The extra mile

by Maria Gomes, RN

BIDMC nurses often talk about going “above and beyond” for their patients, or going the “extra mile” to ensure that patients get what they need. For Maria Gomes, RN, a clinical nurse III at Bowdoin Street Health Center, the extra mile was not just a figure of speech. When obstacles arose related to her patient’s ongoing care, Gomes traveled to the patient’s home to see what could be done.

As nurses, we are taught to advocate for our patients. The idea of advocacy was very much on my mind as I cared for Mr. L.

Mr. L. was non-verbal, wheelchair-bound, and unable to perform daily activities on his own, such as bathing and dressing. His history included diabetes, hypertension, and COPD; he was unable to speak due to a stroke he had suffered in the past. Because of his immobility, he developed a pressure injury to the lower back and buttocks. His family brought him to the clinic for evaluation because the skin had ruptured. The open wound from the pressure injury required debridement in the emergency department. After the ED visit, Mr. L. returned home with a referral for a visiting nurse.

I knew I had to follow this patient and family closely in order to prevent worsening symptoms. In reaching out to the family, I learned that obstacles had arisen with regard to home care services, due to Mr. L.’s lack of insurance. My first thought was to reach out to different home care agencies and try to facilitate home care. But the insurance issue was a significant barrier. I began to worry that Mr. L.’s wound would worsen, complicating his health condition. In an effort to expedite services and treatment, I arranged to do a home visit.

I asked one of our community health workers (CHW) to accompany me to the home. Mr. L. lived with his daughter in a 2-bedroom apartment. He slept on a small twin-size bed. At the foot of the bed was a wheelchair. The apartment appeared in good condition. The CHW and I learned that Mr. L.’s daughter was his primary caretaker. I took the opportunity to do some initial teaching with Mr. L.’s daughter, while doing a dressing change and packing the wound. I was thinking about all the things Mr. L. would be needing in order for his wound to heal.

Mr. L. did not qualify for many community services, but I wanted to ensure he would receive proper treatments and follow-up. Being optimistic and tenacious, I reached out to one of the non-profit elder services agencies in the community. After several messages and calls, I was able to speak with someone. I explained the situation and the urgency of the matter. The agency was able to provide Mr. L. with a hospital bed and air mattress through one of their grants.

I made several more visits to Mr. L.’s home. I worked with Mr. L. and his daughter to set goals for his care. I taught them how to perform dressing changes twice a day, and I explained why it was important for Mr. L.’s position to be changed frequently, getting the pressure off of his wound and off of other areas that could develop new injuries. We talked about the importance of nutrition in wound healing. I stayed in close contact with the family, which allowed me to monitor signs and symptoms.

Within 8 months, Mr. L.’s wound went from 6 cm. to less than 0.5 cm. deep. Mr. L. and his family were very grateful for the services they received. I also appreciated this experience as I learned valuable lessons about persistence, advocacy, and care management. We see many patients in our community health center.

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There are often obstacles in our path as we attempt to provide care, but if we are persistent and resourceful, we can find answers. I know it is my job to advocate for our patients and families so they may receive the best possible care and gain access to any available services.

As an advancing clinical nurse, I was able to develop a solid relationship with my patient and his family. Mr. L. and his family members felt secure confiding in me, and they looked for my help to resolve their issues. I tried my best to advocate for their needs. I was able to make sound decisions by analyzing and integrating all the pieces of Mr. L.’s clinical and social situation. During meetings with Mr. L. and his primary care physician to discuss treatment options, my opinion was valued and added to the care plan. The experience with Mr. L. confirmed the faith I have in the power and importance of the clinical nurse role.

N.B. Clinical nurses at Bowdoin Street Health Center occasionally are able to do home visits for high-risk patients, on a case-by-case basis.

Identifying details have been changed to protect patient privacy.

In November 2017, a team that includes nine BIDMC nurses was honored for its work on the CARE (Communication, Apology, Resolution) Program which, according to Pat Folcarelli, RN, PhD, vice president for health care quality, aims to “improve communication and transparency following adverse events, improve patient safety, reduce lawsuits, and proactively meet injured patients’ needs.” Teams and executive sponsors from BIDMC and Baystate Health who collaborated on CARE shared the prestigious HOPE Award from the organization, Medically Induced Trauma Support Services. It honors individuals or teams whose work “supports healing and restores hope to patients, families, and clinicians impacted by adverse medical events.” Shown left to right are team members Folcarelli; Carolyn Wheaton, RN; Stacey Lunetta RN; Lindy Lurie, LICSW; Dorothy McWeeney, RN; Manuela Rosa, RN; BIDMC President Peter Healy; Cheryle Totte, RN; Debra Barbuto, RN; Mary Fay, RN; Beth French, RN; and Angela Adamson. Not shown are Taj Qureshi and Melinda Van Niel. Executive sponsors were Ken Sands, MD, former chief quality officer at BIDMC; and Evan Benjamin, MD, former senior vice president for population health and quality at Baystate Health.