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The
University
Hospital

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THE U H Nurse

Streamlined 'bed-finding' eases admitting process

For years the daily routine of finding beds for patients admitted at The University Hospital or transferred from one unit to another was a never-ending task. Today, the Daily Nursing/Admitting Meeting has streamlined the process into a half-hour procedure that is receiving rave reviews from everyone involved.

The meeting, held each weekday morning between 8:30 and 9 a.m., is attended by all nurse managers; Anita King, B.S.N., assistant director of Nursing Systems; King's staffing coordinators; Barbara Waters, manager of Admitting; and Bed Controller Linda Champion.

"This is a process that used to take all day," King

'When the new procedure started, it had immediate results' for Nursing and Admitting

said. "It was ongoing. By the time you called all the floors, got their transfers, and found out if they were able to take admissions, many phone calls were made, and there was still difficulty in placing people. When the new procedure started, it had immediate results. There were smoother operations in the admitting office, and less confusion on the patient units as to who's coming and going."

Initially, at the meeting, nurse managers from the

Emergency Room and the Post Anesthesia Care Unit are asked if they have patients who must be transferred to other areas in the hospital. Nurse managers from the ICUs and other in-house units also list for the Admitting Office patients under their care who are being transferred or discharged.

Then, King said, "I just go down my list of patients who must be transferred and find beds for all of the patients who need them. Then, we go back through the list and managers give me bed assignments for the transfers.

"After beds are assigned to all in-house patients, the group turns to the list of admissions provided by the Admitting Office, complete with diagnosis, the name of the admitting physician, the expected length of stay and other pertinent information. The group starts at the top of this list and assigns a bed for each patient.

"If we run into difficulty, such as not having a bed on the floor appropriate for a patient, we do some negotiating right on the spot," King

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Nursing managers, staff members from Admitting and Nursing, and Anita King, R.N., B.S.N., center, shorten the procedure of finding beds for all patients during their Daily Nursing/Admitting meeting.

Quality assurance plan benefits UH patients and nurses alike

Development of a state-of-the-art quality assurance program to promote timely identification of problems with patient care, prompt corrective action, and heightened confidence in nurses is under way in the Nursing Department.

Spearheading the effort is Shirley A. Shea, B.S.N., M.N., J.D., director of the department's newly formed Quality Improvement/Professional Development division. Shea and her staff have established a new committee structure for quality assurance, designed specifically to involve the entire Nursing Department in a formalized manner.

Under the new committee structure, there is a Nursing Unit Committee on each unit

developing a detailed quality assurance plan. These committees receive support from a Quality Improvement/Risk Management Committee, with representatives from all levels of the Nursing Department.

A Nursing Care Evaluation Committee with participating staff nurses elected by and representing nurses in each unit determine which issues

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Editorial: 1991: A year of progress

Dorothy A. O'Sullivan, R.N., M.B.A.
Vice President, Nursing

When I came to The University Hospital, I was excited about the Nursing Department's strengths and potential. A year later, contemplating the future, I am more enthusiastic than ever.

During the first months of my tenure, my goal was to learn more about all of you, make myself accessible, and evaluate the quality of patient care and the ability of UH nurses to do their jobs effectively. I made rounds, attended staff meetings, and met with managers and staff nurses. After much input from all of you, I began to make changes designed to improve the way our department operates and to create an environment that encourages outstanding and consistent patient care.

One of the most important changes concerns the Nursing Department's Table of Organization. The new Table of Organization, established this fall and depicted in the centerfold of this newsletter, eliminates conventional titles, addresses the

'Part of my job as vice president for Nursing is to bring us closer to other departments in the hospital in a way that benefits everyone by promoting quality care'

future of health care, and encourages a redefinition of the department's mission, philosophy, goals, values and vision.

The Table of Organization defines four major areas in the department: Quality Improvement and Professional Development; Medicine and Surgery; Surgery and Ambulatory Care, and Informatics and Neuroscience. The directors in these

areas bring outstanding professional credentials and experience and a lot of enthusiasm to their new jobs.

A new Daily Nursing/Admitting Meeting, organized this summer through the hard work of many staff members, has markedly reduced the time spent on administrative tasks relating to admissions and transfers. Also, a newly established Weekday Surgical Unit, opened in July, is giving us a way to control some of our costs without compromising the quality of patient care.

I think part of my job as vice president for Nursing is to bring us closer to other departments in the hospital in a way that benefits everyone, by promoting quality care. To that end, I've attended as a guest an Environmental Services staff meeting and chaired a multidisciplinary task force on space reevaluation.

Another part of my job concerns contract negotiations, and I'm very pleased with changes in this area. For six months after I came to the hospital, we were involved in a contract dispute with the Massachusetts Nurses Association. I vowed the next contract negotiation affecting my staff would be settled quickly, and it was. This summer, a pact with the Licensed Practical Nurses Association was hammered out in three days—a morale-booster for everyone involved.

As we move into the new year, other important changes are in the works. In 1992, a new committee with staff representation will begin to provide direct input into the Management Council in order to affect overall planning. We will begin to revise the documentation system to make it more user-friendly. In addition, we will start to reevaluate the patient

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When quality assurance is priority

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in the department are management issues and which relate to quality. There's also a new Ethics Committee, Nurse Education/Research/Credentialing Committee, Nursing Informatics Committee, and Clinical Practice/Standards and Policies Committee.

"Previously, we didn't have a well-defined process for making certain that problems with patient care didn't recur," Shea said. "If a nurse made a medication error, they might be disciplined. But there wasn't a mechanism in place to see if a faulty system set the nurse up to make the error. Our goal with this new committee structure is to change this and prevent problems from recurring."

The push in the Nursing Department for quality assurance mirrors similar efforts nationwide by hospitals pressured by regulatory and governmental agencies to prove they aren't compromising quality to save money.

"What's different at The University Hospital is that we are intensifying the Nursing Department's role in quality assurance. We are taking the lead by adding very specific committees to solve problems," Shea said. "If an education process is required to correct a faulty system, we'll do that. If a revision is needed in a particular system, such as the way drugs are sent up or stored, we'll work closely with that clinical support department to do that. If a policy or procedure needs to be developed, we'll do that."

Shea, who serves as an ex-officio member on all the committees, headed a formal orientation program for committee members in Novem-

ber. Through 1992, she will conduct intensive training in quality assurance through classroom instruction and support groups.

Also, as the hospital's clinical risk manager, Shea will

'The result is really optimizing the quality of care for patients'

receive all clinical incident reports from all departments in the hospital in which there is interaction between the staff and patients. These reports, with information about medication errors, patient falls, unexpected patient-care outcomes, and other significant problems, will come to Shea within 24 hours of an incident occurring.

"When an incident is that hot, I can move very quickly and give it to the appropriate educator or a clinical specialist so a solution can be found and implemented immediately," Shea said.

To patients, an outstanding quality assurance program means a lot. Shea said, "It leaves patients in a better situation, because they come into an institution where we have taken measures to minimize risk. The result is really optimizing the quality of care for patients."

In addition, a well-run quality assurance program can bring benefits to nurses by improving confidence and lowering stress. "If nurses are more knowledgeable about policies and procedures and know there are mechanisms in place for double-checking and re-checking to prevent errors, it will make them feel they're not contributing to risk in patients," Shea said.

Ambulatory Care: It's 'love on the run'

Since the new Ambulatory Care Unit opened in late summer, the length of an average stay for a patient coming to The University Hospital for surgery has decreased 50 percent, to three hours. The unit's fast pace is reflected in the motto of its nurses—"Love on the Run."

As many as 60 patients a day pass through the unit, which has a minor-procedure room, a surgical suite and an endoscopy suite filled with state-of-the-art equipment. From 6:15 a.m. to 7 p.m., Monday through Friday, the unit's nursing staff assists with dozens of procedures, in-

'It's a pleasant, upbeat environment and a great opportunity to learn more about ambulatory care, an up-and-coming discipline in medicine'

cluding endoscopic procedures, arthroscopies, hardware removals, carpal-tunnel release, laparoscopies and biopsies.

After checking in with the receptionist and changing into hospital attire, patients go to the pre-operative room, where a member of the nursing staff interviews and educates them and assesses their medical records. The patients wait in the unit, with a television and magazines available, until time for their surgery. After surgery, patients go to the first-stage recovery area, then to the final-stage recovery area, where there are light snacks and beverages. Upon discharge, all patients are

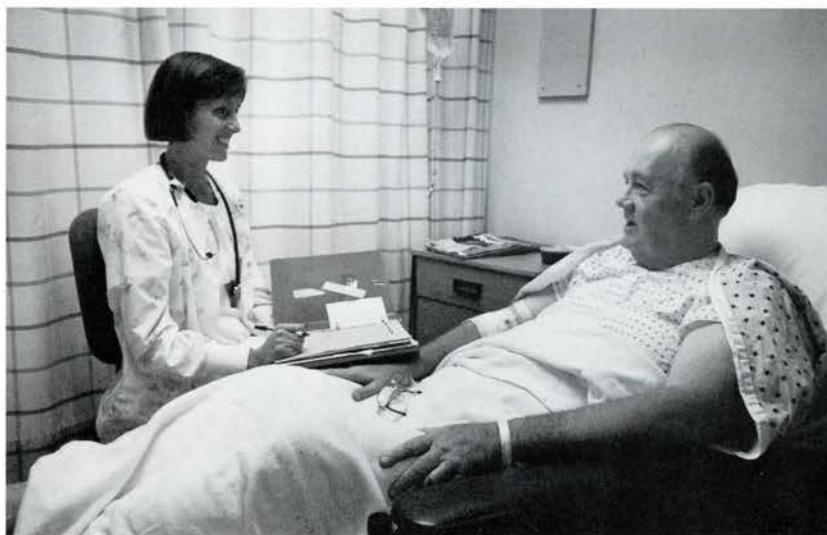
given individualized post-operative instructions. Everyone receives follow-up calls the day after their procedures from a nurse in the unit checking on their progress.

"All ambulatory units have their own specialties and focuses. This one is really diverse," said Deborah F. Mulloy, R.N., M.S., nurse manager of Ambulatory Care.

"We do minor excisions, ambulatory surgery, endoscopy procedures and pre-operative screening of charts."

"Sometimes ambulatory care is seen as an easy job. But you have to work hard all day to keep things moving efficiently, and at the same time be aware of patients' physical and emotional needs. Each new patient presents a variety of issues from simple to complex, and the nurses here must know how to work calmly and resourcefully while addressing these needs. They must have special skills to work in the operating room, recovery room and the endoscopy area. It is essential to be a good team player, a good communicator and a patient advocate in this unit. It's a challenge the staff has met very well."

The patients clearly agree with Mulloy's positive assessment. A vast majority of the responses in patient-satisfaction questionnaires given upon discharge rate patients' experiences at The University Hospital as good to excellent. About 40 percent of the questionnaires are filled out and



In the Ambulatory Care Unit, nurses work at a fast pace, but remain committed to quality care. Here Donna Manning, R.N., M.B.A., jots down pertinent information from patient John Phillips.

returned.

UH's Ambulatory Care also is gaining a reputation for excellence around Boston as a good place to train, said Patricia A. Ide, R.N., M.S.N., director of Surgery/Ambulatory Care. Ide said she is frequently contacted by professionals in nearby nursing schools who want their students to work in the unit.

Donna M. McNamee, R.N., B.S.N., a staff nurse in the unit, said working in Ambulatory Care is both a pleasure and a challenge. "It's a pleasant, upbeat environment and a great opportunity to learn more about ambulatory care, an up-and-coming discipline in medicine."

Ide said ambulatory care has emerged in recent years as an important part of medicine for a number of reasons, including advances in technology and anesthesia. For example, the relatively new anesthetic Diprivan, known commonly as Propofol, works efficiently with few side effects. Endoscopes and lasers have a great impact by allowing for less-invasive surgical procedures.

Also, Ide said, governmental agencies and insurance companies have dictated the future of health care in many ways. "There are a lot of procedures you can't do now on an inpatient basis, because of the way insurance companies pay and reimburse."

Mulloy sees a positive side to this situation. She said, "A lot of patients actually prefer to recover in their own home with their families. This often shortens the recuperation period and allows the patients to return to work sooner."

In order to provide the same level of care and safety on an ambulatory care basis as that received by patients admitted overnight, education becomes a critical component of ambulatory care.

Mulloy said, "In the very short period of time that they're here, patients need to learn a lot so that when they go home, they can take care of themselves effectively. It's very important that nurses have the ability to communicate the type of information patients need for independent home care."

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Vice President, Nursing



Dorothy A. O'Sullivan, R.N., M.B.A

**Director,
Qual. Improv./Prof. Dev.**



Shirley Shea, R.N.,
M.S.N., J.D.

Clinical Instructors



Diane Lancaster,
R.N., Ph.D.



Mary Jo Brogna,
R.N., B.S.N.



Jane Roman, R.N.,
B.A., M.B.A.



Lynn LaFond-
Linehan, R.N., M.S.

Clinical Nurse Specialists



Gloria Shapiro, R.N.,
M.S.N., Psychiatry



Diane Sarnacki, R.N.,
M.S.N., Oncology



Peggy Cronin
Donahue, R.N.,
M.S.N., Medicine



Karen Cuiyylo, R.N.,
M.S.N., Surgery

Clinical Nurse Specialists



Noreen Leahy, R.N.,
M.S.N., Neurology



Joan Vitello, R.N.,
M.S.N., C.C.R.N.,
C.S., Critical Care

Recruitment



Gary Hill, B.S., M.S.,
Manager,
Employment



Catherine Celenza,
M.B.A.,
Nurse Recruiter

Evening Instructors



Patricia Dhooge,
R.N.



Janet Eagan, R.N.,
M.S.N.



Giselda Bousquet,
R.N., M.S.



Carol Daddio-Pierce,
R.N., M.S., C.C.R.N.



Elizabeth Dobrowski,
R.N.

**Director
Med. / Surg.**



Terry Kahlert, R.N., M.S.

**Director,
Surgical/Ambulatory Care**



Pat Ide, R.N., M.S.N.

Nurse Managers

Atrium 6 E/W/N



Geralyn Saunders, R.N., M.S.N., 6 East



Donna Rosborough, R.N., M.S., 6 West



Richard Ridge, R.N., M.B.A., 6 North

Atrium 7 E/W/N



Becky Brown, R.N., B.S.N., 7 East



Rita Galvin, R.N., M.S., 7 West



Lynne Medlar, R.N., B.S.N., 7 North

Evans 7/8



Jane Jansen, R.N., B.S.N., Evans 7



Judy Thorpe, R.N., B.S.N., Evans 8

CCU



Mary Lou Moore, R.N., B.S., C.C.R.N.

MICU



Nancy Couch, R.N., M.A., M.T.S.

Nurse Managers

PACU



Marie Cosma, R.N., M.S.

SICU



Cynthia K. O'Sullivan, R.N., M.S.N.

OR



Patricia Haupt, R.N., M.S.N.

Amb. Care



Deborah Mulloy, R.N., M.S.

Dialysis



Mary Ann McCarthy, R.N.

ER



Warren A. Beattie, R.N., B.S.N.

CSP



Bob Harvey

Clinical Nurse Specialists



Diane Mitchell, R.N., M.S.N.



Stacey Gross, R.N., M.S., Cardiothoracic Surgery



Carmel Fitzgerald, R.N., M.S., C.C.R.N., Cardiothoracic Surgery

**Director
Neuroscience/Informatics**



Tom Hamelin, R.N., M.S.N.

**Assistant Director
Nursing Systems**



Anita King, R.N., B.S.N.

Nurse Managers

Atrium 8 E/W



Jessie Munn, R.N.,
M.B.A.



Janis Yarrusso, R.N.,
M.S.N.

Preston 5



Mary Anne Kieran,
R.N., M.S.N.

Preston 2



Judy Dillon, R.N.,
M.S.N.

IV Therapy



Mary Landrum, R.N.,
B.S.N.

Nursing Supervisors



Jane Keilty, R.N.,
B.S.N.



Jane O'Shea, R.N.,
B.S.N.



Ruthann Cavallo,
R.N., B.S.



Phyllis Davis, R.N.



Susan Crowley,
R.N., B.S.N.



Gail Lopez, R.N.,
B.S.N.

Data Manager



Burlen Baker, B.S.,
B.A.

Easing the pain of admissions and transfers

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said. "By the time this meeting ends, every patient who must be transferred or admitted has a bed. In addition, we have a census for each unit and can predict staffing needs for the next three shifts."

The Daily Nursing/Admitting Meeting has a number of other benefits, King said. It alerts nurse managers to transfers that must occur immediately as well as to future transfers, and it also fosters the concept of primary nursing.

"If a patient was here before and he had a primary nurse on a floor, the nurse manager would know that. So the patient would go back to that floor and to his primary nurse, providing he's not coming in with some diagnosis that would make that move inappropriate. This provides continuity for patients and it's more satisfying for the staff, because they might get to follow a patient from the onset of a disease sometimes through its course."

Since the Daily Nursing/Admitting Meeting was established in August, it has received high praise from virtually everyone involved.

"From Day One I heard nothing but positive comments. I wish we had started this a long time ago," King said. "Our whole admission process has been better."

Barbara Waters from Admitting agreed. She said, "Overall, I think this meeting has helped the whole hospital run a lot better, because by 9:30, everyone has a sense of what their day is going to look like."

The Weekday Surgical Unit: Controlling costs while maintaining quality care

In the wake of a declining surgical census on weekends, the new Weekday Surgical Unit on 6 North is giving The University Hospital a way to control costs while maintaining quality patient care.

The Weekday Surgical Unit is open from Monday at 11 a.m. through Saturday at 3 p.m. Its patient population consists mostly of surgical patients whose hospital stays end on a weekday, although there are some long-term care patients who transfer to other units on weekends.

Since the Weekday Surgical Unit was established in July, said Richard A. Ridge, R.N., M.B.A., the unit's nurse manager, there has been a dramatic change in the patient census on units that remain open 24 hours a day, seven days a week. "Previously we had four units

'The challenge for the nurses has been to make the transition to deal with a high-volume and high-turn-over patient population and the accompanying documentation requirements. It's a challenge they've met very well'

that averaged as low as 50 to 65 percent full on the weekend," Ridge said. "Now we have one unit that's empty, while the others are more than 90 percent full. With one short-term unit to accommodate patients who can be discharged by Saturday, we are significantly reducing the cost of operating several units at inefficient



Ellen Munger, R.N., B.S.N., checks on the progress of patient Linda Wood in the Weekday Surgical Unit on Atrium 6 North, a unit that is open on Monday through Saturday as a way to control costs.

census levels."

Plans for the Weekday Surgical Unit were formulated in early 1991 after it became clear the average length of stay for many surgical patients had decreased to less than five days. This mirrored a trend in the health-care sector toward shorter hospital stays for surgical patients and more emphasis on the utilization of community resources and family support.

Before forming the Weekday Surgical Unit, Ridge and several staff members made off-site visits to a nearby hospital where a similar unit was already established. A major concern of everyone involved was how to provide consistent and appropriate care on an ongoing basis for all patients affected.

Part of the solution came in a realignment of admitting procedures that placed on the unit patients who would go home at week's end. (See related story about the Daily Admitting/Nursing Meeting.)

In addition, Ridge said, nurses on 6 North spent hours learning about the different surgical sub-specialties and preparing nursing care plans and patient teaching guidelines. The manner in which the Weekday Surgical Unit operates will continue to evolve over time in response to changes in the health care sector. However, the unit's goal will remain the same—quality patient care.

"Everyone on the unit is trying hard to do whatever is needed to deliver quality nursing care within budget constraints," Ridge said. "The challenge for the nurses has been to make the transition to deal with a high-volume and high-turnover patient population and the accompanying documentation requirements. It's a challenge they've met very well."

Staff Notes

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

Appointments:

Mary Jo Brogna, R.N., B.S.N., day instructor, Quality Improvement/Professional Development.

Marie Cosma, R.N., M.S.N., nurse manager, Post Anesthesia Care Unit.

Nancy Couch, R.N., M.S.N., nurse manager, MICU.

Carmel Fitzgerald, R.N., M.S.N., clinical nurse specialist, Cardiothoracic Surgery.

Stacey Gross, R.N., M.S.N., clinical nurse specialist, Cardiothoracic Surgery.

Thomas Hamelin, R.N., M.S.N., M.B.A., director of Neuroscience/Informatics.

Robert Harvey, manager, Central Sterile Processing.

Patricia Haupt, R.N., B.S.N., nurse manager, operating room.

Mary Anne Kieran, R.N., M.S., elected chairperson of the Massachusetts Council of Nurse Managers' program committee.

Diane Mitchell, R.N., M.S.N., clinical nurse specialist, surgery.

Mary Lou Moore, R.N., B.S., C.C.R.N., nurse manager, CCU.

Jessie Munn, R.N., M.S.N., nurse manager, Atrium 8E.

Richard Ridge, R.N., M.B.A., elected chairperson of the Massachusetts Council of Nurse Managers' Finance Committee.

Donna Rosborough, R.N., M.S., nurse manager, Atrium 6W.

Shirley Shea, R.N., M.S.N., J.D., director, Quality Improvement/Professional Development.

Certifications:

Advanced Cardiac Life Support

Debbie Almeida, R.N.
Cathy Angeley, R.N., B.S.N.
Glen Blair, R.N.

Alfea Blanchard, R.N.
Denise Buckley, R.N.
Maureen Bulger, R.N.
Kathleen Clark, R.N.

Linda Dorian-Sutherby, R.N.
Patricia Doyon, R.N.
Ann Driscoll, R.N.
Nanette Elia, R.N.

Nancy Fennessey, R.N.
Kathleen Gallagher, R.N., B.S.N.

Donna Grandbois, R.N.
Julie Green, R.N.
Karen Higgins, R.N.

Margaret Higgins, R.N.
Mary Ann Johansen, R.N.
Linda Jones, R.N.

Maureen McCarron-Browne, R.N.

Kathleen McCarthy, R.N.
Mary K. McConville, R.N., B.S.N.

Mary Parlee, R.N.
Christine Smith, R.N., B.S.N.

American Board of Anesthesia

Maureen Hughes, R.N.

Critical Care Nursing

Sharon Cleveland, R.N.
Susan Delaney, R.N.
Carmel Fitzgerald, R.N., M.S.N.

Kathleen Higgins, R.N.
A. Derby Jones, R.N.
Penny Mattus, R.N.

Eileen McLaughlin, R.N., B.S.N.

Virgina Poster, R.N.
Jan Marie Ring, R.N.

Donna Rosborough, R.N., M.S.N.

Emergency Nursing

Mary Duggan, R.N., B.S.N.
Elizabeth Gruenwald-Centanni, R.N., B.S.N.

Donna Hovey, R.N., B.S.N.
John Twomey, R.N.

Medical-Surgical Nursing

Loretta Donald, R.N., M.S.N.
Cheryl Page, R.N., B.S.N.
Linda Vinson, R.N.

Neuroscience

Katie Caunter, R.N.

Oncology

Cathy Angeley, R.N. B.S.N.
J. Kelly Buis, R.N., B.S.N.
Maureen Ritchie, R.N., B.S.N.
Diane Sarnacki, R.N., M.S.N.

Operating Room Nursing

Patricia Ide, R.N., M.S.N.

Psychiatric and Mental Health Nursing

Alan Minsk, R.N.

Gerontology

Socorro Talamera, R.N., B.S.N.

Graduations:

Maura Babineau, R.N.: B.S.N. from Salem State College, June 1991

Jack Gould, R.N.: B.S.N. from the University of Massachusetts, Boston, June 1991

Mary Ann Johnson, R.N.: M.S. in oncology nursing from the Massachusetts General Institute of Health, August 1991
Mary Ann Silva, R.N.: M.S.N. from Northeastern University, August 1991

Lectures and Workshops:

Catherine Bettencourt, R.N., B.S., and **Maura Rowley, R.N., B.S.N.**, are participating in Bridge Over Troubled Waters, a community program for city children.

Terry Branca, R.N.C., lectured at the Geriatric Workshop at The University Hospital in May 1991. Branca also lectured in September 1991 on "Geriatric Assessment" at Cape Cod Nursing Retirement Center.

Christine Di Tuillo, R.N., B.S.N., and **Lynne Lambert, R.N., B.S.N.**, developed an In-Service Program for the care of the Continuous Ambulatory Peritoneal Dialysis patient on 6 East in April 1991.

Diane R. Lancaster, R.N., M.S.N., Ph.D., spoke at the annual Great Lakes Oncology Nursing Conference on "Coping With Appraised Threat of Breast Cancer: Primary Prevention Coping Behaviors Utilized by Women at Increased Risk."

Lynn La Fond-Linehan, R.N., M.S., recently co-presented

two workshops at the Middlesex County Hospital in Waltham, Mass., on the "Care of the Ventilator-Assisted Individual." La Fond-Linehan also spoke on "Psychosocial Issues Relating to Long-Term Ventilatory Support" at the third International Conference on Pulmonary Rehabilitation and Home Ventilation in Denver.

Cindy O'Sullivan, R.N., M.S.N., presented a lecture on "Delegation: Making It Work For You" in Orlando, Fla., at the American Association of Critical Care Nurses' National Teaching Institute in November 1991.

Jane Roman, R.N., M.Ed., and **Gladwyn Howard, R.N.**, conducted a workshop at The University Hospital on "Laparoscopy for the General Surgeon" for general surgeons in the Northeast.

Joanne Ryan, R.N., and **Debbie Smith, R.N., B.S.N.**, conducted in-service training on Continuous Ambulatory Peritoneal Dialysis to the 6 East staff.

Diane Sarnacki, R.N., M.S.N.; **Kelly Starvish, R.N., B.S.N.**; and **Sandy Ziegler, R.N.**, organized a Cancer Awareness Day at The University Hospital in May.

Sheryl Townson, R.N., B.S.N., presented an in-service program on the care of the Tenkhoff catheter at Reshaven Nursing Home in October.

State Boards:

Lorain Baeumler, R.N., B.S.N.
Kristen Burns, R.N., B.S.N.
Kerry Carmody, R.N., B.S.N.
Rebecca Cooper, R.N., B.S.N.
Anna Crane, R.N., B.S.N.
Carolyn Dudley, R.N.
Tracy Factor, R.N., B.S.N.
Judith Howard, R.N., B.S.N.
Maryann Johnson, R.N.
Carla Mahn, R.N., B.S.N.
Julianne Randall, R.N., B.S.N.
Chip Surratt, R.N.
Patricia Tennill, R.N., B.S.N.
Karie Thompson, R.N., B.S.N.

Editorial

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classification system to see if we're giving the appropriate hours of care to patients — a measurement that can be impacted not only by staffing number but also by staffing mix.

Multidisciplinary teams will start to redefine positions in the department. These teams will receive input from the staff at all levels to assure job descriptions don't just reflect what management thinks the jobs should be. This job redefinition will occur for several reasons. Some of our job descriptions don't meet standards set by the Joint Commission on Accreditation. Also, I've found many inconsistencies in job descriptions throughout the organization.

I can't stress enough how strongly I feel that we have a quality department with quality people at all levels. Although there is much work still to be done, I sincerely believe we can make The University Hospital's Nursing Department number one, not only in Boston and Massachusetts, but nationwide.

Ambulatory Care

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To do this, the unit's nurses with input from doctors have prepared pre-operative and post-operative discharge instructions.

The successful operation of a fast-moving ambulatory care unit in a teaching hospital, where the focus frequently is on very sick long-term care patients, isn't always easy. But Ide said, "We have a lot of support from management. This enables us to implement what we need to happen. When we make steps in expanding our services, they're quality steps."

Fellow nurses say fond farewell to Carol Thornton, 40 years at UH

After more than 40 years spent working at The University Hospital, evening nurse supervisor Carol Thornton, R.N., has decided to devote her time to other activities, such as traveling or studying archeology. "There are all kinds of things out there to do," said Thornton, who retired in September. "But I don't have to do anything. I've worked long enough."

Thornton was honored for her years of service during a reception in October at the American Legion Post in Squantum. At the gathering, she was presented with a porcelain nurse's cap as a small remembrance and thanks for her years of service.

"I've known Carol a long time. She's the type of person who is always there for you," said James O. Menzoian, M.D., chief of Vascular Surgery. "She is truly genuine in the care she gives patients, and you can be sure she knows what she's doing. Simply put, Carol's a great lady; she will be missed."

Thornton's long-time affiliation with the hospital began in February 1946, when—at age 17—she came from her hometown



Carol Thornton beams with pleasure at a retirement gift, a porcelain copy of her Massachusetts Memorial Hospitals School of Nursing cap. The cap was presented Thornton at her retirement party.

'She is truly genuine in the care she gives patients, and you can be sure she knows what she's doing. Simply put, Carol's a great lady; she will be missed.'

of Florence, in western Massachusetts, to enroll as a freshman in the Massachusetts Memorial Hospital's School of Nursing.

Thornton's studies and her clinical work both began immediately: "We were put right on the floors. We were 'it' in terms of staffing, although at the time, the hospi-

tal only consisted of the Old Evans, the Robinson and the Colamore Buildings. For the first several months, we were considered probationers. Then, during our fourth month, we were capped," she said.

It was during her training that Thornton met her husband of 42 years, Jens E. Thornton, who worked as a night orderly while attending Tufts University.

Upon graduation at age 20, Thornton worked initially as a staff nurse on the night

shift. Later, while raising seven children, she alternated between night and evening shifts, unable to give up the profession she loved.

In the late 1960s, Thornton was appointed night nurse supervisor—a position she held with distinction for some 12 years. In the mid-1980s, she assumed the role of evening nurse supervisor. In her "spare time," she earned an associate's degree in liberal arts.

Informatics: Empowering nurses through technology

Informatics—the use of information systems—is arriving in the Nursing Department with the help of Thomas A. Hamelin, R.N., M.S.N., M.B.A., who sees technology as a way to increase productivity, promote quality assurance, and improve patient care.

Hamelin, director of Neuroscience/Informatics, was hired earlier this year to help with the budgeting process. However, another part of his job involves bringing computers to all levels of the department.

In upcoming months, Hamelin plans to link all the computers in Nursing Administration through a server on a local area network, a move that could save money and time. "It's less expensive to buy a site license for 40 computers than to buy software for 40 computers, and we could share information easily at budget time," he said.

Eventually, Hamelin

would like to link all the nursing leadership, including nurse managers, educators and clinical nurse specialists, onto the network. This would speed turnaround of care plans, protocols and standards of practice and would enable managers to do 'what if' scenarios on spreadsheets in a matter of seconds.

To curb the fears of anyone in the department not entirely comfortable with computers, Hamelin said, "If you set up a good management in-

'If you set up a good management information system, people don't need to be computer experts'

formation system, people don't need to be computer experts. They just need to be computer literate, and most of the people in Nursing Administration are."

Sometime in 1992, Hamelin wants to place a workstation or microcomputer beside each bed in the ICUs. These computers would download all information from various systems and from the lab system already in place to encourage a higher level of data analysis.

"The typical ICU nurse gets inundated with number after number," Hamelin said. "Most of these nurses are very good at interpreting these numbers. But by having computers gathering the data, they can gain time to do one more level of interpretation and be involved in more patient teaching and more discharge planning."


After the computers are installed in the ICUs, Hamelin will turn to the acute care floors. Computers in this area, he said, could hold standardized case management plans that could be easily manipulated by nurses to fit particular patient needs. Also, Hamelin said, a com-

puterized system could standardize charting and reporting practices. "You'd always know you could find a certain piece of information in a certain place."

Educators could set up screens on the computers to meet their goals for documentation, and guidelines could be placed on-line for use by new nurses and physicians.

Computers can cut down on the need for different people to record the same data, thereby reducing the possibility of data entry errors. Also, a computer system can make real-time quality assurance a reality by providing up-to-the-minute data at any time.

Hamelin views himself as a coordinator in the overall effort to install computers throughout the hospital. "I'll try to show the nurse managers and nurses what's available. Then, they can decide what they want to use."



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