducts an assessment interview, and starts an intravenous line for the procedure.

Elizabeth Kelley, RN, stops by to say hello. She will be your operating room nurse. She ensures that you're ready for surgery and that all your needs are being met. Elizabeth has 24 years of experience as an OR and post-anesthesia nurse; she has worked in the SDSU for eight months. Elizabeth often uses humor to help patients deal with the stress and anxiety of undergoing a surgical procedure.

Elizabeth values every surgical experience as an opportunity to learn. She and your anesthesiologist transport you by stretcher into the operating room.

This is a nice surprise... the operating room isn't as intimidating as you thought it would be. You look around and notice there's someone you haven't met yet. Autaquay Peters is the surgical technologist (ST), or person who manages the instruments for the surgeon.

You see another bed; this is the operating table. Elizabeth helps you onto the operating table; it's a little smaller, but the safety belt and pillows make you feel secure. Elizabeth stays with you as the surgeon comes in and the anesthesiologist initiates the anesthetization process.

Elizabeth remains with you as you fall asleep, throughout the operation, and until you wake up. The procedure went well, and you're off to the recovery room. As you leave, the turnover team is paged to the OR.

Grigory Beynenson, is a member of the turnover team. He helps prepare the OR for the next case, cleaning the equipment, removing medical waste, and providing clean linens. Grigory is efficient, reliable and self-directed. He has worked in the SDSU for ten years, and the SDSU is lucky to have him.

Okay, surgery is over. You're back on the stretcher in the recovery area. You are now in the care of Mike Nichols, RN. Mike sets you up with monitoring equipment and receives report from

*continued on next page*



Same Day Surgery Unit staff nurse, Elizabeth Kelley, RN, cares for patient in the SDSU recovery area.

## Incorporating family-centered care into the pediatric perioperative experience

—by Pamela P. Wrigley RN, MS,  
pediatric team leader, SDSU

Pediatric nursing isn't just about caring for the patient; it's about caring for the whole family. In our pediatric practice in the Same Day Surgery Unit (SDSU) we incorporate family-centered care throughout the whole perioperative process. One of our goals is to let the patient and family members stay together as much as possible throughout their visit. We like to involve the parents in the care of their child.

As we introduce ourselves, orient families to the unit, and begin the admission process, parents can help their child change into their 'PJs.' If children are very anxious, we let them stay in their own clothes; we adapt our care to meet the needs of each child in order to create as positive an experience as possible. We communi-

cate these needs to the pediatric team in the operating room, so they can maintain the same level of continuity.

During the assessment, toddlers and preschoolers can sit on their parent's lap, in a crib, or on a stretcher. We enlist parents' help in distracting the child when we need to obtain blood pressure readings or place a pulse oximeter probe on the child's finger. While interviewing the parent or guardian, we inquire about any special patterns, behaviors, or needs of the child so these needs can be met when the child returns to the recovery room.

Parents accompany the child to the operating room where they can speak with the anesthesiologist who will be working with the surgeon.

Parents are required to don a surgical 'jumpsuit,' booties, and hat to enter the OR; this frequently brings a smile or two, especially from teenagers. Parents typically remain in the operating room through induction of anesthesia, then return to the pediatric waiting room. While in the waiting area, we keep them updated on the procedure and discuss various aspects of care. When the patient returns to the recovery room, parents and guardians are welcome to assist in caring for their child. Often, parents are apprehensive, especially if the child is an infant. With IVs and monitoring equipment, they're often tentative about holding or feeding their child. We work with them to allay their fears, and they usually adapt quickly to



Pam Wrigley, RN  
staff nurse, SDSU

participate in their child's care. As the child recovers, we offer post-operative teaching and answer questions about how to care for their child at home.

In the SDSU, we also see patients who are having general anesthesia for radiology procedures such as MRIs. Eva Panzera, the pediatric anesthesia service coordinator, works closely with us to facilitate and coordinate scheduling of pediatric patients requiring general anesthesia for surgery and other invasive procedures.

Eva's presence helps ensure a smooth flow through the perioperative settings for both the patient and the family.

Creating a child-friendly environment in a predominantly adult surgical unit has presented its share of challenges, but providing a smooth and satisfying experience for children and their families is our first priority. We have found that when the family is involved in their child's care, the outcome is positive for everyone.

### Same Day Surgery Unit

*continued from previous page*

the anesthesiologist about the course of your surgery. Mike assesses your status and attends to your care. He knows the importance of monitoring and listening to patients. Mike reviews your discharge instructions and provides edu-

cation on post-operative pain-management. Mike has been a nurse in the SDSU for four years. He chose the SDSU because of the multi-disciplinary approach and for the flexibility afforded by a cross-training practice model. Because Mike

has been cross-trained, he is able to work in all areas of the SDSU.

Now that you're feeling better, you're transferred to a comfortable chair in the post-recovery lounge where Lisa Glass, RN, greets you. Lisa reviews any prescriptions, post-procedure instructions and information about your follow-up appointment.

Lisa has been in the SDSU for three years; her friendly, knowledgeable presence has a calming effect on patients and their families.

It's only been a few hours since you arrived in the SDSU, but Sam Cohen, of Volunteer Services, gives you a wheelchair escort back to the lobby, and you're already on your way home.

Nursing in the SDSU brings new and exciting challenges every day, and with a highly collaborative team approach, the patient experience is always a positive one. The Same Day Surgery team optimizes quality patient care while competently and efficiently assisting patients through the surgical experience.

## Endoscopy nurse overcomes cultural differences to ensure positive outcome

My name is Ellen Pantzer, and I am a staff nurse on the Blake 4 Endoscopy Unit. Every day at work I am reminded of the impact that nurses have on other people's lives. I use this to guide my thoughts, actions, and usually the words I choose with each new encounter. One of my objectives is to approach the encounter with an open mind and a willingness to learn. This drives me to pursue similar positive experiences each day.

Approximately one month ago I was assigned to work the Blake 4 Endoscopy Unit's Saturday morning flexible sigmoidoscopy clinic. This assignment entails a lot of work. One nurse is scheduled to work the clinic. On this particular day, 24 patients were expected; 21 patients actually showed up.

The morning did not begin well. The other members of the team were delayed in their arrival. Patients became anxious to be admitted. Many expressed concern over the organization of our services. I felt it was important to put forward an even greater effort to assure patients that they would be cared for in a timely manner by competent healthcare providers.

When a patient schedules a 'flex-sig' procedure, they receive specific pre-procedure bowel preparation instructions. These instructions describe a clear liquid diet for 18-24 hours prior to the procedure, the administration of a bowel preparation to clean the bowel, and maintaining an NPO (no food at all) status for four hours prior to the exam. All of these steps are necessary to ensure a thorough examination of the colon.

At about 9:15 that morning, at the peak of my work activity, the secretary informed me that an elderly, non-English-speaking couple had arrived with their daughter. The younger woman understood English and spoke on their behalf. The couple had been without food and had had just minimal fluids for 24 hours. They were anxious and unclear about the reason they were at the clinic that day. Their primary care physician had encouraged them to have this screening exam for colon cancer, but they didn't understand what the procedure involved. They had not administered the bowel preparation as instructed.

I greeted this family in the waiting room. I was taken by their vul-

nerability to an overwhelmingly unfamiliar situation. We could have taken the easy way out and cancelled the procedures. The couple would have had to reschedule their exams and once again gone through the process of trying to comply with the necessary preparation instructions. The thought of sending this couple away did not settle comfortably with me. They were hungry and perplexed.

I found out through careful conversation with the family that they had not received instructions regarding the need for a bowel 'prep.' The system had failed to serve the special needs of this couple. Patient teaching was an important part of patient care that had been missed.

Mrs. S was very apprehensive. She refused to go through with the exam once she understood all the details. She was visibly shaken. I felt the need to complete this screening exam for cancer, but I didn't want to be insensitive to the fear she was experiencing or the cultural needs of this family. They were Middle-Eastern. They wore traditional clothing. I had had some prior education on Middle-Eastern culture from sources within the hospital. In



Ellen P. Pantzer RN, BS, CCRN  
staff nurse, Blake 4 Endoscopy Unit

the staff area on Blake 4, there is a poster prepared by the Trans-cultural Educational Center, entitled, "Seeing through the Veil." The poster addresses some of the customs of the Islamic culture. I had read the poster as well as the printed material available from the program. I also remembered reading articles in *Caring Headlines* about the importance of approach and personal space when caring for people from this background. I knew that keeping the body unseen and not reaching out to shake hands were ways to respect their cultural practices.

With the constant assistance and advice of their daughter, I asked Mrs. S to wait with us in the interior of the unit while we proceeded with Mr. S's examination. He had consented to the procedure. He was willing to take the enemas as a bowel 'prep.' After Mr. S's smooth and successful examination, we were

able to reassure Mrs. S. I was intentionally reserved and gentle at each step of the process. Recognizing Mrs. S's need for a sense of control, we agreed to let her remain covered from head to toe in her traditional apparel. We also agreed to let her daughter remain with her during the exam. The doctor was informed of the situation and was more than willing to participate in the plan. Mrs. S agreed to let me assist her with the administration of the enemas. Again, we proceeded slowly and obtained the desired results.

Once both screening sigmoidoscopy procedures were completed, Mr. and Mrs. S were given good news: both had normal exams. The family sat together for 30 minutes enjoying juice and cookies in the small, post-procedure waiting area. It was clear they were delightfully happy. When they were ready to leave, we all shared how

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## PACU nurse makes lasting impression with care and honesty

My name is Judith Lynch, and I am a staff nurse in the Post Anesthesia Care Unit (PACU). If you sit in a crowded subway station or shopping mall and close your eyes, you'll hear a cacophony of different noises. Imagine... opening your eyes after coming out of a deep sleep and hearing all sorts of voices and noises that aren't familiar to you. I think that's what it must be like to be a patient in the PACU.

Let me introduce you to my patient, Kevin. Kevin was a 23-year-old young man brought to MGH after being hit by a pick-up truck while riding his motorcycle. Kevin was very lucky—he sustained some cuts, abrasions, and an extensive left-leg injury, but his head and the rest of his body were okay.

I met Kevin during report from the night nurse, who expressed concern about the fact that Kevin's left foot was cold and pulseless upon admission to the PACU a number of hours post-surgery. She had tried to contact the surgical resident but had not yet heard back from him. The plan remained, 'close observation and monitoring.'

Kevin was in the extended-stay area of the PACU, and I had taken

over his care for the day shift. He was a young, healthy man and had a lot of questions about what was going on and the eventual outcome of his leg injury. He asked, "Am I going to lose my leg?" and started to get teary-eyed. I reassured Kevin about the condition of his leg and told him we were going to do all we could for him. But I couldn't honestly answer his question. I let him know the plans for his treatment as I knew them.

The next question was, "Can I see my parents?" I told him I would look for his parents and allow them to visit after I had cleaned him up (he still had some blood stains from his abrasions and needed his bedding changed). I located his parents and gave them directions to the PACU. I met Kevin's mom and dad at the door, introduced myself as Kevin's nurse, explained about the PACU, and asked if they had spoken with the doctor yet. They said they were aware of his condition and just wanted to see him. They had driven through the night from another state after receiving, 'that phone call,' as his dad put it.

I continued to care for Kevin and his parents that day in the PACU.

That's right, I cared for Kevin *and* his family. A patient undergoing surgery has loved ones who worry and are concerned for his well-being. It's difficult for family members when they're unable to stay with the patient throughout the entire perioperative period. It is always at the forefront of my mind to try to allay anxiety and concerns for my patients and families.

I later accompanied Kevin to Angiography for a diagnostic procedure, which showed an injury that necessitated his return to the operating room. I called for Kevin's dad to return to the PACU to speak with the physician and spend some time with Kevin. Kevin's mom had already gone to Kevin's apartment to get some rest.

Once Kevin went to the operating room, I spoke with his dad and we decided on a plan. The nurse caring for Kevin after surgery would call his cell phone and let him know when it would be appropriate to visit Kevin once he was back in the PACU. I said good-bye to Kevin's dad and told him I would follow up with Kevin when I returned after my day off. Kevin's dad gave me a hug and said, "Thanks for making the

worst day of my life a little better." All I had done was my job, I thought, caring for post-operative patients in the PACU. I wondered if there had been other patients and families I'd impacted so strongly and hadn't realized it at the time. I became aware that Kevin's dad had purposely expressed his gratitude and appreciation to me so I would truly understand that I had made a difference in their lives that day.

Before I left work I told the PACU resource nurse and operations associate the plan I had set up with Kevin and his family. From home later that evening, I called the PACU to check on Kevin. I learned he was doing well, had a warm foot with a strong pulse, and could move and feel his toes. I sat back in the recliner at home and realized how glad I was that there had been a positive outcome in the OR for Kevin.

Upon my return to

work, I caught up with Kevin and his parents on the post-operative unit. Kevin was doing much better, as were his parents. Kevin would still have a number of surgeries ahead of him to help his left leg heal. But now I felt I could tell him truthfully, "No, you won't lose your leg."

An update on Kevin: He has come through the PACU a number of times following surgery and when I saw him the first time, he said, "Mom and dad say Hi, and I say thanks for being honest with me the first day you took care of me."

Telling patients the truth can be difficult, but I think they can sense what's going on by the way we act. I'm not really sure why Kevin and his parents made such an impression on me that day, but I'm sure glad I made a positive impression on them. Sometimes, we don't even realize that we're having an impact on people; I'm

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Judith A. Lynch, RN  
staff nurse, PACU

## Taking the mystery out of nursing in the PACU

—by Cameron DeMarche, RN

I have been a PACU nurse longer than I like to admit. I attended nursing school when the area was still known as the recovery room. Even then, it was becoming apparent that people coming out of heavy sedation should be closely observed for a certain period of time before returning to their hospital rooms. Back then, hospitals had minimal monitoring equipment; computers were unheard of in clinical application, and a nurse's assessment abilities depended mainly on how well, or how often, she could *look, listen, and feel*.

It wasn't until the 70s that computers began to be introduced in hospitals, and new monitoring devices began to appear. I had the pleasure of working with a physician who was involved with designing the intra-aortic balloon pump (IABP). I was introduced to the IABP when my colleague introduced it in the ICU where I was working as a staff nurse. (Just to give you an idea of how far health care has advanced in a relatively short time), this was when nurses used a 3-bottle chest suctioning set-up that you prepared on your own, and glass

syringes, not plastic. I had an opportunity in the 70s to enhance my nursing career by specializing in the care of children in the PACU. When I began this new career path (at another hospital), the "recovery room" was a 10-bed unit that had one cardiac monitor that always went to the sickest patient. Arterial sticks and the assessment of blood gases were the only means of obtaining oxygen saturation levels. Oxygen was hardly ever administered; if patients looked pink, they were all right!

By the 80s, PACUs were coming into their



Cameron DeMarche, RN  
staff nurse, PACU

own. More surgeries were being performed and patients were sicker. It became obvious that post-anesthesia patients needed to be monitored more closely, requiring better equipment that could provide more information than *look, listen, and feel*. Also, we realized that recovering patients should be close to the operating room in case of a problem.

The 90s brought us to where we are today. Constantly upgrading, constantly acquiring the best equipment to give the most accurate findings with both invasive and non-invasive monitoring. A sub-specialty in PACU nursing has emerged, known as ambulatory or same-day surgery post-anesthesia care.

In the PACU, our team consists of highly trained, highly motivated individuals. From our secretaries, who calmly and pleasantly manage an on-going stream of communication with 42 operating rooms and radiology suites, who

constantly update the status of our patients, and field countless phone calls from concerned family members, labs, and patient care units. And when a patient leaves the PACU, our secretaries play a major role in external communication, and maintaining stability on the unit.

Our patient care associates (PCAs) give of themselves every day to help expedite the comfort and meet the needs of our patients. Their contribution goes far beyond assisting nurses with patient care; they each bring a unique, compassionate, and caring presence to the bedside.

Generally speaking, the PACU is one big room that can be partitioned off to accommodate patients who may be on precautions or patients who have special needs. But usually, it's a large, open space where all caregivers can see all patients and all other caregivers. It is inten-

*continued on page 12*



Staff nurses, Shellie Varano, RN (left), and Linda Pelletier, RN, care for patient in the Post-Anesthesia Care Unit

## The Northeastern Perioperative Certificate Program

### *Recent graduates talk about the program*

The Northeastern University College of Nursing Perioperative Certificate Program was developed in 1999 as a way to effectively train nurses experienced in other areas to practice in the OR setting. The six-month program, designed with input from MGH perioperative nurses, includes both academic and clinical preparation. Graduates of the program go on to work in the main OR and in the Same Day Surgery Unit. This is what some recent graduates have to say about the program.

Pictured below (back row, l-r) are: Amanda Garry, RN; Kristin Frazier, RN; Annemarie Fallon, RN; Janet Doherty, RN; and Ellen Walsh, RN; (Front row): Kara Davis, RN; Lori Schulman, RN; Rosalyn Michelson, RN; Judy Pagliarulo, RN; Amiee Cuzzo, RN; and Annette Corben, RN.

*"Everyone feels overwhelmed their first day on the job. But having that lab experience helped so much. We already had experience gowning and gloving, handling instruments, and sterilization procedures."*

—Annette Corben, RN

*"It was really nice having a mentor, being with the same person, consistently, every day... someone who knows what you're learning needs are, and helps you stay calm when you start to feel stressed."*

*In nursing school you don't learn any OR-specific skills; and that's what the NU program did for me—it gave me the skills to work in this highly specialized area of nursing."*

—Lori Schulman, RN

*"I was surprised at how hard it was to learn everything, and I'm an experienced nurse! Part of it is that every service, every procedure, every surgeon requires different equipment, different instruments, different preparation. There's real pressure to make sure everything is just right. The role of a perioperative nurse is completely different from a unit-based nurse. It's not just transferring skills; it's learning a whole new skill set."*

—Ellen Walsh, RN

*"One of the great things about the program is that there are always new developments in OR nursing. The program prepares you for the latest innovations and advances in technology. I think learning the new technology was the biggest challenge."*

—Kara Davis, RN

*"I think coming in as a student makes the transition easier than if you were a new employee. There's not that pressure to know everything right out of the blocks, and there's an enormous amount of support from senior staff."*

—Kristin Frazier, RN



*"As part of the program, when we start working as OR nurses, we complete what's called 'novice blocks,' where we work for three months in four different services. So when the time comes to select the service we want to practice in, we're better prepared to make that decision."*

—Rosalyn Michelson, RN

*"People think that OR nursing is cold and technical. When I first started in the OR, I was impressed at how caring, professional and team-oriented everyone was. There is a lot of preparation and great attention to detail, but there's also an unspoken understanding that, 'It's all about the patient.'"*

—Amanda Garry, RN

*"We're still in our novice blocks right now, so every day we run into new situations and new challenges. But there are a lot of resources, and a lot of experienced people to lean on. It's a very supportive environment."*

—Lori Schulman, RN

*"I'm finding OR nursing so exciting. One of my first experiences in the main OR was to actually hold a heart! I mean... there it was, beating in my hand! How many people have the opportunity to experience that?"*

—Judy Pagliarulo, RN

## PACU Nursing

*continued from page 10*

tionally set up this way because a patient's status can change very quickly post-operatively, and the more patients we can see, the better it is for everyone.

We work as a 'team within a team' in the PACU. Instead of individual patient assignments, we work together by sections, with one or two nurses assigned to every three bed spaces. For every six-bed section, nurses arrive at various times, so we all work together to decide who goes to lunch or dinner, etc. This is a great system, as the smaller teams

within the larger team (full staff) change every day. I call this, "tag-team" nursing. The beauty of this arrangement is that every nurse on every team can immediately step in and care for any patient, any time. If a certain patient requires continuous one-to-one, or even two-to-one nursing, other members of the team can care for the other patients in our section.

Nurses are informed that a particular patient will be coming to a particular bed space upon completion of surgery. When the patient arrives in the PACU, she is taken to the bed space specifically reserved for her. All available team mem-

bers work quickly to set up monitoring devices, make sure she is stable, positioned properly, and comfortable. Orders are obtained and everyone works together to promote a period of rest and recuperation for the patient. Team members are always close at hand to consult about the proper plan of care. When the patient wakes up, is comfortable and stable with no complaints, she is ready for discharge.

It's important to try to discharge patients as soon as they're ready, to prevent them from becoming anxious in the busy PACU setting. And, for every patient who leaves there's another waiting to come in.

The PACU is a 31-bay recovery room that serves anywhere from 70–100 patients per day. A small area in the PACU is designated for patients who need overnight critical care or close monitoring.

We are a proud group of nurses in the PACU. We are team players who have serious input into the care and treatment of our patients. We adapt the care of our patients to meet their immediate needs either emergently or over a period of time. We are experienced nurses with backgrounds in ICU or ER nursing in addition to our individual specialties (such as neuro, ortho, cardiac, pedi, etc.) Not only do

we provide optimal patient care, but we teach each other and those around us to benefit the patients. We care for patients of all ages from pre-mature babies to octogenarians and beyond.

The PACU may appear to be a place of rapid change and mass confusion, but I can honestly say that I love my job. Working with people who are all striving for the same goal, working together with a willingness to share and not compete, doing what's best for every patient... my work is its own reward. It is a privilege to be an acute critical-care nurse in the Post-Anesthesia Care Unit.

## Exemplar (Pantzer)

*continued from page 8*

content and relieved we felt having been willing to negotiate through this experience to a successful outcome.

Because I was willing to spend some extra time providing individualized care, two more people left the Endoscopy Unit assured that there were no apparent signs of significant pathology in their colons. But more importantly, they had a favorable experience in the 'foreign' environment of a large municipal hospital.

We all worked together to salvage a situation, and it gave each of us a sense of good will.

The doctor went out of his way to thank me for making such an exceptional effort to help this couple. And I have to say... I got a big shot of positive self-esteem from this opportunity to practice my profession.

**Comments by  
Jeanette Ives  
Erickson, RN, MS,  
senior vice president  
for Patient Care and  
chief nurse**

We've all had those days when it seems like everything that can go wrong does go wrong. It is a true measure of a professional that he or she can maintain high practice

standards in the face of repeated adversity. And Ellen does just that.

After an already taxing morning, when this family appears, hungry and ill-prepared, Ellen doesn't look for someone to blame or a reason to re-schedule. She makes every effort to comfort and support them. She enlists the support of the medical team and, respecting their cultural traditions, Ellen makes what could have been a frightening experience, palatable for Mr. and Mrs. S. This is a wonderful example of how our diversity education has improved and enriched the care of our international patients.

Thank-you, Ellen.

## Exemplar (Lynch)

*continued from page 9*

just glad this was a positive one.

**Comments by  
Jeanette Ives  
Erickson, RN, MS,  
senior vice president  
for Patient Care and  
chief nurse**

Judy's narrative is a wonderful example of family-centered care. Every paragraph reveals Judith's skill and sensitivity in caring for both Kevin and his family; from making Kevin presentable for his parents to arranging a plan with the incoming nurse to call Kevin's father when Kevin returned from the OR.

Every caregiver struggles with how to answer those difficult questions for patients. Judith was honest and at the same time, allowed Kevin to be hopeful that he would be able to keep his leg. This is a skill that is acquired with time and experience. This is a skill that makes it possible for patients and family members to say things like, "Thanks for making the worst day of my life a little better."

Perhaps Judith was 'only' doing her job. Fortunately for Kevin and his family, she was doing it very well!

Thank-you, Judith.



Thuhong Tran and her artwork

## PCA lends artistic touch to the PACU

When the windows of the PACU were permanently “clouded over” a few years ago to afford patients a higher level of privacy, staff had no idea they would be so affected by the change. Says nurse manager, Kathy Cullen, RN, “It really affected morale—they missed the sunlight!” Patient care associate, Thuhong Tran, had shown some artistic talent in the past, decorating the unit for various holidays, so staff asked if she had any ideas. She did. Tran, known to her co-workers as, “Thu” (pronounced, “Too”) had come to America from Viet Nam, where her father was a sculptor. It seems Thu inherited some of her father’s creativity. She set to work “etching” shapes in the clouded windows, creating airy scenes and graceful, calming images. When the light is just right, warm sunshine spills through the shapes in lovely, golden rays.

Says Thu, “I really enjoyed doing this. Without the help of the nurses and other PCAs, I couldn’t have done it. They covered for me and took over my responsibilities so that I could work on this project.”

Since Thu completed her project, Cullen reports that morale in the PACU is just fine. Says Cullen, “A pretty PACU is a happy PACU!”

### Negotiation Skills for Those Not Born to the Table

presented by Phyllis Kritek, RN, PhD, FAAN, internationally recognized author and scholar

**November 2–3, 2001  
8:30am–5:00pm  
O’Keeffe Auditorium**

For more information, contact Brian French at 724-7843, or Deborah Washington at 724-7469

### Pediatric Memorial Service

Dedicated to the families of children who have died in MGH pediatric, neonatal, pediatric intensive care, and labor and delivery units. The service is an opportunity for families, relatives, friends and MGH staff to come together to honor the children.

**November 4, 2001, at 2:00pm  
O’Keeffe Auditorium**

Ceremony includes readings by parents and family members, a naming ceremony, and a slide presentation.

Memorial quilts will be displayed this year from November 2nd–November 5th.

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by fax: 617.726.4133  
or by e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)

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The  
faces of  
perioperative  
care

Making a Difference grant recipients, left (Pre-Admission Testing Area): Jane Flanagan, RN; Janet Dauphinee Quigley, RN, and Robin Holloway, RN, and below (Same Day Surgery Unit): Beth Kelley, RN, Paul Craigie, RN, Carolyn Bartlett, RN, and Janet Dauphinee Quigley, RN



Matthew Powers, ortho liaison, and Patricia Lynch, RN



Grace Vargus, ST



Ralston Taylor, Cathy Looney, RN, and Elaine D'Aprile, RN



April Cheney, ST, Margie Kilfoyle, RN, Gema Bien-Aime, RN, Peg Hickey, RN, and Katherine Keefe, RN



Kathy O'Brien, ST



Ana Martinez, ST, Keri Lyons, ST, and Katy Zanetti, RN



Toola Emond, RN



In the Instrument Room, (l-r): Francis O'Brien, Robert Martin, Inez Rattner, Bernadette Dunbar, James Parker, and Carlene Krey, RN

# Educational Offerings

October 4, 2001

When/Where	Description	Contact Hours
November 12 8:00am–5:00pm November 19 8:00am–5:00pm	<b>Advanced Cardiac Life Support (ACLS)—Provider Course</b> Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room.	16.8 for completing both days
November 13 7:30–11:30am, 12:00–4:00pm	<b>CPR—American Heart Association BLS Re-Certification for Healthcare Providers</b> VBK 401.	---
November 13 8:00am–12:00pm	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> VBK 601.	TBA
November 13 4:00–6:00pm	<b>Deb Wing Memorial Lecture</b> Burr Conference Rooms.	TBA
November 14 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza.	6.0 (contact hours for mentors only)
November 14 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater.	---
November 14 5:30–6:00pm networking 6:00–7:00pm presentation	<b>Advanced Practice Nurse Millennium Series</b> O’Keeffe Auditorium.	1.2
November 15 10:00–11:30am	<b>Social Services Grand Rounds</b> For more information, call 724-9115. O’Keeffe Auditorium.	CEUs for social workers only
November 15 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium.	1.2
November 16 8:00am–4:30pm	<b>Caregiver Skills for the New Millennium</b> Training Department, Charles River Plaza.	7.2
Nov. 28, 8:00am–12:30pm November 30 (Exam) 8:00–9:30am	<b>Transfusion Therapy Course (Lecture &amp; Exam)</b> Bigelow 4 Amphitheatre.	---
November 28 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza.	5.4 (contact hours for mentors only)
November 29 8:00am–4:00pm	<b>Clinical Evaluation of the Electrocardiogram</b> Stearns Auditorium, New England Medical Center.	TBA
November 29 and 30 8:30am–5:30pm	<b>Advances in the Management of Polytraumatized Patients</b> Training Department, Charles River Plaza.	TBA
December 3, 4, 5, 10, 11, 12 7:30am–4:00pm	<b>Critical Care in the New Millennium: Core Program</b> Brigham & Womens Hospital.	45.1 for completing all six days
December 3 8:00am–4:30pm	<b>Diversity Within Cultures: Implications for Health Care</b> O’Keeffe Auditorium.	TBA
December 4 7:30–8:30am	<b>On-Line Patient Education: Tips to Ensure Success</b> Patient Family Learning Center.	1.2
December 4 8:00am–5:00pm	<b>Chemotherapy Consortium</b> NEMC.	TBA
December 6 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2

*For more information about any of the above-listed educational offerings, please call 726-3111.  
For information about Risk Management Foundation educational programs, please check the  
Internet at <http://www.hrm.harvard.edu>*

## Surgical nurse as first assistant

Nurses as first assistants originally practiced in the

1800s during the Florence Nightingale era. Nurses prepared wounds for surgery and assisted with procedures. With every war of the 20th century, the need for nurses to work in the role of first assistant increased. By 1980, the American College of Surgeons had clearly defined the duties of the first assistant, stressing that those duties must fall within the scope of practice dictated by the state in which a nurse practices.

I have been a surgical nurse at MGH since 1980. I'm part of a cardiac scrub team that performs open-heart procedures. I was drawn to the RN First Assistant (RNFA) Program because it would allow me to advance my career and

still practice in the OR.

After investigating many programs across the country, I decided on an AORN-approved program in Taos, New Mexico. The one-week program included six weeks of prior readings and written assignments in order to prepare for the classroom experience.

Thirteen nurses from ten different states were in my group. Our 9:00am -5:00pm days were filled with labs and lectures on Anatomy and Physiology, Wound Healing, Tissue Handling, History and Physical Assessment, Role Responsibilities, Legal Issues, and Recognition of Intra- and Post-Op Complications. We learned suturing and knot-tying procedures.

—by Paula J. Kordis, RN, CNOR  
Cardiac Surgery

The final phase of the program, in addition to numerous written assignments, is to return to the operating room and practice as a first assistant under the preceptorship of a surgeon. Each student is required to complete 120 hours as a first assistant in order to successfully complete the course. I am fortunate to have three surgeons supporting my clinical internship: Drs. Cary Akins, Jennifer Walker, and J.P. Warner.

In addition to practicing in the OR, students are required to keep a log of surgical interventions and an activities diary, which are mailed to faculty at specified intervals for evaluation. Upon completion of the course, students receive six college credits and a certificate of completion.



Paula J. Kordis, RN, CNOR  
Cardiac Surgery

This is just one example of the many opportunities that exist for nurses today. Currently, there is no RNFA program offered at MGH.

### DMAT Team presents:

#### "To New York City and Back: a rescue mission to the World Trade Center"

Members of the DMAT Team deployed to New York City following the September 11th attacks, share their experiences and observations in an oral and photographic presentation.

**November 2, 2001  
10:00-11:00am**

**in the MGH Etherdome**

Photographs will remain on display in the Etherdome Museum Gallery.

Contact hours may be awarded  
For more information, call 6-3100

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