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Boston University
Ross Nursing Resource Center: ‘A way to organize, to share and to build’

The Ross Nursing Resource Center, which offers information, consultation, education, and research support to nurses and other health-care professionals inside and outside the University Hospital, opened last May. "At this time, the Ross Center is still an evolving idea, and not yet a place," says its manager, Celeste Thompson. "It gives us a way to organize and build on some of the activities that are already occurring in the department, such as the lectures, workshops, and sharing of ideas offered by our clinical nurse specialists and administrators.

"By having these activities organized and billed through the Ross Center, the specialist is freed from financial negotiations, and a consistent, market-rate fee comes into the hospital. The money raised by the Ross Center will be used to help fund the clinical nurse specialist positions here and to support nursing research."

The Center opened on May 9 with a lecture on "Primary Nursing and The Nurse Extender Model" by Marie Manthey, R.N., President of Creative Nursing Management, Inc.

Examples of recent Ross Center programs include a two-day training session here at UH on administering chemotherapy, offered to nurses from St. Luke's Hospital in Middleboro and organized by Linda Morse, R.N., M.S.N., and an in-service on craniotomy, given at Milton Hospital by Noreen Leahy, R.N., M.S., neuroscience clinical nurse specialist.

Another major example is the consultation program on the nurse extender model, now being offered to hospitals or health-care agencies interested in introducing a similar program. This full-day or half-day program here at UH includes sessions on various aspects of the development and implementation of this program. Participants are Karen Kirby, R.N., M.S., Senior Vice President for Nursing; Gary Hill, recruitment officer; Gisele Bousquet, R.N., M.S.N., and Barbara Perron, R.N., B.S.N., clinical instructors; and Patricia Conway, R.N., M.S., nurse manager in Surgical Oncology.

"We hope to involve nurse managers and other administrators, as well as our clinical nurse specialists," says Thompson. "We are working on board. The staff nurse can turn to a clinical nurse specialist for consultation, enlightenment, and support.

In addition, clinical nurse specialists are valuable to the institution because of flexibility. They can be caring for patients while doing research on ways to reduce length of stay; they are available to UH nursing staff for consultation in their specialty, yet they also generate revenue by charging for the consult-

Clinical nurse specialists at UH: who they are and what they do

Advancement in many professions can be a loss as well as a gain: a gain in status and opportunities to manage and supervise also may mean a loss of hands-on experience. Writers become editors, carpenters become foremen, software developers become company managers, teachers become school administrators.

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In nursing, it is possible to advance professionally without letting go of clinical practice. Through the role of the clinical nurse specialist, which was developed and introduced at UH, a nurse can pursue a master's degree and serve as an educator and consultant in a specialty area, but also can continue caring for patients and offering support and education to patients' families.

For the staff nurse, access to a clinical nurse specialist is like having a personal "guru" on board. The staff nurse can turn to a clinical nurse specialist for consultation, enlightenment, and support.

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Karen K. Kirby, R.N., M.S.N., Senior Vice President for Nursing, will leave her position on January 1, 1990 to pursue other professional projects and activities. She does so "with both sadness and happiness," she wrote to her staff at the announcement of her leaving. "The sadness comes from leaving wonderful people and the happiness from all we have accomplished together. It has been an experience I will always cherish."

Kirby was the answer to the Hospital’s search for a senior nursing executive in 1983. Before that, she had been associate director of the nursing service at the University of California in San Francisco and assistant clinical professor at the University’s School of Nursing. She received her bachelor of science degree from the University of Michigan School of Nursing in 1975 and her master of science degree from the University of California in San Francisco in 1979. She was elected president of the Massachusetts Organization of Nursing Executives (MONE) in 1987, and was awarded the Mary B. Conception Award for excellence in nursing administration in June, 1989.

"Karen Kirby’s leaving is a significant loss to the nursing department, the institution, and the nursing community," says Joan Russo, R.N., M.S., Director of Education and Research. "Karen is a highly respected and exceptional leader. She is a strong supporter of nursing as a profession."

Kirby, who was characterized as "A Humanist at the Helm" in Mass Health Care, the former magazine of the Massachusetts Hospital Association, had a career-long mission of helping nurses care for each other. Early on, she says, "I realized that while we were members of a nurturing profession, we weren’t nurturing each other. I wanted to change that."

Kirby says that nurses must take care of themselves and each other before they can offer quality care to their patients, adding that this is particularly important today, when rapid technological change, coupled with fiscal restraint, can add stress to a nurse’s job. "When nurses do not nurture each other, they may become unable to offer quality care to their patients, or they may decide to leave the profession."

Kirby says of her accomplishments since 1983, "I hope that I have enhanced and highlighted the excellence in clinical practice that was here before I came and strengthened the credibility of nurses. I have tried to do this by providing good management, improving systems, introducing new programs, and providing clinical experts."

Kirby reorganized and strengthened her department by introducing an automated patient classification system, developing a quality assurance program, strengthening nurse recruitment, introducing a nurse extender program, using patient care technicians, and opening the Ross Nursing Resource Center. Under her leadership, nurses were involved in the design of the new Atrium building, progressive care units were introduced, a Short Stay unit was opened and an outpatient chemotherapy and transfusion service was begun. In her role as Vice President for Pharmacy, Kirby helped to make major improvements in drug distribution.

"Karen Kirby is outstanding," says UH President J. Scott Abercrombie Jr., M.D. "She is, in my opinion, the very best in her field and has developed a nursing department without peer. It was a privilege to work with her. The University Hospital is fortunate to have been the beneficiary of her service."

Ross Center

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on a directory that lists the specialists and instructors who can offer consultation or education programs in their specialty or area of expertise.

"We hope that someday the Ross Center will become a physical entity, with books and audiovisuals; a place that our own staff can come to for research and consultation."

The Center is named for William and Anna Ross, who established a generous trust fund in 1980 to be used by the Massachusetts Memorial Hospitals Nurses’ Alumnae Association of which Anna Ross was a member and former president.

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entirety they offer outside the Hospital. (See “Ross Center.”)

"The clinical nurse specialist has a four-part role: teaching, research, consultation, and direct clinical practice," says Gloria Shapiro, R.N., M.S., who specializes in psychiatric nursing. "But these parts are never equal. Each clinical nurse specialist emphasizes one area more than the others, which area receives the most emphasis depends on the setting, the specialty, and the interests and skills of the individual."

"Consultation is the component that receives the greatest emphasis in my practice," Shapiro says. "I meet individually with each staff nurse in my unit for one hour each week, to help him or her integrate theory into practice as well as to help foster professional development. I coordinate the group therapy program on the floor, and I also offer consultation to nurses on other units."

Since Shapiro’s specialty—psychiatry—touchess on every patient and staff member at the hospital, her guidance is frequently sought by nurses helping patients and families cope with the stress of illness. She also helps to build the interpersonal skills of nurses inside UH and beyond; she offers workshops and training in stress management, leadership skills, communication skills, and personal effectiveness.

Like Shapiro, Niki Ayers, R.N., M.S.N., also has a specialty that touches on many areas of the Hospital and lends itself to broad consultation: gerontology. "I conduct workshops and organize education programs in the care of the elderly, both within UH and outside the Hospital, particularly in nursing homes," says Ayers.

Many of the clinical nurse specialists say that supporting the primary nurse is the major focus of their jobs. Karen Cuipylo, R.N., M.S., who specializes in surgical nursing, orient new staff to the progress—continued on next page
sive care unit, where she serves as a role model in her own clinical practice. She conducts workshops on advances in surgical nursing, and feels that it is very important to encourage professional development among the staff. "I try to encourage the primary nurses to look beyond their hours of work here in the hospital, and consider publishing, doing research, joining professional organizations, or going back to school for an advanced degree," says Cuipylo, who is an active member of the American Association of Critical Care Nurses.

Joan Vitello, R.N., M.S.N., orients new staff to the care of patients undergoing open heart surgery. Like Cuipylo, she has a great deal of direct patient contact and conducts workshops in her specialty, surgical critical care. Noreen Leahy, R.N., M.S., offers consultation and education to nurses caring for neurologically impaired patients, both on her unit (8-East) and across the Hospital.

Lynn LaFonde, R.N., M.S.N., who specializes in the care of patients with chronic pulmonary disease, also supports staff nurses in their efforts to teach patients how to care for themselves at home. "We emphasize patient and family education because our goal is to discharge patients on ventilators and teach them, and their families, how to handle the equipment at home," she says. "I act as a consultant to the nursing staff on 8-East and to staff elsewhere in the Hospital who care for patients with pulmonary problems."

Clinical nurse specialists often assume a liaison role for patients whose illnesses require different specialists. Jeanne Doyle, R.N., B.S.N., works with the departments of medicine and surgery in the care of patients with peripheral vascular disease, collaborating with physicians, house staff, and nursing staff to provide continuity in inpatient and outpatient settings.

Research projects, publishing, and participation in professional societies also make up the clinical nurse specialist's job in varying degrees. One of LaFonde's current research projects is identifying parameters for successful weaning from a ventilator.

Vitello, who serves as co-editor of the Journal of Cardiovascular Nursing, recently published her research on a patient who required epicardial pacing. Leahy, who serves on the board of directors for the American Association of Neuroscience Nurses, recently published a book, A Quick Reference to Neuro-Critical Care Nursing. Doyle, who founded the National Society for Peripheral-Vascular Nursing, serves as its Executive Director and Journal Editor.

"The role of the clinical nurse specialist shifts with the institution," says Leahy, "adapting to the priorities of the hospital as a whole and changing with the fiscal climate." For example, Leahy is now working to identify ways to reduce a patient's length of stay, Ayers is offering training in home I.V. therapy, and LaFonde is delineating the costs of home care, hospital care, and chronic care for patients with chronic pulmonary disease.
Profile:
Terry Thornton, R.N.

Terry Thornton, R.N., staff nurse in surgical oncology, combines an old-fashioned, singular commitment to her profession with a contemporary understanding of it. "I never wanted to be anything but a nurse," she says, "and now that I'm here, I wouldn't trade my career for the world.

"When I was a child I loved playing nurse, and as a teenager I lied about my age so I could become a candy striker a year ahead of time. I worked as a nurse's aide from age 16 all the way through college."

Thornton came to the University Hospital in the summer of 1987, just after her graduation from St. Anselm's College, and reluctantly accepted an opening on the Surgical Oncology Unit. "When I heard the word 'oncology' I got scared," she says. "I didn't want to work with patients who would die. It turned out that this is not at all the case on my floor. Most of my patients have their surgery and go home; many recover for good."

In fact, Thornton has gained a deep appreciation for some of the unique aspects of oncology nursing, particularly the opportunity to teach and to make a difference. "You must teach the patients, and their families, all about their disease and its various treatments. And working on a cancer unit is very satisfying for a nurse, because the patients appreciate you so much. Everything you do for them makes a world of difference."

In conjunction with social worker Lisa Botti, M.S.W., Thornton is organizing a support group for the families of cancer patients. The group meets once a week for an hour and is open to families of any cancer patient in the hospital. The most common types of cancer on Thornton's unit are colon, breast, head and neck, genito-urinary, renal, and ovarian; her patients range in age from their 20s to their 90s. Thornton, who gave a talk last December at South Shore Hospital on the care of the laryngectomy patient, says that she greatly enjoys the challenge of working with head and neck patients.

"Teaching is particularly important in the care of patients with head and neck cancer."

"Teaching is particularly important in the care of patients with head and neck cancer who undergo a laryngectomy, a major operation that requires hospitalization for two to three weeks. These patients need a lot of teaching and support preoperatively because they are frightened. They know they will never talk again. And postoperatively, they must learn to do all over again those things they once did automatically, such as breathing, smelling, and talking. They must breathe through the neck, instead of the nose and mouth. They can no longer smell. And they must learn to speak through an artificial device."

"As such, they offer their nurses many great challenges. We must help them through their long process of recovery, which is usually very satisfying because so many of them do very well." Thornton, who lives in Saugus and works two 12-hour shifts and one 16-hour shift each week, credits her patient care technician and nurse manager for her happiness and success as a nurse. "Kim Prunell, my PCT, is my eyes, ears, and hands, and my greatest asset," she says. "She has a degree in biochemical engineering from R.U., and has now decided to go back to school and earn a degree in nursing. We work the same hours and really make a good team."

"And my nurse manager, Pat Conway, is always behind us 100 percent. She gives us independence, but is always there when we need her. She never criticizes, only offers constructive advice."

"We have a group of people on our floor who interlock beautifully and give meaning to the word teamwork," says Thornton. "There is no back-biting. No one says, 'I'm done, I'm going home.' Instead, it's 'I'm done, what can I do for you?'"

For further information, contact Terry Thornton, R.N., x5730 (638-5730).

Atrium 8-East draws

The growing international richness of the University Hospital is particularly evident in the nursing staff of the respiratory/neurology/rehabilitation unit (Atrium 8-East), where nurses and technicians hail from countries as far apart as Honduras and England. This cultural diversity is an educational experience for everyone: patients meet caregivers from other countries, and in some cases find someone who shares their native language; American nurses have an opportunity to learn, from their new colleagues, more about the profession in other countries; and the foreign nurses themselves continue to learn more about a dynamic profession.

"Becoming a nurse in the United States is not easy for nurses from other countries; it involves knowing the English language well enough to pass the Foreign Nurse's Examination or, in some cases, starting over in an American nursing school; passing the State Boards; then continuing to learn the many ways that nursing is different here than it was at home."

Here is an introduction to just a few of the nurses from other countries who worked very hard to bring their skill and talent to UH.

Ruth West, R.N., grew up in Venezuela and worked as a nurse there until 1979, when she moved to Scotland with her husband, who is in the oil business. In 1981 they moved to Norway and in 1986 to the Boston area, settling in Winthrop. Because her English was not proficient enough to pass the Foreign Nurse's Exam at that time, she earned an American nursing degree at LaSalle Junior College and came to UH in 1988.

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"I love working here," she says. "I enjoy each day. Everyone I work with is supportive, understanding, and friendly. On this unit, the nurse's major responsibility is teaching, since so many patients go home on ventilators, and I can be of great help to the Spanish-speaking patients.

"Nursing here is very different from Venezuela. There is more bureaucracy here and more awareness of legal aspects of health care. Nursing is more specialized here."

Egda Cortes, P.C.T., grew up in Honduras, where she worked as a nurse until she moved to East Boston with her husband and two children (now 14 and 8) in 1986. Since her English was not strong enough to allow her to take the Foreign Nurse's Exam or return to a nursing program, she trained as a nurse's aide at Bunker Hill Community College and became a patient care technician at UH, where she teams up with Ruth West.

Marie Helene Guillaume, R.N., moved from Haiti after she graduated from high school in 1980 and entered Simmons College, earning a bachelor's degree in nursing and human services.

"This is a very rewarding job," she says, "particularly on this floor, where so many patients get well. We have a real potpourri here; there is a great variety of patients and medical problems to learn from. I enjoy all the teaching we do so that our patients can learn to care for themselves at home."

Benedicta Kumahia, R.N., moved to Boston from Ghana, West Africa, in 1983, where she had worked as a nurse. Since English is the official language of her homeland, she had no trouble passing the Foreign Nurses Exam and State Boards here. She works weekends only, during the week she cares for her two sons, ages 5 and 3. Even though the two countries share a language, Kumahia finds the profession of nursing to be very different here than it is in Ghana. "Ghana has a British system of medicine and is government controlled," she says. "There, the nurses do not specialize. You are continually rotated through all the specialties so that you gain experience in every field. Every nurse does two months worth of night duty each year.

"Your uniform depicts what level you are and the color of your belt depicts each specialty. For example, when I worked as nurse midwife, I wore a black belt.

"In Ghana, the nurses are very versatile. They take on more responsibility and are less dependent on doctors, although they must improvise more because they don't have enough equipment or support. Here, the hospitals are cleaner and better equipped, and you feel safer in your work because there is so much support and supervision."

Penny Grossman, R.N., trained as a nurse in England in the 1960s, married an American and moved to the Boston area. She worked part-time as a staff nurse at Cambridge City and Faulkner hospitals while her children were young. She left nursing altogether in 1980, and returned to University Hospital for a refresher course in 1988 before joining the staff on Atrium 8-East.

"It's hard for me to compare the profession of nursing in this country with what I knew in England, because I worked there 20 years ago," says Grossman. "I would say the biggest difference is the fact that here you function as a primary nurse, there as a member of a team. Here, you have greater responsibility for your patient.

"I remember some amusing things, like calling the head nurse 'Sister' and standing at attention while the doctors made their rounds. The patients would be lined up, 15 beds on each side of the room; in a way it was good for morale if you were a patient because you always saw someone in worse shape than you were."

Photos on this page by Bradford F. Herzog.
Staff Notes

Department of Nursing members maintain high visibility in the professional community through teaching, publishing, consulting and participating in professional organizations. The following is a partial list of recent achievements.

Appointments and awards
Julie Bonenfant, R.N., B.S.N., was named chairman-elect of the Massachusetts Council of Nurse Managers.
Ellen Casazza, R.N., B.S.N., was introduced into Sigma Theta Tau.
Karen Cuipylo, R.N., M.S., surgical clinical nurse specialist, was elected to the Board of Directors of the Greater Boston Chapter of the American Association of Critical Care Nurses (GBC-AACN).
Jeanne Doyle, R.N., B.S., vascular nurse consultant, was appointed Executive Director of the Society for Peripheral Vascular Nursing.
Carol Daddio-Pierce, R.N., M.S., C.C.R.N., was appointed co-editor of The Chronicle, a publication of GBC-AACN.
Deborah E. Smith, R.N., B.S.N., was appointed Home Dialysis Coordinator at UH.
Joan M. Vitello, R.N., M.S.N., was appointed co-editor of the Journal of Cardiovascular Nursing, and member of the National AACN Task Force on CCRN Certification Role Delineation Task Force.

Ellen Casazza, R.N., B.S.N.
Jill Champagne, R.N.
Jill Jerome, R.N.

Certifications
Recent certifications in Advanced Cardiac Life Support (ACLS) include:
Lynne Anderson, R.N.
Loretta Donald, R.N.
Mary Donahue, R.N., M.S.
Marianne Hurley, R.N.
Ann Nash, R.N.
Carolyn O'Brien, R.N.
Nancy Pietrafetta, R.N., B.S.N.
Joan Fitzpatrick, R.N., B.S.N.
Carol Goudey, R.N.
Judy Heanew, R.N., B.S.N.
Diane Moutrie, R.N., B.S.N.
Mary Parlee, R.N., B.S.N.
Mary Sanford, R.N., B.S.N.

Graduations
Mary Donahue, R.N., M.S., completed her M.S. in Ambulatory/Community Health Nursing at the University of Massachusetts Graduate School of Nursing.

Lectures and Publications
Barbara Healy, R.N., B.S.N.; Cheryl McMahon, R.N., B.S.N.; Lynn Sulfaro, R.N., B.S.N.; Terry Tougthill, R.N., B.S.N., Renal Transplant Coordinator, and Mary Beth Farino, R.N., B.S.N., presented a lecture on renal transplantation at the June Clinical Update.

Joan M. Vitello, R.N., M.S.N., presented three papers at the National Teaching Institute (NTI) sponsored by the American Association of Critical Care Nurses held in May in Alanta, Ga.
Gloria Shapiro, R.N., C.S., M.S.N., published "Family Work in Nursing Practice" in Psychiatric Nursing in the Hospital and Community.
Joan M. Vitello, R.N., M.S.N., co-authored "Differentiated Nursing Practice in Critical Care" published by AACN.

Review of the Literature

This review was written by Susan Zorb, R.N., M.S.N., C.C.R.N., medical critical care specialist.

It has been an electric season for UH nurses who have published recently. Both Carol Daddio-Pierce, R.N., M.S., C.C.R.N., evening clinical instructor and Carol M. Mravinac, R.N., cardiothoracic clinical nurse specialist, published articles or chapters pertaining to the application of electricity to the heart.

In "Transcutaneous Cardiac Pacing: Expanding Clinical Applications" published in Critical Care Nursing Clinics of North America, 1(2) 1989, Ms. Pierce presents a comprehen-
Nurses, nursing and professionalism

By Patricia Conway, R.N., M.S.,
Nurse Manager, Surgical Oncology

As nurses, our efforts to advance our profession should occur in four arenas: nursing itself, the other health care professions, the public at large, and the government.

Most importantly, we must remember that the essence of nursing, which separates it from all other disciplines, is that its primary focus is to care. In order to care for our patients, we also must care for one another by acting as members of one group and respecting one another. We can advance our profession by acting with thought and purpose, and by seeing things from every perspective, and by making our professional beliefs and values known.

Caring for each other means granting each other the authority to make decisions within our areas of expertise, whether it be a cancer nurse making decisions about diagnosing and treating knowledge deficits, pain problems, or grieving difficulties, a nurse educator making decisions about how to orient new employees, organize a curriculum, or teach students; or a nurse administrator making decisions about what delivery system to implement, how to design and manage a budget, or how to interact with hospital administration.

Secondly, we can advance our profession by collaborating with members of other disciplines, especially physicians, with the understanding that our practice boundaries overlap but have very real distinctions. For this collaboration to work, each of us must be crystal clear about what constitutes the domain of nursing so that we both feel comfortable articulating the nurse’s responsibilities. I believe that it is to our benefit, and to the benefit of our patients, for nurses and physicians to work well together.

The third way to advance our profession is to influence public opinion. Our patients and their significant others will value our contribution to their health care more if they know what it is. It helps if we explain what we are doing, why we are doing it, and what the desired outcome is, and if we explain, as well as practice, primary nursing. The public has a right to expect that a registered nurse will manage the nursing aspects of their care once they enter the health care system and will be accountable for the outcomes of such care. It is increasingly necessary for a primary nurse to be both a good clinician and a good manager in order to coordinate patient care.

It also helps our public image if we obtain specialty certification to show that we are qualified to do what we say we can do, and if we continue to develop the art and science of nursing through experience and research. At the very minimum, each professional nurse must maintain an awareness of research findings in his or her specialty area.

The fourth arena in which we can advance our profession is the government. As members of a human service profession in an era of cost containment, radical change, and tremendous turf battles, we should have a constant awareness of political issues and make our voices heard. As individuals, we may speak, write, and vote in any way we like, but when representing the profession of nursing, we must present a united front. Furthermore, we must teach our legislators what we do, as well as what we believe. We cannot expect them to fund nursing research if they don’t know that nurses do research, or fund nursing education if they don’t know what it entails.

To conclude, I suggest that nurses consistently respect, value, and trust each other. I urge that nurses be able to clearly articulate their philosophy of nursing. We have strength in numbers and a power that comes from commitment and intelligence; we must now develop our ability to negotiate, collaborate, and take risks. The best way to advance our profession is to behave in an intelligent, caring, and politically mature manner, and to take pride in what we do as nurses.
Angioplasty patients now cared for on medical cardiology unit

In an effort to ease the demand on the hospital's cardiac intensive care unit (CCU), patients who undergo percutaneous transluminal coronary angioplasty (PTCA) may now be cared for on the medical cardiology unit, Evans 8. After the procedure is performed in the cardiac catheterization laboratory, stable patients are cared for on Evans 8. CCU beds are more appropriately utilized with the new program.

A relatively new treatment for coronary artery disease, PTCA involves inserting a thin catheter with a balloon at its end into the arterial system, usually through the femoral artery, lacing it through to the location of the blockage; and inflating the balloon for several seconds. In most cases, this action presses the plaque against the artery wall and widens the channel, allowing the blood to flow more freely than before.

"We have four or five angioplasty patients each week," says nurse manager Judy Thorpe, R.N., M.S. "Those who come to our unit have not experienced any significant problems during the procedure and are very stable; patients who have complications are still cared for in the CCU.

"When the program began last July, the major changes we had to make were modifying our rooms for the new technology and training our staff in the specialized care of these patients. PTCA patients require continuous monitoring of their femoral arterial pressure. Alarms are activated when the pressure is too high or too low."

A five-day educational program for staff was coordinated by Thorpe and Carol Mallia, R.N., clinical nurse leader of the unit, and taught by Susan Zorb, R.N., M.S., C.C.R.N., clinical nurse specialist in medical critical care, and Catherine Geary, R.N., M.S.N., C.S., clinical nurse specialist in medicine. The program included theory on hemodynamic monitoring, equipment use and care of the PTCA patient, direct observation in the cardiac catheterization lab, and practical experience, working with a clinical expert prior to practicing independently, in caring for a post-PTCA patient.

"For the patients, one of the greatest advantages of our new system is the fact that they spend all their time in the hospital with us, on this unit," says Mallia. "Previously, patients were admitted here, went for the procedure in the cath lab, were transferred to the CCU or Recovery Room for a four-hour recovery period, and later back here again, and then home. Now when they arrive we can say, 'I will be your nurse during your whole stay.'"

"The flip side is that the ratio of patient to nurse was lower before," says Mallia. "In the CCU there are generally two or three patients to one nurse; here, there are four or five patients to one nurse. However, most PTCA patients do so well that this ratio is fine. If there are any complications, the patient is immediately transferred to intensive care."

Thorpe and Mallia agree that the nurses on the unit are becoming much more skillful in caring for the PTCA patients, and that the role of the professional nurse has been enhanced through the challenge of expanding both theoretical and technological knowledge.

For further information, contact Judy Thorpe, R.N., M.S., nurse manager, at x6680 (638-6680).