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Feeding the hungry
Becky Brown, RN, front, Mary Landrum, RN, center, and Jane Keilty, RN, serve up barbecued hot dogs at a Hospital lunch stop during the 24th Annual Walk for Hunger on Sunday, May 2. As is tradition, the walk kicks off an array of Hospital activities celebrating National Nurses Week (see story and other photos, page 4).

THE CHALLENGE BEFORE US:

Molding a new direction for nursing care

by Joan M. Vitello, RN, MSN, CCRN, CS

Today's environment mandates that the way nurses deliver care must and will change. The effectively restructured health care system, in my view, will be one that is driven by the patient's needs, in which nurses make their optimal contribution. I believe this vision requires nurses to think differently about the manner in which they currently deliver care, and to commit their energies to redesigning tomorrow's delivery system.

There is nothing so powerful as an idea whose time has come.
-Victor Hugo

Shifting to a new paradigm

When nurses consider breaking from their traditional ways of delivering care, they are, in essence, engaging in a "paradigm shift." The word paradigm comes from the Greek word meaning the way we perceive, understand or interpret the world.[1]

Changing our perceptions involves new ways of thinking. The paradigm shift I advocate is one of providing care based on the patient's needs, rather than on those of the provider. However, for this vision to take shape, it

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'Critical paths:' Useful tools for collaborative care

by Carmel Fitzgerald, RN, MS, CCRN

Hospitals today are faced with the daunting challenge of finding new ways to deliver high-quality, cost-effective care in an increasingly competitive market. One approach that is gaining widespread acceptance within health care—the use of "critical paths"—may help meet that challenge.

Here at Boston University Medical Center/The University Hospital, critical paths, or patient-care management tools that help define how hospital resources are used, have been tried successfully on cardiothoracic surgery patients, resulting in dramatic decreases in length of stay without compromising care.

From left, Gabriel Aldea, MD, Carmel Fitzgerald, RN, MS, Kathleen Gallagher, RN, Thomas Carr, MD, and Stacey Gross, RN, MS, are part of the cardiothoracic surgery team who utilize critical paths in the routine care of coronary artery bypass patients.

Critical paths were developed and implemented in the Department of Cardiothoracic Surgery during the summer and fall of 1992. A multidisciplinary task force convened to assist in the initial development of a critical path for DRG #107 (coronary artery bypass graft, or CABG, surgery, without cardiac catheterization). The key elements featured in this critical path are consults, tests, activity, treatments, meds, diet, teaching, and discharge. These elements contain the standard interventions necessary to care for the patient undergoing CABG surgery.

Critical path (DRG #107) data on 50 patients was collected over a three-month period with a targeted length of stay (LOS) of nine days (including seven post-operative days). The preliminary data indicated that 68 percent of our sample was discharged before the seventh post-

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Editorial: Staff is key to meeting cost, quality challenges

Maura Mitchell, RN, MEd, Vice President, Nursing

Recently I had the opportunity to attend a conference on the activities of the federal Health Care Reform Task Force led by Hillary Rodham Clinton. The conference was hosted by Sen. Edward M. Kennedy (D-Mass). Approximately 700 leaders from the health care provider community, consumer advocates, health-policy experts and legislators attended. Ira Magaziner, the senior government official heading the task force, provided details of what the administration's proposals are going to contain. Several key trends emerged that will likely have a profound impact on nurses and acute-care hospitals.

The major goals are to decrease costs and increase access for the uninsured and underinsured. Strategies to accomplish this outcome will likely include a movement of patients into managed-care networks; a shift from hospital-based to community-based services; fewer inpatient hospitalizations, with shorter lengths of stay; a greater focus on health promotion and prevention rather than on the treatment of illness, and the elimination of existing barriers that limit the scope of practice for non-physician providers, including nurses practicing in the expanded role.

While federal health care initiatives are taking shape, a similar magnitude of change already is occurring here in the Commonwealth due to the deregulation of the hospital industry last year. Chapter 495 moved us from a highly regulated system to one of managed competition. Thirty percent of our citizens currently are enrolled in health maintenance organizations (HMOs), and it is projected that almost 80 percent will join managed-care plans by 1997. We at Boston University Medical Center/The University Hospital already have felt the impact of the changing environment through increased competition among hospitals for fewer patients and unrelenting pressure to provide discounts to third-party payors who are increasingly in charge of deciding where patients are hospitalized.

The key success factors for all hospitals will continue to be clinical quality and service excellence. However, there will be increased consideration of quality versus cost, or value.

What does this mean for our nursing department? The nursing management team has been working for the past several months on the development of goals that will help guide us over the next couple of years. The most important of these include:

1. The development of critical paths/clinical practice guidelines for nursing diagnoses, and, in collaboration with physicians and other health professionals, the development of multidisciplinary paths for common medical diagnoses.

The guidelines will be research-based; devoid of ritualistic behavior; patient-outcome focused, and represent financial value. We soon will be convening task forces for specific clinical specialties and will seek your participation.

2. The adoption of a nursing care delivery system that has consistent individual nursing accountability for patient outcomes.

The Staff Nurse Council has been charged to decide which model(s) should be selected. Your input is needed. Please contact your unit representative on the Council for more details about the project.

3. Participation in Hospitalwide initiatives to enhance service quality.

Nurses are uniquely positioned to both identify service quality problems (including the patient's perceptions) and propose workable solutions. Our department will be seeking volunteers to serve on a variety of Hospitalwide committees charged with supporting this effort.

4. Increased communication within our department and the enhancement of the decision-making role of nursing staff.

This publication is one example of the ways in which we hope to achieve this goal. We also are resuming publication of the monthly nursing bulletin. I plan to host monthly open meetings for staff to share their concerns and/or suggestions directly with me. The initiatives described in a preceding paragraph also are intended to support this goal.

The future presents both challenges and opportunities. While change is difficult and anxiety-provoking, it allows us to grow. I am excited by the opportunity to improve and expand our nursing practice, and look forward to working with you to accomplish our goals.

Peggy Cenci Award winner

Kate Whalen, RN, of the Emergency Department, right, accepts this year's Peggy Cenci Award from Sarah Coleman, LPN, chairperson of the Cenci Award committee.

Critical paths

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operative day. Twelve percent followed the critical path and was discharged on the seventh post-operative day, while 20 percent was noted to have a LOS greater than seven post-operative days. Two patients with shortened lengths of stay represented same-day surgical admissions, reflecting recent trends in the insurance industry to cut pre-operative LOS.

How critical paths work

To facilitate communication and collaboration, the critical path is kept with the patient's bedside chart and follows the patient back and forth from the Atrium 6-West Telemetry and Progressive Care Unit, to the Atrium 3-West Surgical Intensive Care Unit. During each shift, the nurses on these units evaluate the patient's status and/or progress in relation to the critical path. If a variance occurs, it is documented, along with the reason for the variance. The nurse, cardiothoracic surgery clinical nurse specialist/case manager, physician, and physician assistant then collaborate to alter the plan of care in order to meet the changing needs of the patient.

The cardiothoracic surgery clinical nurse specialist, working with the primary care-giver, follows the cardiothoracic surgical patient and sees to the ongoing monitoring and evaluation of the patient's progress on the critical path. High-risk patients (those with multiple co-morbid factors, reduced cardiac function or poor family support) are identified early to plan for potential variations from the usual CABG course. Early intervention assists in the coordination of services to assure that patients are receiving the necessary care and moving toward established outcomes. Post-hospitalization, the clinical nurse specialist maintains continuity of care through close communication with outside agencies and follow-up in the outpatient clinic, in an attempt to monitor and prevent readmission.

Cost savings realized

Less than a year after the CABG critical paths were implemented, significant service improvements were noted in cardiothoracic surgery. Such improvements have contributed to maintaining a high standard of care, as well as reducing hospital costs by decreasing length of stay.

Similar collaborative efforts are under way to develop critical paths for cardiology patients undergoing cardiac catheterization and percutaneous transluminal coronary angioplasty. Sound planning and decision making through critical-path use will allow nursing and other Hospital disciplines to continue to share in and contribute to the improvement in the delivery of quality, cost-effective health care.

'Critical paths' are useful 'road maps' for care

A "critical path" traces the step-by-step progress for a patient's recovery, alerting each care-giver to what needs to happen in order to achieve a predictable outcome and timely discharge. It is more comprehensive than a nursing care plan in that it describes and defines the optimal course of hospitalization, delineating the appropriate use and timing of diagnostic tests, therapies and interventions for patients with similar problems or diagnoses.

Critical paths employ a multidisciplinary approach. Outcomes, clinical processes and time frames are defined by nursing and medicine in collaboration with other departments such as respiratory, physical therapy, dietary, and social services, as needed. Accountability is built in for team members to assist patients in reaching their goals in the stated time frame. Ongoing communication and collaboration among team members enhances early problem identification and, ultimately, the quality of care.

The challenge before us

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must first be embraced and nurtured within each individual nurse.

Paradigms create the lenses through which people view the world; this is the source of their power. Each person sees through the unique lens of his or her own individual paradigm. If we, as nurses, are willing to change our paradigms, then our nursing practices also will be transformed. This takes commitment and courage. To make changes in nursing care delivery methods, nurses must be willing to give up some of their comfortable patterns of thinking and doing in their daily practices.

To begin, nurses must first identify the true needs of their patients. Questions that they must consider include:

- What will nursing that is driven by the patient's needs be like?
- What can I do to make patients feel more like partners in their care?
- What are the patient's priorities?
- What can I do to keep the patient as the guiding force?
- What can I do to facilitate a paradigm shift among the health care team to patient-focused care?

The answers are waiting to emerge from nurses' own creativity, compassion and commitment.

Managing the chaos

Exploring new models of care delivery means that nurses must wander a bit, challenging their old habits and comfortable practices, and opening themselves to new possibilities. It won't be easy to do this. In fact, it might become pretty chaotic! However, there have never been as many opportunities for nurses to do this as there are today. Hospitals now are supporting new ideas to redesign nursing services. In fact, private funding groups also are committing huge sums of money to new work-redesign projects. Some examples are:

✔ The Robert Wood Johnson Foundation and Pew Charitable Trusts committed $26.5 million to 20 hospitals and consortia across the country to the institutionwide restructuring of roles. This project supports reshaping nursing services, improving interdisciplinary communications, and enhancing support services.

✔ Thirty New Jersey hospitals were given $8.4 million by that state for "experiments to improve nursing environment and efficiency."

✔ Many of the JCAHO-approved hospitals are embracing the total quality movement, which is an institutional commitment to continuous quality improvement.

These are excellent examples of new paradigm shifts in nursing care. If nurses are going to succeed and manage the chaos, they will need to be proactive and open to such suggestions.

Together, nurses must creatively mold a new direction for nursing.

[1] Covey, S. *The Seven Habits of Highly Effective People.* Simon & Schuster. 1989

Documentation task force closes in on its mission

by Judy Thorpe, RN, MS, and Gloria Shapiro, RN, MS, CS

The Documentation Task Force is nearing completion of its mission of designing a new nursing documentation system that is expected to be implemented sometime this summer.

The committee's goal is to devise a system that is user-friendly, in keeping with guidelines imposed by the Joint Commission on Accreditation of Healthcare Organizations, and capable of being upgraded to a bedside computer.

Prior to undertaking its mission, the task force completed reviews of the literature and of current systems in use at other hospitals. Because the group was unable to locate a system that met its criteria, it developed its own. After a significant amount of work by task force members, including staff nurses, nurse managers, clinical instructors and clinical nurse specialists, the proposed system was presented during a four-hour meeting attended by staff nurse representatives from each inpatient unit.

The new system will contain the following documentation components:

- A universal signature sheet: All care-givers will note their initials, signature/title, beeper number (if appropriate), and service on one sheet. All initial/signature sections of all other forms will be eliminated.
- A functional health assessment form: Revisions were made in several areas.
- A patient problem index form: This will be an easy reference listing of all current nursing and medical diagnoses for the patient.
- Documentation of medical plan of care: Non-medication physician orders will be transcribed onto this sheet. There will be a place to initial when orders are carried out, as well as a place to document outcomes, if appropriate.
- Documentation of nursing plan of care: Specific nursing orders will be noted directly on this sheet. There will be a place to initial when orders are carried out, as well as a place to document outcomes, if appropriate.
- A discharge and education flow sheet: All information concerning educational and discharge activities will be logged in this central location.
- The DAR (data action response) note format will continue.
- Medication administration record: Minimal revisions.
- An intake and output sheet: Revision in format similar to format used in the critical-care areas.
- Graphic sheets: Revision in format including a combination with neurological vital signs and pain scale.

The Documentation Task Force would like to thank everyone for their hard work in developing this program.

Nurses salute their own during National Nurses Week

A crowd of 76 people filled the Hiebert Lounge to hear a provocative talk by Susan M. Wolf, JD, left, on "Ethics at the End of Life."

The Department of Nursing celebrated National Nurses Week from May 2 through 7 with a variety of programs and events. The week began in traditional fashion with the Walk for Hunger on Sunday, May 2, an event in which BUMCH nurses have always actively participated. Nurses provided for foot-weary and hungry Hospital walkers at a food stop and first-aid station some 11 miles into the walk, at Daly Field in Newton.

Continuing the celebration, morning and afternoon ceremonies were held on Thursday, May 6, where a record number of 149 staff members was recognized for providing excellent patient care and contributing to the professional growth of the nursing department. Also on May 6, the annual Spring Distinguished Lecture was delivered by Susan M. Wolf, JD, of Harvard University, who spoke on "Ethics at the End of Life." The lecture was sponsored in part by the Massachusetts Memorial Hospitals Nurses' Alumnae Association.

Grey Graham, RNC, congratulates Sandra Snyder, RN, MS, CS, a Psychiatric Unit staff member, top, and Atrium 8-East staff member Lisa Thornton, RN, bottom, during nurse-recognition ceremonies.

Research network bolstering the role of nurse as researcher

In any clinical setting, the first and foremost role of nurses is to provide expert patient care. Perhaps as significant, however, is the secondary role that nurses play in conducting important clinical research.

In an effort to bolster the role of nurse as researcher, the Nursing Research Network at Boston University Medical Center/The University Hospital (BUMCH) was established three years ago by Diane Lancaster, RN, PhD, director of nursing research. Since the network's inception, its mission has evolved to include: the appraisal of the quality of nursing care; the promotion of research-based nursing practice, as well as the development of the research interests and skills of the nursing staff; the provision of support for new and ongoing nursing research projects, and the opportunities for BUMCH nurses to network with faculty from affiliated schools of nursing.

During the last three months, the focus of the network has been to provide educational sessions that are related to the process of critiquing existing nursing research studies. Building upon these research critique skills, the function of the network over the next several months will be that of research utilization.

Research utilization is a process that involves the reviewing and critiquing of research literature on a clinical topic. This review is conducted by clinical experts using principles of a research-utilization model. Based on the outcome of this process—that is, if the research on a topic meets certain criteria—then changes in practice may be implemented.

The initial utilization project that was selected by network members involved the evaluation of nursing research as it related to causes of diarrhea in tube-fed patients. The following nursing interventions that were found to have an impact on reducing diarrhea in tube-fed patients and that were firmly supported by sound existing research are:

- handwashing prior to feeding;
- limiting to 24 hours the time with which the feeding bag hangs;
- swabbing the feeding container with alcohol prior to opening it, and
- using sterile water for tube-feeding dilution.

These interventions were compared to those included in BUMCH's clinical policy. After discovering the policy did not contain the last two items, the group discussed the cost and feasibility of implementing both practices. Based on its findings, the network will make recommendations to the Clinical Practice Committee for revisions in existing clinical policy.

Diane Lancaster, RN, PhD, director of nursing research, left, and clinical instructor Kristy Swiech, RN, MS, are involved in a study that will test the effectiveness of a bedside manometer in deter-mining the proper placement of the nasogastric tube. Please notify Kristy Swiech at beeper 679 if you are caring for patients who would like to be enrolled in the study.

A variety of other variables related to the issue of diarrhea in the tube-fed patient population was also studied, but the related research findings were too mixed or not appropriate for application in an acute-patient population. Though clinical-practice changes in relation to these variables were not implemented, the information culled will be forwarded for use by the Quality Improvement/Risk Management nursing committee.

Other nursing research studies currently under way or in the planning stages are aimed at: determining the effectiveness of a pressure gauge to differentiate gastric from pulmonary placement of nasoenteral feeding tubes; ascertaining the differences in venous versus arterial blood samples for blood-gas analysis, and evaluating the use of rectal tubes for diarrhea, as well as the effectiveness and clinical usefulness of chest physical therapy.

Staff members who would like to participate in nursing research projects or would like to suggest clinical issues they believe could be improved by research-based practice changes are encouraged to contact Diane Lancaster at x5823, or to attend the next BUMCH Nursing Research Network session. The group meets on the second Thursday of each month from 3 to 4 p.m.

The challenge of change in psychiatric nursing

by Grey Graham, RNC

I first came to work at Boston University Medical Center/The University Hospital eight years ago as a staff nurse in the psychiatric unit. At that time, patients resided in treatment for several months. The year before I started here, the scope of the program had changed from long-term psychiatric treatment to one that constituted a short-term, medical-psychiatric focus. For nurses, that meant learning to provide care on a different level to patients with IVs, oxygen, wheelchairs and a host of complex, medical follow-up needs. At the time, the unit had only one wheelchair-accessible bathroom, and no central oxygen or suction.

Gradually, as our patient population grew more medically acute, our needs for more accommodating space became apparent. Following a temporary move to Preston 3, the unit eventually relocated one floor down to Preston 2, our current "home" of four years. This move came at an ideal time, because it provided us with wheelchair accessibility and oxygen in every room, as well as better space in which to care for our patients.

We settled in and continued refining our program, developing our skills, and defining specialized nursing care plans, in addition to managing increasingly more acute medical and psychiatric problems. At the same time, however, we had to adapt to a new constraint: decreasing length of stay. This illustrated the need for more rapid and intensive multidisciplinary assessment and interventions, along with more complex discharge

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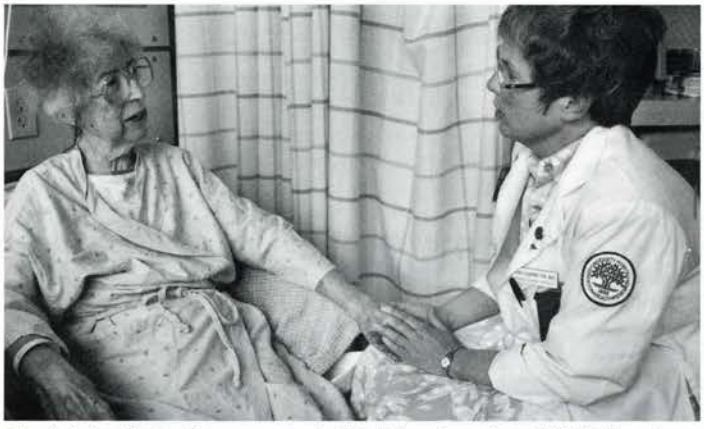
Clinical nurse specialists play pivotal role in managing change

by Peggy Cronin Donahue, RN, MS, CS



Geriatric clinical nurse specialist Edna Laurino, RN, MS, takes a moment to chat with patient Elizabeth Reddy.

The health care industry is experiencing dramatic changes. Nursing as a profession must anticipate and address the impact of these changes on the practice of nursing and on patient care.

At Boston University Medical Center/The University Hospital, there are currently 11 clinical nurse specialists (CNSs), encompassing specialty areas of medicine, surgery, critical care, neuroscience, pulmonary, geriatrics, oncology, cardiothoracic and psychiatry.

This group is responsible for demonstrating and promoting excellence in nursing practice within specified clinical areas. The CNSs accomplish that by providing direct patient care; consulting with nurses and other members of the health care team; educating both patients and fellow nurses, and conducting research and quality-assurance activities.

Members of the CNS group have been involved in various projects within the Department of Nursing and the Hospital that are preparing department members to meet future changes and challenges in health care. For example, clinical nurse specialists have been involved in developing and refining a nursing documentation system (see story, page 4). Many CNSs have been developing nursing care guidelines for various nursing diagnoses that will be integral to this documentation system as well as to the nursing practice.

Other projects and activities in which CNSs are involved include:

- Collaborating with staff nurses to determine an optimal model of a nursing care delivery system.
- Developing critical paths as a framework for the multidisciplinary care received by patients undergoing cardiothoracic surgery (see story, page 1).
- Undertaking a project that is aimed at reducing patient falls through early identification of risk factors.
- Assessing and recommending treatments for various skin impairments through consultation by the "skin-care team," which is composed of CNSs.
- Developing clinical protocols and standards of care and educating nurses in preparation for a new bone marrow transplant program.
- Providing critical-care nursing education through teaching classes at the Intensive Care Unit (ICU) Consortium of several Boston teaching hospitals.
- Participating in various research activities. One initiative was part of a national research study that examined physicians' perceptions of needs of families of critically ill patients.
- Practicing as case managers, a role in which clinical nurse specialists coordinate patients' Hospital care in conjunction with staff nurses and physicians.

Many changes are expected in the health care field over the next few years. The educational preparation and clinical experience of the clinical nurse specialist places this group in a pivotal position to meet future challenges and opportunities.

Psychiatric nursing

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planning.

The challenge of maintaining a sense of balance, despite what seemed to be a constant state of change, was difficult at times. I personally felt as if I needed a pair of dancing shoes to keep up with the pace. But the strength and cohesion of the nursing staff, supported by our nurse manager and psychiatric clinical nurse specialist, helped us all to keep the beat and keep moving in the same direction. Over time, I felt that I was as adept at medical-psychiatric nursing as I was at adapting to change.

The past year alone has seen some dramatic and unexpected changes in health care, once again producing a dramatic need to refocus our energies. A decreasing length of stay, coupled with changes in insurance reimbursement, has adversely affected our patient census. The simple fact is that there are too many acute psychiatric beds in the metropolitan Boston area, and the competition for patients is enormous.

With the added influence of a national priority to lower health care costs, the very nature of psychiatric treatment continues to evolve. New emphasis is being placed on a continuum of outpatient treatment, with movement away from hospitalization.

The BUMCH Department of Psychiatry is keeping in step with all of these changes. We are in the midst of making the transition to an involuntary locked unit on Preston 2, which will enable us to expand our services. Soon, in addition to caring for our current voluntary patient population, we will have the ability to care for involuntary patients as well.

As part of our new array of services, we recently opened a partial hospitalization program, in essence, an outpatient psychiatric "step-down" unit that provides patients with the structure and support of intensive daily treatment without the need for overnight hospitalization. The unit houses clinical offices, a large community area for group activities, and a dining area for the patients.

This unit will help the Hospital to reduce the amount of expensive inpatient care it provides, and minimize patient dependence on the hospital environment. In addition, it will enable the psychiatric staff to focus on enhancing patients' independence and coping skills through group, and milieu treatment and education. With the move to this new program, the clinical acuity of our patients will demand more frequent and immediate assessment, and an increased variety of nursing interventions.

I look forward to this new challenge, and to the opportunity to expand my role as a psychiatric nurse.

Nurses can make a difference by not sitting on the sidelines

by Karen Cuipylo, RN, MS, CCRN

What does it mean to be involved in a professional organization? What are the responsibilities and the rewards that go along with such an obligation? These are the questions that one must address before committing to be an active member of a specialty organization.

Professional organizations are designed to best serve their members' interests; specifically, those of a distinctive orientation. There are many specialty organizations in nursing today. Probably the best-known group is the American Nurses Association. A multitude of others include, but are not limited to, the American Organization of Nurse Executives, the Society of Peripheral Vascular Nursing, the Emergency Nurses Association, the Association of Operating Room Nurses, and the American Association of Neuroscience Nurses. The largest nursing specialty organization is the American Association of Critical Care Nurses (AACN) with over 78,000 members. All of these groups also can claim local or state chapters.

The national AACN is very involved in the broad issues facing its particular specialty. Some examples are: addressing health-policy issues, credentialing, and setting the standards of care for that specialty population. Conversely, the local organization is more involved with happenings in its community and addressing those issues in accordance with national policy. The national group collects information from all the local groups to assist in problem identification and resolution that then can be carried out at the local level.

To be an active member of AACN and other nursing professional organizations means to become involved and make a commitment to support the goals of the organization. It means that nurses have an opportunity to share ideas with others who hold the same interests and concerns. It also enables nurses to discover what is happening at other institutions and to learn about the issues they are confronting. An active member wants to make a difference in her or his specialty area of nursing, not just sit on the sidelines and wait for things to happen.

Joan Vitello, RN, MSN, surgical-critical care clinical nurse specialist, provides follow-up care to a cardiac patient.

The Department of Nursing at Boston University Medical Center/The University Hospital (BUMCH) is very committed to its nursing staff becoming involved in specialty organizations. The department feels that professional involvement enhances the care that is delivered to its patients. Nurses involved in specialty organizations bring new viewpoints to patient care. They also are kept current by attending conferences and reading their organizations' journals.

Joan Vitello: A case in point

Joan Vitello-Cicciu, RN, MSN, CCRN, CS, became actively involved in the AACN 17 years ago, and was recently elected president-elect of the organization. A surgical-critical care clinical nurse specialist at BUMCH since 1984, she has been a member of many of AACN's national task forces, addressing such issues as certification, role delineation, and clinical practice. By becoming increasingly involved in her specialty organization throughout the years, Joan has realized that she has made a difference in nursing and in patient care in general. In doing so, she has brought back much to our institution by assisting her fellow nurses to become more committed to the nursing profession and to move forward with new ideas.

Ethics committee: There when nurses need it

Whether one is a nurse or a physician, ethical dilemmas related to patient care and professional practice are bound to arise. To support the BUMCH nurse at the bedside, the newly formed Nursing Ethics Committee meets monthly to discuss a myriad of patient-care issues that are brought to its attention. The goals of the meeting are to strengthen the members' own preparation in the field of ethics, to plan and critique ethics rounds on the nursing units, and to suggest and/or support Hospital policies.

Successful ethics rounds have been conducted on a number of units to date, with a broad range of issues being discussed. Any concerns that nurses feel are important to discuss can be addressed in rounds on their units. In addition, issues of a more sensitive nature may be discussed in confidence before the committee or one-on-one with its chairperson, Nancy Couch, MS, RN, who holds a master's degree with a focus in ethics.

The committee, composed of representatives from each nursing unit, offers professional support to nurses upon request. Those requests may be made by calling the nursing department at x5700, a nursing supervisor (off-shift requests only), or committee chairperson Couch at x6671.

The members of the committee are as follows:

Pat Cahill, *CCU*

Nancy Couch, *MICU*

Susan Crowley, *supervisor*

Carmel Fitzgerald, *CT Surgery*

Mary Duggan, *ED*

Donna Granbois, *SICU*

Maria Gregory, *Atrium 7 East*

Diana Hackett, *IV team*

Gladwyn Howard, *OR*

Maryann Hurley, *CCU*

Jane Jansen, *Atrium 7 East*

Edna Laurino, *geriatric clinical nurse specialist*

Noreen O'Shea, *Atrium 6 East*

Warren Prescott, *Evans 8*

Diane Sarnacki, *oncology clinical nurse specialist*

Carolyn Walsh, *dialysis*

Trish Weir, *Atrium 7 North*

Patricia Wong, *Atrium 7 West*

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Staff Notes

Appointments and awards:

Mary Ellen Bowers Feldman, RN, MS, from Beth Israel Hospital, was appointed nurse manager of the Post Anesthesia Care Unit, February 1993.
Karen Cuipylo, RN, MS, CCRN, was appointed president of the Greater Boston Chapter of the American Association of Critical Care Nurses, June 1992.
Susan H. Crowley, RN, BSN, CNA, was appointed co-chairperson of the Massachusetts Nursing Association's Cabinet on Nursing Ethics for 1992 to 1994.
Cynthia S. Fitzgerald, RN, team leader of Neurosurgery/Gynecology OR, was appointed president of the Greater Boston Chapter of the American Association of Neuroscience Nurses.
Lynne Lambert, RN, BSN, was appointed acting nurse manager of Atrium 6 East, June 1992 to March 1993. She developed unit specific competencies on Transplant Care and Care of the Continuous Ambulatory Peritoneal Dialysis patient.
Catherine Rumble, RN, BS, from Carney Hospital, was appointed nurse manager of Atrium 7 North, October 1992.
Joan Vitello, RN, MSN, was named president-elect of the American Association of Critical Care Nurses (AACN), for the term beginning July 1993. She also was appointed to the Health Care Policy and Legislative Committee of the AACN, July 1992, and was inducted as a fellow of the Council on Cardiovascular Nursing sponsored by the American Heart Association in New Orleans, November 1992.

Graduations:

Julie Bonenfant, RN, director of surgical nursing, received a master's degree in business administration from Babson College in May 1992. She graduated with high honors and was inducted into Beta Gamma Sigma, the Business Honor Society, last fall.

Presentations and publications:

Susan H. Crowley, RN, BSN, CNA, presented "Ethics in Nursing" at Somerville Hospital, March 1993.
Carol Daddio Pierce, RN, MS, CCRN, made the following presentations: "Advanced Hemodynamic Monitoring" at Metro West in Framingham, February 1993, and "Clinical Application of the Hemodynamic Profile in Management of the Critically Ill Patient," for the Intensive Care Unit Consortium, May 1992. She also authored the following: "Identifying Acute Cardiac Tamponade" in *The Chronicle,* a publication of the Greater Boston Chapter of the American Association of Critical Care Nurses, and "Acute Postinfarction Pericarditis" in *The Journal of Cardiovascular Nursing,* July 1992.
Joan Vitello, RN, MSN, made the following presentations: "Recognition and Management of Low Cardiac Output Syndrome" at the American Heart Association Scientific Sessions in New Orleans, November 1992; "Networking and Collaboration: The Keys to Our Future," St.Thomas, November 1992, and "AACN's Vision of a New Health Care System" at Massachusetts General Hospital, October 1992. She also published the following: "Introduction to Hemodynamics" in *Introduction to Critical Care Nursing,* 1993, with **Cindy O'Sullivan, RN, MSN,** and "Making a Critical Decision Before It Becomes Critical," in *Heart and Lung,* 1992.
Loretta Donald, RN, MSN, CCRN, CNS, presented "Managing Coronary Artery Disease" to the Boston Vegetarian Society, September 1992.
Cynthia S. Fitzgerald, RN; Noreen Leahy, RN, MS, and Merrie Waters, RN, BSN, presented "Omentum Transpositions" at the American Association of Neuroscience Nurses national meeting in Pittsburgh, Pa., April 1993.
Jane Jansen, RN, BS, presented "Peritoneal Dialysis" at an all-day workshop at St. Luke's Hospital in New Bedford, October 1993.
Edna Laurino, RN, MS, GCNS, presented "Nursing Assessment and Management of the Geriatric Surgical Patient" at the Cardinal Cushing General Hospital in Brockton, March 1993.
Gloria Shapiro, RN, MS, CS, presented "Psychological Aspects of Surgery" at Cardinal Cushing General Hospital in Brockton, March 1993.
Kristy Swiech, RN, MS, authored chapters on "Alterations in Skin Integrity and Alterations in Pulmonary Function" in *Nursing Diagnoses and Intervention,* April 1993.

Certifications:

Critical Care Registered Nurse
Patricia Dhooge, RN, BSN
Catherine Wiejaczka, RN
Glen Blair, RN
Maura Babineau, RN
Kathleen Anastos, RN
Jean Tavener, RN
Donna Grandbois, RN

Advanced Cardiac Life Support Instructor
Loretta Donald, RN, MSN

Advanced Cardiac Life Support
Linda Koster, RN
Linda Mossey, RN
Cheryl Krasker, RN
Kathy Hart-Hopey, RN
William Sisson, RN
Julian Carey, RN
Nanci Hodge, RN
Lynne Lambert, RN, BSN
Maureen Plunkett, RN, BA
Noreen O'Shea, RN, BSN
Christine Ryan, RN, AD
Katherine Caunter, RN, BSN

Post Anesthesia Nursing
Linda Hanna, RN
Kathy Hart-Hopey, RN
Cheryl Krasker, RN

Oncology Nursing
Kelly Starvish, RN
Amy Kennedy, RN

Psychiatric Nursing and Mental Health
Paul Boucher, RN

Operating Room Nursing
Lisa Fahey, RN

Emergency Department Nursing
Donna Hovey, RN
Warren Beattie, RN
Maureen McLaughlin, RN

Medical-Surgical Nursing
Jill Champagne, RN

Central Sterile Processing Technician
Bob Harvey

Nursing board successes

February 1993:
Salon Ea, RN, Atrium 8E
Lisa Savage, RN, BSN, Atrium 6E
Eileen Murray, RN, BSN, Atrium 8W

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