The Nurse Shortage and My Guardian Angel

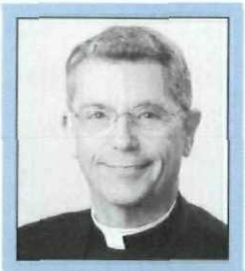
BY FR. MICHAEL D. PLACE, STD

In the two years before I joined CHA, I had several surgeries because of problems with disks. (They seem to have been "made for walking.") While the lower back surgery was not complicated, it did involve a period of convalescence and rehabilitation. The cervical fusion, which obviously was more complicated, involved an extended hospitalization, longer convalescence, and more extensive rehabilitation. Unfortunately, the first fusion did not work and the entire process had to be repeated, with all its components being even more complex than the first time.

Though I had no idea at that time that I would be joining CHA, I was very involved in health care issues and in the health care ministry. As a result, I was probably more knowledgeable than most patients about delivery issues. (This was the era of strong HMOs and the rapid expansion of investor-owned hospitals.) Consequently, I went through the surgeries as an observer as well as a patient.

One of my most vivid memories of that time is awakening from the second cervical surgery on a ventilator with my hands and arms restrained. (I knew that I was to be on it during surgery, but had been assured I would be off it long before I awoke.) It is hard to describe the panic and fear that ran through me as I struggled to emerge from the haze of the anesthesia. My first thought was that I must have had a cardiac event or a stroke during the surgery.

After finding that I could move my hands and feet and doing an "internal scan" that detected no gross deficits, I relaxed a bit—but returned to full panic when my best friend suddenly entered the room. My friend, who had accompanied me to the hospital for the surgery, had planned to return to his parish after it. The fact that he was there in my room frightened me. Even worse was the look on his face when he saw me on the ventilator. It was then that I learned how hard it is to cry when you are on a ventilator.



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"Enter Heroine from Stage Right"

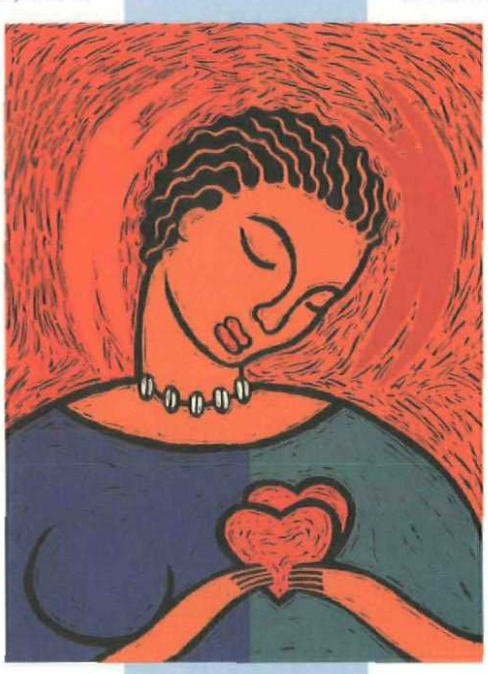
It was at this moment that the ICU nursing director entered the room. She explained that the anesthesiologist, over the objection of the surgeon, had left me on the ventilator because my heartbeat was too slow. All other vital signs were normal, however, and she assured me I would be extubated shortly.

Unfortunately, that did not happen. Instead, a drama began to unfold. The details would fill pages, but the story line was simple: The ICU nursing director started battling with an arrogant physician. This meant that, at one and the same time, she and her nurse colleagues provided me with needed postoperative nursing care; tended to my fragile psyche; related well with my worried and increasingly frustrated friend; consulted with the surgeon; and, in the end, became my advocate within a web of bureaucracy that seemed determined to leave me on the ventilator for what appeared to be no good medical reason.

Later in the morning, after another of what seemed endless blood oxygen level checks proved normal, the nurse's professional patience began to wane. She returned to the room and said, "I am not going off shift until we get you off the ventilator and out of ICU. Let's start from the top." She then worked her way through my medical history, trying to explain conflicting evidence. She needed "proof" to verify her clinical intuition. After what seemed like endless questions, she set down her chart and said to my friend, "What haven't I asked?" Perplexed, he said, "What do you mean?" She glanced out the window and then said, "Does Father exercise regularly?" The reply was: "Until these surgeries, he swam a half to three-quarters of a mile four to five days a week."

While her next words cannot be repeated in polite company, she had found the "smoking gun." Though it took another two hours and the serious botching by an anesthesiologist of the extubation (which added another complication to recovery), long after her shift was over, the ICU

nursing director walked along beside me as I was moved, bed and all, to the orthopedic floor. As she said goodbye, my "guardian angel" bent over my bed, squeezed my now-liberated hand, and in a confessional-like voice said, "Forgive us, Father. I am sorry we could not have done better for you. This is not what health care is supposed to be all about." With tears in her eyes, she squeezed my hand again and walked away.



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The Way It's Supposed to Be

I have not forgotten those words. "This is not what health care is supposed to be all about." While she was correct in part, she also was quite wrong because, during this process, she had incarnated what a critical component of health care, the profession of nursing, *is* all about. She had provided human touch, medical treatment, delivery coordination, and patient advocacy with a determined, albeit strained, professionalism. Though the drama inherent in the situation brought these elements into bold relief, they really were not that extraordinary. Rather, they were the ordinary "stuff" of her calling, as they were for the other women and men nurses who cared for me during a hospital stay that seemed determined to be a showcase of "worst-case practices in a world-class hospital."

In time, I was liberated (otherwise known as discharged) to a home setting, where another remarkable cadre—this time of home health nurses and nursing aides—continued to provide care. (At another time, I may reflect on home health and rehabilitative services from the patient's perspective.) It was in that more relaxed setting that I asked one of the home care RNs what had drawn her to home health. (It certainly was not the money.)

Her reply was instant and almost guttural. "So I could be a nurse again," she said. She was a former nurse supervisor who had left a secure hospital position because the environment was, as she put it, "toxic." No need here to chronicle the dimensions of the "toxicity." We are all too aware of them. Though paid less, this nurse described herself as quite content in the home health setting.

The Nurse Shortage Crisis

Why do I share all of this? Obviously one reason is the fact that this issue of *Health Progress* is about nursing. The issue topic and the column, however, have not happened accidentally. Both reflect a growing concern within health care, within the ministry and within CHA's board of trustees about nursing.

Several years ago, I was privileged to serve on the University of Illinois' Nursing Institute Commission on the Future of the Health Care Labor Force in a Graying Society. The commission, which was chaired by former Secretary of Labor Lynn Martin, issued a study that was one of the first to highlight the crisis now facing U.S. health care delivery: the shortage of nurses. That study (and others like it) prompted CHA, the American Hospital Association, and other organizations to support passage of last summer's Nurse Reinvestment Act and to work for its full funding.

As important as this and other efforts will be in increasing the size of the pool of nurses, everyone involved knows that, in the end, the nursing environment must be transformed if we are to recruit and retain nurses in the acute care and long-term care settings. In fact, our board at its November 2002 meeting explicitly engaged the topic of nurse retention/recruitment as part of a larger discussion of workforce issues. That discussion was greatly assisted by the observations of board member Sr. Rosemary Donley, SC, PhD (a professor in and former dean of the School of Nursing at The Catholic University of America, Washington, DC), and Julie Trocchio, RN (CHA's senior director of continuum of care services), both of whom served on our association's Catholic Health Ministry Workforce Initiative.

Sr. Rosemary reported that in order to determine a role for the ministry in attracting a more stable nursing workforce, the CHA Health Ministry Workforce Initiative Committee asked nurses for ideas. "We issued a 'Call for Innovative Ideas,'" she said, "and offered $10,000 for the winning idea." That idea, Sr. Rosemary continued, would:

- Involve collaboration among Catholic health and other ministries

• Draw on the strengths of the ministry's tradition and experience

• Have a potential for improving the quality of nursing care

Nearly 350 entries were received from nurses throughout the country: from acute care long-term care, parishes, and schools of nursing; from staff nurses, supervisors, directors of nursing, student nurses, and faculty. Some of the ideas were exciting but not practical (tax breaks for nurses and their families); others broke my heart ("Know my children's names"); one made me laugh (more pizza at staff meetings). Although only 50 words were requested, some entrants gave multiple pages. One nurse sent her resume. A great many thanked us for asking their opinions.

The winning entry came from Elaine Hlopick, RN, MSN, emergency department case manager at Saint Vincent Health Center in Erie, PA. (The hospital is not part of a large health care system.) She is from St. Philip parish in the rural town of Crossingsville, PA. She earned her nursing and graduate degrees in Catholic colleges. (See p. 43 for an interview with Ms. Hlopick.)

Ms. Hlopick suggested that CHA establish an office of nursing advocacy to promote the image of nursing as compassionate and essential to the outcome of patient care. Catholic health care facilities would also be encouraged to have a nurse advocacy program to promote nurses' accomplishments and identify and deal with problems.

Sr. Rosemary noted that, in following up on the award-winning proposal, the Award Committee discussed establishing a distinct nursing presence within CHA, although not necessarily a separately staffed function. CHA could make an effort to consider the viewpoints and interests of nurses in our strategic directions in our focus areas. We could seek opportunities to include nurses from the ministry on committees and in other member engagement activities. In the spirit of New Covenant, we could build relationships with Catholic-sponsored schools of nursing nationally and locally.

Two Themes

Sr. Rosemary and Julie also shared two themes the committee had learned from the process: First, there is a strong feeling that nursing is tied to spirituality and the mission of the church. Second, there is profound unhappiness among many nurses in our facilities.

Many nurses thanked us for asking their opinions.

We found an untapped element of spirituality in nursing. One nurse wrote that nursing is a "calling that embodies compassion, spirituality, and human touch." Another suggested that we tell students about the "pastoral joy" that being a nurse can provide. To many, nursing is a vocation and patient care is sacred work.

On the other hand, we heard loud and clear that nursing is hard, frustrating, and often unpleasant. There is a high level of disillusionment and disappointment. Being underappreciated and insufficiently respected were recurring themes. A nurse from acute care wrote: "A naturally hard and strenuous job is made more difficult by the lack of respect nurses receive from doctors, patients, and the institutions we work for. The only way to attract people into the profession is to prove to them that nurses are respected and valued."

It is disturbing that between our first and second meetings, the two nurses from our committee who work in clinical areas of hospitals resigned their positions to assume what they hope will be less demanding jobs. One was a young assistant head nurse who said that whenever she wasn't working, she was on call. The other had been director of a coronary care program for over 20 years. She said that to take care of her patients and supervise her staff properly she had to work more than 55 hours every week. Both nurses said the long hours were no longer tolerable and they needed time with their families and for themselves.

The committee discussed problems in our institutions that they fear are approaching dangerous levels. Staffing shortages are leading to new graduates being given responsibilities they are not prepared to take and to nurses being made supervisors without getting needed supervisory skill training.

In light of these reflections, CHA's staff and board will work in the near term to respond to what we have learned. Certainly, the area of the spirituality of nursing is a "natural" for CHA to address. The soul, however, is united to a body, and we also must attend to the body of health care delivery if we are to effectively address nursing and other staffing issues. These other issues

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COMMUNICATION STRATEGIES

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The hospital website should have a media center.

Organizations should ensure that once a crisis occurs, their command centers are equipped with the necessary technology and their media centers are set up to respond to the crisis, Bagg says. This preparation should include room or location assignments where T1 lines for Internet use may be accessed and where copiers, fax machines, laptop computers, PDAs, or walkie-talkies are readily available. The media center should be equipped with a radio, TV/VCR, a computer with a projector, a lectern, and other equipment that might be needed by broadcast or print reporters as the crisis wears on. The command center of a multihospital system should also be equipped with teleconferencing or videoconferencing equipment.

"In these tough times, it is often difficult to fund all the equipment that might be needed in a crisis, but having good relationships with vendors and arranging pre-set lease or rental agreements with them can solve that problem at a low cost," says Bagg. Agreements can also be set up for delivery of cell phones or walkie-talkies or the activation of 1-800 or 1-888 "hotline" numbers.

A Word about Media Relations

Now a word about media relations: The hospital's website should have a media center with a crisis or disaster section (hidden or open) that can be accessed through the Internet with a password so that information can quickly be posted, photographs uploaded, and background information made available to the media. This reduces the amount of time public relations professionals will have to spend on the phone with media representatives, thereby giving them more time to gather information, develop appropriate statements, and help make strategy decisions as the crisis evolves.

"Effective use of the media center on your website can help you reduce confusion, respond to rumors, and assist in facilitating work with the media," Bagg says.

St. Francis Hospital & Health Centers' media center is a good example. The site (www.media.stfrancishospitals.org) is set up with a "third-level domain" so that media representatives can bypass St. Francis's home page and go directly to the media center. The center contains background information, facility data, and biographical material about its leadership and a dedicated disaster/crisis section. On this section of the site, media representatives can learn of the hospital's policy and procedures in a crisis, access guidelines for the media, contact members of the hospital's community relations department, and access a log of events related to the particular crisis.

"Hospitals across the country have been upgrading their crisis planning since September 11, 2001, but few have thought about the role technology can play in that planning and response process," Bagg says. □

REFLECTIONS

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were cogently summarized in an oped column that appeared in the *Boston Globe* of December 15, 2002. The piece was coauthored by Michael Collins, MD, a former chair and current board member of CHA, and Richard M. Freeland, president of Northeastern University. They wrote:

> But much more needs to be done. We need to finance health care at a level that enables hospitals to increase caregiver time and lower patient-to-staff ratios, thus reducing burnout among workers. That means changes in Medicaid, Medicare, and the private payer system so reimbursements come closer to covering the actual costs of providing care. We also need to expand retraining for existing staff and provide opportunities for career advancement tied to skill enhancement, through both formal classroom instruction and clinical learning—especially critical given rapid technological changes.
>
> Reasonable workloads, employment stability, decent pay and benefits, and a chance for upward mobility are important, but attracting and retaining more health care professionals requires something more. We must organize the delivery of patient services in a way that honors the values that have motivated so many dedicated staff to the service of those in need of care. For it is that motivation and dedication upon which the future health of our Commonwealth depends.

The test of whether we are successful will be quite simple: Will my "guardian angel" nurse feel at home in Catholic health care? □

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