Introduction

As the largest group of healthcare professionals, we nurses are a diverse lot. Whether it’s the inner city or the Outer Banks, we are there caring for patients who have just entered the world, those who are preparing to leave this world and everyone in between. We work in hospitals and homes and care for patients of all ethnicities and income levels.

Though we work in different settings and with different clientele, we still connect with each other over universal truths that are present when caring for patients. There are times when the emotions, insights and revelations you have seem almost indescribable, and your friends and family just don’t seem to “get” what you are saying. But then you talk to a fellow nurse, and the two of you develop an instant bond over a similar experience.

I believe it’s these types of connections that make Nurse.com’s End of Shift articles so popular with our readers. These stories celebrate the joy, fear, frustration and triumph unique to nursing and allow nurses to develop a kinship that can change the dynamic of the profession. When you share an experience with someone, he or she stops being just a colleague or co-worker and becomes a brother or sister in nursing.

To help foster these connections, Nurse.com has gathered 30 End of Shift stories in one e-book. We hope this treasury of touching first-person accounts inspires you in the work you do each day and fuels your passion for nursing. These stories illustrate just how important nurses are and how great of an impact they can have on patients, families and each other.

I hope you see your experiences reflected in these stories, and that after reading them, you realize how valuable you are to patients and their families. It’s not said enough, but nurses make a world of difference. Thank you for all you do each and every day.

Jennifer Thew, RN, BSN, MSJ
National nurse editor
Nurse.com
# Table of Contents

- Sleep with the Angels ........................................... 1
- Patience with Patients ........................................ 3
- A Special Moment ............................................. 5
- The Virtual Classroom ......................................... 7
- Miracle Man ..................................................... 9
- In It Together ................................................. 11
- Passionate Pursuits ........................................... 13
- Four Words: One Year. Deployment. Afganistan. ...... 15
- Coping with Unexpected Events ............................. 17
- A Special Place ................................................ 19
- Looking Beyond the Obvious ................................. 22
- A Mother’s Story ............................................. 24
- A Job Well Done ............................................... 26
- Death: An Awakening ......................................... 28
- Tying Up Loose Ends ......................................... 30
- Leading the Way .............................................. 32
- Freedom Needs a Little Nursing ............................ 35
- Glass Half Full ................................................. 37
- Diary of a Nurse-to-Be ................................. 39
- This is Why I am a Nurse ............................. 41
- The Last Dance ........................................... 43
- Care Until the End ...................................... 45
- Plant Healthy Habits ................................. 47
- Making Grandpa Proud ............................... 49
- The Power of Love ................................. 51
- Sharing is Caring ........................................ 53
- Goodbye to Baby ....................................... 55
- Seeing Him Through ................................. 57
- The Deciding Factor ................................. 60
- A Chronic Life ........................................... 62
- All That Matters ................................. 64
I walked into work one evening expecting a typically uneventful night. I looked at my assignment, saw only one patient assigned to me and wondered what that meant. Little did I know that this one assignment would change me in many ways.

A fellow nurse came to give me report. She seemed unusually serious, and I wondered what I was walking into. She told me I would be taking care of a co-worker’s sister, who had just had a cesarean section to deliver a full-term, stillborn baby boy. I never had taken care of a woman who had suffered such a loss. I was shocked, saddened and frightened, and wondered, “How am I going to do this?” I sat there for a few minutes, gathering the strength and courage to go down to the patient’s room. I was nervous, afraid and so worried I would not be able to give this woman the care she needed and deserved.

I walked down the hall slowly. I could feel my heart pounding. I stopped outside the door, knocked and walked in. The room was full of family members, and I could see the sadness in their faces. I introduced myself and walked to the patient’s bedside. There in her arms was a beautiful, lifeless baby boy. I told her I was sorry for her loss. She thanked me and introduced me to her baby son, Christopher. Her sister, my co-worker, came over and hugged me and started to cry. My eyes filled with tears as she held me and sobbed. I remember thinking this must be the saddest day of my nursing career.

I spent the rest of the evening taking care of the patient’s physical and psychological needs and supporting the family. The patient and her family were incred-
ible, and through their grief I gained the strength to get through the evening. They spent many hours holding, talking to and trying to let go of Christopher. I gave them time alone when they needed it and supported them when they needed me. I took many pictures for them and tried to help them create memories of their precious baby.

As the evening went on I could see that they were having trouble letting go. I knew I needed to take the baby at some point, but they just were not ready. Finally, my co-worker came to me and said they were done saying goodbye, and I could come get Christopher. I went to the room and the parents were sitting on the bed, holding Christopher and sobbing. They kissed their son goodbye and handed him to my co-worker, and she walked with me to the door. She handed me the baby, kissed him and said, “sleep with the angels.”

I will never forget those words or that night. As a result of that night, I knew I wanted to become involved in the bereavement program. I asked to go to Resolve Through Sharing Bereavement Training, and hospital management agreed. It was a life-changing experience.

Since then I have made it my passion to try to do everything possible to improve the care we give women who have experienced such a loss. I have participated in seminars, collaborated with other nurses, read books and studied all about grief, but I have learned the most from these patients and their precious little babies. I have tried to allow them to grieve with dignity, to help them create memories and, most of all, to give them the care and support they deserve.

We have come a long way in recognizing the needs of these patients, but we have a long way to go. I recently had a father tell me he will never forget me and that I was the only other person who knew their son and got to hold him. This made me realize how important our roles as nurses can be and how we affect our patients’ lives in so many different ways. I have held, footprinted, dressed and taken pictures of many of these precious babies, and each time I do, I repeat those words: “Sleep with the angels.”

Written by Susan Straszynski, RNC-OB.

Her passion is providing maternal-child health bereavement care.
I
could share numerous stories about the people I cared for during my many years working as a nurse in correctional facilities. Sometimes I almost lost my cool because of their behavior, and other times I went home and cried. I know I should not take my job home, but it happens.

I am going to share two stories. The first is about a man named “Joe,” who was a very challenging individual. Joe did not like where he was and kept making demands of the nursing and security staff. First he did not want his vital signs taken or finger stick performed, nor any medication or nursing care, then he demanded that same care two hours later. At times he would not eat for days, which dramatically affected his glucose levels.

One day I went to his room and found he had fallen and cut his arm. Because it was time for his finger stick, I told him I would take the sample from his arm. He said, “You cannot do that. You can only do it from my finger.” I replied, “Blood is blood, isn’t it?” He started to laugh. “No matter how hard I try, I cannot get mad at you Ms. Mary,” he said.

That was the start of a working professional relationship between us. Because he was so dangerous to himself and the staff, he needed four security officers with him at all times, especially during nursing care time. He refused all care from everyone except me. He told me he adopted me as his mother, and depending on his behavior, I would call him my son, stepson or distant cousin. I always made sure he was aware it was a professional relationship.

In this setting, the patients are supposed to have no choices. I always would give patients choices, especially Joe. I asked permission to come into his room. I asked him which finger I should prick for his glucometer reading, if I could take his vital signs. He liked having choices, and I respected his choices, even when the answer was no.
It is important to give patients choices and information that allows them to make informed decisions about their healthcare. In this institution, the nurse was responsible for doing the teaching. Joe eventually moved to another institution. The first night he was gone, everyone admitted they missed him and wondered how he was.

The second person who tugs at my heart was a difficult, demanding elderly lady. Nothing we did satisfied her. The food was too hot or too cold. She said we had not given her pain medicine, when in reality she had received it 15 minutes earlier.

It got to the point that I was losing my cool with her. I prayed to God for an answer about dealing with this difficult individual. Then a light bulb turned on: Why not treat her with kindness? I asked if she would like to take a shower in the morning. She said she could not stand up. I told her I could help give her a bed bath. She agreed.

The security staff sergeant and I gathered all the items we’d need for personal care. I filled a basin of nice, warm water. I asked her if she wanted soap to wash her face, and she said no, she never washed her face with soap. I told her how good her skin looked. She told me the answer is not to use soap, ever.

She did all the washing herself. She also brushed her teeth and brushed her hair. Her hair was down to her waist and full of knots. She worked and worked, and next thing we knew, she had beautiful, free-flowing hair.

The next day the daytime charge nurse told the patient something looked different with her. The patient said Ms. Mary had helped her have a bed bath. The daytime charge nurse complimented her on her appearance, and the patient became much more cooperative and pleasant.

When she was discharged, she left a message for me: “Tell Ms. Mary I love her.”

Written by Mary Clare McNamee, RN, has worked as a correctional nurse for 20 years and strives to respect her patients by giving them choices.
In all my years in oncology, I never had seen anything like this. Meredith was a 44-year-old mother of two young boys. Her health had been deteriorating since she was readmitted to our stem cell transplant unit.

She’d had an allogeneic transplant after suffering from non-Hodgkins lymphoma and was experiencing complications. Meredith often would tell me how frustrated she was about how weak she was feeling. She would tell me about how she needed to constantly be on the move. I’d had Meredith as my patient when she was still able to get up, walk, feed, clean and dress herself. Weeks later, she was unable to do any of those things.

She was getting dialysis for her kidneys, which were failing, and photopheresis for her liver daily. She could not get out of bed, and sadly she also was having a severe change in mental status. She could do nothing more than mumble incoherently. She often would begin screaming for no reason and had to be calmed with medication.

I vividly remember helping a co-worker try to give Meredith her medication. Meredith wasn’t one of my assigned patients that day, but I had missed her and wanted to spend some time with her. She simply could not swallow her pills. We placed each of them in a spoonful of applesauce, and she would somehow manage to get the applesauce down yet the pill still would be sitting on her tongue. We couldn’t make out a word she was trying to say because she was disoriented and her speech was garbled. Her eyes were practically swollen shut from scleral edema. The rest of her limbs were filled with fluid, making any kind of movement difficult.
As we continued to try to give Meredith her medications, I heard two little boys’ voices getting louder and louder as they ran down the hall toward her room. I knew at once these were Meredith’s sons, about whom she had talked so often. Meredith had told me how hard it was to conceive both of them, how she needed a donor’s eggs because of all the chemotherapy she had received. She also said what a miracle they were, adding, “When you want something bad enough, you don’t stop trying until you get it.”

I recalled the very first day she was readmitted, being in the room when the doctor told her we weren’t able to discharge her yet. Her big blue eyes filled with tears as she stared down at a picture of her boys on her laptop and said, “I just want to get home to them.”

On this day they came bounding into the room and ran to the bed, shouting “Mommy, Mommy, Mommy,” jumping up and down because it probably had been about three weeks since they had seen her, trying to climb onto the bed to be close to her. That sight alone made my eyes immediately well up with tears. As I was about to excuse myself from the room the most incredible thing I have ever seen happened. It was as if another person had temporarily invaded Meredith’s body. She reached her arms out to her boys, opened those poor swollen eyes and began speaking to them. The voices of her boys evoked something within this terribly sick woman that made her rally like I have never seen another patient rally before.

After that my floodgates opened, and I had to leave. The feelings were so intense, I went into the utility room and just allowed the tears to flow. Could it have been because I am a mother to a baby girl and I was thinking of her? Was it because I knew Meredith might never be home again with her boys to hug or kiss them? Or was it from witnessing a simple miracle of the human body, a mother who heard the voices of her children and gained a strength that allowed her briefly to be their mother again? Meredith died not long after that day, but in this moment her words made sense, she was speaking clearly and she was able to interact with her boys. I could see it was exhausting her, but she was not going to have it any other way.

While I cried, I thanked God to have the job I have. Although terribly sad at times, my job makes me grateful for my life and health every single moment of the day because you never know when it all may be taken away. I am so privileged that I am able to do what I do and witness such beauty and love and, yes, miracles. That day will be embedded in my memory forever.

Maria Tessinari, RN, OCN, appreciates the miracles her oncology patients share with her every day.
I decided to return to school for my master’s in nursing education after opportunities to precept and mentor new employees began to come my way, and I realized I enjoyed teaching new graduates the role of an ICU nurse and working with colleagues on the unit education council. I had achieved my goals of specialty certifications and leadership roles in the clinical setting. When the opportunity to have my tuition partially covered presented itself, I set forth in pursuit of my dream.

I settled on a school that had a brick-and-mortar campus, but its nursing education master’s degree program was completely online. I wasn’t sure how it would work, but I was willing to give it a try. I completed the application and was accepted into the program.

When the course opened and I had access to the virtual classroom, I felt lonely and isolated. There was no one to greet me at the front of the class and read the syllabus page by page and explain each detail. I was on my own. I timidly clicked through each section in the classroom, including assignments, announcements, discussion boards and much more.

The biggest surprise was the expectations for participation on the discussion board: when the boards opened, when they closed, how many times I needed to post and to how many of my classmates I needed to respond. I couldn’t just agree with a classmate’s post, but had to respond with a critical analysis and a reference for just about every word typed. I found myself referencing my own thoughts.
If I skipped logging into the course for a few days, I would miss segments of lively online discussion that would go silent quickly. I recognized discipline was going to play a large role in my success in the program.

My classmates and I started to become a little more familiar with each other a few weeks into the course. We started to recognize that we were on the same journey, with the same questions and fears. We began connecting in the student chat rooms and collaborating on group projects. We became like a little online nursing community, supporting one another every step of the way, even though we knew each other only by the pictures we were required to post with our introductions.

The only regret I have is that I did not attend the graduation ceremony. I didn’t think it was worth it to travel to a large campus with which I had no affiliation, where I could not recognize any favorite locations. Looking back, I wish I had gone. I’d been a student at the school, even if on a virtual basis. I enjoyed my experience and should have concluded it in my cap, gown and hood.

I went on to accept a faculty position at a local community college, teaching pediatrics and growing in the areas of theory and clinical practice. My assigned courses were taught in hybrid format with an online component. My online education had prepared me well to be in the driver’s seat of the virtual classroom. I was able to use my experience as a student to enhance how I interacted with my class. The students appreciated the timely responses to posted questions and my involvement on the discussion boards.

After much contemplation and guidance I decided to return to school for my PhD in nursing education, and again chose to attend online. I no longer feel isolated when I enter the virtual classroom. I understand it is an ideal way to learn that allows for flexibility and creativity.

To those thinking about pursuing an online nursing education, I would say to give it a try but don’t take it for granted. I would recommend getting engaged in the virtual classroom early and following the syllabus carefully. Don’t be afraid to ask questions to your professor or your classmates. Use the email system within the classroom and the student chat rooms. Post meaningful responses to the discussion questions and engage with your classmates daily. Online learning definitely is what you make it.

Sonique Sailsman, RN, MSNEd, CPN, CCRN,

enjoys mentoring online students.
Every once in a while you meet a patient who changes your practice. If you are lucky, you meet a patient who changes your life. Ben was that patient for our unit. Caring for him renewed our commitment to our patients and each other.

Coworkers found Ben in cardiac arrest in late November 2010. He was airlifted to St. Elizabeth’s Medical Center just outside Boston, where a Code STEMI was called. After being stabilized, he was transferred to Seton 6 West.

When we first met Ben, who then was 49, he was in a near-vegetative state. He occasionally seemed to respond to his name, but was unable to interact with us in a meaningful way. He required complete nursing care for all ADLs. He had a moderate degree of agitation and was difficult to comfort.

With all of the challenges he faced at this time, one thing was clear: Ben was making eye contact with his wife, Mary. It wasn’t consistent, but it was meaningful. Mary drove two hours a day to visit. She was able to take time off from her job and was the key to Ben’s recovery.

From Christmas through the beginning of February, Ben made steady progress. It was an emotional and triumphant moment when he first started walking again. Soon he was able to eat by mouth, and his diet advanced from pureed foods to solids. His interactions with his family and us were significant. It was an amazing time, seeing this man make such strides. We began to know Ben as the man he was before his MI.

Then, in February, his progress inexplicably screeched to a halt. Ben never
developed any medical complications, but something happened emotionally. He became increasingly agitated, angry and afraid. We thought it was a type of post-traumatic stress disorder. Ben fought us when we tried to help him wash, eat and ambulate. Mary was discouraged and we were frustrated, and trying to figure it out was our main topic of conversation.

The medical staff did not share our concerns. Our request for a psychiatry consult was denied. Finally, on a particularly rough Sunday with Ben, we adamantly insisted on a psych consult. Ben started Seroquel, and within a few weeks there was a significant change in his behavior.

By the middle of March, Ben was participating in his care again. He was walking, feeding himself and becoming more independent with ADLs. Ben liked to sit in a chair in front of the nurses station and “supervise” the unit. One day I was dragging linen bags to the laundry chute. Standing behind me with a wheelchair, Ben called my name. He put the laundry bags on the chair and brought them to the chute with me.

After Mary returned to work, part of our care included taking pictures of Ben and texting them to her so she could keep up with his day. Ben became a part of our 6 West family and was a presence throughout the hospital. He visited the gift shop and cafeteria. When the weather improved, we accompanied him on walks outside.

On May 6, 2011, Ben was able to go home. His wife, daughter, granddaughter and brother joined us for a celebration in our break room (where Ben frequently had taken “breaks” with us). We said goodbye to a patient and family we never will forget.

The following August, Ben and Mary returned for a visit. Mary thanked us for not giving up on Ben, because they were not ready to let him go. We thank them, because they taught us about advocacy, inspiration, love and hope in a new and dynamic way.

Lisa Mancuso, RN, BSN, PCCN, CCRN, LNC, advocates for her patients in the progressive care unit.
As I gather the mail from the mailbox, I can’t help but smile as I thumb through and see the nursing journals, this time addressed to me. My husband has been a nurse for more than 20 years, and I’ve always loved reading the journals. Now that it’s my name on the label, it’s even more special.

I had four children — and worked as a lunch room supervisor, in medical billing and as an office manager — before I finally made it down this road. Through it all, my husband was encouraging me toward the path that brought him the most happiness: nursing.

His passion for caring for patients has always been apparent, and now I can truly share in it. He became a nurse out of his love for the job and his desire to provide for our planned family. We always knew one day I would go back to school, and through his nursing career experience, I learned that was the field I wanted to pursue.

The road hasn’t always been smooth. If I close my eyes I can still picture myself sitting at the computer in our one-bedroom apartment with our first son, just a month old, in the bassinet at my side. I’m typing as my husband dictates his care plan for his nursing school assignment. We would take his nursing books with us to the laundromat. On long car rides I would quiz him while we tried to get the baby to sleep. We had three more children and moved twice; lost all four of our parents in a span of four years; and generally lived our busy life. Through it all, becoming nurses was our shared mission.

When I started nursing school, I had him cheering me and supporting me all
the way. Our children were even old enough to help tutor their mom with some of the algebra and chemistry equations.

Married for 25 years, we shared so many life experiences, and now we add a new dimension to our relationship. You know how sometimes at the end of a challenging shift, only another nurse could truly understand and relate to you? Or know where your mind may be without saying a word? We have that in each other. We have learned when we need to just listen or when we need to offer ideas and perspectives to help ease the other’s mind.

One time our connection even proved beneficial to direct patient care. It was in my last semester of nursing school, and I was doing my clinical management rotation. I was at the same facility where my husband worked. I was in acute care and he was in the extended care and rehab area.

One of his patients ended up being transferred back to our unit for various complications. We were having trouble getting her to take her medications; she had dementia and didn’t trust any of the new faces caring for her. The manager on my unit suggested I contact the other unit for insight on getting her to take the medication.

Who was one of the nurses who cared for her? My husband! He told me: “Tell her Fred said to take the meds.” I went back into the room and said exactly that. Her face lit up like I could never have imagined. “You know Fred?!” She could remember him and trusted him, and once she knew that I knew him, things took a turn for the better. She started taking all her medications without a fuss. If she faltered, I would gently remind her that I knew Fred.

Of course, it’s not always picture perfect. At times our nursing obligations stretch us to the limits, and we have to remind ourselves that our relationship comes first as a married couple. On the flip side, I believe the characteristics that bring all nurses to the profession (strength, caring, nurturing, giving, patience and selflessness) help us be better partners to each other. We have a new source of conversation to be explored as well.

We can do continuing education hours together, too. In fact, finding day seminars to attend is one of our new “date” ideas.

Rosanne Bacaling, RN, is a wellness nurse and has joined her husband in the nursing profession.
Ballet and nursing are surprisingly similar — both grounded in art and science. I believe those who are successful at either are born with the ability to make a difference in all the lives they touch.

You can teach the legal and moral implications of a nurse’s actions and the various positions of a ballet dancer. You cannot teach someone to genuinely care or to have effortless grace because those emotions come from within your soul. Those familiar with the physicality of both ballet and nursing can grasp the underlying, relentless passion in both endeavors. It is the X-factor that distinguishes someone as extraordinary.

Ballet is my escapism. Nursing feeds my mind, while ballet fuels my soul. The confident, poised, gentle-hearted person I am today is a result of the intense ballet training I received during my childhood.

Growing up, I had an obvious talent for dance. I was naturally thin, with long arms and legs, eccentric spinal flexibility and graceful hands. When I was 12, after I had outgrown my local dance studio, my parents took me to an open audition at a Russian ballet school in New Hyde Park, N.Y.

I was nervous as I settled in at the barre, engulfed in a sea of black leotards and pink tights. The instructor, Fleur, was an older French woman with prominent wrinkles and a gray bun. She did not move to show the combination but stood tall, holding her walking stick and reciting words I had never heard before. I tried to keep up as my leather ballet slippers kept squeaking against the floor. Fleur banged the walking stick constantly, commanding: “Stand straight, tuck under, turn out, no sickling ....”
Being humbled is an odd thing. It is scary and frustrating. I blamed my previous dance teachers after that session. I blamed my ballet slippers. I blamed Fleur for not seeing how good I was.

But I soon realized: What good is being the best of mediocre? I watched the advanced class spin and leap across the floor as the delicate sound of pointe shoes rumbled into an extravagant roar. It was beautiful and whimsical. This, I realized, was my dream.

It took a lot of hard work, dedication, talent, blood, blisters and tears, but I did get to the advanced class. The Russian ballet instructors saw my potential and drew it out of me with tough love and honesty. “An elephant can stand on one foot,” they would say. “Why can’t a beautiful girl?”

As an adult, I can reflect on this amazing experience with an educated and insightful eye. In being accurately assessed for skill and then challenged, I was given an important foundation on which to grow. My success was completely in my hands, and the instructors were there to guide me with their knowledge and experience. They never held my hand or sugarcoated anything; they allowed me to fall in the most literal sense.

From my experience, learning comes from being appropriately challenged. I feel stagnation reverses the learning process because when one is comfortable, he or she becomes sloppy and unfocused, and makes mistakes.

I recently obtained my master’s in nursing education. I want to watch the metamorphosis that occurs over the course of an undergraduate’s BSN program. Freshman students will feel as I did standing at that barre, lost in a sea of hopefuls and overwhelmed with a new vocabulary. They will get frustrated and blame their high school teachers, noisy roommates and me for not seeing how smart they are.

However, I will not be Fleur, standing there with a walking stick. I will stand there with a warm smile and a humbling memory of feeling the same way. I will be a support person who challenges and encourages those first leaps and turns when such progress may seem impossible to achieve.

I will bring my passion for nursing and share my own experiences because I am not perfect. My students will not succeed in everything the first time around. They will stub their toes and feel defeated at times. However, when it comes time for them to graduate, I will be off to the side watching the beautiful and whimsical reality of their hard work come to life.

Nicole Filippazzo, RN, MSN, is a nurse manager who warmly welcomes students into nursing.
t was a bleak, cold day in January 2011 when my husband broke the news. I tried to keep my composure as he spoke, but after hearing four words, the tears became uncontrollable. One year. Deployment. Afghanistan.

In addition to his civilian job caring for our state’s veterans, my husband also is a nurse in the Army National Guard. He was assigned to a medical company deploying to an Afghan military base in November 2011.

After that derailing January day, I found an unexpected source of resilience, one that has helped carry me through his yearlong absence.

This strength lies within me, for I too am a nurse.

Nursing is an extraordinary profession that prepares us for anything. Our work ingrains in us so many fundamental life lessons that we use whether or not we are wearing scrubs: about the value of flexibility, seeking knowledge, good communication and patience.

**Flexibility:** As nurses, we know better than to expect our shifts to be without surprises and unexpected twists. Despite our best intentions, life is no different.

My husband and I knew deployment was a possibility. After acclimating to the news, my nursing instincts kicked in. I realized the situation was out of my control, so the best thing I could do was roll with the punches and make the most of it. I jotted down a list of different activities, such as cross-country skiing, that I wanted to try during the year.

**Seeking knowledge:** Nurses are taught to research what we do not know. We
teach patients and families what to expect during an unfamiliar procedure. We mentor new staff members until they learn the ropes.

For me, adapting to my new reality meant that I went into preparation mode. I read books written by military wives about their husbands’ deployments. I attended the monthly meetings of the Family Readiness Group. Perhaps most importantly, my husband and I had numerous discussions on what to expect and what lay ahead.

**Good communication:** Our clinical experience teaches us how to streamline our report to the oncoming nurse, how to efficiently communicate with preoccupied physicians and how to broach difficult subjects with our weary patients.

These skills were put to good use during discussions with my husband about his impending deployment. I never thought that, at age 32, I would be discussing my husband’s funeral preferences, or broaching the topic of remarrying if I am widowed. Other conversations were simpler but still important, such as how to turn the water main off or remembering to add gas stabilizer to the lawn mower in the fall.

Communication also has been the cornerstone of our relationship during his absence, the glue that holds us together while we are geographically separated.

**Patience:** How many times have we walked into a patient’s room to quickly check on IV fluids, only to have this lonely patient begin a conversation with us, eager to share some life stories with someone who will listen? Nurses exude patience every day when interacting with patients, nursing students, new graduates, physicians and family members.

Patience has been vital during my husband’s deployment. Patience and understanding were necessary during the weeks leading up to his departure, as we both began to mentally disengage ourselves from each other. Patience has been essential during the time that passes between my husband’s calls. Patience has gotten me through being a “single mom” to our beloved dog. And patience will be vital during the reunion period, as we get to know each other again.

Clara Barton, the famed American Civil War nurse, said: “If I can’t be a soldier, I’ll help soldiers.” That has been my mantra during the deployment. By drawing from the skills acquired during my clinical nursing career, I have faced the challenges. I have been able to help my soldier, because I am a nurse.

*Julie Dickinson, RN, BSN, MBA, LNCC, used the skills she learned as a legal nurse consultant to get through her husband’s deployment.*
My student was typical: She was highly stressed and didn’t have much time to study, but was smart enough to anticipate what might happen with an unexpected patient assignment. Although I was impressed with her background as a practical nurse, I felt the usual nagging feeling of anxiety. I have been a nursing instructor for almost a decade and have learned anything can happen with nursing students in the clinical arena. This would prove to be a unique day.

After having spent hours filling out the multipage pre-assignment the day before, the student approached me in the morning with a look of disappointment.

“Professor, the patient I did my report on is gone. She was sent home late last night,” she said. Having listened to report on 34 patients, I figured there had to be an adequate substitute.

Suddenly, I remembered a new patient on the unit — just arrived a few hours ago — who was transferred from the trauma unit after having been airlifted from an island vacation spot where she’d been spending her honeymoon. As I continued to present the patient’s history, I could see the expression on my student’s face begin to change.

My duties as an instructor included supervising multiple students during medication administration, catheter insertions and anything else their patients needed, so it was about an hour before I saw the student again. I asked whether she had seen the patient yet and done her assessment. “No,” she replied in a very distressed tone. “I think you really do not like me,” she added.
I asked why she would make such a strange declaration, and she told me the worst story I probably have ever heard. “My patient was on her honeymoon at a resort in the Caribbean when she fell off a second-floor balcony. She fractured her cervical vertebrae and severed her spinal cord. She is a quadriplegic. She will never walk again, and she is only 27 years of age! And she was just married!”

Although I felt bad for the student’s plight, I felt worse for this young girl who’d had the most tragic thing happen during what was to be the happiest time of her life. Shaking my head in disbelief, I told the student to please visit her new patient. “Don’t jump to conclusions,” I said. “You never know what you will encounter.”

Although a part of me was thinking it would not be as bad as the student was making it sound, I knew in my heart this was not going to be a pleasant situation. I could imagine the mother of the patient at the bedside, crying occasionally, and the patient in a trance-like state.

So when I saw the student again with a big smile on her face, I was rather surprised. “Professor,” she said, almost singing every word that came out of her mouth, “You will not believe what just happened!” There was no holding the student still. She jumped, shook and trembled all at the same time. The behavior exuded happiness and enormous relief.

She could not wait to tell me how the experience was nothing like she thought it would be. “Come in and meet her, please; she is so cool,” she said with a gleeful expression. “Well, I don’t know … ” I said with real hesitation.

“No, really, I spoke to her for about an hour, and she is not depressed at all,” my student said. “She told me about how she believes in God and Jesus and how her fate is in their hands. She was so interesting too; she has been to so many places. Please come and meet her.”

When I remember this story, I think about how as clinicians, we have preconceived notions on which we base our opinions and actions, and about how deceiving those notions can be. As humans, we seem to lack the machinery to deal with events such as major illness and death. Our patient was content to fall back on her spirituality. It would bring her solace at a time when most of us would fall apart.

What if we clinicians all could be free from what binds us to programmed emotional responses that filter out other possibilities? We seem so suppressed because society teaches us to be afraid and disingenuous about our limited abilities to intervene. Imagine a world that was free from appropriateness and predictability. We all could live as this young woman, accepting challenges and ready to accept what we are given.

Andrew Frados, RN, BSN, DNP, ANP-BC, is a nursing professor and has learned much from his students.
The community known simply as Carville, a few miles from Baton Rouge, La., on the banks of the Mississippi River, was always going to be a special place to my friend Pat and me. We had dreamed about visiting this hospital for leprosy patients ever since our days working with the disease as nurses at the Jordan Hospital near London.

We had read Carville’s publication, The Star, and were full of admiration for its editor, Stanley Stein, who was blind as a result of the disease. “Radiating the light of truth on Hansen’s disease” was the motto of the newspaper (which consistently called leprosy by its more modern name), and it certainly fulfilled that mission with its erudite articles opposite details of bingo nights and concerts, while the personality of Mr. Stein shone out on every page.

Now Pat and I were traveling around America in our old Ford, affectionately known as Flatus (a name truly appreciated only by fellow nurses!), with three new friends — Molly, Maureen and Celia — whom we had met at Mount Sinai Hospital in Cleveland in 1957, two years earlier. We had just visited New Orleans for Mardi Gras and were driving back to Los Angeles, where we all had found temporary nursing jobs. We would never be this close to Carville again.

As we pulled up in front of the grand old plantation house that had been a hospital for 60 years, I thought about my patients at Jordan who had been as sad to see us go as we had been to leave them. I brightened up when Miss Nelson, the health education officer, appeared and welcomed us warmly. After a brief talk, she introduced us to Pete, a young patient who was to be our guide.
We all were struck by the happy atmosphere and the way Carville felt more like a small town than a hospital. With the exception of the very sick, most patients simply were going about their daily lives — studying, shopping, working. Some were employed as orderlies; others had their own private businesses. Most of them lived in two-story residences, each with a living room and porch, and married couples had their own cottages adjacent to the golf course. A golf course! We hardly could believe it. There also was a softball field, and Carville even had its own team — the Carville Indians.

Pete told us about their Mardi Gras celebrations the previous day, and added mischievously that sometimes he and some of the younger patients slipped out at night to go to dances in Baton Rouge.

“But we don’t tell folk where we come from,” he added in a more serious tone.

“Why does this disease have such a stigma?” Maureen asked, shaking her head sadly.

Pat sighed. “People talk more openly about cancer and syphilis,” she said. “Sometimes the label causes as much suffering as the illness. I suppose that’s why calling it Hansen’s disease rather than leprosy is so important to some.”

Pete told us he had come to the hospital voluntarily, but not everyone had been so willing. Some had arrived in shackles, forcibly quarantined when it wrongly was believed that leprosy was highly infectious. Patients had changed their names to protect their families. Lives were shattered overnight, expectations for the future destroyed.

Attitudes slowly were changing, and advances were apparent in the treatment of the disease since the introduction of sulfone drugs. Some patients had been discharged, although others no longer had homes to go to, or found the outside world had moved on too much for them.

In the afternoon we went to meet Mr. Stein, busily working on the next edition of the paper. The large dark glasses he wore seemed only to add more character to his lively face. He laughed upon hearing how we had broken down on the Alaska Highway and ended up employed as gas station attendants to pay for Flatus to be repaired.

“I’ve heard of working one’s way through college. You’re working your way through the United States,” he quipped.

“We’ve realized that a nurse’s training prepares you for anything,” I said, regaling him with some of our other adventures, and we promised to write from Los Angeles to let him know our next move.

I’ve often thought about Carville throughout the years, and last year I found myself reliving that day once again while my daughter, Barbara Fox, was writing a book about my experiences during the time I spent in the U.S. She discovered during the course of her research that Carville now is the site of the National Hansen’s Disease Museum and no longer is a hospital, although a few of the former
patients still live on the grounds, finding, like many before them, that Carville had become their one true home.

Mr. Stein, too, lived out his days in Carville, dedicating his life to working to remove the ignorance surrounding his affliction. He died in 1967, but The Star still is published and carries on his crusade.

_Gwenda Gofton is a retired state-registered nurse and state-certified midwife from Newcastle, England, who lived and worked in the U.S. from 1957 to 1959._
The nurse practitioner at the health department handed me a new referral. “Evan’s a healthy 6-year-old with Down Syndrome,” she said. “No cardiac problems. He’s short with a body mass index at the 90th percentile. Can you make a home visit?”

Two days later I was sitting in the family’s apartment talking with Leslie, Evan’s mother, a stocky middle-aged woman wearing khaki slacks and a white T-shirt.

Dressed in a navy sweatsuit, Evan sat in the corner of the room in an oversized children’s rocking chair watching Sesame Street on television. A box of Cheez-Its sat on the table beside him.

Piles of men and women’s clothes were stacked on top of a sewing machine by the back wall. “I alter people’s clothes,” Leslie said. “I have to work. We need the extra money.”

I smiled at her. “Let’s talk a bit.”

“There’s nothing a nurse can help with,” she said. “Evan’s doing OK. So what if he has a little baby fat?”

“He’s really not a baby anymore,” I said.

Leslie swallowed hard. “You don’t know what it’s like. I’m here every afternoon with him. Mornings, too, when he doesn’t go to school.” She sighed. “Evan sits watching television while I sew. He loves to rock and eat. I know it’s bad for him but ... .” Tears filled her eyes.

I learned Leslie and her husband, Sam, felt overwhelmed with caring for their son even though they’d adjusted to the fact that he would always have develop-
mental challenges. Sam worked long hours as a security guard and was emotionally detached from the family.

Although toilet trained, Evan had poor muscle tone, a lumbering gait and was prone to upper respiratory infections. His tongue protruded slightly. Developmentally, he functioned as a 3-year-old.

On another home visit I said, “Obese children tend to have weight problems all their lives.”

Leslie smoothed her T-shirt over her stomach. “What else can I do?”

“Let’s write down some ideas,” I said. “You first — something you think could help.”

“Not giving him Snickers bars after supper.”

“Good idea,” I said.

Together, we developed the care plan. She agreed to complete a three-day food diary, including snacks, which showed the family’s regular meals contained too much bread and dairy and not enough fruits and vegetables.

I tailored my teaching to the family’s food preferences and eating style. The goals were for Evan to maintain his present weight until it fell within the normal range for his age and to eat foods daily from each of the major food groups.

Leslie agreed to a referral for food stamps, allowing her to purchase more fresh fruits and vegetables. I taught her healthier food choices using pamphlets with heart-healthy recipes. She prepared more low-calorie, low-fat meals with fruits, vegetables and whole grains.

To encourage Evan’s physical activity, Leslie enrolled him in an afternoon play-group for developmentally delayed children. On Saturdays, the family shopped for groceries together. The parents compared food labels and let Evan participate in the final selections. Leslie declined referrals to a nutritionist and the National Association for Down Syndrome, but agreed to save the phone numbers for future reference.

On my last visit, a smiling Evan met me at the door. Leslie had limited his television watching to two hours a day and replaced his candy and cookie snacks with granola bars or small dishes of dry cereal and raisins. Instead of buying milkshakes at fast food restaurants, she prepared them at home with skim milk and fruit juice.

“Sam and I are losing weight,” Leslie said proudly. “We have more energy and feel more like a family now.”

Nurses must be creative and look beyond the obvious to find long-term solutions to complex health problems. Referrals to community resources broaden the family’s base of support and increase the likelihood that care plan goals will be met and maintained.

Lois Gerber, RN, BSN, MPH, is a retired community health nurse who has connected many families to community resources.
I am a hospice nurse, and I say that proudly. I feel so strongly about the work hospice does for patients and families that I received my certification as a hospice and palliative care nurse in 2006. Hospice works with a team approach (medical director, nurses, social worker, chaplain, aides and volunteers), providing patients and families the support and compassion they need to live every day to the fullest. People often associate hospice with dying, but hospice is about living — living every day we have with the best possible quality of life. I have explained this concept to so many patients and families, but I never expected someone to be telling me the same thing.

Two weeks after my son Alex graduated high school, he was diagnosed with a germ cell tumor. The diagnosis was even worse because the tumor did not start in the testicles, but in his mediastinum. It also had metastasized to his brain. As a nurse, I knew it was bad and we were in for a fight. As a mother, I wanted desperately to win.

My husband, my son Brian and I knew we would do whatever it took to help Alex. Our journey took us to the Cancer Institute of New Jersey, Memorial Sloan Kettering and Hackensack Medical Center. We drove from New Jersey to Indianapolis to meet with Lawrence Einhorn, MD, one of the physicians who cared for Lance Armstrong. Brian even became a stem cell donor for his brother. In the end, 17 months later, the cancer was too aggressive and we were told it was time for hospice.

In my practice, my patients typically are 80 to 90 years old. Alex was only 19.
I thought I had to figure out how to separate being a mom from being a hospice nurse. Then I realized this wasn’t something I should do. I needed to make every day Alex had comfortable and symptom free, but also to continue loving him like only a mom can.

We had a hospice nurse, Elaine, who understood my thinking and helped me fill this dual role. As a nurse, I managed Alex’s pain and anxiety and placed him on oxygen when needed. As his mom, I slept in his bed with him every night, never leaving him alone. My husband and I cared for him together, bathing him, feeding him and most important, just being with him. I am grateful that my knowledge as a hospice nurse allowed me to keep him comfortable.

The hospice philosophy involves living with the best quality of life until the end. A week before Alex died we went as a family to Nathan’s in Coney Island, Brooklyn. It was something we did at least once a year as a family. Alex was so happy that day. We packed up everything — oxygen, walker, wheelchair and pain medicine. Alex ate a chili bean hotdog that day. It is a memory I always will keep.

Alex was home with hospice care for exactly three weeks. He was surrounded by his family in the home in which he had grown up. He passed away Nov. 19, 2010, with his brother, father and me holding him in our arms. Elaine understood our need to be alone as a family and told us to call her when we were ready. I am grateful for her understanding.

Although life never will be the same, and even now the pain has not diminished, I find comfort knowing Alex died peacefully. During the three weeks he was home on hospice we were able to provide him with the best possible quality of life.

I was able to use my knowledge as a hospice nurse in this effort, but I also was able to do the most important thing: love him and be his mom.

Sharon Criscione, RN, BSN, CHPN, has been a hospice nurse to patients as well as family.
Most of our patients don’t look forward to dying; they struggle to survive against daunting odds. I never had heard anyone complain about being alive until I met 92-year-old Esther, a hospice patient.

Bedridden and near tears, she angrily told me: “I am no good to anyone. All my life I have taken care of everybody else, and look at me now. I’m just so useless.” Lifting an arm a few inches off the top sheet, she let it drop to demonstrate her wasted condition. “Why can’t I just die? Every day I ask the Lord to take me home,” she cried. “Why does God keep me here? I can’t do anything for anybody.”

I wanted to help her, but how? It would have been ludicrous to tell her, “Everything is fine, Esther. You will be dead in no time.” She had been a productive farm wife who kept busy with family, church and volunteer work. Although her mind was still sharp, she physically had deteriorated to dependence for every ADL.

I decided to appeal to her strong faith. “Perhaps God is not finished with you, Esther,” I said. “Maybe you have a job left undone. After you complete it, then he will take you home.”

My wife and I recently had sent our oldest son off to the war in Afghanistan. On my next visit with Esther, my son’s departure was very much on my mind. Since hospice patients have enough problems of their own, I had resolved I would not share my personal difficulties with them.

Near the end of our visit, I violated my code and asked, “Have you ever had to send a son off to war?” I regretted saying those words as I spoke them.
“Yes, twice,” Esther said. “One died in the war, the other a little later.” I was shocked. I do not remember what I said, or how I ended our visit, but I recall feeling great embarrassment. Instead of making her feel better, I just brought back painful memories.

About six weeks later, there was a knock on my door at home. The soldiers in Army uniforms said our son was killed in the war. They said something about his being a hometown hero. My wife and I plunged into a whirlpool of grief that will continue as long as we can still feel love.

When I was able to return to work after three weeks, Esther was the first patient on my list. She was still alive, but this time she was calm. “I heard about your son,” she said. She proceeded to tell me about the nightmarish tortures she faced as a mother who twice lost sons.

She told of her grief, how much she missed them, that their lives made her so proud. She spoke of her faith, where she found comfort in her distress. She expressed how, instead of anger at their loss, she came to feel gratitude for the years she had with them. She told of looking forward to seeing them again in eternity.

Esther explained grieving in a way I never had heard or imagined. We talked, cried, laughed and remembered our sons. It was a visit where time did not matter. Only a parent who lost a child could have spoken like Esther.

At the end of our visit, while I was thanking her for what she did for me, she suddenly lifted her head off the pillow. Looking at me she said, “You! You are the reason I am still alive. This was a job only I could do. To think that in my condition I could actually help someone.”

As her head settled back, she said, “My work is done; now I can go home.” I’ll never forget the beam of satisfaction — the feeling of a job well done — on her face.

A few days later I got a phone call. She passed away in her sleep. Peacefully. Thank you, Esther.

Mike Barry, RN, MA, is a former hospice case manager and a proud father of a U.S. service member.
Death: An Awakening
Nurse goes through lifelong process of learning to accept mortality

I have not always been comfortable with death. Accepting it has been a lifelong process that probably will not end until the day I die.

I remember my first exposure to death, when I was a preteen and our family dog died of a heart ailment at an old age. We said a prayer, had a brief service and laid her to rest under our backyard apple tree. I never was able to look at the tree in the same way after the experience; somehow that tree represented death to me.

A few years later, I endured my mother’s death from lung cancer and my father’s death from a massive MI only 15 months apart. I was a college student at the time, and I can remember reading about hopelessness, helplessness and powerlessness in my school books while I cared for my dying mother. I knew even at that time I would never forget those words and lessons.

When I graduated from nursing school in December 1982, I landed my dream job at a local pediatric hospital. At the time, the hospital cared only for children with orthopedic anomalies. Luckily, the children were not gravely ill. But the hospital grew and expanded and now is a full-service pediatric hospital with diagnosis-specific units including oncology. I associated cancer patients with death, specifically my mother’s death.

I quickly told my head nurse I wanted a transfer to the orthopedic unit. The nurse manager probably was thinking only of staffing issues when she told me to give it a few months, and if I still felt the same way, she would let me transfer.

Fifteen years later, I still work with pediatric oncology patients. I truly enjoy caring for this special patient population. I can’t believe something I resisted became a blessing and a chance for growth and healing.

During the first few years caring for oncology patients, I feared the possibility
that my expertise could not save them and they might die. That perception changed more than 10 years ago, when I cared for a 6-week-old infant diagnosed with an undifferentiated abdominal tumor.

Palliative care was the only treatment offered, with a care plan focused on keeping him comfortable and pain-free until he passed away. One night going into work, as I anticipated caring for this patient, my inner dialogue was: “Please not on my shift.” Strangely, my thoughts switched and I heard, “Why not on my shift?” At that moment, I think I finally embraced the final phase of life — death. I realized I had the capability, skill and, most of all, the desire to help this child transition into death. During his short time here on earth, that baby taught me a profound lesson I never have forgotten.

I cared for that baby all weekend and watched him become weaker and start to slip away. Thankfully, the child was peaceful; he required a little oxygen but was able to sleep easily and did not appear to be in any pain.

In the wee hours of the night, when the immediate family tried to rest, I made frequent rounds to check on my little patient. I swaddled him, untangled all the tubes and wires and even neatly arranged all the religious items in the crib. At one point I read a prayer card and really looked at this special person.

It was then I sensed a sort of energy in the room and felt an overwhelming sense of comfort. I realized this child would be OK. Not here on earth, but this child would somehow be OK.

That first time I felt this presence, it was overwhelming. I am so glad I was open to sensing it. I was able to recognize what it meant to me as a person, not just as a nurse. It meant all my loved ones who are deceased were OK.

In some way, this lesson has given me comfort and has helped me to move forward in my grieving process. Sometimes I still can feel that energy, that static in the air when called upon to care for a dying child. It doesn’t surprise me anymore. I recognize it, accept it and somehow feel at peace. Death really can be an awakening. Just be still and listen.

Marie Ranalli, RN, BSN, is a pediatric nurse who has comforted many children.
My husband, Parker, who’d been a potato farmer all his working life in Southold, N.Y., was always physically fit and active. Except for appendicitis and a fractured collarbone and wrist as a child, the only other remarkable symptom he exhibited was a slow pulse; it went along with his even disposition.

But his pulse got a little too slow when he was 78, so in 2004 he ended up having a pacemaker implanted. It’s a relatively simple procedure, but a complication developed a few months later, requiring emergency surgery for bleeding around the heart. He never bounced back from the surgery and instead began a slow, downhill slide.

I knew caring for him would be difficult in our two-story house. So that year, we decided to sell our beloved home on Mill Creek and build a modular, one-story, accessible ranch house on the 11 acres remaining of the family farm in Southold, where Park had grown up. We moved in just before his 80th birthday and right after our 50th wedding anniversary.

Only moving back to the farm could fill the role the creekside house had held in our early retirement years. Park was happy to be back where he could watch (and worry about) the farm activities the way his father had. Until his cane wasn’t enough support on the rough ground, he loved to simply walk around the barns near our house.

I am eight years younger than Park, and had worked as a nursing supervisor in a home care agency. I knew about advance directives, nursing home expenses, Medicare, Medicaid eligibility after spending down income — all the problems to
consider if it looks like a person may need long-term care in the future. I knew a little about trusts, too, having been a trustee for an old friend who became a nursing home resident. I worried about what I thought of as "saving the farm."

It wasn’t that we were farming anymore, but I knew what it meant to Park, and how he and his father and brother had worked to make the farm profitable, add to it and keep it. By this time, I had taken over all the bills, house-building arrangements, etc. Experts I consulted advised me to protect our assets because although no one can positively predict the future, we can plan for most eventualities. With the support of our three children, that’s what I tried to do.

The strategy for saving assets and enabling Park’s care was to ensure he didn’t own any of our assets if and when he had to enter a nursing home. My concern was making sure he would be able to receive Medicaid under New York eligibility rules if he had to enter a skilled nursing facility on a permanent basis.

This meant transferring everything into my name, on the assumption that I would outlive Park. Now, all this sounds very logical and practical and wise when you hear it from your lawyer or accountant or any other advisers. But I spent a lot of time agonizing over taking these steps.

For one thing, I didn’t think of the farm as mine — it was truly Park’s. My roots were in the suburbs, not on a farm. The only farm work I ever did was drive a potato truck on occasional Saturdays during harvest time when no one else was available. My contribution to our finances was my nursing job. So while our lives were steeped in a semirural lifestyle, and we thrived on it, it was Park’s history. It seemed to me like a betrayal to be taking over all that had been his. Even though he did not realize all that had transpired those last few years, I hated to take those steps. But I did it, because I knew inaction on my part could be worse.

Before he died in 2009, Park no longer owned the farm, house or car, nor was his name left on any of our assets, except one small joint bank account we used for direct deposit. When it was all done, I accepted it as necessary, but I never liked having to do it and it always saddened me.

We all know what happens sometimes to the best-laid plans. When Park was admitted to the hospital for the last time, I thought he might not be able to come home again and would end up at the nursing home close to us, for who knew how long. At that point, I couldn’t know how ill he would become in the next four days. Then our doctor, a good friend, came to me outside the ICU.

He asked me whether I thought we should release Park from suffering any longer, and he wanted to know if I had signed the DNR form. I was grateful for his support. That was the one form I had never filled out. But I did, then and there. I knew I couldn’t agonize over the most agonizing signature of all.

Betsey Dickerson, RN, BS, is a retired school nurse educator and home care agency nursing supervisor who managed her husband’s care.
When I was a young nurse, I defined “leader” as a prestigious role for great people. To be a leader, I thought, one must possess qualities that would define greatness, such as intelligence, an authoritative manner, eloquence of speech and the ability to wear designer suits with flair.

As I gained experience, my definition of the term evolved. I began to recognize leadership is about facilitating achievement of a common goal. I have worked with many types of leaders in the past 15 years and observed their strengths and weaknesses. My perspective on leadership changed when I realized effective leadership is not about me, but rather the achievements of those I lead. A leader is influential, highly organized and outcome-driven.

Leading others means sharing the journey so all may reach the destination. It is not survival of the fittest. And it is not easy. Instead, the journey involves taking many turns, navigating detours and resolving distractions.

As a staff educator focusing on ambulatory care nursing, it seemed clear I needed a reliable guide to assist me in helping others reach their common goals. A compass seemed the perfect tool.

When I hold a compass in my hand, I see N-E-S-W around the dial. But to me those letters mean something entirely different than the inventor intended; they stand for the four qualities a leader must possess: Nurture, Excellence, Strength and Wisdom.

NURTURE: Leaders nurture their teams with compassion and a deep under-
standing of reality. Moving in the direction of compassionate leadership means mistakes are seen as opportunities. Mistakes often are a result of complex system-wide problems. Approaching problems with a compassionate attitude helps avoid jumping to conclusions.

To nurture with compassion means the leader listens before speaking and carefully considers a situation before acting. In return, the team remains motivated to finish the journey.

Nurturing team members also has to be balanced with the three other "directions." A leader who mistakes nurturing as a reason to let team members perform below the standard of care is not providing the guidance required for patient- and family-centered care.

EXCELLENCE: Nurses who continually strive for excellence naturally will advance their professional practice. Without excellence, any goal might work, but with excellence, patients, families and healthcare systems benefit. The most effective leaders demonstrate their commitment to excellence every day, and when they fall short, they take responsibility for problems and failures.

A leader who is moving in the direction of excellence knows the power of walking the walk along the journey. Yet balance is required to be a fully developed leader. To achieve excellence and maintain the focus on the destination, the three other interconnecting qualities act as balancing and supporting factors.

STRENGTH: When a leader accepts a job, the journey begins. Everyone is tested when working to achieve a difficult goal. The journey to a safe and effective nursing unit, free of hospital-acquired infections, uncivil behavior and other common problems, means encountering many distractions. Mental, emotional and spiritual strength are required to overcome the inevitable detours, wrong turns and other delays.

While stress is every leader’s enemy, strength can beat it. Strength brings out persistence, perseverance and resiliency, which later build courage and the feeling of mastery. A leader always is willing to take on new journeys that lead to success.

A leader who is overly strong or aggressive often fails to listen to others and fails to heed warning signs that the team has taken a wrong turn. Strength at its best is balanced by a commitment to excellence and the ability to nurture others — and the remaining compass direction.

WISDOM: In leadership, knowledge and wisdom are not always the same. A knowledgeable leader has an understanding of the latest information about a topic, expertise in complex legal issues and other issues and skill in managing limited financial resources.

A wise leader knows how to balance the interconnected needs of a complex organization and communicate a shared vision. A wise leader recognizes the signs of trouble ahead and takes the necessary steps to clear the path for the team.

When a leader spends too much time considering alternatives, and not making
a decision, the team will struggle to keep moving forward. Wise leaders make the best choices they can, given the situation, and rely on the team to move a project forward. Wisdom must lead to action. Without action, nothing can be achieved.

As I finish one journey and begin the next, I rely on my compass and the four “directions.” When I lose my way, I go back to these four essential attributes and find my way again.

Christine Yalong, RN, BSN, is a staff educator who helps nurses give their careers direction.
Having received my RN license in 2007, I still am relatively young in “nursing years,” which as we all know are different from “human years.” Human years are filled with happiness and sadness; birth and death; unbelievable stress and unending boredom; love and anger; sickness and, of course, the elusive good health.

Nursing years, too, are filled with all those things but then are multiplied by every patient for whom we have cared. Whether we are aware, through our eyes and ears, hands and hearts, voices and actions, we have gleaned time.

As a newer, second-career nurse, born of long days and night school, I came to this profession at the perfect time. Construction work (my original career) was becoming scarce and my children were being born, requiring better insurance and security. Nursing not only fulfilled these needs but also gave me something I had not realized was missing. I began to experience a sense of usefulness and vibrancy in my work. I felt the pride of being necessary and competent. I know there are many nurses who understand this feeling of humble importance. It’s a part of what we get back as nurses. Even when we are silently standing shadowed in the corner of a patient’s room during an all-important doctor-patient conference, we know they will look to us with questions afterward; questions that only we, as nurses, can answer. It’s OK to be proud.

Nursing opens doors to learning, knowledge and experience; you need only to walk through them to benefit. There is so much career diversity in nursing that there is no excuse to be bored or professionally unfulfilled. My own short history
is an example. I have worked telemetry and cardiac and medical intensive care at
different facilities. I have worked in endoscopy and endo-surgery centers. They are
all very different environments requiring different approaches to nursing. I have
loved every minute of it: the hard parts, the tears and bad news, the never-ending
codes and screeching monitors, the bedpans and relentless call bells, even the
grinding stress and paperwork mountains. Well, honestly, some of it I enjoyed
only after I had clocked out.

Now, I am an occupational health nurse with the Federal Air Marshal Service. I
don’t wear scrubs to work (which I occasionally miss; there’s nothing like wearing
pajamas in the daytime), and I have a desk and business cards. I work with law
enforcement officers across the country while they protect our lives and freedom
all over the world. What other career could provide such varied and awesome
opportunities to learn and care? Working with the Air Marshals, I cannot help but
have a renewed sense of patriotism and a feeling that I am not only promoting
good health but also helping to protect our American freedom. Once again, I think
it is OK to be proud.

In light of the post-9/11 America we live in, I leave you with these thoughts:
Nursing is like freedom because both must be tolerant, patient and unselfishly
hard working. Both must be ever-evolving, ever-learning and ever-advancing.
Freedom and nursing must be open to and strive for constant positive change
in the face of denial and resistance (or bedpans and codes). We, as Americans,
are invested in freedom and like those of us in nursing, must strive for personal
growth and should support growth in those around us. As nurses, we constantly
encourage these qualities in our patients and should be nurturing the same in our
fellow nurses. Nursing can be all you make it to be; make it freedom.

Andrew Tabussi, RN, is an occupational health nurse
who has cared for Federal Air Marshals.
I opened the closet. There was Charlie’s right leg, standing on the floor. It wore a sneaker and a white ribbed athletic sock, pulled up high. Part of Charlie was in the closet.

I got his black leather toiletry bag from the hook where the night nurse had hung it. We had to do almost everything for Charlie, a patient with Type 1 diabetes who was a frequent admission to our floor. He didn’t have the strength to get out of bed anymore. He lay on his stomach, looking at his laptop. I took his razor and shaving cream out of the bag and put them on his table.

“Thanks, Priscilla. I’ll get to that in a minute. Shaving. Wow.” He smiled, widening his eyes. “What a fun day I have planned.”

“I have your pills, and I need to connect you to your antibiotic.” “Yum, yum.”

He held out his arm, where he had a PICC line. A semicircle of needle marks in the pale, baggy skin of his forearm indicated a failed dialysis shunt. He had this in the other arm, too. Now his dialysis was through a catheter in his chest. The wrapped ends of it stuck out of the neck of his T-shirt.

Charlie snapped the computer shut and rolled onto his back, putting the laptop on the table with the shaving things. He could still do this much, even with one leg gone and the other in a bulky dressing, half the foot amputated and the incision not healing. He was 36. I wondered how well he would be able to move when he was old. Then I realized he never would be old.

I connected the antibiotic. He reached over to the table and opened his com-
puter again, pushing his thick glasses up his nose. “I’ll shave later. In fact, you might as well put that stuff back. My boss needs me to work on this. I have to get out of here soon and get back to work.”

I didn’t think he’d be getting out soon, or for very long. His incision was black and a sour smell rose from the dressing. He would need another amputation. They were chopping off pieces of him, removing the diseased parts bit by bit.

“What kind of work do you do?” I asked.

“Programming. That way I can work from home.” He smiled, running his hand through his thinning brown hair, and rolled back onto his stomach, careful, as he always was, not to dislodge the IV.

I opened the closet to put his toiletries back and was surprised again by the leg. Did all legs come with a sneaker and sock? Or had he done that himself? How did he get used to it? First it was a toe, then half a foot and a few toes on the other foot, then the leg below the knee. You could get a prosthesis, dress it in your own footwear, still go to the mall, climb stairs.

Then it was half your other foot, and you spent most of your time in a wheelchair. You couldn’t drive a car, or ride a bike, or take a walk on the beach. Or in the woods. Or anywhere. But you could still get to work, go to dialysis three times a week, go to a ballgame or a restaurant. Then the other leg was gone. You were confined to the wheelchair, and needed someone to help you all the time. How could you still smile, work, crack jokes at the nurses?

I thought of all the things I’d grown accustomed to in my life: this job, to start with, working four hours at a stretch without a break to sit down, going home with excrement smeared on my pants, never feeling like I had done enough, though I had done all I could. I was resigned to the idea that my husband was adorable and funny but unambitious and not bound for greatness. That I would never be beautiful or tall or rich, that I would have to work hard all my life to have what my parents had.

But all that was nothing. It left so much to be happy about, good things that could catch me by surprise every day. Charlie must feel this, too, in some small way.

I closed the closet and turned to leave. “I’ll be right back with your insulin.”

Charlie looked up and gave me a big smile and waved. “I’ll be waiting breathlessly.”

Priscilla Mainardi, RN, BSN, learned to appreciate the little things with the help of her med/surg patients.
All day, my parents were acting somewhat strange. I had been to the doctor’s office that morning after I was up going to the bathroom six times the night before. What was going on? I didn’t know what was happening but, even as an 8-year-old, I knew something wasn’t right.

Around dinner time, the phone rang. My dad answered it, and he and my mom had very intense eye contact with each other. The doctor’s office was on the phone. Dad was told I had to go to the hospital right away because I had an elevated blood sugar level. I was diagnosed with juvenile diabetes.

The next hour or so before going to the hospital is a bit blurry. But I distinctly remember throwing myself on the living room floor in the midst of a full-blown temper tantrum, refusing to go to the hospital. I don’t think I really knew why I should be scared; I just knew that going to the hospital was not generally a good thing.

We drove to Victory Memorial Hospital in Waukegan, Ill. (now called Vista East Hospital and Medical Center), and it seemed to take forever. In later years, I would drive by there and think, “Wow, that really only took 15 minutes to get here from home.”

Once at the hospital, we registered and I rode up to my room in a wheelchair. That was fun! Little did I know what was yet to come. Over the next five days, I remember lots of pokes, shots, blood, IV fluids, very little good sleep and horrible food. On top of it, I was just not sure what was happening.
But I also remember getting many presents, balloons, flowers, teddy bears and thinking that was very fun. Family lore has it that when my grandparents called to say they were coming down to visit, I responded with, “Oh, it’s OK. You can just send the presents.” (I still have not decided if I truly believe I said this.)

One key thing I will never forget about my diabetes diagnosis is the nurses. Every nurse there truly seemed to see me as just a “normal” kid, and not a sick patient in the hospital. They really tried to see the real me, not just a disease.

Later when reflecting on the situation, I decided I wanted to do that for other people. Patients are people, not diseases, injuries or illnesses. They are people who — for whatever reason — have something wrong with their bodies. I wanted to make sure I could be there in the same way for other patients.

I graduated from nursing school in December 2010. I was certain for a long time that I would go into pediatric nursing and be either a pediatric nurse practitioner or a pediatric certified diabetes educator. Through my time working and volunteering in the healthcare field — which started when I was a junior in high school — I have changed my mind many times about what specialty I want to pursue. I have even considered becoming a certified registered nurse anesthetist, neonatal nurse practitioner, CDE or certified nurse midwife. The one thing that never has changed: I always will treat the patient as a person, not a condition.

Patricia A. Moore, RN, EMT-B, was inspired to become a nurse as a child with diabetes.
Being a nurse, you frequently are asked the question, “What made you become a nurse?” My answer always is, “I love being with people, helping them and their families; that’s the kind of person that I am.” They would look at me and just smile.

I was introduced to Betty when she was admitted to Urban 4 with a small bowel obstruction. As I walked into her room, I felt an instant connection with her. She looked at me with her big brown eyes, grinning from ear to ear, even with her nasogastric tube clamped. Betty was completely obstructed and needed surgery. But because she had chemo a few weeks before, she had to wait some time. As I stood at her bedside pushing barium through her NGT, we really got to know each other. She would tell me about her two boys, how much she loved her grandkids, and all the cross-country adventures she had with Roger, her husband. I would talk about my family, how my parents recently had moved cross-country to Oregon and about a big family reunion I was planning at my house.

Because Betty was going to be with us for a while, I decided to move her into a private room. At that time, I got to know Roger. He was coming in every day and spending all day with her. He cracked me up with his stories of Betty and him. This pair was a class act, and you could see how much love they shared. It was truly amazing. Betty eventually had her surgery and went to CCU postoperatively.

The day she was transferred back to our unit, I personally went down to CCU to help transport. I was excited to see her, and she gave me the biggest hug and
kiss on the cheek. “Robyn, I missed you,” she said with a huge smile. “How was your party?”

I was glad to have her back with me. I would change my assignment just to have her as a patient.

But suddenly, Betty took a turn for the worse. She was having difficulty breathing and needed BiPAP machine. Physicians performed a thoracentesis and made her comfortable. She would be discharged within the next few days. I was going on vacation and was upset to have to leave her. She was sad I was going. We embraced, and I told her I would always be with her. I checked on her while on vacation, and she made it home.

My first day back, I ran into Roger, who told me Betty was about to have surgery to remove more fluid from her lungs. I was able to surprise her in the holding area of the OR and then postoperatively on another unit. She was doing well and was to be discharged soon. Just two days later, Betty was readmitted to PCU.

She was dying and was given a DNR order. She wasn’t going to make it through the night. I ran down to see her. She looked so peaceful, resting comfortably in bed, surrounded by her family and friends. Tears immediately ran down my face as I leaned on Roger for comfort. “You’re all she talked about when she got home. She loved you so much,” Roger said.

He thanked me for all the care I had given his wife while she was with me. I was overwhelmed with sadness, something I had never experienced with a patient. I whispered in her ear that I was there next to her and gently kissed her cheek.

Betty died just a few hours later. She was at peace.

To me, being a nurse is unlike any other profession. We may get yelled at by our patients and physicians, but the love we get from patients and the care we provide outweigh all the rest. This is why I am a nurse.

Robyn L. Pascale, RN, BSN, is a nurse who loves her patients.
I have been a nurse for 36 years. But when I started working in an inpatient hospice three years ago, I found my true professional calling. Hospice is bedside nursing at its finest, and palliative care means only symptom management.

The true challenge of hospice is to treat the entire family and create a dying experience in which they all can find some solace, resolution and peace with this difficult transition.

Mr. F was a 58-year-old patient with melanoma that had become metastatic brain cancer. He was only mildly confused at the time of his admission but was weak and unable to transfer without the assistance of three staff members.

He was divorced from his wife, so from the beginning of his stay, his children would come for short visits on the way to work in the morning or on the way home in the evening. His days were long, and this lonely and lovely patient was very verbal with the staff on our unit about his fear of dying.

One day, I was outside Mr. F’s room working on my computer when I heard cheering, clapping and music emanating from his room. I went to see what was happening in the otherwise quiet room. Three young and very pretty women were sitting by Mr. F’s bedside, gathered around a laptop computer watching a competitive dance competition. It turned out Mr. F, looking to spice up his life as a divorcée, had joined a ballroom dance class to fill his lonely nights.

It was clear from the expression on their faces that his dance partners were very fond of him. Unlike his other visitors, the women already had visited for
two hours that day. At lunchtime, one of the ladies asked if I could get him into a wheelchair.

“Why?” I asked. “I want to have a last dance with him,” she said. “He was my dance partner, and he is an incredible dancer. It would be my final gift to him.”

Mr. F had been bedridden during his days on our unit. He was a large man and had minimal use of his legs, so it was a very difficult and painful effort to transfer him out of bed. It was clear that his friend was determined to dance with him before she left.

So I quickly medicated him with a low dose of morphine, offered him the urinal, then ran to find two other staff members to attempt a challenging transfer from his bed to a wheelchair. We were determined to grant this last wish. By the time we managed the transfer, we all were sweating.

We wheeled Mr. F into our spacious dining room, which serves as a meeting place for families because very few of our patients are alert or strong enough to eat, especially outside of their rooms. His young dance partner moved chairs and tables out of the way and set up a portable CD player. I waited and watched in case Mr. F became uncomfortable or out of breath.

His partner turned on the music and the dining room transformed into a ballroom. The dance partner moved gracefully as she whirled and twirled his wheelchair around the room. He was concentrating on every move, and his eyes never once left those of his partner. My eyes filled with tears as I realized that in Mr. F’s mind, he really was dancing his last dance.

For 20 minutes, Mr. F’s partner pulled him forward and then pushed him back ever so gracefully and gently so that his wheelchair was in a constant fluid and twirling motion and the dance took him back to a happier time.

An hour later while I was making rounds, I went to see if Mr. F was comfortable and if he needed anything before my shift was over. He asked me to look at the card that his dance partner had brought him. She inscribed it “to the father I never had.” I read the card out loud, and his eyes filled with tears.

“After your divorce,” I said, “your dance group has become your community, hasn’t it? It is obvious that they adore you and miss you. They stayed for a long time!”

As the tears streamed down his cheeks, I wiped them gently with a tissue, took his hand and sat down on his bed to share this moment with him. With a quivering lip, he said, “You know, I was leading.”

Then, with a more solemn look, he said, “It was a good day.”

I love my job, and these are the moments that remind us of the people our patients were before they came to our hospice.

It had been a good day for me, too.

Amy Silverman Berkowitz, RN, is a hospice nurse who has had many good days.
As an RN on a palliative care team, I often am consulted to help families who are making end-of-life decisions. One patient and family offer a great example of these important conversations. The 87-year-old patient, who was diagnosed with anoxic brain injury, had been in the hospital for two weeks before palliative care was discussed.

“The doctor met with us,” a family member said to me. “He said we should think about withdrawing care. What does that mean?”

I asked the family what the physician had told them about their loved one’s condition. “He said she won’t get better, that he has done all he can; that we should stop everything.”

I explained to them in detail the process of using comfort measures only. “We will give her a little pain medicine, no more than she needs,” I said. “We can untie her hands [which were restrained to keep the patient from accidentally extubating herself] and let her take that mask off if she wants, too. We won’t worry about her saturations — won’t even watch it. We can give her a tiny bit of something she likes to eat, maybe ice cream?

“We won’t worry about a swallow study; we aren’t forcing her to eat a lot of food, just as much as she wants. We will give her little swabs of water and, of course, continue to turn her and keep her clean. We won’t withdraw care, we will increase it. We will only withdraw artificial life support, the things she said she doesn’t want, according to her living will.”
“I wondered what he meant by withdrawing care,” said the daughter. “I thought, ‘Will they put her in a corner and let her die?’”

I reassured them, “We are honored to care for your mother at this time, and we will take very good care of her. We will increase our nursing care and only decrease the machines.”

They asked the right questions; questions we expect. “Will she die right away once the breathing machine is stopped?”

“We don’t know. A higher power decides when we die; we can only decide to follow her wishes, to make her comfortable.”

“I am worried that she will gasp for air and suffer.”

“She will not suffer; we will treat her symptoms very carefully.”

“If the monitor is turned off, how will we know when she dies?”

“We will check her very frequently, and if you need us we will come in right away. We will listen with a stethoscope for heart and lung sounds. We will know.”

“What shall we do while we are waiting?”

“Why don’t you tell her a story? Talk about the things she was good at and the things that she wasn’t. Talk about your memories.”

Finally I asked them, “Are there any religious or cultural observances with which we can help?”

“Yes, can we have the chaplain come and pray with us? Then we will be ready.”

What I remember most often are a family’s emotions — grief, guilt, understanding and acceptance. I want them to know all their options. I want them to articulate the patient’s preferences and not to feel guilty about their decision. Families want to know how long the patient will take to die. I tell them only God knows that, but we will continue to take very good care of their loved one as long as he or she is with us.

Jeanette R. Stevens, RN, BSN, CCRN, CHPN, has taken very good care of many patients as a palliative care nurse.
When a nurse spends 20 years in acute care, specifically oncology, he or she learns a lot about health and wellness by default — in other words, what not to do. I saw unwise lifestyle choices, terrible diets and poor health habits force people into the hospital for acute and chronic care for too many years. It caused me to seek a radical change in my own lifestyle.

Like most people, I was raised on American fare. I lived in southern Louisiana — an area famous for its decadent cuisine — for 25 years. My parents and extended family suffered all the ailments associated with fried foods, buttery sauces and lack of exercise, including cancer, stroke, heart disease and Type 2 diabetes.

About eight years ago, in my 30s, I started on the path to becoming a vegan. At the time, I was working as a night-shift oncology nurse in central Colorado, a pretty active, young and healthy area. I met a lot of vegetarians, and as a Southern carnivore who had attended many funerals and been at many hospital bedsides after cardiac procedures, I was intrigued. So I decided one day to give up red meat. After several months, I gave up chicken. (I had never eaten seafood.) This was a pretty easy transition — I still ate dairy, and products made with eggs and dairy, although I did not eat eggs prepared alone.

I continued my vegetarian diet after moving to southwest Florida. While living in Florida, I met a physician who applauded my vegetarianism, but proposed an even healthier alternative: veganism. I had never heard of this diet, so I researched it thoroughly. I decided this was indeed the drastic lifestyle change I was seeking.
not only to avoid the fate dictated by my hereditary history of disease, but also to ensure a thriving future.

Vegans consume no animal products at all, including meat, fish, dairy, eggs or any product made with these, such as certain cakes, breads, spreads, drinks and frozen foods.

Why vegan? Books and Internet information painted a gruesome picture for me of the dairy, meat, chicken and egg industries. This was all I needed to make up my mind, along with the substantial health benefits of a completely plant-based diet.

I think making a slow conversion in phases, eliminating one food category at a time, was the key to my success. Also, if I accidentally ate something I did not prepare that had dairy or egg ingredients, I didn’t get discouraged or overly critical of myself. I just worked harder to find the right foods and become knowledgeable about everything I ate and drank. I asked a lot of questions, such as: “Does this have dairy or egg?” and “Can you substitute olive oil for butter?” I have found that if you are polite, restaurant chefs will work with you. In fact, most will go above and beyond to help you.

However, I found preparing my own food and purchasing food from vegan restaurants were the only completely safe options.

Allergy ingredient labels can be helpful in identifying “egg and dairy” as ingredients. As a vegan, one also must look for less-obvious animal-based ingredients, such as milk proteins, whey, casein and sodium caseinate. Many health food stores and groceries such as Whole Foods offer vegan sections, and the word “vegan” may be printed directly on product packaging.

Produce (organic, if available), especially greens, are essential for calcium. Protein can be found in tofu, beans, nuts, seeds and grains. There are wonderful vegan milk substitutes available, including almond, coconut (my favorite), soy and rice varieties.

I start each day with a vegan protein smoothie made with frozen berries and coconut milk, take this out the door to start my shift and bring snacks such as nuts (almonds, cashews, pecans) to work. My organization offers veggie burgers and a prepackaged hummus snack in the cafeteria. So veganism is pretty attainable, even in our fast-paced nursing world.

After about a year, I looked and felt amazing, and everyone starting asking me: “How did you do it?” I don’t lecture people on what to eat or not eat — that’s a personal choice. I share what works for me.

I feel I am an example to my patients and my peers in healthcare. If I do not represent health, then who does?

Susan Theroux, RN, BSN, MBA, is an oncology nurse who loves her veggies.
When I started my second career as an RN in May 2009, I knew I didn’t have all the answers. But I believed I had a firm grasp of what the RN’s job entailed — both skill-wise and knowledge-wise. I just needed on-the-job training to become what I wanted to be.

What I didn’t realize was my greatest learning experience would be caring for a family member.

My grandfather was diagnosed with pancreatic cancer in August 2010 at age 81. He sent me an email to let me know he had gone to the ED and they had done a CT scan that showed a mass in his pancreas. He had been at my graduation from nursing school, and I knew I could help him.

In the weeks that followed, I accompanied him to all his appointments. I spent much of my time re-explaining terms and describing procedures he would have to endure. I communicated to all of my relatives about the status of the cancer and what we should expect in the coming months of chemotherapy and radiation. I had to ask the tough questions to which no one really wanted to know the answers.

I made every appointment, followed up on every medication and made sure he and my grandmother knew everything they needed to know during this process.

After chemotherapy, radiation and a recovery period, my grandfather’s surgeon gave him the green light for possible resection of the cancer. Unfortunately, during the operation, they found the cancer had spread and resection was impossible. I stayed by his bedside after everyone had gone home after a long day. When he woke up, he asked me if they had done the surgery. I repeated what the physician
told him earlier — that no, they had not been able to remove the cancer. I held his hand and cried with him, as I explained what happened.

Complications arose after surgery in the form of his second heart attack (the first was a silent one before the cancer diagnosis). He also endured fluid buildup in his lungs and a DVT.

My grandfather spent two nights in the care of ICU nurses and eventually left the hospital with more than 20 staples and a broken heart — both physically and emotionally.

Along the way, I watched the nurses who cared for my grandfather and saw how much they enjoyed helping him.

I witnessed the oncology nurses who joked with him and my grandmother, so they could laugh. I saw the floor nurses who listened as we explained his condition was not normal. They responded by having him sent to the ICU.

There were the ICU nurses who kept us updated on his condition, no matter what they were doing or what time we called. I interacted with a nurse practitioner who found the original heart attack and discussed his condition at length with me.

Each one of my fellow healthcare professionals taught me that just because a patient is not a family member by blood, it doesn’t mean the patient isn’t part of your family.

Through these experiences, I’ve changed the way I look at each of my patients. I see them as family members I can help, even if just for a short time. I ask questions about their families, their support systems and who can help them out. I look at my job beyond giving medications and bandaging wounds. It’s also about making sure patients understand their conditions and where they can go for more information.

When the surgeon told my family there was nothing more he could do for my grandfather, he looked me in the eyes and told me I made my grandfather proud, that I had done a good job of helping him through this difficult time. That comment made me cry.

I was able to see my grandfather the day he died from pancreatic cancer. We talked about current events, and I made sure he knew that I loved him. As much as I miss him on a daily basis, I am relieved he is no longer in pain. I will always care for my patients as if they are family because of him and because of all the wonderful healthcare professionals who surrounded him and did the same. He always encouraged me to do my best, and I will continue doing just that in his honor.

Looking back, I realize I had made my grandfather proud. I had become the nurse I always wanted to be — caring and compassionate to everyone in my care.

*Toni Steres, RN, is a staff nurse who treats all her patients like family.*
Mr. and Mrs. B were an elderly couple who spent more of their lives together than apart. Married for 61 years, they had the kind of connection you read about in fairy tales. One summer, they decided to embark on a vacation to Florida to see the sights and enjoy the sunshine when something went terribly wrong — their tour bus crashed and their vacation abruptly ended.

The lovebirds were rushed to Tampa General Hospital with life-threatening injuries that would separate them for the first time in years. Mr. B suffered spinal and rib fractures and lung contusions that required him to be on a ventilator for several weeks. His stay in the trauma ICU was a rollercoaster of bad and worse days, and his age was a huge factor against progressive healing. Infection, delirium and immobility contributed to a poor prognosis. Mrs. B was taken to the neuro ICU with similar injuries. I cared for Mr. B many times and experienced his ups and downs firsthand. I thought about how lonely he was, even though the nurses were at his bedside most of the time. I made an effort to remind him that his wife was doing well and he would see her again.

Many days passed, and as their three loving children bounced back and forth between the two units, their apprehension increased. To help ease their anxiety, the nurses and management of the two ICUs arranged for Mrs. B to be moved to the room next door to her beloved husband. Mrs. B improved quickly, but Mr. B’s progress was much slower.

Mrs. B was doing well off of the ventilator for a couple of days when the nurses
decided it was time for them to be reunited. It was quite a challenge to move each of them into chairs and ensure their safety. They both required oxygen and neck and back braces to keep them stable. A respiratory therapist, a physical therapist and Mr. and Mrs. B’s nurses worked as a wonderful alliance to take Mrs. B next door to see her husband.

When she arrived in his room, Mr. B’s face changed. He looked at her in shock, as if he were dreaming. She was parked next to him, and for the first time in weeks they held hands. Because they both were trached, they were unable to speak, but they didn’t need words. Mrs. B was smiling from ear to ear, and Mr. B’s face relaxed as though his fears had been eased by her presence.

Many nurses gathered in the hall in front of his room to witness the reunion. Many of us were teary-eyed and overcome with joy. I imagined the emotions I would experience if I were in Mrs. B’s place, and it touched me.

I am a strong believer in will and purpose in life. Many times I’ve heard patients say they were too tired to keep fighting and then die shortly thereafter. I also have witnessed couples injured in car accidents who died within hours of each other, too ill to be mentally aware of the other’s passing, but I think they must have felt it in their spirit. I believe the encouragement this couple received from the staff and the pure connection of their souls fueled their will to fight.

Mr. and Mrs. B were transferred to a rehab facility back in their home state. Now when I walk by those rooms, I am reminded of the power of empathy, collaboration and — most importantly — love.

*Katina Franke, RN,* is a nurse who has seen the power of empathy and love help her patients.
During report, I was told my patient had stage 4 non-small cell metastatic lung cancer and all treatment options had been exhausted; no more chemotherapy or radiation. He was DNR/DNI. As his healthcare proxy, his wife followed his wishes and indicated he was to receive comfort care only. He was transferred from the MICU to our unit to die.

Unfortunately, dying at home no longer was an option. This was my first encounter with a dying patient with the family present. I was unsure how to act, what to say or what to expect, but I was determined to get it right.

I started with a warm smile and polite introduction. I received gentle smiles and everyone’s names in return. I gently touched my patient’s hand as I told him my name and got a strong squeeze in return. He was alert and oriented, his demeanor calm and pleasant. Initially, his two daughters and a son-in-law were at the bedside, and their mom and brother arrived shortly thereafter arm-in-arm. I could feel the love they had for one another as they embraced.

During the first shift there were written orders for 1 mg of morphine sulfate per hour as needed for respiratory distress. On the second shift, a morphine drip was started at 1 mg per hour with titrate to comfort. I took my cue not only from my patient, but also from his family. I was there to help, teach and guide them, and they me.

My wife, Athena, shared a story with me early in her career as a social worker in the ED. A gentleman had been brought to the ED after suffering a major heart attack, and efforts to resuscitate him proved unsuccessful. His wife arrived shortly thereafter, and Athena was there for emotional support and guidance.
They asked his wife, who was crying and distraught, if she would like to see her husband. She said she didn’t want to see him that way. Going with the moment, Athena took her hand and told her that she would go with her to see her husband and say goodbye. Athena gently told her that she would regret not going to see him. They went together holding hands to say goodbye and pay respects.

Sharing her story, Athena admitted that at that moment, she did not know what she was doing and went with what felt right. There was no script, as there often isn’t. Athena received cards with many thanks and warm wishes act for many years after that kind of act. There were no regrets, only fond memories.

During an awkward moment of silence, I experienced a similar moment when the daughter asked what the family should be doing. Their loved one no longer was responsive. Remembering Athena’s story, I told them, “Sit with him, hold his hand and stroke his arm if you wish. Tell him about your day, what’s going on in your lives and about his grandchildren. Talk to him and share.” It is said the sense of hearing is the last sense lost. The sense of presence is powerful, too.

It was clear the end was approaching. I noticed a rosary and gold chains with crosses. I asked the family if they would like a priest to come to the bedside for spiritual comfort. They were appreciative. Absorbed in the dying process, they had not thought to ask.

Pastoral services were called, and within the hour a priest was at the bedside. He provided religious and spiritual guidance, prayers, blessings and last rites. My patient died peacefully, his family by his side, surrounded by love. I hugged everyone and gave my condolences, my eyes swollen with tears.

Sharing is an important part of the human experience. Sharing her story with me, Athena helped me share with my patient and his family. Caring involves sharing our compassion and empathy. Teaching and learning entails the sharing of knowledge and wisdom. This is a large part of what it is to be an RN.

Every day we encounter new experiences, and I am humbled and privileged to have so many opportunities to share with my patients, families and colleagues.

*Julius J. Motal, RN, ASN, PCCN, is a staff nurse who shares knowledge and wisdom with his patients.*
During a routine prenatal appointment, Kathleen and Brian got the news every parent dreads: Their near-term fetus no longer had a heartbeat. After the ultrasound results were confirmed, preparations were made for delivery. For those of us who work in labor and delivery, it doesn’t get much worse than this.

On a recent Thursday, some 100 staff members at Mount Auburn Hospital in Cambridge, Mass., gathered in a tiered auditorium listening intently to the story of the devastated couple, as told by their obstetrician/gynecologist, their grief counselor (who also is a nurse), and two labor and delivery staff nurses who assisted at the birth — I was one of them. The occasion was Schwartz Center Rounds, an educational program hosted at more than 200 healthcare sites — primarily hospitals — in 33 states.

Unlike traditional medical rounds, Schwartz Center Rounds help caregivers express and process feelings that arise when patient care becomes tough for emotional or psychosocial reasons. The hourlong sessions, which generally take place every month or two, begin with a presentation of the patient by a multidisciplinary panel of caregivers who were directly involved. A professional facilitator and the hospital’s rounds leader then open a discussion of the issues raised.

It’s not an hour for problem-solving (although rounds discussions have resulted in specific policy or system changes), but rather a unique opportunity to talk about the emotions caregivers typically do not have time to discuss during the regular workday. It’s an opportunity to examine our prejudices; the moments of transcen-
End of Shift
dence when we really connect with our patients; our feelings of loss or guilt when patients die; our frustration with “difficult” patients and families; and our beliefs about spirituality, end-of-life care and so much more.

Schwartz Center Rounds is the signature program of the Schwartz Center for Compassionate Healthcare, a nonprofit organization based at Massachusetts General Hospital with a mission to support and advance compassionate healthcare. The center is named after Ken Schwartz, a healthcare attorney who died of lung cancer in 1995 at the age of 40. Schwartz wrote movingly about his experiences as a patient in a cover story for the Boston Globe Magazine.

“For as skilled and knowledgeable as my caregivers are,” Schwartz wrote, “what matters most is that they have empathized with me in a way that gives me hope and makes me feel like a human being, not just an illness. Again and again, I have been touched by the smallest kind gestures — a squeeze of my hand, a gentle touch, a reassuring word. In some ways, these quiet acts of humanity have felt more healing than the high-dose radiation and chemotherapy that hold the hope of a cure.”

On his deathbed, Schwartz outlined the organization he wanted created in his name, with a bequest from his estate. It would be a center that would nurture the compassion in healthcare — encouraging the sorts of caregiver-patient relationships that made all the difference to him.

Our discussion that Thursday morning began with sharing the ways in which we try to ease the pain for our patients when they suffer the loss of a baby. Clinicians spoke about providing mementos for the grieving families, including memory boxes that contained a lock of hair, the baby’s footprints, photos of the baby with the parents and prayer blankets, among other items. One staff member said she bathes the infant and scrutinizes him or her for family resemblances as she does with any other baby.

“The little things you do make such an impact on the family,” I told the audience. “These mementos are the only connection families have to their baby. It’s very rewarding to be able to do this — to know that you’ve helped a family.”

Maria Smyth, RN, BSN, is a nurse manager in labor and delivery who has used Schwartz Center Rounds to improve patient care.
On a typical day on our busy cardiac unit, I met one of “those” patients — the kind you will always remember. It is easy to get caught up in our day-to-day activities, but along came Mr. G and I was again reminded of one of the reasons I became a nurse — to help people through life’s transitions. Mr. G did not expect anything from us, as opposed to some noncompliant patients who expect us to reverse years of abuse in a four-day hospital stay. He did not want to be fixed; all he asked of us was to let him die his way.

I first met Mr. G when, as the charge nurse, I admitted him to our cardiac unit. He was a 90-year-old man who had been living alone and doing well with family support. His son had called to check on him, and when Mr. G did not answer, he and his wife went to his home and found him on the floor. He was experiencing some chest pain, shortness of breath and weakness.

I helped Mr. G settle into his room, oriented him to his surroundings, gave him his call bell and taught him the process for ordering his meals — all the standard admission practices. He was started on telemetry, weighed and had his vital signs taken. I introduced myself to him and his son and daughter, and described the lab work and tests we would be conducting.

I learned that Mr. G’s wife had died about four years earlier. When I asked about his living will status, he simply smiled and calmly stated he was “ready to see what it is like on the other side.” He was not depressed; he was a man who had lived a long, good life and was ready to find out what else there is beyond this...
worldly existence. My response was, simply, “After 7 p.m., please.” He said, “OK,” and we both laughed.

The lab work showed Mr. G’s troponins were elevated and he had a non-ST elevation myocardial infarction. I tried to explain to him why he felt weak and that it may take some time to regain his strength. After discussions with his physicians, Mr. G and his son and daughter, it was decided he would be medically managed without additional interventions. He said, “I’m 90.” And that was that. His confusion level still was mild, and he was medically coherent.

For the next couple of days, I took care of Mr. G and he introduced me to his family and some church members as “my nurse Kathy.” He talked a lot about his wife and reflected on their long life together and their children. He said he believed he would see her again. He had no regrets, and felt he had lived a long, full life and was ready to die. His family found him a bed in a nursing facility near their home. We said our goodbyes, and I told him I hoped the “other side” was a nice place.

A week later, I was receiving information on a new admission when I realized it was Mr. G again, this time with pneumonia and respiratory difficulties. I was, again, the charge nurse at the time, so I assigned him a bed and went to see him when he arrived. I knew he had been confused and I wasn’t sure he would remember me, but he said, “Yes, you’re my nurse Kathy.” He said it was nice of me to come see him. I was told by his family that his shortness of breath was worse and he was unable to regain his strength.

I knew Mr. G was going to get his wish, but I wasn’t sure when. Over the next few days, he improved with medication. He was disappointed that we had successfully treated him and he would again be discharged to the nursing home.

A week-and-a-half later, I received word of a new admission who needed a bed assignment, and again it was Mr. G. His son and daughter and their spouses were there. They said he was getting progressively worse and felt the end was coming. I went to see him and found he was more confused than in the past, and more short of breath. Still, he smiled and said I looked familiar, but he couldn’t remember my name. I reminded him and promised to stop in regularly. He responded with a broad smile and told me I’d better.

The day before he died, Mr. G thanked me and another of his nurses, and told us he loved us. When I stopped in the next day, he was restless, and the physician had ordered a morphine drip. Later that afternoon, the nurse assigned to him found me and told me Mr. G had just died with his immediate family surrounding him.

I gave his family my sympathies, with Mr. G lying peacefully in the bed behind us. They thanked us for the wonderful care and told me he had said two girls from the nursing home came to see him, but they couldn’t understand that because no one had come. I wondered if he meant the visit from the other nurse and me the previous day, and his daughter said, “Oh! You know, he did say Kathy came
to see me.” His family and I said our final goodbyes, and later I helped with the customary procedures involved in getting Mr. G ready to see what was on the other side.

*Katherine Foley, RN, is a staff nurse who has formed strong bonds with her patients.*
Aug. 20, 2004, forever will be etched into the deepest crevasses of my mind, heart and soul. My senses seemed keener than usual. My trip to the hospital seemed to go in slow motion. I paid attention to every mundane detail, not wanting to forget one second of that day. It was the day I would welcome my first child, a son, into the world.

My labor was hard. The pain was so excruciating that at times I thought I might pass out. My son was stuck, and no amount of pushing was going to extricate his rather generously proportioned head. Then I was wheeled into the OR. The room seemed cold, sterile. It was a stark contrast to the joy, exhilaration and sense of wonder I was feeling.

After what seemed like just a few moments, my magnificent son emerged, screaming, kicking and even peeing. The instant I welcomed Austin into my arms I felt a monumental surge of happiness that I never had experienced. It seemed to engulf him and me, and at that moment we were the only two people in the world.

During the course of the evening I noticed that my son seemed to be grunting. As a first-time mom, I thought I was being a bit paranoid. The nurse acknowledged my concern without seeming too alarmed, and I dropped the matter. Still, into the evening he seemed to be struggling ever so slightly to breathe.

Again I pressed the issue, this time with a little more fortitude in my voice.
His pediatrician was called, and things began to happen at such a pace that I could feel the wind being forced out of me by the intensity of the activities. Austin was rushed away, out of my safe arms to a special room where they attempted to perform a lumbar puncture. I could hear my baby screaming all the way down the hall from my room, about 100 feet away. I’d just had a C-section, but I leaped to my feet and moved with speed that surprised even me.

Austin was flown 60 miles away to a NICU at St. John’s Hospital in Springfield, Mo., where he was diagnosed with a severe lung infection. I could not accompany him on his journey because I’d just had surgery and could not leave the hospital. I was devastated.

Two days later, I was able to travel to be with Austin in Springfield, where my life would forever change. All I had wanted to be growing up was a mother. Not just any mother, but an amazing one. Fate, however, stepped in and redirected my life. After observing the care my son received in the NICU, I wanted to have an impact on the lives of others the way the nurses taking care of Austin had an impact on mine. I decided right then and there, at age 26, that I would be a nurse.

I knew my relationship with nursing would be rough and long, but I was unwavering in my determination. I made a list of pros: a great career, good health benefits and a position I could be proud of. The cons: little to no money to accomplish the task, childcare needs and hours upon hours of study in addition to my duties as a partner and mother. After weighing the benefits and drawbacks, I entered nursing school.

Since making my decision, I have not looked back. It has been a long and difficult journey, not to mention a massive learning process not only about nursing but also about who I am. Time and again, my abilities, strengths and fortitude have been tested, and I have risen to meet every challenge.

I have learned through my experiences that motherhood and nursing are very similar. Both children and patients test your resolve and your ability to think on your feet. Both will look to you to be their chief advocate.

My son is alive today because of the expert care he received in the NICU. I want to follow in the footsteps of the nurses who watched over my son for me, in the hope that someday someone will remember me as an image of caring.

Lisa Boggs, RN, BSN, was inspired to become a med/surg staff nurse by wonderful nurses who took care of her son.
My husband is dying. No, that’s not quite accurate; he’s been dying for years. Let me explain. Bill and I have been married for 26 years. He is 61 and has been a type I diabetic for the past 50 years. He has lived a full life of career, family and friends. In the past five years, he has lost half of one foot, one leg and vision in one eye, and had four heart attacks and a stroke. Somehow, he managed to survive all of that. Some say it’s because he’s married to a nurse; others say it’s because he’s too stubborn to die. I think it’s a bit of both.

Then, a month ago, came the diagnosis that threw us all for a loop — advanced gastric cancer. My first reaction was: “Are you freakin’ kidding me?” I know what to do for the diabetes, the heart disease, the depression, but I don’t know what to do with cancer.

I know his end-of-life wishes well and kept my promise — he came home with hospice. I fell right back into providing the same “treatment” that I have for years. I continued to give the Plavix, Toprol, Amiodarone, Lipophen while making med sheets to track when the morphine, Ativan and ABHR gel were being given. I took vital signs, gave hygienic care, transferred him out of bed to the chair — like things were the same as before. But they weren’t. I got the hospital bed in place, the commode, shower chair and every piece of equipment that a hospice patient could need. He couldn’t eat solid foods, tolerated only small amounts of liquids, voided less and less, but I continued to search for the liquid that would provide the nutrition I believed was so important. Over the next few days, the deterioration...
was not to be denied. I was carrying him to the wheelchair instead of transferring, the weight loss was staggering and he was becoming more and more confused.

Then reality hit. I was going to lose my best friend, and there was nothing I could do about it. This wasn’t about providing good nursing care, this was about dying. I didn’t have to watch for every symptom and decide if it was something we could handle at home or if it required a hospital trip. I was released from constantly having to make those decisions.

Bill wanted to be put back in his own bed, so we put him there. He wanted a Kahlua and cream, so that’s what he had. We stopped his cardiac medications and reduced his insulin. The small heel wound didn’t start the internal dialogue: “Do I call the podiatrist? How am I going to get him there? What product should I use to fix it?”

I was no longer the nurse, I was the wife who was going to be there for him, to make him comfortable and ease his journey. It was time to put away the technology.

This morning signaled the change that Bill’s journey is coming to an end. I’ve told him it’s OK to go, to which he replied with his one clear sentence: “I want to go to the shore.” We’re Jersey people, and Bill loved the shore (or beach, to those not from New Jersey). So I told him to go to the shore, see the waves and feel the sea breeze. I hope this is what they mean when they speak about symbolic talk. I cried for what he has been through. I cried for what we, as a family, have been through. But, most of all, I cried to God to please bring him home — enough!

God answered my prayer 24 hours later. Bill passed away in my arms, in his own bed, as he wished.

The nurse in my head questions whether I did enough. Then the logical side kicks in, and I have to ask myself whether I would want him here in that condition. He lived a “chronic” life, in which he battled a horrible disease every single day. His fight is over, and now he’s at peace.

Now what do I do? I guess for now I just breathe. And I wait to see what life has in store for me beyond this.

Laurie Yorke, RN, is a wound care nurse who is looking toward the future.
I know I am not the only nurse who has trudged to the car two hours past shift change, feeling dirty and unappreciated and wondering why in the world he or she chose this job. It seems that as time goes by and you become more knowledgeable and efficient, remaining compassionate and connected becomes more difficult. But it always seems to be those days when I feel most disconnected, distracted or exhausted that I witness a moment of grace so powerful that I remember why being a nurse is as much a gift as it is a job.

I recently cared for a 77-year-old male patient whom I will call Mr. Stone. He had been diagnosed with bladder cancer about a month before arriving in our surgical ICU. The surgeon had determined the bladder tumor was so invasive and extensive that Mr. Stone would need a radical cystectomy. He was sent home to recuperate from the initial surgery, participate in physical therapy and improve his nutritional status prior to the cystectomy. Once he was home, however, the bladder tumor began to impede his ability to urinate, and he went into acute renal failure. He was transferred back to our hospital. He underwent several rounds of dialysis, and his surgeon placed bilateral nephrostomy tubes to drain his urine before it reached his bladder.

When I met Mr. Stone, he was close to being transferred out of our ICU to the regular floor. I knew that the most important thing I’d be doing for him would be to get him out of bed, walk him in our hallways and make sure he was eating his meals and nutritional supplements. But Mr. Stone was tired, in pain and had no appetite. He was having frequent, painful bladder spasms, and he had a constant
leakage of a foul-smelling drainage. I could tell it was an embarrassment to him, but much more than that, a distressing reminder of the “wrong” thing that was inside of him, causing him so much pain. And yet, each time I went in to help him walk to the chair for a meal, he nodded yes and started to move.

Only once in the two days I cared for him did Mr. Stone voice any complaint. After I moved him from the commode to the bed during a bladder spasm, he exhaled and said quietly under his breath, “This cancer is killing me.” I sensed for a moment the weight of what Mr. Stone was enduring. It was not only the physical suffering, but the possibility that the cancer would end his life, surgery or not.

I could tell Mr. Stone was a great man because he had a steady stream of children and stepchildren visiting. I learned Mr. Stone’s wife, so distressed by his hospitalization, had suffered a flare-up of her own illness and been admitted to the floor above us. Their children shuttled between the two rooms, reporting to Mr. Stone on his wife’s condition and vice versa. He seemed very concerned.

In the afternoon of my second day caring for Mr. Stone, a bed became available for him on a regular floor. It dawned on me that Mr. Stone’s wife was on a different wing of the same floor. The transporter helped me locate Mrs. Stone’s room. We gently knocked on the door, pushed Mr. Stone in and moved him up to the bed. Mr. and Mrs. Stone embraced, both crying, and whispered to each other while all looked on. The transporter, tears in his eyes, handed me Mr. Stone’s things and said gruffly, “I have to step out for a minute.” There was not a dry eye in the room. It felt like they were starting to say goodbye.

Sometimes, the patients we care for are so battered and torn, they are stripped of everything except the very things that make them human. We nurses are in the trenches, tending to their broken bodies and helping to ease the pain. Removed from their homes, their jobs, even their own clothes, we see people for who they really are.

I spent less than 24 hours with Mr. Stone, but when I hugged him goodbye I felt I knew him better than some people I have known for years. He was a good man who loved his family above all, and who reminded me that the greatest gift in my job is witnessing over and over again that love is the most important thing.

Anna Reda, RN, BSN, BA, is a staff nurse in a surgical trauma ICU who sees the humanity in all of her patients.
End of Shift