1997/Issue 3

Nursing Voice

LEHIGH VALLEY HOSPITAL

Sending Out an SOS

I think I'm dreaming . . . at first. The weird numbness of my flesh is unusual. My mind is in exile; thinking requires great effort. Only random images fill the blackness, like the surrealism of a Dali. I cannot open my eyes, so I listen. I hear exotic noises - peeping, bubbling, a soft gust of wind like someone blowing out a candle. Suddenly, there is an intense pain in my right side. It hurts so bad I cannot breath. I try to struggle up. I hear someone call my name. "No, Susan, NO!" Please, someone, help! But the only help that comes is an escape into a distant memory.

"Mom. Don't forget to say your prayers."

"Thanks, honey. You too."

"OK. Now I lay me down to sleep. I pray the Lord my soul to keep. If I should die before I wake, I pray the Lord my soul to take."

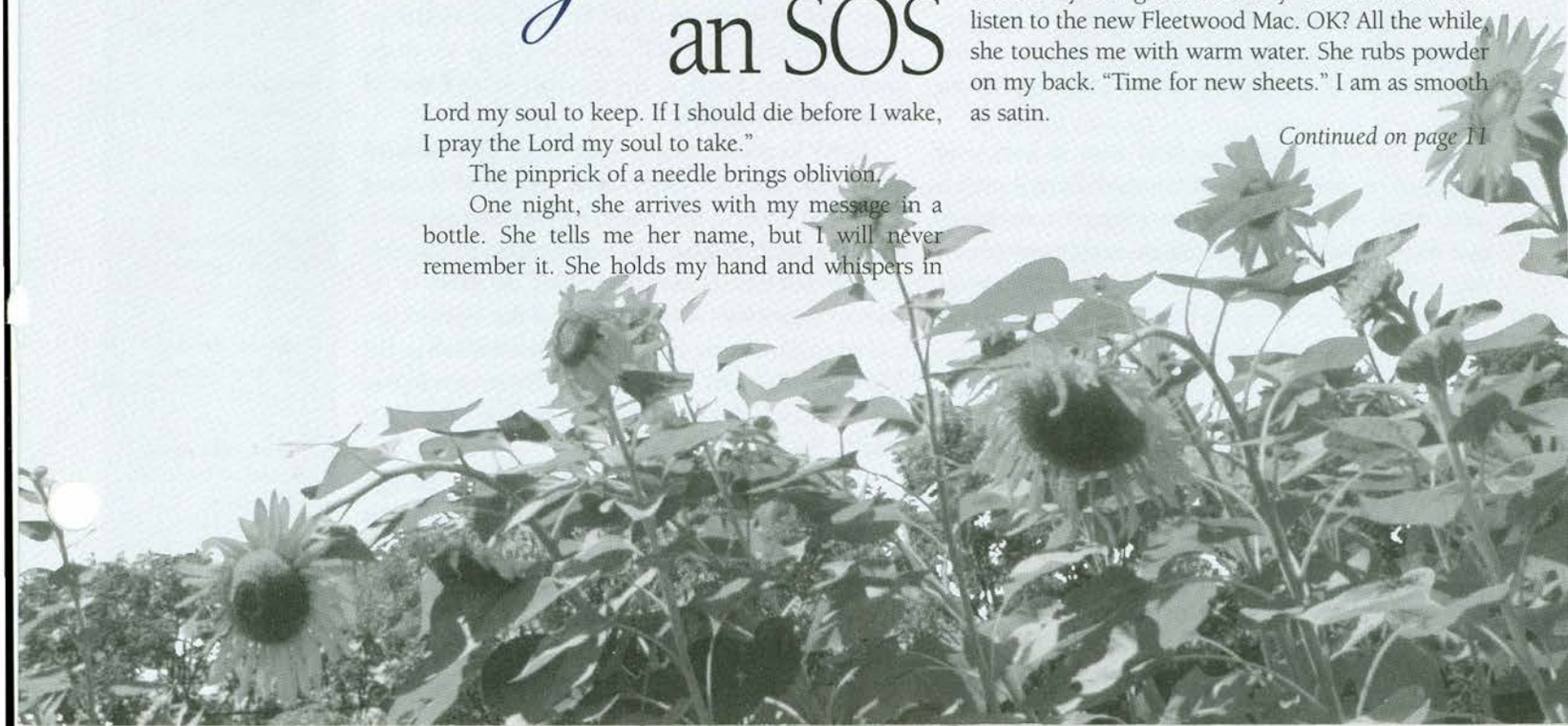
The pinprick of a needle brings oblivion.

One night, she arrives with my message in a bottle. She tells me her name, but I will never remember it. She holds my hand and whispers in my ear. "Susan, wake up. You've been sleeping long enough. You are in the hospital. There was an accident. You were hurt, but you are getting better every day. Come on Susan, show me two fingers so that I know you hear me." I wonder what the heck is she talking about? An accident? Two fingers?

"OK, not quite ready to sing and dance, are you? Susan, I am going to give you a bath," the stranger says to me. What? This is very odd. But I guess I'll play along. Getting up and into a shower might wake me out of this fog. Soon I feel warm water running onto my head and neck. Then, hands gently massaging my scalp. Well, this is not what I expected, but it feels really good. I soon realize that music is playing. Hey, it's the Cranberries, one of my favorite bands, doing "Ode to My Family." I love this song. I wonder, "Where is my family?"

Now I hear her speaking to me, just like she read my mind. She says what handsome boys I have. They brought some of my CD's and next we'll listen to the new Fleetwood Mac. OK? All the while she touches me with warm water. She rubs powder on my back. "Time for new sheets." I am as smooth as satin.

Continued on page 11



Nursing Voice is Your Voice

5th Annual Essay Contest

It's that time again! Time to submit essays and poems to the annual Nursing Voice Essay Contest. This is your opportunity to speak to your peers, to share your thoughts and feelings. Don't tell yourself that no one is interested in what you have to say. Each year, this issue is the most widely read and inspires the most positive comments.

Its impact comes from your stories, which reflect the heartfelt emotions and life-changing experiences common to nurses. These 'reflections on nursing' are the heart of the essays, but more significantly, they are the heart of nursing. Glimpses of technical skill and clinical knowledge are evident, but the personal relationships between nurses, patients, and their families express the essence of our profession.

Surely you've all noticed that, when a bunch of nurses get together, the conversation often revolves around nursing. Even when someone says "Let's not talk about work," the talk returns to work time and time again. But it isn't about the latest medication or the newest equipment with all the lights and alarms, rather it is about the human experience. "I remember a patient who . . ." Or "I wanted to cry when . . ." "Wait till I tell you about the funny . . . " These tales told by nurses communicate the hard work, the broad knowledge, the emotions, and satisfaction of this profession. These are the stories that connect us and touch us; these are the stories we want for *Nursing Voice*.

But we want more - we also want to hear your thoughts on other aspects of this multifaceted profession. How has your profession affected your family and friends? Have nursing students taught any important or funny lessons to you, their teachers or preceptors? What is your vision for the future of nursing? Tell us your stories and we will share them with other nurses, thereby promoting the community of nurses.

We also hope to use your literary efforts in another form. A long-range goal of the board is to publish a collection of pieces from the essay contests and from other sources within Lehigh Valley Hospital and Health Network (LVHHN) as a book. Board members who are not eligible for the contests may write for this collection but contributions from our readers are essential if we are to gather enough quality material for the success of this endeavor. Submit an essay but also consider volunteering if this project interests you.

Although the book is an intriguing venture, the primary objective of *Nursing Voice* is to publish articles that are interesting, or important, or impact nurses in the LVHHN. Topics may include clinical programs, current happenings, profiles on people influencing health care, trends in nursing practice, and human interest features. Our goal is to speak to and for nurses in this system.

To meet that goal, the editors need your input and assistance. Participation in the essay contest, in Speak-out, or in other features is one step but consider other ways to be part of the Voice. Membership on the committee isn't required to be an author; offer to write on a specific subject that interests you or to be available for a writing assignment. Uneasy about writing but overflowing with ideas for great articles? Suggest a topic and a board member will gladly help with the writing and editing. Curious about a clinical development or a department of the network? Tell a board member and it may become a piece in the next issue. Not all suggestions will be used but all will be considered and your influence will help to shape future editions. Speak to any member of the Editorial Board about your ideas.

Don't forget to submit your essay! The editorial board will judge the entries and Friends of Nursing will award $300 to first place, $150 to second place, and $100 to third place. As many entries as possible will be published and distributed in Issue 1 of *Nursing Voice* 1998. All employees of the network are invited to participate but all essays must relate to the theme, "Reflections on Nursing." Please send your essay contest entries to Darla Stephens in Suite 403, JDMCC, by January 9, 1998.

And please join us in promoting nursing through the *Nursing Voice*! Remember that your voice is important to us.

Darla Stephens, R.N., C.R.N.I.

A Letter *To Sari*

Dear Sari,

It has been a long time since I spoke with you. I think of you often and remember the great times we shared. I will never forget the wonderful friendship we created which has continued throughout our lives.

We did not know each other when we became roommates at the School of Nursing. We each arrived with our $150.00 tuition check, $35.00 book expense, horrible grey uniforms, and navy blue and red wool cape (I bought mine "second hand" for $20.00). That cape became a valued possession. It kept me warm many cold, hectic mornings while I crossed the street to the hospital for a hearty breakfast after attending mandatory chapel. Then our days continued, working on the floors and trying to stay awake through all of our classes. I was even sleepier when I thought of the long night ahead, staying up to complete all of our school work. The one good thing was that those late night study sessions enabled us to build a wonderful friendship.

Patricia Stein, RN, AKA "Flossie".

I am just about ready to "hang up" my cap and "turn in" my scissors. You remember, that was our way of saying we quit for good. The old east wing of the hospital has been torn down to make room for a new parking lot. The old hospital is still standing, a grand old lady whose youthful adventures are forgotten. Just remember, Sari, she is and will always be our mother hospital. We experienced many things here: open heart surgery without today's advanced technology, caring for burn victims, the beginning of kidney dialysis, and multiple cases in shock trauma.

As head nurse, staff nurse, and preceptor, I gave almost 50 years to this dear old hospital. These experiences let me accomplish everything I desired. Now, at the end of my career, I am a hospice nurse on the inpatient unit, and I honestly do believe it is my most rewarding position. I only hope that, when my last days are near, I will be cared for with the love and respect that I always shared with my patients.

Sari, please take good care of yourself and never forget about us. I have so many fond memories of the good and bad times we shared. We were a great team, and I will continue to cherish that for the rest of my life.

Your Forever Friend,
Flossie

This letter to Sari was written by Patricia Stein, R.N., the author of other "Letters from Flossie" published in ***Nursing Voice*** over the past ten years. Since graduating from Allentown Hospital School of Nursing in 1953, she has worked for the hospital as staff nurse and as Head Nurse on a ward, Section D. On night shift since 1960, she currently works on the inpatient hospice unit. As she contemplates retirement and looks on the past with nostalgia, she continues to care for her patients with knowledge, skill, and love. Lehigh Valley Hospital and the nursing profession owe respect and thanks to Pat and the many dedicated nurses who have given so many years of fine care.

Words from Mary

October 22, 1997

In this our Fall/Winter issue, I would like to take this opportunity to formally welcome our new readers: the nurses and staff of the Muhlenberg Hospital Center. By the time you read this issue, hopefully the merger is complete. I say this tongue in cheek. The legal formal components of merger may actually be complete but OUR work to achieve integration and true operational consolidation has just begun. I say "OUR" work because that is what it will be. Each of you will be actively involved as we move forward to identify opportunities as a merged organization.

In this issue we concentrate on "teams" and "teamwork". What individuals think about teams, examples of how teamwork has shown improvement in patient care and the importance of teams to accomplish personal, professional, organizational and community goals. As I reviewed previous work I had done on teams and collaboration within groups of teams, I came across an article I used previously that is worth sharing again. As we continue to manage ongoing and often times unsettling change, we need to pull together, work together as a team and move toward our mission and our goals. The article is called *"Lessons We Learn From Geese"*.

FACT No. 1: As each bird flaps its wings, it creates an uplift for the bird following. By flying in a V formation, the whole flock adds 71% greater flying range than if one bird flew alone.

LESSON No. 1: People who share a common direction and sense of community can get where they're going quicker and easier because they are traveling on the strength of one another.

FACT No. 2: Whenever a goose falls out of formation, it suddenly feels the drag and resistance of trying to fly alone and quickly gets back into formation to take advantage of the lifting power of the bird immediately in front.

LESSON No. 2: If we have as much sense as geese, we will stay in formation with those who are ahead, where we want to go, and be willing to accept their help as well as give ours to others.

FACT No. 3: When the lead goose gets tired, it rotates back into the formation and another goose flies at the point position.

LESSON No. 3: It pays to take turns doing the hard tasks and sharing leadership.

FACT No. 4: The geese in formation honk from behind to encourage those up front to keep up their speed.

LESSON No. 4: We need to make sure our honking from behind is encouraging, and not something else.

FACT No. 5: When a goose gets sick or wounded or shot down, two geese drop out of formation and follow it down to help and protect it. They stay with it until it is able to fly again - or dies. Then they launch out on their own, with another formation, or they catch up with their flock.

LESSON No. 5: If we have as much sense as geese, we, too, will stand by each other in difficult times as well as when we are strong.

The lesson we all can learn and sometimes need to remember, is the advantage of working together — the power and benefit that we can gain if we all pull together, sharing our unique skills and talents, to achieve our goals and mission. We need to creatively improve and cut costs so we all can benefit.

It is well established in the literature that for individuals to rally around a common goal and to make a commitment as they function in their teams, they need to have a grand purpose. A

mission with a larger meaning gives them something to identify with, something to inspire them, A PURPOSE. I first established the following vision in 1992 and recently updated it for our upcoming JCAHO visit. I believe it is an important reminder to the LVH staff and a first introduction to our MHC colleagues. I share it with you now in hopes that we can all work together as that team needed to achieve our vision, our dream, and our future.

VISION FOR THE YEAR 2000
PATIENT CARE SERVICES

There are a number of guiding principles we must maintain throughout our activities, movements, and changes within Patient Care Services. The first one, and utmost in our mind, is our patient focus. We must provide the highest level quality of care to our patients and their families and significant others. Remembering that our patients are at the core of our vision, philosophy, and mission, we must also keep in mind the staff that is necessary to provide that quality care to our patients. As a Patient Care Service, we must position ourselves to respond to the changes in health care. We must be open and honest to be able to address those issues and come forth with recommendations, plans of actions, implementation schemes, time frames and an evaluation process. We must put aside our protection mode and open our eyes to see what it is that will lead us to our goal of quality patient care. Our management structure and support staff must be positioned to continually support the care of the patient. They must be cognizant of the regulatory bodies which impact on our ability to provide care to our patients. They must have the initiative, the know how and the "guts" to do programmatic development which can be exciting, difficult, frightening and threatening. We must drop our barriers of the traditional turfing and face the issue of interdependence. An interdependence not only with other disciplines but with each other. We must pursue and jointly develop professional practice models with physicians to foster one plan of care with unified approaches, goals and language in our pursuit to provide quality patient care. We need to support, pursue, enhance and encourage our staff and ourselves toward higher education. We must look beyond the traditional modes and methods of educating our staff and maintaining their competence. We must provide the leadership support to guide them to greater and better heights. We must redesign, refocus, get back to the basics and establish new initiatives, bring back some old initiatives, and rid ourselves of current draining initiatives in our pursuit to provide quality care in an environment which is conducive and supportive, and in a manner which is cost-efficient, time effective, caring and personal.

My vision is a Patient Care Service where not only our patient care stands out and is respected and regarded as one of the major reasons patients come to Lehigh Valley Hospital and Health Network, but where we are major leaders in education, research and clinical practice. We can do it. We have the resources, we have the knowledge base, we have the people, but we need not be afraid to face difficult issues as we continue to revise, redesign and refocus what we do based on what is happening with health care, cost reimbursement and trends.

My vision also includes a Patient Care Center of Excellence. A center where we can establish education, research and clinical initiatives which trial, experiment and develop new and better ways of providing quality care. This Center would be recognized by not only internal staff but by our external communities. This recognition would be achieved by presentations at local, regional, and national conferences, publishing articles which share our successes and learnings in professional journals and providing opportunities to have visitors come to our organization and experience the strategies which have succeeded in supporting us through change.

My vision for the staff is shared leadership. To accomplish this, we must develop our staff. We must give them the responsibility and the accountability for managing patient care in their department and environment. If we are sincere in wanting shared leadership, we must change the way we perform our roles as managers. The staff become more responsible, more accountable, more knowledgeable of all aspects which affect their provision of care. The Director/ Manager role continues to change from decision-maker to facilitator, developer, mentor, role model, clinical expert, researcher and supporter. The Administrator maintains two major foci; one, oversight responsible for clinical departments and/or large programmatic initiatives and two, responsibility to identify new trends, participate in research, serve as a role model, and provide education in areas such as management, practice, and programmatic development.

I find this time in our lives an exciting, totally rewarding and uplifting experience. We can do it! We have the knowledge, we have the people, we have the stamina. Together we can make it happen.

Mary T. Kinneman, R.N., MSN
Sr. Vice President, Patient Care Services

CRNA *Members*

Bernadette Monchak Barski remembers when she needed to wear a hard hat to enter the operating rooms which were still under construction at Lehigh Valley Hospital-CC. A certified registered nurse anesthetist (CRNA), she is one of a group of highly specialized nurses whose education, capabilities, and responsibilities are not well known outside of the surgical suites. Approximately 63 CRNAs administer general, spinal, and monitored anesthesia care (MAC) at the Cedar Crest, 17th and Chew, Fairgrounds and Muhlenberg sites. Nurse anesthetists work closely with an anesthesiologist, the physician who chooses the anesthetic agent to be used and who supervises its delivery. As a member of the operating room team, led by the surgeon, the CRNA is responsible for the ventilation, anesthetic management, fluid and electrolyte balance, and pain control of the patient during procedures. It may be the only time that a patient is guaranteed a one to one nurse-patient ratio.

Accountability begins when the CRNA assesses the patient - in the OR holding room or, for a ventilated patient, in the critical care unit. Responsibility ends only after report is given by the CRNA to the recovery room or ICU nurse post operatively. What happens in between is individualized care given to each patient based on medical history, procedure, and intra-operative course. Perhaps the most vital function of the CRNA is observing and recognizing any untoward changes in the patient during surgery. If a difficulty secondary to the surgical procedure occurs, the CRNA must act quickly to treat the problem and to prevent any further insult to the patient.

The next time you look at the OR record, note the name of the anesthetist. While all are generalists, some work mainly in specialties. Mary Ann Halada is a urology specialist; Brian Patton and Bill Borger, orthopedics; Paul Evans and Richard Albright, neurosurgery; Jim Prudente, Ron Horvath, Steve Raimo and Scott Wilson, open heart procedures. Dan Ohl works with the thoracic surgeons, and Andy (now your problems are all behind you) Kovach with colorectal surgeons. Plastic surgery specialists include Evelyn Ocher and Dan Jones. Ernie Deeb, Ray Yedloch, and Tony Iachini work primarily at the 17th and Chew site where obstetrical cases are common.

Prior to 1988, most nurse anesthetists were RNs who acquired additional education in hospital-based two-year programs leading to CRNA licensure. Since 1988, a bachelor's degree has been required for entrance into an accredited school. After completion of a 2-2 1/2 year program which includes a practicum, the nurse must pass a national certification exam. Master's level courses are included in the curriculum; therefore,

At 17th and Chew, Karen Vorhees, CRNA, MA, (left) and Evelyn Ochar, CRNA, (right) review the next patient's plan of care.

# of Many Teams

nurse anesthetists are considered advanced practice nurses. Previous critical care experience is also a requirement for admission to an accredited program. Janice Gerlach was an ICU head nurse in Boston before continuing her education, while Karen Holscher, Greg Binder, Joe D'Amico and Keith Landis were Shock Trauma nurses here at LVH.

Have you ever noticed a nurse in OR scrubs carrying an orange or blue box (gray at 17th and Chew) down the hallway to X-ray, MRI, GI lab or Cardiac Cath Lab? As the art and science of anesthesia has changed over the years so have the areas where it is given. Because anesthesia is safer, many procedures are being done outside the operating room arenas in such diverse areas as the lithotripsy trailer and the multi purpose room of the cancer center. Monitored anesthesia care (MAC), a combination of hypnotic, sedative, and narcotic agents, is now being administered in ancillary areas. The box that the CRNAs carry is their portable tote, filled with anesthetic agents and equipment needed to handle an emergency outside the operating room. CRNAs also are integral members of the team at Code Blues, Trauma Alerts, or Code Reds. In those situations, they are responsible for assessing and maintaining the patient's airway.

Dan Jones, CRNA,MS (left) and Don Connell, CRNA, MS (right) verify the stock in the orange box before heading to a MAC procedure at the CC site.

Changes in health care delivery have expanded the role of CRNAs by moving them onto teams in a wide array of care environments. However, managed care has also lessened the amount of time CRNAs spend with patients in the peri-operative period. Cost cutting has made turnaround time (the time required to finish one procedure, prepare the room, and start another procedure) a hot issue, as is the cost of drugs, especially antiemetics used during and at the end of cases to prevent post operative nausea and vomiting. The multitude of changes has not decreased the desire to provide the most comprehensive patient care. Nor has it decreased the satisfaction that comes from meeting the challenges of each individual and each procedure. As Janice Gerlach states, "The best part of this job is that each patient is different."

When you see the nurse with the anesthesia tote, remember that he or she is your patient's advocate at a time when they are most helpless, during their anesthesia and operative experience.

Cathleen Webber, R.N., PACU-CC

Challenge Leads to Innovation

How many times have you heard, "It can't be done" or "We've always done it that way?" Health care professionals at Lehigh Valley Hospital (LVH) are saying, "It can be done," and "I challenge you to do it this way!" Innovations in patient care are evolving from practitioners at the bedside. Have you ever had a hunch or a gut feeling that things you routinely do in patient care could be done differently, and perhaps more efficiently? The following is a sample of "hunches" that LVH health care professionals have evaluated and acted on to improve quality care for patients.

AMBULATORY SURGERY UNIT (ASU-17)

Nurses working in the Ambulatory Surgery Unit noticed a higher incidence of Post Operative Nausea and Vomiting (PONV) in the ASU patients. PONV can lead to decreased patient satisfaction and an increased length of stay. With an average daily caseload of 40-50 patients, an increased length of stay for one patient could delay care for others. A performance improvement study was started in October 1996 with input from Dr. John Collins, Department of Anesthesia.

Through a literature search, Dr. Collins found that ambulatory surgery patients experience more PONV than surgical inpatients due to a disturbance in the vestibular portion of the brain from movement postoperatively. The literature also shows that patients who are hydrated up to three hours prior to surgery may experience less PONV but may be at an increased risk of aspiration. This review prompted the staff in the ASU staging area and the Post-Anesthesia Care Unit (PACU-17) to do a six-month study which found 38 percent of patients experienced an extended LOS due to PONV. Patients at greatest risk for PONV were those having gynecological, orthopedic and plastic surgery. Patients hydrated with 8 oz of clear liquids up to three hours prior to surgery had less PONV while those who were NPO more than eight hours experienced a higher incidence of PONV.

The results were presented by Dr. Collins at a PONV lecture on July 29, 1997 and affected practice by all members of the multi-disciplinary surgical team. Now patients are instructed that they may take 8 oz clear liquids up to three hours preoperatively although they remain NPO after midnight for solid food. PAT patients are screened for a significant history of PONV. For those patients, Zofran is the drug of choice preoperatively and effectively treats 56% of the patients with PONV in ASU. All anesthesia care providers at 17th Street are encouraged to give Inapsine intra-operatively for identified high risk patients undergoing gynecology, orthopedic or plastic surgery.

The ASU PI group is now investigating PONV after discharge, in the car or at home.

3C SHEATH REMOVAL PROGRAM

An innovation has Technical Partners from 3C and the Acute Coronary Unit (ACU) removing femoral artery sheaths after invasive cardiology procedures. Prior practice was to hold patients on litters in a small holding area of the cardiac cath lab until the femoral artery sheath could be removed safely. Nurses realized that patients would be more comfortable and less anxious in their own room; therefore, they evaluated and altered the work process to facilitate a timely return from the lab back to the unit. Patients may be transferred more quickly now because specialized instruction allows unit Technical Partners to perform the procedure which had been the responsibility of the cardiac cath lab staff.

After attending a Sheath Removal Instructional Program, doing ten manual sheath pulls and five C clamp pulls with supervision, and validation, the technical partners may remove sheaths independently. They are responsible for running a quality check on the Activated Clotting Time (ACT) machine, doing an ACT on blood drawn from the

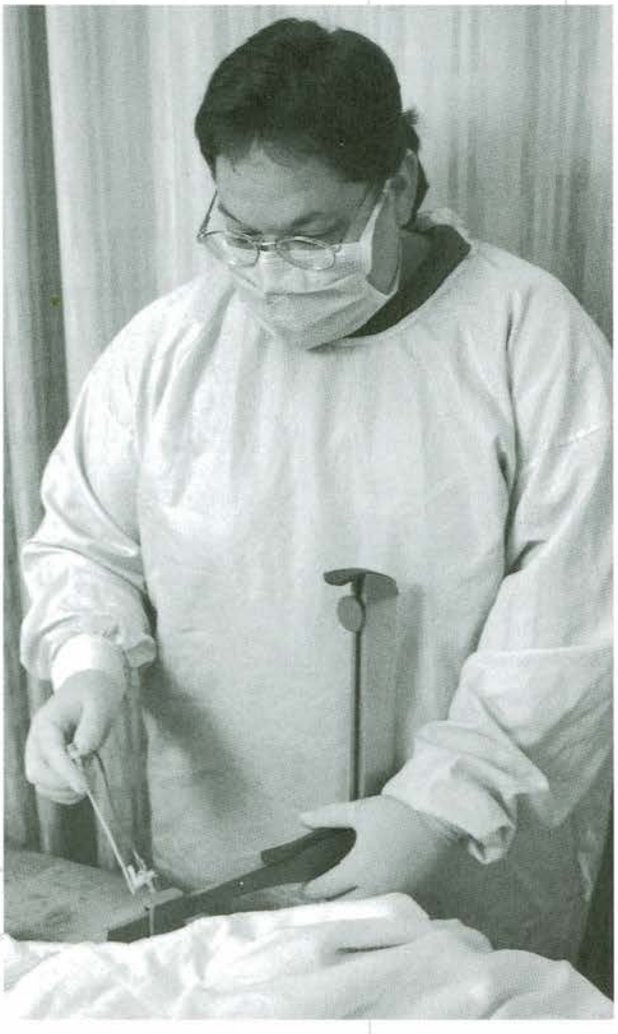
existing femoral sheath, and then pulling the sheath. The technical partner holds pressure on the site up to 30 minutes, or until hemostasis is achieved, after femoral arterial sheath removal. The primary RN assesses the effects of the sheath pull on the patient's vital signs and responds to any problems noted. The RN monitors the patient's pedal pulses and watches for hematoma formation.

Outcomes of sheath removals post invasive cardiology procedures are monitored and are documented to provide constant quality assurance. The Patient Care Specialist and Patient Care Coordinator for 3C inspect for hematoma formation and intact circulation in the affected extremity the next day, thereby maintaining an ongoing PI study. The Invasive Cardiology Care Map Data Collection Sheet was revised to reflect any changes in length of stay due to complications of sheath removal.

5C ORTHOPEDIC MODULE REDESIGN

In anticipation of work redesign, the 5C staff gave input into the layout of the unit to enhance care for orthopedic patients. Teaching rooms and cameras linked to the OR for resident viewing of pertinent surgical cases were built into the plan for the unit.

Diane Helinsky, 3C-TP, removes a femoral arterial sheath utilizing a C-clamp.



The staff also had input into the redesign of work processes, including those involving orthopedic equipment which were revised to enhance patient care. RNs, technical partners, and support partners who have attended the Orthopedic Module have been validated on the set up of orthopedic equipment. Therefore, prepared staff are on the unit, allowing more rapid application of individualized patient equipment than previously possible. Not only does the patient get his overhead trapeze promptly, but he also sees one of the same staff members that he will see throughout his hospitalization.

The Orthopedic Module was started in November 1995, and was then made into a self learning packet at the request of the participants. Videotapes were developed to serve as additional reinforcement for learning, and performance checklists identify the key learning concepts needed to safely assemble orthopedic equipment on the units. A Safety Checklist is used to maintain quality care for these patients.

CRITICAL CARE UNITS

Several critical care units have opened their doors to their families by changing limited visiting hours to a "flexible" visiting policy based on the needs of the patient and family. When a patient is admitted to the unit, a spokesperson from the family is designated to be the contact between the care providers and the family. This person is responsible for giving consent for procedures, and arranges for family meetings with the nurse and physician caring for the patient. Family members may stay at the bedside while care is being provided. The amount of time spent at the bedside, and which procedures are viewed or participated in by the family is at the discretion of the patient, the RN, and the spokesperson. Families now participate in the care of their loved one by doing mouth care, soothing skin with lotion, and applying splints.

In the past, children less than 12 years were not allowed to visit. Now, with the flexible visiting policy, they may visit at the discretion of the parent and care provider. This allows the parent who is suddenly hospitalized to maintain bonds with his or her children. This allows a trusting relationship to be built between the parent, child and practitioner. Also, teaching may be more effective with the significant other present. The satisfaction of the family members with the flexible visiting policy will be assessed utilizing the newly developed Critical Care Family Satisfaction Survey. (See "Families Count Too!!!!")

We, the health care professionals at the bedside must be innovators in care, testing and exploring new ways to deliver efficient, quality care. In that way, we can assure that the changes in health care delivery, driven largely by the economy surrounding health care payment, will not compromise the quality of our patient care. The above examples are testimony to the pride, dedication and commitment shown by health care professionals at Lehigh Valley Hospital.

Roberta Hower, R.N., M.S.N.,
PCS - ASU\PACU\4S - 17

Families Count Too!!!!!!

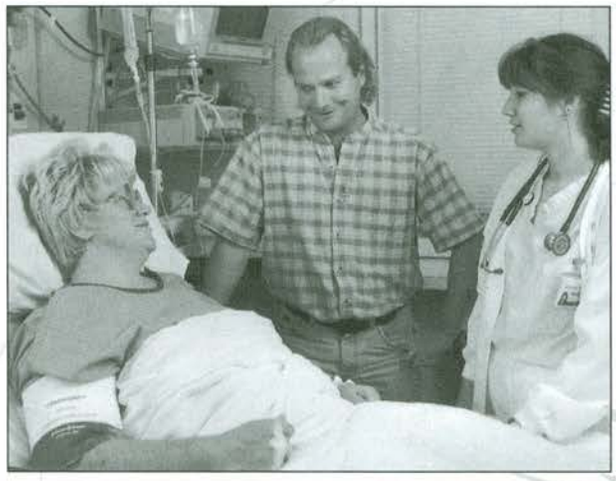
It is 5 PM and you have already worked ten hours of your twelve hour shift in the critical care unit. Your day has been crazy, but that is the norm....you transferred two of your three patients to med-surg, spent half of the afternoon in radiology with your last patient, had two unit committee meetings, finalized the staffing schedule for next month and have now been informed that you are getting another admission. You know your attention and energy will be focused on meeting your patient's emergent needs, but you wonder if you will have the stamina and compassion to meet the special needs of his family as well.

In today's challenging healthcare environment, work redesign efforts are being introduced to control escalating costs. Ideally, work redesign focuses on environmental and process changes, that most often include redesigned roles, to improve organizational performance. The difficulty with these efforts is that healthcare providers often become frustrated, feeling at times, that they are continuously being forced to do more with less. Furthermore, frustration and concerns intensify if one feels the quality of the care provided to patients and families is being compromised.

Lehigh Valley Hospital and Health Network (LVHHN) recognizes these concerns and has employed a rigorous evaluation strategy to measure outcomes to assure that redesign maintains quality with positive patient outcomes protected. From the forefront, every step of work redesign at our institution has been carefully planned with the patient's perspective and fundamental needs first. To date, measured outcomes include patient, employee and physician satisfaction; clinical quality outcomes; and efficiencies and costs of care.

Because we have redesigned with our patient's needs in mind, significant emphasis is placed on measuring how satisfied our patients are with the care that is provided during hospitalization. In simple terms, we want to know if our changes in the way we deliver care are keeping our patients happy. Satisfaction is achieved if there is a match between expectations and the reality of the experience as one perceives it. Traditionally, in the medical surgical setting, we have measured patient satisfaction, but in critical care, the patient is often too acutely ill to participate in their care, let alone remember the environment. It is the family that recollects their loved one's stay in the critical care unit, therefore, it should be the family that determines satisfaction with care.

Critical care families have expectations about how healthcare providers should act and about what will happen to them and their family member. When expectations are not met, conflict occurs. This conflict may result in satisfaction problems for families of our critically ill patients. Humanistic caring for the family is as integral as caring for the patient themselves. Even during stressful times, when resources are stretched to the limit, we must remain responsible for meeting family as well as patient needs, to provide the holistic care we are accustomed to delivering. We are equally responsible to evaluate if the patient's and family's needs are met in this changing environment.



Art Miller knows Michelle Reimer, R.N., will answer all the questions about his mother, Frances Miller.

Evaluation of family satisfaction with critical care delivery proved to be difficult, however, as there are no reliable and valid tools to complete this task. Recognizing this limitation, a multidisciplinary team composed of critical care providers, redesign project directors, and researchers, has developed a research based instrument, named the Critical Care Family Satisfaction Survey (CCFSS), to assess the level of family satisfaction in the critical care setting. Utilizing research findings, ten "need statements" of critical care families have been identified. Need statements express the kind of care and facilities the family want and expect from the staff while their loved one is being cared for:

The "need statements" are:

1. Families need the feeling of hope.
2. Families need their questions answered honestly.
3. Families need to know that the best possible care is being provided for the patient.
4. Families need to be assured that they will receive a call at home if any changes occur in the condition of the patient.
5. Families need explanations in simple terms and timely responses to their questions and concerns.
6. Families want to be with/near the patient as much as possible.
7. Families want to be informed at least once a

day of the patient's progress.

8. Families want to know specific facts about the patient's prognosis.
9. Families want to feel comfortable in the hospital setting.
10. Families want the staff to be warm but also professional.

Twenty-five survey questions were constructed based on these needs. These questions will ask families their level of satisfaction with such things as flexibility of the visiting hours, timeliness of tests and x-rays for their family member, respect for their beliefs and attitudes, and the degree to which the family was included in decisions regarding their loved one's care. Family members will also be asked to rate the level of importance of that need.

A pilot study is underway in the Shock Trauma Unit (STU), Medical Intensive Care Unit (MICU), Surgical Intensive Care Unit (SICU), and Acute Coronary Unit (ACU). Family members, defined as adults (18 years of age and older) related to the patient by blood, marriage, adoption, or affinity as a "significant other" (e.g. life partner, close friend) will be given the CCFSS by the unit staff when their family member is transferred from the critical care unit.

Completed surveys will be returned to the Office of Professional Development, Measurement and Research for collation and analysis of the data. If preliminary analysis is satisfactory on the pilot data, housewide critical care implementation of the survey can be expected. The results of the family satisfaction data will be disseminated to all units so that we can continuously improve the qualilty of services we provide.

Work redesign is a fact of life in most hospitals in the United States. Healthcare providers need to take an active role in the restructuring of patient care to ensure quality care and positive patient outcomes. LVHHN has assumed that active role and with a strong commitment to outcomes research, will utilize the CCFSS to assure that we meet the needs of our patients and family members as their loved one enters a critical care unit at our institution.

Mae Ann Fuss, R.N., MSN, CCRN
Professional Development, Measurment and Research (PDMR)

Sending Out an SOS

(Continued from front cover)

"Susan. This must all seem very unreal to you. Try not to be afraid. But if you are, try to think pleasant thoughts. Your boys said you grew sunflowers this summer. See, they brought in a picture," my new friend says to me. I open my eyes and look at the photograph she holds. I remember the flowers. I close my eyes and see the flowers swaying with the wind. I picture three blue jays stealing the seeds. I see the rain fall; they bend towards the green grass. It is like she opened a door.

"You have visitors." She put their hands in mine.

"I don't know what to say," he says.

"It doesn't matter, just let her hear your voice."

I squeeze the two hands and hear their voices. The icicles melt. A tear falls.

"Is she crying?" they ask.

"Maybe. Maybe having you here is making her happy enough to cry."

"That certainly is possible," they both reply. "She cries at the drop of a hat. You should see at the movies or at birthday parties, when they sing Happy Birthday to..."

I listen to these three, talking and laughing. I feel joyful, contented and loved. It is like I was gone for a while, drifting away in the open sea. And now I am sailing back home.

Yes . . . I was dreaming. But it is a daydream that helps me imagine what my patient may be experiencing, as though floating in a endless sea waiting for someone to find the SOS in the bottle. It is based on what I've learned from patients over the years and has taught me to practice as though I or my loved ones were in that bed.

This year, I celebrate 20 years as a critical care nurse. I have mastered many skills, attended countless conferences, remained certified and educated. As time goes by, I more clearly realize what a unique position I possess in the human lives I am entrusted with each day. And I also realize that it is the simple things, the basic things, that people really need and miss when they are in the hospital. Feeling safe, clean, cared for, and loved.

I know the value of those simple things and get joy and satisfaction from doing them. Now changes in health care are causing changes in how patient care is given. It is a little difficult for me to share some of those tasks that I feel help my patients as much as hanging an IV does, but I am learning. So, if you are here to help me, please be patient with me. I will share them with you but I do ask for one thing! Remember, it is more than what you do that makes our patients well, it is *how* you do it. In the end, if you are the one to make that connection with someone who is hurting, it will not matter whether your shirt is white or blue, or whether your socks are on inside out.

Would it matter . . .if that someone in the bed were you,?

Susan Busits O'Neill, R.N., STU

Speak Out

I knew I was part of a team . . .

. . . when everyone I worked with called me by my first name.

Anne Brown, R.N., PACU-17

. . . during an experience I had while traveling to South Carolina in June. The plane encountered bad weather and had to land until we received clearance. I noticed a passenger limping off the plane and offered to help her. As we walked into the terminal, another woman asked if she also could assist. Later, after we applied a few Band-Aids and some TLC, I learned that this lovely woman working with me was a night shift ER nurse at Lehigh Valley Hospital where I was a Technical Partner in MICU/SICU. It was a pleasure meeting "Mary Queen of Scots" (as she referred to herself) and being part of her team.

PS: Hello Mary, I hope you had a wonderful vacation!

Kathi Charles,
Technical Partner, MICU/SICU

. . . when I had an unforgettable experience a year ago.

The phone rang about 12:45AM that weekend I was on call for Lehigh Valley Hospice. It was the daughter of a patient who was dying that night. The daughter was so upset she could hardly talk but she needed a nurse to help her care for her mother. She and the family also needed emotional support and the spiritual comfort of a chaplain's visit.

As I reluctantly crawled out of my warm bed and got dressed, I thought about the patient whose status I knew only from team meetings. I wasn't very familiar with her town, especially at night, but knew it was 35 minutes away. Since I didn't have time to waste, I called the answering service and asked them to notify the on call chaplain.

Thankfully, the house was well lit when I found it and lots of cars were in front. I introduced myself and started to assess the patient and make her comfortable. Deep in a coma with labored breathing, she was within moments of death.

Just then the doorbell rang and in walked the Director of Spiritual Services, not the "on call" chaplain I expected. "What's she doing here?" I thought. I didn't know who was covering, but I had never intended to get the manager out of bed at 1:00 in the morning!!!! My thoughts were going haywire but we absolutely needed a chaplain, and yes, I would make the call all over again . . . but somehow, it didn't seem right that the boss came in the middle of the night! "Oh, well," I thought, "I'm going to hear about this tomorrow!" But I never did.

With kindness and concern, she spoke briefly to the patient and prayed with her. She then requested that we all form a circle at the bedside and pray together. In those moments, the patient went to her God; the link between us in that circle was unbreakable.

While I confirmed her death and gave postmortem care, the chaplain gave support to her grieving family. Then we were finished. Time to go home. We said goodnight and left.

On my way home that morning, I experienced a tremendous sense of peace. Despite my concerns about getting lost and calling the Director out, I realized that all was well. All the players had been present and had played their parts well with the chaplain and me as co-directors. TEAMWORK in this case and at this time had included an unexplainable bonding throughout the circle of joined hands as we supported each other. What more could anyone ask of a team? I was honored to be a member of that team. I worked on pure adrenalin that whole day and realized I was blessed by being a member of the Hospice team.

Dear God,
Let us never forget that
As you healed, you touched,
As you helped, you listened,
As you ministered, you cared,
As you served, you loved.
Let us do likewise, never less . . .
Let us faithfully carry on what you began.

Helen Koshensky, R.N., B.S.N.,
Lehigh Valley Hospice and Cancer Care
Stroudsburg, PA