THE CLEVELAND CLINIC FOUNDATION

A PUBLICATION FOR NURSES BY NURSES WINTER 2004 NOTABLE NURSING

asking questions, getting answers

RESEARCH sets the stage for CHANGING nursing practice and IMPROVING patient care

Most research starts with simple questions. Is this the best way? Is there a better way? What if we did it this way? Would that make patient care better? "This is what sustains research and drives improvements in patient care," notes Bruce Robinson, RN, Nurse Manager of the 36-bed colorectal surgery unit.

Robinson, who has cared for patients on the unit for 20 years, was reflecting on his experience with research, an inseparable and essential aspect of clinical practice.

Today, use of nasogastric (N-G) tubes is not standard practice in the unit following surgery, but it was not always that way. Someone asked a question, one that a host of specialists from nurses to physicians to biostatisticians and many others deemed worth answering.

It began when one of the staff nurses questioned the variations in the use of N-G tubes post-operatively. Some patients were intubated with N-G tubes for several days and in others N-G tubes were not used at all. Because patients do not tolerate N-G tubes well, the nursing staff wanted a protocol that would provide more specific direction for when and how long N-G tubes should be used.

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in this issue...

Claire M. Young, RN, MBA

It is my privilege to serve as the newly appointed Chief Nursing Officer of The Cleveland Clinic. As I begin my appointment, I am mindful of the outstanding tradition of nursing administration at the Clinic and grateful for the accomplishments of my predecessors. At the same time, I look forward to meeting the challenges to come.

As you can see from the articles in this issue of *Notable Nursing*, our nurses are on the cutting edge of nursing care, practicing in an environment that supports their autonomy and decision making. This environment fosters a partnership between physicians and nurses, which results in quality patient care.

Delivering the best possible care includes implementing systems and practices that allow for more effective management of patients who are admitted to the hospital. For example, streamlining discharge times and medication administration will allow our nurses to do what they do best: deliver optimal care.

As our vision states, "The Patient First, Always," we must remain open to the opportunities to not only advance the practice of nursing but to improve the performance of our systems to yield a result of more efficient and effective patient care. These innovations will mean greater patient and employee satisfaction.

The information revolution and the advances in technology have equipped us with the tools we need to move forward. Coupled with the talent of our nurses, I have no doubt we will be able to accomplish much together. I am proud of our Cleveland Clinic nurses and thrilled to be part of this team.

We hope you enjoy this issue of *Notable Nursing*. Please share it with your colleagues and let us hear from you.

Claire M. Young, RN, MBA, was named **Chief Nursing Officer** in October, 2003. She joined the Clinic in 1995 as the Administrator of Preventive Cardiology. From 1997 to her new appointment, she served as Director of Quality Management, where she was involved in performance improvement, patient satisfaction, clinical quality data abstraction, clinical practice guidelines and competency assessment. Young received her BS from Texas A&M University in 1986, her ADN from Houston Baptist University in 1991 and her MBA from Lake Erie College in 1998. She was a staff nurse in trauma, cardiac intensive care and cardiothoracic intensive care as well as Manager of Preventive Cardiology at Hermann Hospital in Houston, Texas. E-mail comments to **youngc@ccf.org**.

from the chairman

Clinical Leadership Award for Excellence

At the October 2003 meeting of The Academy of Medical-Surgical Nurses, Diane Palec, MSN, RN, received the Clinical Leadership Award for Excellence.

The Academy of Medical-Surgical Nurses is a national organization formed more than a dozen years ago. Its mission is to enhance the clinical expertise, professionalism and leadership of nurses caring for adults in hospitals, the community and long-term care facilities.

The Academy established the Clinical Leadership Award to recognize those who have developed innovative approaches to the improvement of quality patient care; demonstrated leadership skills in the clinical setting; created practice standards that reflect positive patient outcomes and utilized research to enhance patient care.

Diane Palec, who joined The Cleveland Clinic in 1998, is a clinical nurse specialist for vascular medicine and surgery, colorectal surgery and general surgery. She received both her BSN and MSN from Kent State University. E-mail comments to **palecd@ccf.org.**

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The clinical nurse specialist on the colorectal nursing unit, Diane Palec, MSN, RN, in collaboration with Robinson and his staff nurses, initiated the process that set the stage for the research project.

For assistance, they turned to the Department of Nursing Education and Research, which was established 16 years ago to support the nursing staff in all aspects of a clinical investigation from posing the initial questions to gathering and analyzing data to putting the data in comprehensible presentation formats.

"Our department emulates the mission of The Cleveland Clinic, which is to improve patient care through education and research," notes senior nurse researcher Linda Lewicki, Ph.D., RN. "If nurses have a question about a practice and are considering researching it, I help them conduct a literature search to determine the answer and interpret findings. If there isn't an answer, we help them develop a research protocol, assist them in presenting it to the Clinic's Institutional Review Board, and then help them conduct the study."

Palec, Robinson and Lewicki framed the questions and designed the study. The initial step was to relate patient outcomes to the use of N-G tubes. Outcomes can only be compared when initial conditions are similar. The team decided to focus on the hemi-colectomy population. The study eventually would bear the formal title: *An Analysis of Postoperative Ileus, Use of Postoperative N-G Tube Decompression and Clinical Outcomes of Colorectal Surgical Patients Undergoing Uncomplicated Hemicolectomy Surgery*.

"Deciding whether this was to be a retrospective or prospective study was a key point," notes Robinson, who was able to lend a historical perspective. Palec and Robinson decided on a retrospective review because the volume of patients supported that type of study.

The collaboration between nurse manager and clinical nurse specialist was essential to framing the question, assembling the patient statistics and developing a database based on the outcomes they wanted to measure. Palec and Robinson used an Excel database, reviewed the records of 253 patients and then requested data analysis by the staff in the Clinic's Biostatistics Department.

AFTER ANALYSIS, THE RESEARCH STUDY DETERMINED:

- **younger patients undergoing uncomplicated surgeries seldom required N-G tubes.**
- **in many patients the tubes could be removed early in the post-op period, usually on day 2.**
- **tubes were primarily indicated for older patients undergoing complicated procedures.**

The conclusions were sound enough to change practice on the floor, a decision that brought great satisfaction to the nursing team.

"It gets down to improving patient care," says Palec. "The environment at the Clinic supports and encourages nurses to become fully involved in changing and improving nursing practice. It is part of our culture."

Diane Palec and **Bruce Robinson** won the First Place in Research Posters Award at the annual meeting of the Academy of Medical Surgical Nurses. E-mail comments to **palecd@ccf.org** and **robinsb@ccf.org**.

TEAM BUILDING IMPROVES
STAFF AND PATIENT SATISFACTION

palliative care

nurse manager sees a need and fills it

Two years ago, when Catherine Lawrence BA, RN, C CHPN became nurse manager in the Horvitz Care Center for Palliative Medicine on M-71, the unit was beset by turnovers in staff and management. As Lawrence watched her 40-member staff deal with difficult patient care issues and with each other, she saw the need to provide a program that would care for the caregivers.

"We all have a commitment to take care of the patients and their families," Lawrence says. "I felt I had to make a commitment to take care of the nurses so they can take care of the patients."

Palliative medicine can exact incredible stress on nurses and staff who tend to the broad spectrum of physical, emotional and psychological needs of people with life limiting illnesses.

Vigorous pain and symptom management is a critical care component as is education of patients and families about the nature of the illness. Although about 20 percent of patients die on the palliative medicine unit from complex, advanced illnesses such as cancer, congestive heart failure and ALS, other patients transition to home, nursing care centers or hospice.

Lawrence believed that patient care and staff effectiveness would improve if staff members learned to understand and appreciate their similarities as well as their differences. The usual route of in-service training didn't appeal to Lawrence. "Most in-service training is done during the work day," Lawrence concedes, "and it just piles up the work. Nurses need to get away."

For the past two years, Lawrence has conducted a one-day, off-campus continuing education retreat for her entire staff, taking half the staff on retreat one month, the other half the next month. Last year, the retreat focused on caring for patients at the end of life. This year, the focus was on team building.

"It's very hard to tell people that they are different without giving them the tools to discover and understand their differences," Lawrence says, who worked with Kirste Carlson, ND, RN, CS, the clinical nurse specialist for psychiatric and behavioral sciences. "The first step was to give the group information about their personality type, which influences how they interact and work with one another," says Carlson. Prior to the retreat, Carlson administered the Myers-Briggs Type Indicator (MBTI), a self-reporting personality inventory, to all the nursing staff. During the reatreat, Carlson discussed the different personality types, providing valuable information on how personality affects work and personal interactions. "I was stunned that the personality profile suited me exactly," says Gloria Morgan, BSN, RN, a master's student in palliative nursing from New Zealand. "Everyone felt the same way."

Edgar W. Miller, PCNA, says that the MBTI helped him understand why some co-workers were not as talkative and friendly; he is extroverted and his co-workers are introverted.

Following the discussion of how the staff could use this new information to achieve more effective working relationships, Lawrence closed the retreat with a ceremony that was optional: A Blessing of Hands. The entire staff stayed for the ceremony led by Rev. Jim Fondriest, bereavement coordinator for Cleveland Clinic Hospice.

"The idea was to close the day by refocusing on what was most important to all of us — the care of our patients," Lawrence says. The ceremony included affirmation, prayer and then a blessing of each staff members' hands with oil. "We contemplated the work of our hands," says Nurse Morgan.

"Taking the staff off campus and challenging them to understand themselves and each other was a risk," Carlson says of the retreat, "but Catherine Lawrence dared to do it. She goes out of her way to show staff how much she values them."

Back on M-71, Lawrence offers mini in-service training to further develop communication skills and team building based on the MBTI. And it is paying off. "Patient satisfaction scores on M-71 continue to climb — they are at 98 percent now — and this is truly

reflective of what is happening on that unit," says Lauren Charles, MSN, RN, director of medical and behavioral services for nursing.

"The retreat days provide a foundation for more effective teamwork," says Lawrence. "There is still a lot to do. I see it as an evolving process, ever changing, ever growing."

E-mail comments to **lawrenc@ccf.org.**

With 23 beds, the Harry R. Horvitz Center for Palliative Medicine, which commemorates its 10th anniversary this year, is the largest palliative medicine unit in the United States. The American Hospital Association reports that 17 percent of registered community hospitals and 26 percent of U.S. academic teaching hospitals have palliative care programs. *U.S.News & World Report* has added palliative care services to its evaluation criteria for hospitals that strive to be included among the magazine's top-ranked hospitals.

RESEARCH STUDY DOCUMENTS RESOURCE DEMANDS OF OBESE PATIENTS IN THE ICU

Caring for overweight and clinically obese patients is a problem intensive care unit (ICU) personnel are seeing with increasing frequency. Trends suggest it may continue to be an issue in the coming years. The National Institute of Diabetes and Digestive and Kidney Diseases estimates that close to 40 million or 57% of American adults are overweight and nearly a quarter of all U.S. adults are obese. Obesity has doubled among Americans during the last two decades in every state, in both genders, and across all races and ethnicities, age groups and educational levels. Obesity increases the risk of mortality and morbidity among critically ill patients and places additional demands on ICU personnel and resources.

There is a paucity of data about the nursing care of obese patients in the ICU. There are no data about how care resources may affect outcomes. Only one observation/case report and one interventional study are reported in the nursing literature. The medical literature reports outcomes related to patients undergoing open heart surgery, those admitted with trauma injuries, critically ill medical patients, and patients hospitalized outside of the ICU. There are no data about how resources are linked to outcomes in these populations and/or the ICU setting. *(For a copy of the medical and nursing references, e-mail the editor halunr@ccf.org.)*

A consortium of Cleveland, Ohio, nurse investigators from Case Western Reserve University, The Cleveland Clinic; Fairview Hospital; MetroHealth Medical Center; and University Hospitals, collaborated on a study to understand the problem.

The study, funded by the Frances Payne Bolton School of Nursing, sought to characterize the ICU population of patients with a calculated body mass index (BMI) of >30 kg/m2 and to describe staff and material resources needed for their care.

Cleveland Clinic nurses involved in the research study include clinical nurse specialists:
Nina M. Fielden, MSN, RN, CEN, Co-Investigator,
Deborah Klein, MSN, RN, CCRN, CS, Co-investigator

Forty-three patients with an average BMI >47kg/m2 were enrolled in the study as a representative sample. The sample was younger (mean age – 56; range 23 – 83) and less severely ill than the average ICU patient. The average ICU stay was four days. The majority (63%) was admitted for cardiopulmonary problems.

Specialized equipment was used most often for those patients with a BMI >40kg/m2. Some 75% of all patients required a special bed or overlay mattress. Close to two-thirds (63%) required two or more staff to position them and one-third required two or more attempts to gain intravenous/arterial access. Ten (23%) needed special skin care. Respiratory complications developed in 21%. Owing to the prevalence of obesity in the U.S., these findings have implications for ICUs across the nation.

E-mail comments to **fielden@ccf.org** and **kleind@ccf.org.**

More than 300 nurses gathered at the Cleveland Clinic's 23rd Annual Dimensions in Cardiac Care Conference at the InterContinental Hotel and MBNA Conference Center on September 7 through 9, 2003. The conference featured a wide-range of presentations and discussions, some of which are highlighted in this issue of *Notable Nursing*.

A Portrait of Professional Commitment

keynote speakers provide inspiration

Coming from entirely different experiences, the keynote speakers at the Cardiac Care Seminar presented a shared vision of the nursing profession. It was one of courage, conviction, dedication and optimism.

Gladys Mouro, MSN, RN, who has been on the nursing staff at the University of Beirut Medical Center since 1970, is the author of "An American in Crisis — The Story of the Lebanon Crisis from 1976 to l994."

Mouro reflected on her career in Lebanon, telling of the horrors inflicted by war. "Our basic necessities were eroded," she said. "Air conditioning, ventilation, and electricity services were maintained only in the operating rooms, intensive care units, critical care units and emergency units.

"In one year, from April 1975 to April 1976, the emergency room received 8,326 casualties out of a total of 8,945 in all of Lebanon. During that year, 6,387 were killed."

The close-knit group of health care professionals coped with shortages of personnel, supplies and equipment. All but four of ten operating rooms were shut down. Two ORs were reserved for emergency cases already in the hospital and two were left open for anticipated emergencies. The normal shift was 20 hours.

In May, 1992, Mouro was awarded the Lebanon Silver Medal for her services. Her mother wanted her to come home, but Mouro stayed on as director of nursing services at the hospital.

Gladys Mouro, MSN, RN

"I can only say that I have been privileged to serve the people of Lebonon, the American University of Beirut, and as an American, to follow the values and principles of the country and the family that raised me."

Dorrie Fontaine, RN, DNSc, FAAN, President of the American Association of Critical Care Nurses, called for a national policy to focus the attention on the nursing shortage that has caused extreme burdens on practicing nurses, especially those caring for older and sicker patients in critical care units.

She noted that there was already some movement in that direction, but financial incentives such as scholarships, student loans, and loan-repayment programs need to be expanded.

Fontaine said ensuring adequate staffing is a key strategic focus of the American Association of Critical Care Nurses (ACCN), which supports staffing that is based on the healthcare needs of the patients. "Nurses are the primary professionals capable of recognizing those needs," said Fontaine.

The AACN is cognizant of its role as a collaborator and meets frequently with members of the American College of Chest Physicians and the American Thoracic Society. "We see physicians as our number one strategic partner," she said.

Fontaine called for nurses to be champions of their profession, and to care about each other. "This is what keeps nurses on the unit — when they can trust and depend on each other."

Dorrie Fontaine, RN, DNSc, FAAN

Is your patient at risk for endocarditis?

Monica Weber, MSN, RN, CIC

There are between 10,000 to 20,000 new cases of endocarditis each year in the United States, a rate that has remained stable for about 30 years. The median age of those affected is 50. The mortality rate is around 20% with death most frequently resulting from heart failure secondary to heart valve dysfunction or uncontrolled infection. Native valve endocarditis accounts for 75-90% of cases nationally.

The most common type of endocarditis is left-sided disease that involves the mitral and/or aortic valves. Right-sided endocarditis, which affects the tricuspid valve and sometimes the pulmonary valve, is less common.

All patients with prosthetic cardiac valves whether they are autologous, homologous or mechanical are at high risk for endocarditis. Others at high risk include people with previous endocarditis, congenital heart disease such as single-ventricle defects, transposition of the great arteries, tetralogy of Fallot, and those with surgically constructed pulmonary shunts or conduits.

Rheumatic heart disease, now seen infrequently in the U.S., acquired valvular disease, hypertrophic cardiomyopathy, mitral valve prolapse with regurgitation and/or thickened leaflets, and bicuspid aortic valve place individuals at moderate risk.

CLINICAL MANIFESTATIONS

William Osler presented diagnostic clues for endocarditis in the 19th century that remain accurate today. They include remittent fever with valvular heart lesions, embolic findings, skin lesions and progressive cardiac changes. The most common symptom is fever. Endocarditis should be suspected in cases of persistent bacteremia without a clear focus. Chills, weakness, dyspnea and other symptoms may also present. Dermal clues include Osler nodes (small raised lesions with a blanched center) and Janeway lesions (non-painful macular lesions), which appear on palms and soles of the feet. Other visual clues are splinter hemorrhages beneath nail beds, round or oval white spots in the retina, and petechia in nail beds, palms, soles of feet and conjunctiva. Occasionally endocarditis will manifest as acute septic arthritis.

FIRST, TREAT EMPIRICALLY

Heart failure is the major concern with endocarditis. While awaiting diagnostic data, patients can be treated empirically with antibiotics directed towards the typical pathogen (organism.) In patients suspected of native valve endocarditis, the organism to target is streptococci, which is usually treated with penicillin intravenously for at least four weeks with or without the addition of gentamicin. Vancomycin is only indicated for penicillin-insensitive streptococci. For those with prosthetic valve disease, the organism targeted is staphylococcus. Oxacillin or nafcillin with or without gentamicin and rifampin is given intravenously for at least six weeks. Vancomycin is again only indicated for methicillin-insensitive organisms (MRSA, MRSE) Patients are treated for four to six weeks with IV antibiotics, which can be managed at home.

Unless the patient is unstable, medical management is always the first approach, with surgery following if indicated.

EDUCATE PATIENTS

Patients who are at risk for endocarditis should be educated about the disease and its symptoms. Until the controversy is resolved about whether dental procedures serve as routes for infectious organisms, assume that they might be. Instruct patients about good dental hygiene and recommend that they inform their dentists of their risk status. The American Heart Association Guidelines provide information about antibiotic prophylaxis.

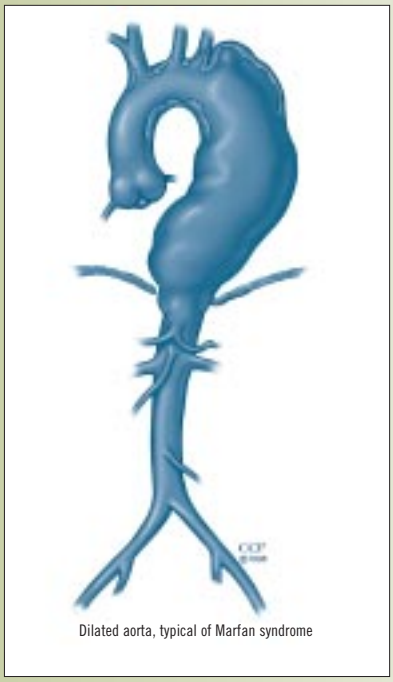
Monica Weber joined The Cleveland Clinic in 1992. Prior to assuming the position of Infection Control Practitioner in 2001, she was a clinical nurse specialist for cardiac surgery at the Clinic. She received her MSN from The University of Pennsylvania in Philadelphia in 1988.

E-mail comments to **weberm@ccf.org**

Marfan syndrome can elude patients and health professionals alike

Deborah Klein, MSN, RN, CCRN, CS

Marfan syndrome, an autosomal dominant genetic disorder of connective tissue, affects about 200,000 people in the U.S. Up to 90% of individuals with Marfan syndrome will develop cardiac complications, such as aortic root dilation and aortic aneurysms. The disease can have devastating effects, but if it is diagnosed and treated early, life expectancy can be significantly increased.



Dilated aorta, typical of Marfan syndrome

DIFFICULT TO DIAGNOSE

While the physical manifestations of Marfan syndrome seem perfectly obvious after diagnosis, the symptoms seem to elude health professionals and even patients before diagnosis. Marfan syndrome is caused by a mutation in the fibrillin 1 gene; the way the gene expresses itself physically varies from individual to individual.

PHYSICAL CHARACTERISTICS

Individuals with Marfan syndrome are often tall and lean. They have a thin, narrow face and perhaps a small lower jaw, long, thin limbs and spidery fingers. Some will have a funnel chest (pectus excavatum) or a pigeon chest (pectus carinatum). They can be double jointed at a number of locations. Flat feet and various ocular problems, including myopia, malformed (flattened) corneas, lens dislocations, and retinal detachments may be present or develop.

CARDIOVASCULAR PROBLEMS

Cardiovascular problems stemming from altered connective tissue development are serious and challenging. Up to 90 percent of individuals with Marfan syndrome will develop alterations in their hearts or vessels. Mitral valve prolapse is not uncommon. Weakened connective tissue compromises the aortic wall, and aneurysms can develop anywhere along the length of the aorta from its root at the heart down through the abdomen. Although the aorta is dilated, it can become stiff, giving rise to hypertension.

MISSED DIAGNOSIS

These clinical events can proceed silently and painlessly until the aorta begins to dissect, causing sharp pain in the chest or back. In individuals ignorant of their true clinical situation, it is not unusual for the origins of the pain to be missed in emergency rooms.

A tragic, well-known example of missed diagnosis is that of noted play writer Jonathan Larson, who won an Emmy for "Rent." Larson went to two different emergency departments within a week complaining of chest pain. Because he was young, because the medical staff did not suspect Marfan, and because he himself was ignorant of his status, Larson was treated for a "viral syndrome" and sent home. He died just before the opening of his play. Only after he died was there suspicion that he may have had Marfans or a Marfan-type syndrome.

Aortic aneurysms can and do occur in young people. We expect cardiac events that cause pain in men and women over age 60 and in those with a history of atherosclerosis, diabetes, hypertension, or non-compliance with hypertension medications. We don't expect them in a 35-year-old, but we should.

COMPREHENSIVE TREATMENT

Young patients with Marfan syndrome are treated with beta-blockers or verapamil. In young people with a family history of aortic dissection, prophylactic replacement of the aortic root before its diameter exceeds 5 cm should be considered. Valve-sparing re-implantation or valve replacement also are prophylactic options.

Perhaps the most difficult aspect of therapy in younger individuals is modifying lifestyles. High impact sports such as football and soccer and those with risk of an impact such as baseball or rollerblading are prohibited.

If possible, patients should be treated at a medical center that specializes in Marfan syndrome. A team of nursing, medical and surgical specialists staff the Marfan Center at The Cleveland Clinic.

Deborah Klein is a clinical nurse specialist for the CICU and Heart Failure Special Care Unit. She has been with the Clinic since June 2000. Klein received her MSN from Case Western Reserve University. E-mail comments to **kleind@ccf.org.**

Vigilance is the best heart transplant therapy

Ross Swanson, MSN, RN, CCRN

The human immune response presents a formidable challenge to heart transplant patients and those who provide care for them. Nurses caring for transplant patients must be experienced, skilled and vigilant to meet this challenge.

There are two primary rejection phases in heart transplant patients — acute and chronic. The risks of each generally follow established patterns. The body begins to reject foreign tissue as soon as it comes into contact with it. Acute rejection generally occurs within two weeks to a month postoperatively when about 60 percent of patients will present with one or more episodes. Nearly half of all rejection episodes occur within 6 months of the procedure. The patient then makes a transition, wherein the risks of chronic rejection stabilize at around 40 percent and then begin to climb as the years pass. Rejection is now a chronic degenerative process that each individual experiences differently but one that few escape.

All transplant patients are at risk of rejection, but some are at increased risk. Women are at greater risk than men, especially those who have had children because of the human leukocyte antigen (HLA) antibodies that they develop to protect themselves and their unborn child. Others at increased risk include those who have received multiple blood transfusions; patients with co-morbid disease; patients who have had cytomegalovirus (CMV) infection and patients who are non-compliant with medications.

SUPPRESSING THE IMMUNE SYSTEM

Both humoral and cell-mediated immunity must be controlled in transplant patients. The humoral immune response releases antibodies that bind to antigens on cell surfaces and in doing so either destroy the cell or mark it for destruction by the cell-mediated response. This response attacks disease-causing entities outside the cell. The cell-mediated response attacks entities within a cell such as viruses and cancer-causing molecules. Both are potent responses and both must be suppressed in a balanced fashion. Over-suppressing the immune response or eliminating it entirely can subject the patient to a host of diseases that may or may not be related to the transplanted tissue.

CURRENT THERAPIES

Not too long ago, the standard post-transplant therapy was a three-drug "cocktail" of cyclosporine, azothioprine and methylprednisolone. These carried a certain degree of nephro-toxicity as a side effect. Cyclosporine and azathioprine have since been replaced by tacrolimus (Prograf) and mycophenolate mofetil (CellCept) respectively. The steroidal agent, methylprednisolone, remains in the mix. One of the significant advantages of this therapy is that therapeutic drug levels can be established. Immunosuppression can be better controlled and balanced against risk. In addition to this therapy, the patient is often treated with a short course of monoclonal or polyclonal antibodies. Biopsies are taken weekly or biweekly during the first three months postop and monthly thereafter for two years or longer.

ANTI-REJECTION STRATEGY

Once a therapeutic regimen is established the most effective anti-rejection strategy becomes the vigilant assessment skills of the nurse. He or she is often the first to identify the signs and symptoms of rejection, which include fevers, sweats, chills, nausea and a variety of other symptoms that resemble those of infection. Heart transplant patients who enter the chronic rejection phase frequently develop a form of accelerated atherosclerosis, sometimes referred to as transplant coronary artery disease (TCAD). Patients with typical coronary artery disease present with discrete, focal lesions. In transplant patients with TCAD, the entire arterial wall appears thickened and inflamed.

All transplant patients will eventually enter a chronic rejection phase but can continue to lead useful productive lives with proper management of their symptoms as they appear. The research effort into all aspects of transplantation from controlling the immune system to managing the varied aspects of acute and chronic rejection is substantial. A nurse in this arena must be diligent in pursuing continuing education so as to be skillful in the early identification of rejection symptoms.

Ross Swanson joined The Cleveland Clinic three years ago. His prior experience included working as the ventricular assist device coordinator at University Hospitals of Cleveland. He received his master's degree in nursing at Case Western Reserve University in 2001. E-mail comments to **swansor@ccf.org.**

CLEVELAND CLINIC DIVISION OF NURSING

nursing news

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Saturday, February 28, 10 a.m. to 2 p.m.

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Cleveland Clinic Launches Video for Hospital Patients

Beginning in February 2004, admitting nurses will ask patients to watch a video featuring Cleveland Clinic leaders who explain how inpatients and their families can become more involved in their care.

"Medical studies demonstrate that patient satisfaction and outcomes are better when patients are informed and involved in their care," says Deborah Nadzam, Ph.D., RN, director of the Office of Quality of The Cleveland Clinic. "The video urges patients to ask questions and to let their nurses and physicians know when they have concerns."

As educators, health care professionals play a critical role in helping patients understand the purpose of medications or treatments. Patients who are aware of the positive or adverse side effects that may occur will know when to bring their concerns to their physician's attention. "The key is to convince patients as well as their family members that it is okay to ask questions and to participate actively in their care," says Nadzam.

The initial use of the video, which was coordinated by staff in The Quality Institute, is geared toward adult medical-surgical patients and will be shown through The Cleveland Clinic Get Well Network.

Excellence in Practice Award

Advanced practice nurse Kirste Carlson, ND, MSN, RN, who specializes in psychiatric and mental health at The Cleveland Clinic, received the award for Excellence for Advanced Practice during the annual meeting of the American Psychiatric Nursing Foundation in October 2003 in Atlanta, Georgia.

Nurses receiving the award must demonstrate excellence in psychiatric-mental health nursing and serve as a clinical role model for other nurses by making tangible contributions to enhance nursing practice and patient outcomes. Honorees are recognized for the significant refinements or unique contributions they have made to the delivery of psychiatric-mental health nursing care and for demonstrating excellence in working with individuals, families and communities.

Kirste Carlson, who has worked at The Cleveland Clinic for 18 years, is also on the clinical faculties of Kent State University and Case Western Reserve University, schools of nursing. She received her master's degree in psychiatric and mental health nursing from Kent State University and her doctorate from Case Western Reserve University. E-mail comments to **carlsok@ccf.org**.

the future of nursing is here

The Cleveland Clinic is a not-for-profit multispecialty academic medical center located in Cleveland, Ohio. When you make The Cleveland Clinic your career choice, you will be working at one of the nation's premier medical centers.

Our physicians recognize that much of the Clinic's success lies in the strength and commitment of our nursing staff. Here, nurses and physicians work as partners, exchanging ideas and knowledge with a shared goal — to deliver the highest quality patient care and improve patient outcomes.

For more than a dozen years *U.S. News & World Report* has ranked The Cleveland Clinic among the "Best of the Best" hospitals in the country. In 2003, the magazine ranked the Clinic among the top five hospitals in the nation. Our Heart Center has been ranked number one in the United States for the past nine years by *U.S. News* and many other specialties, including urology, neurology and neurosurgery, orthopaedics, otolaryngology, gynecology, gastroenterology, geriatrics, endocrinology, nephrology, respiratory disorders and rheumatology are ranked among the top ten.

With more than 900 beds, The Cleveland Clinic is one of the world's largest and busiest medical centers, serving patients from every state in the nation and around the world. Our staff includes more than 1,400 physicians and scientists representing 120 specialties and subspecialties. Annually, the Clinic records nearly two million outpatient visits and more than 50,000 hospital admissions.

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nursing career focus:

FROM THE CARDIAC INTENSIVE CARE UNIT TO THE **BATTLEFIELDS IN IRAQ**

"I had always wanted to join the military," says Judy Uzell, who has been a nurse for the past 20 years, 10 of those at The Cleveland Clinic. Uzell, a mother of four, chose the Air Force when her oldest son was attending the Air Force Academy. She was assigned to the Wright-Patterson AFB Medical Center in 1995–1997, until there was an opening in the 445th Aeromedical Evacuation Squadron in 1998.

In early September, Uzell returned from a two-month deployment that took her from a base in Kuwait to Iraq, Bahrain, Qatar and Germany. The crew included a three-person medical team — Uzell, plus two technicians — who completed missions to evacuate about 100 injured or sick military, dependents and civilian personnel, contract workers and a baby. Missions averaged about 15 patients.

"Many were army guys injured by rocket propelled grenades or remotely detonated weapons," says Uzell. "Summer temperatures reach 130 degrees, 150 degrees on the flightliner, so we had patients with dehydration and heat stroke, also pneumonia and psychological problems.

Judy Uzell, RN, spends most of her professional life as assistant nurse manager in the controlled and contained environment of G20, the Cleveland Clinic's Cardiac ICU. That is, until a phone call thrusts Uzell into her other life with dramatically different surroundings. Major Judy Uzell, RN, is a flight nurse for the 445th Aeromedical Evacuation Squadron, United States Air Force Reserve. She can be deployed anywhere, at any time.

"We carried weapons and wore body armor," says Uzell. "If the mission is in a combat area (called "the box"), we have to get in quickly ("dive bomb"), keep a low profile, load the patients from an ambus and ambulances, and get out as soon as we can," she relates. This is no easy feat for huge transport planes, some which can carry 103 patients on litters to a hospital, usually Landstuhl Military Hospital in Germany.

Delays, destination changes, additional stops, and coincidence make every mission unpredictable. "Once, when we had just landed in Baghdad, a Black Hawk helicopter came in unexpectedly, carrying wounded patients from a Hum-Vee landmine accident. We opened our cargo hatch and loaded them on."

Just after the two-month assignment, Uzell went to Baghdad to evacuate critically injured soldiers from a Chinook helicopter attack. "We transport heroes, and we tell them what heroes they are. They often say that it's the first time they feel like heroes. Their faces light up."

Uzell says her experience in the Clinic's Cardiac ICU overlaps significantly with her military work. "The pace, the decision making, and the acuity of patients we care for on the unit has served me well."

Judy Uzell began her nursing career in 1984 after receiving an associate degree in nursing from Lakeland Community College. She completed her BSN at Bowling Green State University. In her "spare moments," when Judy is not working at the Clinic or on assignment with the Air Force Reserve, she enjoys golfing, traveling and reading. E-mail comments to **uzellj@ccf.org**.

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