McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

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Nursing NETWORK

Creating Connections

A Case of Pulmonary Embolism

By Katherine Athens, RN

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My name is Katherine Athens and I am a nurse in the electroconvulsive therapy (ECT) clinic. It was a busy Friday in the clinic in March, a year ago. We were preparing to treat over 50 patients that day. Our practice had been expanding over the years, and it was hardly unusual to treat 50-plus patients a day — but it was busy nonetheless. (Since then, we have moved to a newly renovated and expanded space within the hospital.) I had recently assumed the role of preceptor for a nurse who had just joined our ECT team. I had been an RN in the ECT clinic just shy of two years at the time.

I was preparing to care for my first patient of the day, "Bob," with the new RN shadowing me. He was a single 62-year-old male, in his second week of ECT treatment. A tall, big man, with large hands and salt and pepper hair, he was profoundly depressed and had very little energy. He had missed a lot of work of late, and his inactivity had resulted in a weight gain of 25 pounds over the past few months. He had a history of hypertension and multiple orthopedic surgeries (hip and knee replacements).

This would be Bob's sixth ECT treatment, the third one that week. Bob was in the acute phase of ECT treatments. Typically, patients have three ECT treatments a week for three to four weeks in the acute phase. Thanks to the treatments, Bob was finally starting to feel better: he said his mood had improved 50% since starting ECT. The best part of my job is when patients finally feel some relief from their depression. It's a great feeling and I am so happy for the patient when it happens. I find that it's easy to be hopeful that a patient will get better because the majority of patients do respond, and we experience patients getting better all the time. But not everyone does respond, so each treatment brings with it a little bit of anxiety that this person may be "the one" whose depression doesn't lift.

Because I had cared for Bob with the new RN just two days prior, his case was clear in my mind. That day, his recovery from anesthesia was memorable because it was somewhat complicated. He had experienced rapid oxygen desaturation, meaning the levels of oxygen circulating in his blood and tissues had plummeted. He quickly became cyanotic — blue— despite being hyperventilated prior to transport into the recovery room. It's very scary when patients' blood oxygen levels get low and you witness them turning blue. A value of less than 88% can result in the death of cells and other problems.

Bob had a difficult airway, which had required me to do an extended jaw thrust maneuver in order to keep his airway patent — open and clear. It is not unusual to perform this maneuver initially, until the short-acting

Continued on page 7

Contents

A Case of Pulmonary Embolism .....*page 1*
Showcasing Our Clinical Practice.....*page 2*
Sustainable Compassion Meditation .....*page 3*
2015 Fall Nursing Conference .....*page 4*
The Cole Center Offers Resources, Support and Hope .....*page 6*

Showcasing Our Clinical Practice

By Linda Flaherty, MS, RN PCNS
Senior Vice President for Patient Care Services

I am delighted to report that the McLean Hospital Nursing Department was well-represented at the recent American Psychiatric Nurses Association Annual Conference held in Orlando Florida, with four posters accepted from our nursing staff.

This is the largest conference of our professional organization with over 1,000 psychiatric nurses participating. It provided a wonderful opportunity to network and learn with our colleagues.

Cindy Ruscitti's poster was entitled, "Older Adults Enhancing Mindfulness, Meditation and New Technologies". Jeanne McElhinney and Mary Lou England presented their poster on, "Patient-Centered Communication in Daily Psychiatric Inpatient Rounds". Paula Bolton's poster addressed "The Evolving Role for Nurses in Neuromodulation Services". In addition, Paula participated in a panel presentation, "Brain Stimulation- What Psychiatric Nurses Need to Know". Lastly, my poster addressed two projects that I and many others have been working on, Recovery-Oriented Practice and our Patient/Family Advisory Council. The title of my poster was, "Promoting Recovery-Oriented Practice: Partnering with our Patient/Family Advisory Council".

Please think about submitting a poster for next year's conference. It will be held conveniently close-by in Hartford, Connecticut!

McLean Nursing poster presentations at the American Psychiatric Nursing Association Conference in Orlando, Florida, 2015. Clockwise from top right: Linda Flaherty, MS, RN, PCNS; Mary Lou England, RN, BSN; Jeanne McElhinney, MS, RN, BC; Cindy Ruscitti, MS, RN; Paula Bolton, MS, ANP-BC

Sustainable Compassion Meditation

By Barbara Waldorf, BSN, MPH

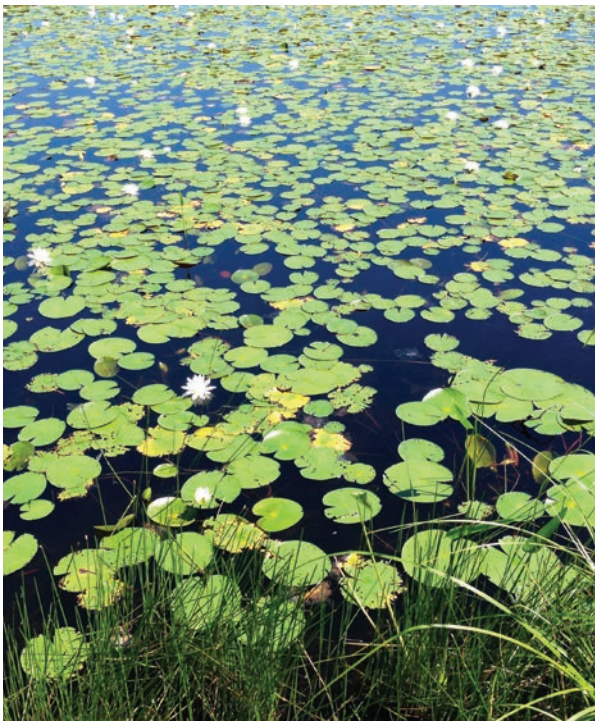
Last year I wrote an article for the Mclean Nursing Network about traveling to India and my journey with global health nursing. This year I am writing about another journey; an inner journey. A journey of burnout and creating resilience which has brought me to teach a class in compassion meditation here at Mclean Hospital for nurses and other healthcare providers.

In my career as a psychiatric nurse, I have been "burned out" at various times. This has caused me to change positions, leave jobs, return to school and study a new form of meditation based on compassion. These experiences led me to ask many questions. How can we retain the core motivation that inspired us to enter this field of caring? How can we restore ourselves? How can we create resiliency within the profession and within ourselves?

Compassion can be defined in many ways – one is: loving, empathetic concern for someone who is suffering, and wishing him or her to be free and deeply well. Compassion is a core value of all the healthcare professions (Baur-Wu, Fontaine 2015).

Some of the challenges faced by those working in mental health (and other fields) can be described as compassion fatigue, empathic distress or burnout. Compassion fatigue has been characterized as the "cost of caring" for those in emotional or physical pain (Figley 1982). Because we care, because we have empathy for the suffering we see on the job every day, we are susceptible. These effects are physical, emotional and can result in work related stress. The impact of compassion fatigue and burnout on both providers and patients has been well documented (Lombardo, Eyre 2011).

There are many strategies suggested for nurses on how to reduce the tendency to burn out and the effects of secondary trauma. Lombardo and Eyre write; "Developing positive self-care strategies and healthy rituals are very important for a caregiver's recovery from compassion fatigue. Healthy rituals are those activities that one participates in on a regular basis and that replenish personal energy levels and enhance feelings of well being."



Meditation is one of the ways that we can learn to evoke our natural compassion. Sustainable Compassion Meditation is a practice, a means to cultivate the innate capacity to find our own inner resource for replenishment, to cultivate resiliency, and a sustainable source of compassionate presence to others. We are not seeking to find it outside of ourselves, in a better 'strategy', but rather to reveal to oneself our innate capacity for care and compassion.

The basic understanding of Sustainable Compassion Training is that we are all compassionate by nature. However, our habitual patterns of thinking and judging obscure a free flowing power of care. The purpose of Sustainable Compassion Training meditation is to interrupt these mental patterns with the loving energy available to us in moments of care and connection, so that our innate compassion can manifest. The ability to sense what others are going through evokes a spontaneous wish for their freedom from suffering and an urge to alleviate their pain.

This involves training in three aspects of care, receiving care, extending care and deepening oneself in the field of care. The practice allows us to touch in on the rich and sustainable source of loving care that surrounds us, and sustains us all whether we are normally aware of it or not.

After studying various forms of meditation for many years, I was introduced to Sustainable Compassion Meditation. I am continually impressed by the impact that these seemingly simple practices have had on my ability to be present for my patients and myself. The power that these practices seem to unlock in so many, has led me to learn to teach, as I feel they are a key skill for anyone in a caring position.

These practices began as the "Compassion beyond Fatigue" workshop, offered by Dr. John Makransky, a professor of Buddhism and comparative theology at Boston College, who adapted these meditations to make them accessible to people of all backgrounds and faiths. They have been taught to people in many diverse professional settings including therapists and clinical psychologists, social workers, social justice activists, health care providers, pastoral counselors and ministers through organization, The Foundation for Active Compassion.

Continued on page 5

2015 Fall Nursing Conference

Friday, December 4th
Pierce Hall
9:00 a.m. – 3:00 p.m.
5.5 Contact Hours

8:30 a.m. – 9:00 a.m.
Coffee and Registration

9:00 a.m. – Noon
"Clinical Work with Transgender Patients: Issues in Development and Care"
Presented by:
Rubin Hopwood, MDiv, PhD- Coordinator
Timothy Cavanaugh, MD- Medical Director
The Transgender Health Program at Fenway Health

Noon
Presentation of the Marguerite Conrad Award
to Tanya Bastone, RN/STU for Excellence in Teaching & Mentoring

Noon – 12:45 p.m.
LUNCHEON

12:45 p.m. – 2:00 p.m.
"A Faulkner Nursing Presentation: Experiences with EPIC"
Paula Knotts, RN, MSN- Nurse Director, Psychiatry
Chris Richard, RN- Clinical Lead Faulkner Hospital

2:00 p.m. – 3:00 p.m.
"The Photo Voice Project"
Megan Mooney, MS, OTR/L- Program Director & Occupational Therapist Waverly Place

Continued on page 5

Surrounded by staff from the Short Term Unit, Tanya Bastone, RN, receives the Marguerite Conrad Award for Excellence in Nursing.

Sustainable Compassion Meditation
continued from page 3

http://foundationforactivecompassion.org/

In 2014, The organization Mind & Life Institute, (founded in a series of dialogs on science with the Dalai Lama), launched its Ethics, Education, and Human Development Initiative, inspired in part by the Dalai Lama's call to design a curriculum in "secular ethics." Working with experts in psychology, neuroscience and education theory, they modified these practices and created a program of contemplative training, designed for teachers and children, the "Call to Care Initiative".

https://www.mindandlife.org/the-care-proposition/
https://www.mindandlife.org/

A new program titled, "Courage of Care" is the next iteration. Part of the program was specifically created with the intention to present this training to heath care providers, nurses, mental health counselors, therapists and doctors.

An 8 week class in Sustainable Compassion Meditation will be offered at Mclean Hospital in Belmont MA, starting on Feb 11, 2016. The class will run from 5-6pm on Thursday afternoons. We welcome everyone. If you have any questions, please contact Barbara Waldorf at bwaldorf@partners.org.

Thank you to Tamara Daly RN and Ilona O'Connor RN for their contributions to this essay. We will be co-teaching the class above.

Bauer-Wu, S; Fontaine, D. "Prioritizing Clinician Wellbeing: The University of Virginia's Compassionate Care Initiative." Global Adv Health Med. 2015;4(5):16-22. DOI: 10.7453/gahmj.2015.042

Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner-Mazel.

Lombardo, B., Eyre, C., (Jan 31, 2011) "Compassion Fatigue: A Nurse's Primer" *OJIN: The Online Journal of Issues in Nursing* Vol. 16, No. 1, Manuscript 3.

The Cole Center Offers Resources, Support and Hope

Bettina Hoffman, (standing) Executive Director of the Cole Center, works closely with Evie Barkin, (seated) co-founder and President.

The Jonathan O. Cole, MD, Mental Health Consumer Resource Center has been a lifeline for countless people, according to executive director, Bettina Hofmann. Named in memory of McLean's late chief of psychopharmacology, whose pioneering research established the entire field, the 25-year-old Cole Center is information central for patients and families looking for answers to everything from what housing options exist for mental health consumers to how to apply for disability to where to find affordable medications or legal help. The resource center is stocked with mental health reference books, resource guides, pamphlets and fact sheets about every aspect of living and thriving with a psychiatric illness. Hofmann and others have worked hard to make the Cole Center a warm, welcoming space where people sit, read, chat and get their questions answered by its all-volunteer staff. But the center provides so much more than information, according to Hofmann.

"One of the most important things we offer is a safe place— a community of peers," said Hofmann, who initially came to the center as a consumer, became a volunteer a year later, and took on increasing duties until becoming executive director and volunteer coordinator in 2013. "All of the volunteers are those who have lived and dealt successfully with mental illness. We can offer empathic support, informed guidance, compassion and hope. There are no language barriers, as we have all lived with similar issues and challenges." Family members as well as McLean staff — who sometimes accompany their patients to introduce them to the Center — also use its services.

The Center's Offerings

Hofmann admits that over the years, the Cole Center's services and hours expand and contract depending on the number of volunteers, who, as part of its Recovery Enhancement Program, do everything from answering phones to researching visitors' questions to updating resources. The Center's consumer-run businesses, the gift cart and book cart, enable volunteers to learn retail skills.

Current Director of Volunteer Services Joe Ferris is a terrific recruiter, so Hofmann has big plans for 2016, including:

- Continuing the Center's peer counselor-run Shared Decision Making workshops, where attendees learn how to collaborate with their caregivers to make treatment decisions
- Offering workshops on topics including health and wellness, bodywork (e.g. acupuncture and Reiki) and career services (career counseling, job search support, resume writing and mock interviews)
- Hosting a weekly Wednesday luncheon "chit chat" group in the de Marneffe cafeteria from 12-1 p.m. for mental health consumers, families and McLean staff
- Expanding its job-seeking assistance through new collaborations with Career Source, a state-funded career center, and Jobs Without Limits, a statewide network of employers and other partners whose goal is to increase employment among people with disabilities.
- Doing outreach to McLean's inpatient programs to educate patients and staff about the Cole Center and its services
- Joining McLean's Patient Family Advisory Council to address consumer and family concerns in order to enhance treatment and recovery

Continued on page 8

A Case of Pulmonary Embolism
continued from page 1

anesthetics have worn off and patients are breathing and exchanging air on their own. But because Bob was a heavy set male with a large abdominal area and a lot of soft tissue surrounding his throat, he was more susceptible to airway obstruction, requiring extended airway support.

In visually observing Bob prior to the day's treatment, I noted that his skin color was pale; he just did not look healthy. I asked him how he felt physically. He said he was tired and had low energy and had been hypoactive for the past few months. He denied being short of breath or having chest pains and said that he could walk up a flight of stairs without dyspnea — shortness of breath. His blood pressure was elevated prior to the treatment. He had taken his amlodipine, a blood pressure lowering medicine, two hours prior to treatment as instructed. His oxygen level was an acceptable 94-95% on room air. His EKG showed normal sinus rhythm.

I consulted the treatment team to review the assessment and the events of the previous treatment's recovery. After careful review, the consensus was that we should proceed with treatment. It was decided that we would place an oral airway post-treatment. If his blood pressure remained elevated, we could give him an additional beta blocker in his IV. I would instruct him to see his primary care physician about his elevated blood pressure prior to his next treatment. We were anticipating another busy recovery— meaning lots of monitoring and various efforts to keep his airway open. And we were right.

Bob's ECT treatment was uncomplicated. But once in the recovery room, he deteriorated rapidly, as he had during his last treatment. Despite clearly exchanging air with a patent oral airway in place, he began de-saturating again. Quickly, his oxygen level dropped to the low 60s (percent), requiring manual re-oxygenation via an ambu bag by the attending anesthesiologist.

There are few things scarier than when a patient's oxygen level plummets. Low oxygen levels can trigger an arrhythmia, which can snowball and before you know it, you have a huge emergency. The anesthesiologist mentioned that in the operating room, they often see rapidly de-saturating oxygen levels in patients who have a pulmonary embolism. His statement was the catalyst that made me consider the likelihood that this was the disease process we were observing. A few minutes later, Bob remained hypertensive (usually by this time BP begins to approach baseline) and began having a ventricular dysrhythmia called trigeminy. This dysrhythmia is not rare to see here, but it is concerning when a patient goes into this rhythm for the first time without a history. I notified anesthesia and he was given IV labetalol. He resumed normal sinus rhythm and his blood pressure decreased.

Thirty minutes after his treatment, we still were not able to wean him off the 02. His oxygen level was 88% on room air and only 94% on 10 liters of 02. Usually, by this time, patients are able to maintain normal parameters on room air. I went into troubleshooting mode: repositioning the head of the bed, having him breathe deeply and cough, and double-checking the monitor to make sure it wasn't malfunctioning. He was mildly tachypneic — breathing fast— with 24 respirations a minute, but was not diaphoretic or using accessory muscles for breathing. Again, he denied feeling short of breath and had no chest pain or dizziness. He wasn't particularly anxious either. By 45 minutes post-treatment, his 02 was 91% on room air – still too low. I consulted with the treatment team, who recommended I get Bob ambulating and have his vitals rechecked in the recovery lounge. I communicated the events of the day's treatment to the mental health specialist who would now take over in the recovery lounge, emphasizing the need to monitor his 02 (at the time we monitored only blood pressure and temperature in the recovery lounge, but that has changed), which she did. At one point, it dipped dangerously low again.

The MHS came to me privately when Bob was ready to be signed out and told me that his brother told her that Bob had not been feeling right at home and felt sick after going up some stairs. I took Bob into a private exam room and asked him if this was true and he admitted it was. I let him know that I was not upset at him, but concerned something was wrong and I genuinely cared for his wellbeing. I assured him that we would find out why he was feeling this way and I would have our internal medicine physician see him before he left. When I asked him why he hadn't told me pre-treatment that he had been feeling unwell, he said he was beginning to feel less depressed and was afraid we would turn him away. It made me sad to think that the treatment was so important to him that he would lie— and potentially risk his life —to ensure he could access it.

I informed the treatment team of this new information and the discharging psychiatrist came in to see him again. The psychiatrist was able to contact Bob's primary care physician, while I worked on getting internal medicine to see him. Bob's PCP asked us to send him to Newton-Wellesley

Continued on page 8

The Cole Center Offers Resources, Support and Hope

continued from page 6

A Model for Other Resource Centers

The roots of the Cole Center can be found in Boston's Depression and Bipolar Support Alliance (DBSA), a peer-to-peer education and support organization. Cole Center co-founders Evie Barkin and Anne Whitman, who knew each other through DBSA, noted that many people were calling the organization seeking information related to other psychiatric illness. So they drew up plans for a resource center with a wider focus and began looking for a psychiatric hospital to host the fledgling center. Barkin, who today serves as the Center's president, was pleased when McLean Hospital offered space, enabling the Center to open in 1991. Today, the Cole Center is located on the first floor of the de Marneffe Building.

As the first resource center of its kind in the nation, the Cole Center has become a national model for others, including Massachusetts' Department of Mental Health-funded recovery learning communities. These days, Barkin is not as involved in the day-to-day running of the Center, but she is the go-to person for wisdom and advice on just about everything, commented Hofmann.

Hofmann said that one of the most fulfilling parts of her job is helping family members of recently diagnosed people begin to negotiate their new reality. "It's very frightening for them," she explained. "They feel lost, alone and confused. How do they navigate the medical system, recovery, interact with each other, get support themselves? A loved one who is willing and able to get involved is a critical piece in the recovery process for both the consumer and the family. And the Cole Center provides them with support, assistance and hope."

The Cole Center is open on Tuesdays and Wednesdays from 10 am-4 pm and Thursdays from 1-5 pm. Hofmann hopes to open the center on some weekends and evenings as well. The center's outer foyer is accessible 24/7 and offers an extensive library of mental health resources. ■

A Case of Pulmonary Embolism

continued from page 7

Hospital to be evaluated. Our internal medicine physician saw Bob shortly after. Because he was not in acute distress, he agreed that it was OK for Bob's brother to take him to the hospital.

After Bob left McLean with his brother, the nurses and the MHS had a quick debriefing. The MHS became a little tearful as we all recounted what had happened, which in turn made me emotional. I think contributing to the intensity of the case was the fact that I felt responsible for the nurse I was training and hoped I had been a good role model. One of the strengths of the ECT service is how well we function as a team and I think that teamwork had helped avert a potential tragedy.

The following Monday we found out that Bob was admitted to Newton-Wellesley Hospital over the weekend and was found to have multiple pulmonary emboli. He was successfully treated with Coumadin and Lovenox without any adverse sequelae, and was discharged a few days later on Coumadin. He ended up continuing his ECT treatments at Newton-Wellesley.

Our ECT practice is expanding and we are treating more patients than ever before. Compared to the general population, our patients are at an increased risk of developing a PE, and many travel long distances to McLean for ECT, putting them at even greater risk because of the time they spend sitting in a car. So it makes sense that I am going to encounter more cases of pulmonary embolism. Fortunately, this case had a positive outcome from a medical point of view. Having had this experience, I feel I am better able to identify patients at risk of and suspected of having a PE, and I am more confident in my ability to educate my patients of the risk factors and warning signs. ■

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