New Transitional Care Unit
"Tender Care Unit" For Patients

A special unit where critically-ill patients can receive an intermediate level of care will open at The Allentown Hospital in late February. Patients in the 12-bed Transitional Care Unit will be cared for by specially-educated nurses and allied health personnel. The unit has the latest state-of-the-art equipment.

The concept of a transitional care unit is based on the premise that certain patients require close nursing surveillance, but not necessarily the same level of surveillance as that provided in the Acute Coronary Care or Intensive Care Units. We will meet the needs of these patients by providing them with a safe, quiet environment for recovery under the careful observation of our nursing staff.

It is anticipated that patients with a variety of disease entities will be cared for in the TCU. Patient conditions will include cardiac, respiratory and renal diseases as well as metabolic and hemodynamic instability.

The TCU, located on the first floor of the Tower, provides a comfortable environment conducive to patient convalescence. There are five semi-private rooms and two private rooms, one with an isolation anteroom. The patient rooms and corridor are wallpapered, creating a pleasant, homely atmosphere for the patients.

The TCU nurses will complete either the critical care course or a modified version of the course including telemetry monitoring. The (please turn to page 7)

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Guest Editorial

The merger of The Allentown Hospital with Lehigh Valley Hospital Center provides an exciting opportunity to better maximize the efficient use of scarce hospital resources. We seldom have an adequate level of funding to meet all or even a reasonably high percentage of the patient needs identified each year. We expect the merger to help us eliminate as much duplication of effort as possible and permit the new hospital to continue to provide high quality care at a more efficient level than has been possible in the past.

David Buchmueller, president of HealthEast, recently outlined the following more specific advantages of the merger in the Dec. 17, 1987 issue of HealthEast Report.

Specific Advantages of the Merger:

Quality
a. Better able to transfer technology and talent between facilities;
b. A joint clinical planning process;
c. Better able to retain and attract adequate numbers of superior nurses and other health professionals;
d. The Office of Medical and Academic Affairs:
   (1) will emphasize the Quality Assurance function;
   (2) can provide better clinical leadership on both sites. Strengthened accountability will mean improved problem solving and better response to patients;
   (3) faster, more effective development of the Regional Resource Centers will bring programs and services to more people;
   (4) integration of wellness and health promotion programs with clinical services;
   (5) strengthened approach to the medical school affiliation will continue and will expand the availability of talented young professionals who interact with and help patients.

Cost of Care
a. Achieve further integration of services. A savings in operating costs of only 1 percent through such improvements would be worth more than $1,000,000 annually.
b. Better utilization of all facilities, accommodating more patients at a relatively lower unit cost. This should help us control further rate increases.
c. As a consolidated credit, TAH and LVHC have been able to issue bonds and borrow money at a lower cost ($25-50,000/year) than if each hospital had operated individually.

Access to Care
a. When medical-surgical workload is balanced with more use being made of TAH facility, critically ill heart, trauma and other patients will have greater access to LVHC.
b. The merger will ensure adequate funding for TAH clinics and other outreach programs even if patient volume continues to increase and government funding decreases.
c. Overall, an 800-bed, financially strong, high volume, well-managed hospital can most feasibly be in a position to meet its mission and community service obligation, serving all who are in need.
d. New programs resulting from the clinical planning process and other joint efforts can mean availability in the Lehigh Valley of services that might otherwise have required a patient or a family to leave the area.

In general, the merged hospital will be more efficiently governed and managed. With less time devoted to organizational processes, the board, medical staff and management will have more time to devote to further improving the delivery of services. Therefore, individual patients and the community at large will clearly benefit.

Nurses and other employees will probably not notice many differences during the first several months of the merger process. Most of our initial effort will be directed toward establishing a new governance and management structure and making sure that both facilities continue to operate as effectively as in the past. However, once we begin to focus intensively on integrating together appropriate functions at both hospitals, changes should become more and more noticeable. The key throughout all of this activity will be continuing sensitivity to the needs of patients and employees and to meeting one of our primary goals—that the merged hospital will be an even better place for all of us to work.

I would personally welcome hearing any questions that you may have about the merger or any other hospital-related subject. Please feel free to send me a note indicating those items to which you would like me to respond.

Sam Huston
CEO, TAH-LVHC
Two colleges and three health service agencies currently comprise the TPR program: Allentown College of St. Francis de Sales, The Allentown Hospital-Lehigh Valley Hospital Center, Cedar Crest College, Muhlenberg Hospital Center, and the Visiting Nurses Association of Lehigh County.

There are five major goals of the TPR program: (1) enhance the knowledge and skills of faculty and practitioners, (2) retain high quality nursing personnel in the Lehigh Valley, (3) promote collaboration between the agencies and the colleges, (4) generate interest and facilitate opportunities for clinical research, and (5) enhance nursing programs in educational and service institutions.

By providing professional growth opportunities for faculty and clinicians and through shared and joint appointments, funding for clinical research studies and opportunities for consultation, the TPR program contributes to the retention of a highly-skilled and valued group of nurses.

Shared Appointments

A shared appointment is an exchange of time and roles between a faculty member from one of the colleges and a nurse from one of the participating institutions. Home Care of The Allentown Hospital—Lehigh Valley Hospital Center has participated in three shared appointments over the past year. In one appointment, Maureen Dever, R.N., assistant professor of nursing at Cedar Crest College and a pediatric nurse practitioner, served as a resource for nurses in the development of an orientation program, procedures and a standard care plan in pediatric nursing. During the initial 18 months of the TPR program, 12 shared appointments between faculty and clinicians contributed over $30,000 to the participating institutions.

Joint Appointments

Because shared appointments proved to be so successful, a model for joint appointments (a more formal arrangement than a shared appointment) was then developed in 1986. A nurse in a joint appointment is responsible to an educational institution and a health care agency and is compensated by both institutions based on the proportion of time committed to each.

Research

Beginning in 1985, the TPR program began offering a series of research seminars to nurses in the Lehigh Valley. Annually, a nursing research day is held for area nurses to present completed research studies. These seminars not only stimulate nursing research, but also provide a forum for and recognition of the contributions of area nurses to nursing and health care. Stephanie Oravec, R.N., and Andrea Geshan, R.N., nurses at The Allentown Hospital—Lehigh Valley Hospital Center, presented poster sessions at the last seminar.

In 1986, the TPR program began providing small research grants and consultation for clinical nursing research. Two nursing studies have been funded thus far. Small research grants are available to any nurse in the participating institutions. Applications are reviewed bimonthly on a first-come, first-served basis.

A two-day research seminar will be held Sept. 22 and 23. The seminar is co-sponsored by the TPR program, Theta Rho of Cedar Crest College, and Sigma Tau of Allentown College. Donna Diers, professor of nursing from Yale University, editor of Image and past president of Sigma Theta Tau, will be the keynote speaker. The seminar is titled "The Application of Research in Practice: From Idea to Publication." In addition to continuing education sessions, oral and poster presentation of completed studies will be offered. A call for abstracts will be issued in the near future.

Newsletter

A quarterly newsletter is published by the TPR program. The TPR Newsletter provides recognition of participating nurses for their contributions to nursing practice, education, and research. The newsletter also serves as a means of communication between the six participating institutions on program activities and developments.

The TPR program has begun to achieve national recognition and will serve as a model for other communities as it is expanded and refined. Anyone interested in learning more about the TPR program or in participating in any aspect of the program, should contact Kathy Lucke, director, TPR Program, at Lehigh Valley Hospital Center, extension 8692.
Richard Abrams, M.D., professor at Chicago Medical School, presented a program sponsored by the Department of Psychiatry to area registered nurses. The program was called "Update of Theoretical and Practical Aspect of ECT Services."

Dr. Abrams described the history of one of today's most important treatments for mental illness. The 15th anniversary of the introduction of electroconvulsive therapy (ECT) by Ugo Cerletti and Lucio Bini will be observed this year. Convulsive therapy without electricity goes back to the 17th century and the use of the camphor to produce seizures.

Ladislas Meduna, M.D., a neuropsychiatrist, noticed that epileptics who had psychiatric problems seemed to show improvement, which he attributed to the seizures. In 1933 in a state hospital in Budapest, Dr. Meduna gave Metrazol intravenously to produce convulsions in the patients with the diagnosis of schizophrenia. This was one of the first biological treatments used with psychotic patients.

Around 1940, Dr. Cerletti suggested using electricity to produce the convulsions. Up until then, with animal experimentation, electrodes were placed at different orifices such as the mouth and the rectum. However, Dr. Bini's suggestion was to put the electrodes on the head. The first person to receive ECT was a catatonic schizophrenic, who responded very well to the treatment.

Soon ECT was considered the proper treatment for almost all types of mental illness. The patients who responded best to ECT were the patients with endogenous depression or the affective and catatonic types of schizophrenia. Neuroses or anxiety disorders, personality disorders or drug abusers did not respond to ECT treatments. With the advent of antipsychotic and antidepressant drugs in the 1950s, doctors could now choose between ECT or drug therapy. Studies done in the 1960s revealed that ECT was the best form of treatment for the very depressed patient.

Anesthesia technique with ECT treatments was introduced in the 1960s. Curare was the first drug used to modify the grand mal seizure. Today, anectine or succinylcholine is the drug of choice. Using the muscle relaxant before applying the electrodes eliminates fractures and dislocations. It also allows oxygen to be administered while the patient is having the (please turn to page 7)

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**Across**
2. Open or ____ fractures are associated directly with open wounds.
5. Department with ext. 2751.
6. A fat soluble vitamin that is the precursor of Vitamin A.
8. Results from the breakdown of hemoglobin in the red blood cells.
10. "Nurses are ____ people doing incredible jobs."
12. Name for a very common cough syrup.
15. Nurses call the "____ ."

**Down**
1. A nationally recognized nursing association.
2. A triangular bandage useful as an emergency cover or as a sling for a fracture.
3. OB/GYN resident who responds to beeper #3383.
4. Brand name for Tamoxifen.
5. Department with ext. 2333.
7. Hormone which lowers blood calcium levels by increasing calcium clearance by the kidneys.
9. White blood cell.
11. Acute allergic reaction of the body to overwhelming sensitization by a foreign protein.
Experience Speaks For Itself: Debbie Williston

I had always thought of Debbie Williston as a vivacious, fun-loving person, a caring and conscientious nurse and a special and dear friend.

After not seeing Debbie for a long time, I was pleasantly surprised to meet her late one afternoon. Debbie looked wonderful. She was the same bubbly, happy person and a picture of health. I could not contain my astonishment when Debbie told me she had just returned from open heart surgery.

Debbie was diagnosed at age 26 as having aortic valve stenosis. As a youngster, she suffered bouts of rheumatic fever at age 11 and again at 17. She was aware of the damage to the valve and knew that at some point in her adult life, surgery would be indicated. "Thinking back," Debbie recalls, "the idea of surgery was very frightening to me, but I did come to accept it. It was that acceptance that helped me to come to terms with the surgery when it was necessary."

Debbie graduated from the Allentown Hospital School of Nursing in 1983. She worked as a staff nurse on the renal unit for two and one-half years and then transferred to the Acute Coronary Care Unit (ACCU). It was at this time that Debbie decided to have a complete cardiac work-up for baseline information. A cardiac catheterization was done to evaluate the valves. The result indicated that Debbie needed to have aortic valve replacement as soon as possible.

Although Debbie was aware of the possibility of this diagnosis, she could not control the feelings of shock and disbelief she experienced. The reality of surgery was suddenly upon her.

Hearing the news in the presence of her family, she felt she needed to be strong. Many decisions regarding the surgery had to be made. The impact it would have on the rest of her life had to be considered.

The most outstanding question, Debbie says, was "Would I live through the surgery?"

Other questions involved what type of valve should she choose and how could this affect a pregnancy. She also wondered what limitations she could expect.

"As I look back, the entire episode was a learning experience for me," Debbie says. "I've returned to work, having a better understanding of the apprehension felt by a patient who is undergoing cardiac evaluation or surgery. I try to take that extra time to talk with them and comfort them. Many patients find it hard to believe that at age 26 I had open heart surgery."

Debbie decided not to postpone surgery. Dates were set and preparations began for surgery at Lehigh Valley Hospital Center. The support of her friends and co-workers helped sustain her through this difficult period.

The immediate preparation for surgery was intense. Her family was included in pre-operative teaching. A member of the Zipper Club became involved to answer questions.

The morning of the surgery, Debbie felt very comfortable and her spirits were high. After the pre-operative medication, Debbie remembered nothing until she awakened in the open heart unit. She could only recognize the voices of friends who came to visit, which was comforting to her. "The worst experience of all," Debbie says, "had to be the endotracheal tube, and it was a great relief to have it removed."

"I can relate to patients on ventilators, having had that experience myself," Debbie says. "Working with the patients now, I can understand their feelings of helplessness and total dependence on the nurses to control the monitors and infusion pumps." The noises and activities of an intensive care unit seem louder and more threatening to the patients than to the nurses.

Debbie's surgery and recovery went well and she was discharged from the hospital within a week. She began an exercise program of walking and aerobics, and felt she had more energy than ever.

Debbie has become a member of the Zipper Club, a non-profit organization comprising patients who have had open heart surgery. The group's purpose is to prepare others for surgery by sharing experiences and offering encouragement.

Debbie certainly has every opportunity in her capacity as an Acute Coronary Care nurse to encourage and help her patients through their illness. We thank you, Debbie, for sharing your story with Nursing Voice.

Stephanie Oravec, R.N.
Department of Nursing Education
Recognizing

The Allentown Hospital's Definition Of Versatility — Gerry Moyer, R.N.

Webster’s dictionary defines versatility as changing or fluctuating readily; enhancing a variety of subjects, fields or skills; turning with ease from one subject to another.

Gerry Moyer, R.N., retired from The Allentown Hospital on Dec. 31, after 32 years of service. During her career, Gerry achieved many noteworthy accomplishments that deserve recognition.

Gerry graduated in 1943 from the University of Pennsylvania School of Nursing. She started her nursing career as a labor and delivery nurse at St. Luke’s Hospital. In 1949 she came to The Allentown Hospital as a 3 to 11 p.m. staff nurse on sections C and D and later was the first 3 to 11 p.m. nurse on W-1 North. (Sections C and D were on the third floor of the East Wing and W-1 North was the location of our current ICU, for those of you too young to remember some of our wards.)

In 1950, Gerry became an operating room nurse. It was here Gerry worked most of her years at The Allentown Hospital.

During a six-year sabbatical from 1961 to 1967, Gerry and a partner established The Lehigh Prescription Formula Service. It was the second baby formula service in Pennsylvania, and the fifth formula service in the country! Their business provided baby formula to hospitals in the Lehigh Valley, and as far north to Pottsville, Scranton, and south to Quakertown/Doylestown.

In 1968, Gerry returned to The Allentown Hospital as assistant head nurse in the operating room until 1974, and head nurse from 1974 to 1976. During these operating room years, Gerry organized the first local chapter of the American Association of Operating Room Nurses (in 1969) and was its first president.

Gerry started next to organize The Allentown Hospital’s first Ambulatory Surgical Unit. She served as the unit’s first head nurse. Gerry moved on to the Outpatient Department as head nurse of the Emergency Center and Clinics from 1979-1983. Gerry then went to the Central Processing Department as nurse manager where she assisted with the existing design to organize the new area.

Gerry is quite versatile and has a talent for new ventures. Those who got to know her discovered a woman with a heart of gold. Gerry, we will miss you and we wish you good health and happiness in your retirement.

Kay Fenstermaker, R.N.
Nursing Administration

Cynthia Mompie, R.N., Nursing Education, was recently elected as treasurer for the League of Intravenous Therapy Education. She will be serving a two-year term.

Susan Steward, R.N., Nursing Education, was recently elected to the office of Director in the Pennsylvania League for Nursing, Area II.

Bonnie Smith, R.N., vice president, and Kay Fenstermaker, R.N., assistant director of Nursing Central Functions, have completed requirements for a Master of Science degree in Human Resources Administration from the University of Scranton.

On Nov. 1, Evelyn Bowers, R.N., retired from the nursing profession after 40 years of service. The majority of her nursing career was spent at The Allentown Hospital.

Evelyn graduated from The Allentown Hospital School of Nursing in 1947, where she was a member of the Cadet Nurse Corps. After graduation, she fulfilled her obligation to the school by doing six months of public health nursing in Pittsburgh. She then returned to The Allentown Hospital where she did private duty as well as general duty staff nursing on W-3 North and 4-T, mainly on the 3 to 11 p.m. shift.

Her friends and co-workers of 4-T honored her at a retirement luncheon at the Hamilton Plaza. Mayor Joseph S. Daddona issued a proclamation on her behalf applauding her for her fine contribution to the Hospital and to the nursing profession. We all wish Evelyn much happiness on her retirement.

Patricia Stein, R.N.
4T
Hospital Departments

Pharmacy

Medications are usually the first therapy when a particular ailment is treated. There are thousands of medications, over the counter and prescription, available for use.

A particular medication is used to treat a patient. Medications are added and subtracted until the right combination is found. When used properly, they can save or add years to the patient's life and possibly prevent the need for surgery. When used improperly, they can have serious side effects.

It is the responsibility of the Hospital Pharmacy to determine that medications are being used appropriately. When a doctor's order is received in the pharmacy, it is reviewed to assure that the proper dose, dosing interval, and route of administration are ordered. Also, allergies, drug-drug interactions, and food-drug interactions are checked. Drug utilization reviews are done on medications to assure their proper use. The Pharmacy records any adverse drug reactions a patient experiences, and if necessary, reports this information to the Food and Drug Administration.

The greatest role Nursing and Pharmacy can serve is to assure that patients receive their medications properly. Pharmacists must be aware of the associated side effects and toxicities. Nursing can help pharmacy by observing whether patients are benefiting from their medications while they are hospitalized. Together, the departments must educate patients about their medications. Pharmacy and Nursing must work side-by-side to assure that patients have a quality lifestyle when discharged.

Pharmacy will be working with Nursing to assure that our Hospital staff can stay one step ahead of other hospitals with regard to medication usage and education.

The Pharmacy Department staff looks forward to working with you.

Fred Pane, R.Ph.
Assistant Director
Pharmacy

Psychiatric Department Conference (from page 4)

Unilateral ECT is becoming more popular. Applying the electrode to only one temple reduces the amount of post treatment confusion. Bilateral application of electrodes still works best for the severely-ill patient.

Dr. Abrams pointed out that informed consent for ECT has become a complicated legal issue. The patient must sign for permission to receive treatment or the patient must legally be declared mentally incompetent at which point a guardian may sign the permit. Another legal implication is that patients and family must be told about possible memory loss which could continue as long as six months.

Dr. Abrams ended his presentation with two suggestions for the department. He suggested that a separate room be utilized to treat all the ECT patients. The second suggestion was to use the newer type of ECT machine which monitors the heart (EKG) and the brain (EEG). The department has purchased the new ECT machine and plans to use a separate room for ECT treatments.

La Rue Reppert, R.N.C.
School of Nursing

ECT (from page I)

critical focus of care will be holistic, with special attention given to the educational needs of the rehabilitating cardiac patient.

Each nurse will work a 12-hour shift. The nurse to patient ratio will provide the nurse with the opportunity to meet the educational needs of the patient.

Each patient in the TCU will be monitored via the Hewlett-Packard (H-P) Telemetry System. The telemetry box, applied to the patient by electrodes, will transmit a signal to antennas located in the ceiling. This signal is then transmitted to the arrhythmia detection computer and is finally displayed at the nurse’s station.

The H-P Telemetry System is also equipped with a component called CARENET®, a sophisticated, state-of-the-art system not available at any other facility in the Lehigh Valley. The CARENET® component is an integrated software package in combination with a personal computer that will enable the nurse to transmit a patient’s cardiac rhythm to a physician’s home or office.

A new type of headwall system is installed in each patient room. The headwall is a term used for the metal box which holds the oxygen, air and suction ports, and is mounted on the wall at the head of the bed. A series of tracks or channels is built onto the headwall. These tracks permit movement of the oxygen flowmeter, suction apparatus, air output valve, and blood pressure manometer to the most comfortable position for both the patient and the nurse.

Hospital stays may be shortened by monitoring earlier increases in activity levels. Costs will be reduced by utilizing a less intensive unit for the care of patients having a stable intensive or coronary care experience.

Jack Schwab, R.N.
Transitional Care Unit
Dear Sari,

Hi! A small amount of progress has been made in the East Wing since I wrote to you. They are also breaking ground in the Fairgrounds for a free-standing surgical unit.

Several recently graduated nurses are starting their professional careers by working night duty. It is certainly different from 30 years ago. The biggest difference being that you now work with the lights on!

Remember those dark wards and halls with the only light being that tiny desk light? I don't believe that I was ever afraid, even though we worked alone or only with an aide. We learned to do a lot in the dark, especially changing beds. Since there were no 'blues,' only thick flannel pads when a bed was wet, the entire bed had to be changed.

Starting IV's by flashlight also became an art. Steel needles were the only type available. IV's were not time taped; the flow rate usually needed many adjustments. Also, many different types of IV solutions were not available in those days. Blood was given as whole blood along with a solution of normal saline. Plus, we collected blood from donors in our own laboratory.

Included among a night nurse's duties was sterilizing all the enamel-ware and the basins and trays which had been utilized the previous day. No disposables or plastic items were available then. All the enamelware went into the autoclave by the night nurse and was removed by the treatment nurse on the day shift. Wasn't it great when you dropped an arm load of these at 2 a.m.?

I don't think dating the charts has changed much, but remember all our notes were printed. I do know one thing, excessive paper work was not heard of.

I really hustled at 5 a.m. when I filled a litter with buckets of warm water and passed out bath water. There were no bathrooms or sinks available in the wards. The semi-private patients, those with insurance, could wash their face and hands and then go back to sleep. The wards patients, those who had no insurance, had to take their baths.

The entire ward was then 'tidied,' including bedside tables, shades all drawn to the same level, and all the bath equipment put away. Did I get finished? I hustled, because I still had to give out medications and do treatments.

At 7 a.m., an oral report was given to a small staff of nurses in freshly starched white uniforms who stood in an erect position to write their assignment. I went to my bed in a very weary state.

Times sure have changed. I don't know how I did it, but I did, and it was fun. I don't know if I would want to do it the same way again.

I'll write again soon.

Your friend,
Flossie

Patricia Stein, R.N.

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Crossword Puzzle Solution

**Across**

2. compound
5. pharmacy
6. Carotene
8. Billirubin
10. professional
12. Robitussin
14. Dalmane
15. shots

**Down**

1. ANA
2. cravat
3. Guenther
4. Nolvadex
5. pediatrics
7. Calcitonin
9. leukocyte
11. Anaphylaxis
13. nurse

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