January 29, 2016 and February 15, 2016 – Grace Spena (DN 1971) speaking with archivist Kelsey Duinkerken at Thomas Jefferson University in Philadelphia, Pennsylvania

Guide to abbreviations:[1]

KD: Kelsey Duinkerken
GS: Grace Spena
{CG} cough
{LG} laughter
{BR} breath
{NS} noise
- partial words
-- restarts

[Start of recording from January 29, 2016]

GS: Um, OK. My name is Grace Ann Spena. Uh, I graduated from Jefferson, the Diploma School of Nursing in nineteen seventy one. Um, and since that time I have had a wonderful career in nursing, um, spending probably twenty-seven years plus in the acute care hospital setting. Uh, and almost um seventeen and half years in the college health setting. And then along with that since I retired in um January of twenty fourteen I've continued to do some part-time work at the college that I was working to assist with employee wellness programs and special projects and maintain relationships with our community up in the Montgomery County and Burks County area. Um, the um, the thing that I loved most about my nursing career is that it offered me the opportunity to do a lot of different things, um, and just continue to grow on my experiences that I had, which I found to be extremely helpful and um, supportive. But in addition to that one of the biggest things it helped me do well in my career is that I've had some great mentors from the time that I was at Jefferson to all the way through until my retirement.

KD: OK, great. Um, so could you tell me how you first became interested in nursing and how you arrived at Jefferson?

GS: OK. Uh, I'm originally from Philadelphia. Uh, I live, I lived in South Philadelphia most of my life, and um, my father died when I was seven and a half and my mom was a single parent with three children. And she was a seamstress and she worked in some of the um factories up in Center City Philadelphia. And back then in the fifties and sixties, um, we still had trolley cars that would come up Eleventh Street from South Philly, and so, uh, I passed Jefferson many, many times, and used to see the doctors and the nurses walking back and forth on Eleventh Street. Um, and I was always curious about it, um, never thinking at that time that I was interested, um, but when I became a sophomore in high school I um, between sophomore and junior year I was able to volunteer as a uh Red Cross volunteer at one of our

[1] Transcription rules are based on the University of Pennsylvania's February 2011 Transcription Guidelines: http://www.ling.upenn.edu/~wlabov/L560/Transcription_guidelines_FAAV.pdf

local hospitals. At that time it was Saint Agnes Hospital on Broad Street. And um, at the same time my uncle married a woman who was a medical technologist, my Aunt Rose. And Aunt Rose talked about all the work that she did. And I loved science. I was more a science person than an English person. I loved math. And um, and I thought, "Wow," I said, "that would really probably be something I would like to do." So I was actually interested in medical technology and I, and I had told my mom that. I said, "I think I'm going to maybe look at how Aunt Rose got her career and maybe go that way." So in the meantime though I was doing my Red Cross volunteers, and uh, volunteer duties, and they had asked me, you know, where I wanted to do my duties. And I said, "You can put me anywhere, I don't care." And so they actually had me in the admission office of Saint Agnes and so I um, was doing that work and I would go up to the floors and bring the patients up, and I would interact with them and all that. So this one day the nursing program, the nursing school at Saint Agnes was having um, an open house. And they had invited all of the Red Cross volunteers. So a couple friends of mine said to me, "Hey Grace, do you want to um go to the open house?" I said, "Nah," I said, "I'm, I don't," I said, "I'm not interested in nursing." I said, "I want to become a medical technologist." And they said, "Well, they had cookies and ice cream."

KD: {LG}

GS: So that's how they got me there. Well, that's, that changed my life. Because um, when I was sitting there, and I'm sorry if I get a little filled up, because it still hits me.

KD: Sure.

GS: Um, the nurses, the nursing students were talking about all that they had learned, all that they did, and I was like, "Wow, that is really like unbelievable." I'm like, and it just touched me. And that night I went home and I said to my mom, we were cleaning up after supper, and I says, "You know mom," I said, "you know how I kept talking about wanting to become a medical technologist?" I said, "I don't want to do that." I said, "I want to become a nurse." And she looked at me and she said, "A nurse? Why?" And I said, "Mom, you don't know what they do, I mean all they have to study." And she said, "Are you really sure?" She said, "Because you know, they don't all have good reputations." And, because if you think back into the sixties, um, the mid sixties, mid to late sixties, most of what people knew about nursing was what you saw on T V. And most of it was either in soap operas where the nurses were, you know, always like guessing the doctors or sleeping with the doctors, OK. Um, but nothing like really about the role that the nurse really played as an advocate for patient care, as the one who knew the most really about the patient, not the doctor, but the nurse. So I was telling her, she said, "If you really think you want to do that, where would you go to school?" And I said, "You know, I think I would love to go to Jefferson, but I don't know if I would get in." So, I said, "I want to apply to Saint Agnes, Methodist," which were two community hospitals. I said, "I want to apply to Jefferson." I said, "I'm going to apply to Hahnemann, and I'll see which one I can get into." And I was fortunate I got accepted at all four, and when I got my acceptance letter from Jefferson I was like, "Oh my god, I can't believe this!"

KD: {LG}

GS: All those years there must have been a reason why I was connected going up and down in the trolley car. So I uh, so I came in for my interview and, and everything and they looked at all my grades. And so I

got accepted and I was one of I think of about maybe ten or twelve students, who um, had a few of our scores were on the low side for our pre-entrance test, but they said that they felt that based on everything else that they had found from us that they thought that we could still do the program. And they actually um, gave us all, um, a uh, an enhanced reading program, that they brought somebody in from outside to give us some uh better reading skills and comprehension skills for what we were going to have to do. Like most of us were already really good with math and science, but it was on the reading end of certain things that we, some of us had difficulty with.

KD: Yeah.

GS: So um, anyway, so we did that, and, and we had that program, and it was very very helpful. And from there, you know, I went and got my -- actually let me just stop and backtrack a second. When I went to go get my books for Jefferson my uncle happened to stop over, my Uncle Charlie happened to stop over. And he was looking at the books, and um, he, when I got in after I, I had dropped them off he had come, and then when I came back home he says, "Are you going to be a doctor?" And I said, "No." He said, "My god," he said, "these books are so like detailed." And, and I said, he said, "Wow." I said, "Well what they tell us," I said, "is we actually do get taught by some of the doctors, you know, or our teachers or our nursing faculty also teach some of the medical students." So I said, "Sort of like," I said, "you know, it's going to be interesting to see all this." So, first day comes and you know, we're here and um, I lived in the residence hall, uh, four thirty five for the four -- three years I was here. And um, it was a very difficult program. Um, the faculty were demanding, um, but their message was, "If you don't get it right now, the option is is that you will do it wrong for a patient, and that patient's life is in your hands." And they always said if you went to a program where you just kind of flew through it, chances are you're really not getting what you need and the bottom line is it's your patient is going to suffer. And they kept just drilling that into us. Um, they were very detailed oriented. They were very focused on your ability to, um, learn the procedures that were being done at that time so that you, you felt that you really knew them. It wasn't just like you just sort of had a taste of it.

KD: Sure.

GS: You had to repeat it and, and do it several times so that you could walk and say, "Well, you know, yes, I did that and I do feel comfortable." Or no.

KD: Do you remember what any of those procedures were?

GS: Well, it could be anything from suctioning patients to, colo-, colostomy care to, uh, any kind of wound care, surgical care. Um, really learning about nutrition and the impact nutrition had on the healing aspects of the body. Uh, which it was interesting, because as my career progressed, um, and in the um, mid-seventies, when um total parenteral nutrition, which we used to called T P N, came out, um, nutritionists were really trying to help doctors understand, you can do this surgery and if you have to keep them N P O for ten days, chances are they're not going to heal properly. So the role of the nutritionist really in helping us understand, you know, "Yes, you can't have this person eating for ten days because they just had major gastric surgery, but we have to provide them the subsequent nutrients in another way. So that became a very um, prominent thing in the mid to late seventies on how to get

physicians to recognize, don't wait ten days and then start it. Start it almost immediately so then your patient has the best chance of not only having a successful surgery but having the healing process be successful. So um, so the, there was a real uh effort to look at the team approach among the entire uh group of healthcare providers. You know, the physicians were always looked at as, yes, they're the uh, if you might say top dog. But behind every top dog there is a team of nurses who really help them be successful. In no matter what area that you work. And that is even true today. I mean, you can have doctors out there, physicians out there who like think they're god, OK? But the bottom line is they have been given the talent and the skill to do something that I'm in awe of many times. But I know that if all of the work they've done is then not supported by an assertive and attentive and knowledgeable team, that patient will not do well. And so all the work that they have gone to school for to learn and to have the tenacity of opening somebody up and knowing what is there {LG}.

KD: Yeah.

GS: I look at it like, "OK, yeah, if that's what you say it is, that's fine." But to be that, that skilled, um, to be able to do that, they need a good team working with them. And sometimes it's a matter of them recognizing um, that we value what it is that they do, but we also want them to value what we contribute to it as well. Because the bottom line is there's no patient I ever know that's cured by one healthcare provider. It's really by a, a team that's working together. And when that team is not working together you and I are at tremendous risk and our families are at tremendous risk of having incompetent care and uh, and having people not really see it, that's the thing. So um, so we always laugh about the check books having to, you know, check off this and check off that, and I'll tell you, all of us, all of my teammates, my classmates, and later on colleagues, appreciated the fact of the intensity of what we did have. We may not have liked it at the time {LG} but we appreciated it and wished there was that same level in more schools today. Now I know the Jefferson School of Nursing, the College of Nursing, with its Bachelor's program and the Master's program and now Doctoral program, uh, they've learned over the years too the uh, how to try to make it work as a, as a collaborative effort and realizing that when you put a new nurse in any hospital today, um, they still need to develop their own self confidence beyond what they had in school because now it's no more a matter of, "Well, can I do this, Miss. So and So or Mr. So and So," if it's a faculty member. It's you're expected to know to do it, but you're also expected to know what you don't know. And when a nurse knows what she doesn't know and knows how to go ask the questions and have somebody on the other end of that question being able to respond, then it really is important that that dynamic is available. Because over our lifetime career we don't know everything. And things do change and procedures change. There was always within the hospital systems of, of schools of nursing, the diploma schools of nursing, there was always, well, um, back in the day where it was, "Well, well this is the way we do it here. That's the Jefferson way, but we do it this way." And I always would ask, "Well why do you do it that way?" To see if it made any more sense than what I learned from Jefferson. Because sometimes people get rooted and things, and many of us that are of the older group of nurses, or I should say the not so young group of nurses, um, need to realize that even some of the procedures we did back in our day have been shown through research to maybe to not have been the best, you know. Um, and so, or may not have been necessarily the most appropriate way to do it.

KD: Yeah.

GS: OK. So, so if you stick with one thing and say, “Well that’s the way we did it back in the day, and that’s the way we should do it now.” You really need to test it. Did it really work, was it really working? You know, maybe in that patient it worked fine, but maybe not in all patients, you know. So the, the, the availability now of the research that’s being done to validate procedures, uh, that have been done both in the past and still currently, uh, so that we’re always giving the patient the best care.

KD: Alright. So what can you tell me about your time at Jefferson. So, let’s start perhaps maybe with the classes, the instructors, the clinical setting?

GS: The uh, the classes were um, awesome. Uh, and I realized that more when I left Jefferson and went on for my Bachelor’s degree, later on. Um, when I, uh, looked at some of the curriculum that the four year program that I went to had, that I’m like, wow, well we had all this plus, you know?

KD: Yeah.

GS: So it was really interesting to realize just how good of an education we had, uh, at that time. And the faculty were thorough. Uh, I can’t recall, I really cannot recall one faculty member that we had in the diploma program that did not know her, her stuff. I mean we didn’t have, other than, um, was it Dr. Mendel who was our um, um, microbiology, I think pretty much everyone else was our female instructors. I’m trying to think if there was one other fe- male, Dr. Trepeo(?) possibly. I can’t recall exactly the name. But uh they, they knew their stuff. They knew their stuff. And they wanted -- and the interesting thing is they wanted you to know it. They were not afraid for you to become as knowledgeable as they were. Because the whole name of the game if you might call it was, “I want you to be as good as you can. I want you to be the best nurse you can be, and if I can do that for you, then that’s what my job is,” you know. Um, yeah there were some what you would call, um -- you know we had our curfews, and um, let me just take a drink here.

KD: Sure.

GS: {CG} Uh, students today laugh about curfews. Uh, we weren’t allowed to be married, we weren’t allowed to have children {CG}. Excuse me. And um, could you shut that off for a sec?

[Recording paused]

GS: So we’re back again. Um, you know, talking about the, the quality of the faculty at Jefferson, um, I can’t speak more highly than to say they were, they were really, really good. Even, even some of the ones who uh really kind of drove you really extra hard, um, almost like you were in the military. And we did have one who was a former Army, uh, um, veteran. Miss Gamble. She would actually come into your room with a white glove. You know, she’d drop a coin on your bed, you know. And, and people today would probably laugh and say, “Oh, that was probably a little overdone.” What I got out of that, and I think most of our colleagues got out of it is the difference of looking to try to do the most you can for a patient. And today often times when you go into patient rooms they’re an absolute mess. Uh, and nurses will say, “Oh well that’s housekeeping.” Well, housekeeping does certain things, but the

environment for the patient is still part of our responsibility, because if you connect a chaotic environment it doesn't -- with recovery of a patient it, they don't go quite well together. It's, any chaos that a patient has both in the uh, their own health situation and maybe a difference of opinion with family and uh, you know, maybe they're struggling with work, and now their room is a disaster, and it looks like nobody cares, OK? Sure patients might say, "Oh, well you don't have to worry about that. You know, that's OK." You say, "No, it only takes a couple seconds to do it." So whether it's me the nurse or I have the nursing assistant, you know, we don't have a lot of licensed practical nurses in acute care settings but there's a lot of them in the long-term care settings and assisted living settings, you know, when they go in and help a patient or a resident, um, get more a little more organized and they feel a little bit of a connection, it means that, "Wow this person does care about me." It really does. It does make a difference. So, I think what they, what they were trying to impart to us is that while they were doing this in school to try to focus on more of the perfection, they knew when you got out into the real world of nursing, that all is not always perfect, but you are going to strive to look at the things that you can make better for a patient. Um, you know today, um, you know, you can go in and be a patient in a hospital and not have anybody come up and offer you any kind of personal care. Um, and they say, "Well, you know, you don't, some people don't do it when they're home all the time." That's not the point. The point is the more you can connect with a patient at a personal level, the more likely the patient is to confide in you, to let you know maybe their fears, uh, because how often can you go into a room and maybe a person has had, maybe they've had a mastectomy or they've had a um, a colon resection and now they have a colostomy. Um, they're hesitant to talk about it, and they're more hesitant when it's a stranger. And a nurse is a stranger until you establish a relationship with a patient. And, and I know a lot of folks will say, "Well we don't have the time. We have all the paperwork to do. We have all the computer work." We can find the time. And I know we can find it because I've been back in the field. I left hospital nursing, not because I wanted to, but there was a lot changes occurring in the eighties and early nineties, with the changes in the healthcare system. Um, D R G's came in, diagnosis-related groupings came in, followed by H M O's, health maintenance organizations, and that made a different flow for hospitals in terms of how long they could keep patients. Uh, so beds were becoming empty, hospitals were closing units down and a lot of hospitals closed. And we've had a lot of hospitals close that have closed in our tri-county area over the last forty years. Uh, so, what has happened is there has had to be a refocusing and a re-planning of what you're going to do. But the bottom line is, is for every nurse who worked then, every nurse who works now, if your patient isn't your priority, then you have missed the boat. How you then do for your patient who you have made your priority, you have to maximize your time. And we had to do it back then and we still have to do it today. One of the best gifts that I got was in two thousand seven. I had been out of the hospital setting for twelve and a half years. Uh, and it was interesting how that happened. Let me just backtrack a second.

KD: Sure.

GS: My career spanned from Jefferson to Medical College of Pennsylvania, where I became a -- I left Jefferson as a staff nurse. I worked here a couple of years in the critical care unit, um, surgical care unit, surgical I C U. Uh, I wanted to expand my uh, critical care experience to include cardiac. And back then

um, you had to leave your primary position, work out on a nursing unit before you could get into the cardiac care unit. And I didn't like that idea. So uh, some of my friends had went to Medical College of Pennsylvania, and they had a combined medical-surgical unit, so I got to care for post-open heart patients, I got to care for medical M I's, I had head trauma, you know, overdoses, stab wounds, whatever it was. It was a real diverse opportunity. Uh, I did that for a couple of years and they started prodding me about maybe looking at a head nurse position, uh, on one of their units that they wanted to make a step-down unit for post-op hearts. Because back then hearts stayed in I C U at least ten days. Today you're lucky if you get a day and a half. But -- or two. Um, but um, you know, so they needed to have a unit that would be responsive and receptive. And so, I was already doing some teaching as part of my I C U experience, and I had really wanted to be the head nurse of the I C U, but at that time there was a nurse from Medical College of Pennsylvania who graduated from their program who I thought even if I thought I was better than her to do the job, she was somebody from inside, and my opportunity to do the job as well as I would have wanted to may not have been as good because more of the staff were from the Medical College of Pennsylvania and the rest of us were outsiders. And so I thought, well, what'll I do is, I withdrew my application, she got the position, I did everything I could do to support her, and then in the meantime this other opportunity came up which I had not thought about because I wasn't really thinking about going back and working on a medical-surgical type of unit because I really enjoyed I C U. But again, it was somebody whispering in my ear, saying, "You can do this, you can do this." And I did it. And I did that for a couple, about uh, two and a half years, and my Director of Nursing had encouraged me to go back to get my degree. And, and I said, and she said, and I said to him -- it was a him at the time, which was unusual back in the day, that if you, you know, I said, "You know, there's been so much controversy about us having to be required to go back and get a Bachelor's degree." He said, "Look Grace," he said, "you're my youngest head nurse. You have already proven you are a good nurse." He said, "This is going to give you more opportunities in the future. You're not getting trained to be another nurse. You are a nurse. But you need to get this for your advancement later on, even though you may not see it right now." He said, "Just start one course at a time." And he said, "Go and find the college that will do the most for you. When you go, don't let them just interview you, you want to interview them as to what do they have to offer you. And this is what -- and you tell them what you have, your training at Jefferson, what you have, and your work experience." And, and it was interesting, 'cause we did that, another colleague of mine, her and I did this together, and it was interesting to see the responses. And most of them, at that time, they're not that way today, but at that time it was, "Well, we're going to make you the full nurse now." Except one program, and that was Villanova. The person there, Julia Paparella, who passed away last year, was phenomenal, and I always tell Dr. Fitzpatrick, who's the Dean of the College of Nursing, that she was the best gift Villanova had. Because she knew how to put forth what Villanova wanted to do to take nurses with their R N already, and help them transition into getting their Bachelor's, but not feeling like they are not a nurse. And so, um, I enrolled there.

KD: About what year was that?

GS: That was nineteen um, it was nineteen seventy uh, seventy-five. I started part-time at Villanova. I was still working as the head nurse and then uh, when it came time for the clinicals, they were all during

the day, they didn't have them at night like they do now. And so I needed to change my job. So then I put in for a supervisory job on the evening shift at the Medical College of Pennsylvania. Um, which was a whole other opportunity, which in disguise was like, I couldn't believe the experience that I got from that. So I was doing my clinicals during the day, working three to eleven shift full time evening supervisor for four years, finished my Bachelor's in nineteen eighty, and um, one of the ladies that worked at Medical College of Pe-, Medical College of Pennsylvania, Doris Gormley, she was the um, um, director of the, um, educational program at Medical College of Pennsylvania. And um, she had, she had offered me, or had asked me and another colleague of mine, Nancy Tankel to, if we'd be willing to go over to the osteopathic hospital over on City Line, Philadelphia Osteopathic Hospital, to teach their L P N's a uh cardiac arrhythmia course. And I said, "Sure, yeah, I'd love that because I like to do that kind of stuff." I did it with my staff. So, we did, and then I said to her, "Do you think I could ever become a clinical instructor?" And she said, "And how far along are you in your program?" And at that time, I still had a couple years. And she said, "I can't take you on yet, but when you get that degree, you know, then I, then I can consider if, you know, like the last six months, because I have to know you're getting it." Because there was like an increasing requirement to make sure that if you were going to be teaching that you had your degree. I said, "OK." So, nineteen eighty comes, I got my degree. And I said to her, "Now don't forget, I have my degree" I said, "so if anything ever opens up, let me know." Well sure enough, she winds up leaving the hospital and she went to work at Northeastern Hospital which is in Port Richmond. And uh, she's there like a couple months, she calls me on the phone, I had just gotten back from work, picked up the phone. She said, "I have, I have a job I'd like you to come out to talk to me about." And uh, I said, "Am I finally going to get that instructor job?" She said, "No, it's not that." She said, "I have an Assistant Director of Nursing position." And I'm like -- if a hole had opened in the floor I would have fallen.

KD: Yeah.

GS: I said, "Doris, I'm not ready for that." She said, "Oh you're more than ready." She said, "I've been watching you all these years." She said, "You're more than ready. I want you on my team." So I went and I interviewed and um, long story short, I got that job. I was there five years. And for two of the years we had another Assistant Director. I had all of the critical care areas, she had the med-surg. Um, when we had a work, you know, when we were having the issues with the D R G's, the diagnosis related groups, you know, downsizing and stuff like that, we had to do some layoffs, and so her position was laid off, because she was the newer of the positions. So what was really nice is that even though I was the Assistant Director, Doris said to me, she said, "I want you to co-direct the department with me." She said, "I'm still responsible, but I want you to get that feeling. I want you to get that experience, because one day you will be a Director, and maybe more." You know. So um, it, it, you know, when you have people in your life like that who encourage you, who help you think more about what you can do than what maybe you are thinking about, you know. So, and she said, "And the other thing is, she said, "I want you to go back and get your Master's." And I'm like, "You've got to be kidding me {LG}." I said, "I just spent five years getting my Bachelor's." She said, "Take a year off, but that's it. You're going back." So, I said, "Oh my goodness." And, and the thing was is, my staffs that I worked with, um, you know, I learned a lot from them, I learned sometimes the hard way, you know, that when you say something to

someone that's, you know, you can't say, for example, my night staff at um, Northeastern Hospital, um, they, in the I C U, they wanted to know why they -- they wanted to get paid more than the nurses in med-surg because they had all this responsibility as critical care nurses. And I said to them, "You know," I said, "I, you know, that's been talked about so much and I really, you know, there's really, you know, nothing we're going to do about that. It's sort of like something in the past." I made some sort of comment like it being like water under the bridge. I don't know. Well they went to Doris like I turned them off, I wasn't listening, and I'm like, "That's not what I was saying." I said, "It wasn't, what I meant was like, this isn't the time, we don't really, this isn't the time to focus on that, but I'm not dismissing it. It's just let's try to move forward." And I said, "I'm always looking for ways to, if there's an issue, how to bring it up at the right time, at the right moment." So, the one issue they had was this issue about, you know, they thought they should get paid more than the med-surg. And I said, "You know what, rather than my tell you what I think," I said, "because I've been on both sides." I said, "Why don't we have you, and we'll ask four of the medical-surgical nurses to come up," and I said, "why don't you guys talk it out. And if you, after talking with them, can really make a really good argument why you should be getting paid more than them, we will entertain it." So, we got the nurses together and I said, "We're not going to sit in the room. We want you guys to talk, OK?" It was probably maybe forty-five minutes. The door opened and I said, "What do you guys think?" "The medical-surgical nurses should be getting more money."

KD: Oh wow.

GS: "We have the technology that helps us. They have to constantly be using their intuition, all the, all the non-monitoring tools. They have to use every part of their being to figure out what's going. And so no, they should." I said, "Listen, can we just settle the argument? Nobody's going to get more money than the other because you're all valued for what you're doing. You're just doing it in different ways. The bottom line here is let's start respecting the role that each of us play in this world of care. Because, you know, if, if we're at each other all the time, then we're really not focusing on the real product there, or the person, the patient, the care that we're doing. You know, we're all infighting because we all think everybody else is better. OK?" So um, so that was a real interesting experience for me to actually coordinate that with them and let them do it and see that if you allow staff to problem solve things out together, oftentimes they'll come out with the right answer, and you don't have to tell them that's really what you were thinking, you know.

KD: Yeah.

GS: So um, but they thanked me for the time, and, and I said to them, you know, I said, and I told those four nurses, Claire and, I remember Claire was one of them. Um, I said to Claire, and I've friended her different times over the years, and I said, "I will never forget when you said that my making that comment 'it was kind of water under the bridge and let it go.'" I said, "I was at first angry," I said, "but you taught me such a valuable lesson. That what I think's valuable is not necessarily what my nursing person, staff, thinks. And I've got hear what you have to say. And I have to communicate that if I can't do anything with it at this time, that I'm not dismissing it." And I said, "And that has helped me a lot through my career because you run into so many different scenarios, uh, with staff, uh, where you're

not going to be the one to change it, but you might be the one to voice it to somebody else above you or to a group of other people who might be able to say, “Well maybe we need to look at that.” To be the advocate for your staff, uh, but to realize while you’re doing that, they need to know that you’re still going to still hold them accountable for their care that they are providing. And their interaction with each other. Because in the long and the short, we can always come up every day with different issues and say, “Well, you know, I’m not going to do this because of this.” Well, no, you still have to do this because this is the patient, you know. Or this is the doctor, you still have to work with the doctor. Or, or the physical therapist, or whoever it may be, you know. So, anyways. So, um, so I, I decided to go back to get my Master’s, and I figured well, you know, I was comfortable enough with Villanova and I thought the programs was very good, so I went to go take the entrance test and I failed it {LG}. And like they said, “What happened?” I said, “I don’t know.” I said, you know, I said, “English has never been my strength, and uh, reading was always hard,” and I said, “Don’t forget, remember Jefferson did all that for me?” So they said, “Do you have a mentor that could work with you? Do you have somebody who could work?” I said, “Yeah, my boss down at, at Northeastern. I’ll go back and talk to her.” They said, “Well, we’re going to give you some study materials, and if you um, we’ll have you re-take the test in like six weeks.” So every lunch day we went through different things and all. So, I went back and took the test and I was like, “OK, we’re going to do this.” I did a hundred percent better, but it still wasn’t the right passing mark, and they said to me at Villanova, they said, “You know what, Grace. You had this in your, in your Bachelor’s program. You’re now Assistant Director, you went from staff to head nurse. We have to look at that. We’re not just going to look at this entrance test, you know.” And I, and I really appreciated that because whatever, whatever that part of my brain that wasn’t working {LG} to pass that test, they felt like I had passed that test already with my career choices. And my references. So, so I got into the Master’s program, and it took me four years part-time. I finished that in eighty-five. And um, you know, I just, that, both what my former Director of Nursing, Bill Miller had said about going back and getting my Bachelor’s, and then Doris encouraging me with my Master’s, you know, that really gave me a lot of, um, um, opportunity to move forward if I so choosed, you know. And I was able to, down the line, um, I became uh, when Doris left Northeastern she went up to Saint Mary’s in Langhorne. I said, “I’m not coming up there, it’s too far of a drive” {LG}. And I said, “You have to have somebody up there.” I knew the situation when I got to Northeastern I knew why she had, she really sought outside. But I said, “There’s really got to be somebody up at Saint Mary’s in Langhorne.” And a few months later she called me. I said, “You’ve got to be kidding me.” She said, “Listen. The person that I want is Meg Astin, and but she was the E R manager and she really wants to go back to being the E R manager. That’s her love.” And she said, “And everybody else here,” she said, “They just, they’re just not looking at it the right way, you know.” So I went up for an interview and I uh, met with the staff, and two fellows, Jim, Jim and Joe Gentile, they were twins. They said, “You’re coming here, aren’t you?” I said, “No, I’m just checking you out.” I said, “I don’t know.” “No, you’re coming here.” And it’s like, when you go for something, like I’ve, I’ve always had the opportunity that there’s that feeling you get inside that says, “Mm, maybe I should do this, you know. And if I’m being encouraged to do it maybe I could do it, you know.” So the woman who was, the long and the short, I went there, I was the Clinical, uh, Clinical Director for the special care division. The uh, I was the, uh, I helped set up their uh level two trauma center. We actually, I wound up going into the O R for almost seven months to get that straightened out because they were having tremendous problems with the operating room. They couldn’t hold on to managers. And I finally one

day, I said to Doris, I said, “You know, I really prayed about this over the weekend.” I said, “I kind of feel like I should go into the O R.” And I said, “Like really go in, like the inner sanctum.” I said, “But I’m not an O R nurse,” I said, “you know, and, and even though I had, you know, good training and all, I’m not an O R nurse and that’s not my cup of tea.” But I said, “I have this feeling that if I could have a couple of the staff who are really good just work with me, then we’ll figure out what we need to do here.” And um, she said, “You know,” she said, “let me think about that.” And uh, she talked to the President at the hospital, Sister Clare Carty. And but I said to her, my concern was that when I, “If I go into the E R,” I said, “I can’t handle the other areas because once you’re inside the inner sanctum, {LG} you don’t get out.” She said, “Well let me talk to Meg and see if Meg will come back out and do an interim while you’re in there.” And that’s what we did. So I spent seven months in there and it was a real eye-opener for me, um, and for the hospital to realize how little attention they really had given the operating room, uh, and so you have three major factions working in the operating room. You’ve got the surgeons, you’ve got the anesthesia staff, and you’ve got the nursing staff. And when they’re not working together, it’s like hell to pay for, OK? And O R, O R time is money. If you don’t maximize that time properly, you are costing a lot of money. The other aspect of it, O R time is important for patients because if it’s not being managed properly and I’m sitting upstairs, waiting, waiting, and waiting, or I came in from home and I’m waiting, waiting, waiting, and then my case isn’t being done until tonight because it should have been -- there’s all different aspects of it. And most times, I’m not saying all people who go into those fields, at least now, back then you had little conversation with patients. You either put them to sleep, uh, and you only saw them for a brief before and after, and then they were out of your hair. So, patients have a right to know that the people that are working in the room are working collaboratively because they can hear. You know, until they’re asleep they hear what’s going on. And, and um, if you have an irate doctor, if you have a conflict between staff, whatever it may be. So the bottom line is, I think that doing that really was an unexpected course of my career that I didn’t expect and but turned out to be extremely, extremely beneficial to me in the long run because then I actually went down, I was actually, um, I left Saint Mary’s to go to Saint Agnes. So I wouldn’t have to be driving up ninety-five falling asleep on the way home at night. And they were sister hospitals so it was like a transfer, so to speak. Uh, I went there as director of med-surge, and my vice president a year later left and I wound up becoming vice president.

KD: Oh wow.

GS: For patient care services with an expanded role, Uh, so I networked with a lot of people in the community, uh, and with other, you know, at that time we had a program called, or a group called deans and directors. So deans of schools of nursing and directors of hospital programs, so we would get together to try to figure out how to make the transition for nurses into the hospitals, into hospitals, and what did the hospitals need, what did the nursing schools need to be doing. And it was a very nice collaborative group that tried to address that. That group does exist today but it, it has a different name. I saw uh, a write-up about it in one of the magazines, and I said, “Oh, that’s our old deans and directors group.” People trying to work together so that when a new nurse would come out of school there would be the support systems there available to help him or her really achieve their dream of becoming a true professional nurse, um, and not just get thrown in with the wolves, so to speak. Um, so, I was at Saint

Agnes and then uh, I was there like for about five and a half years. And then I uh left, um, took a consulting job for a, a group, and actually went down to Patuxent River Naval Hospital in Maryland three days a week to help them with their O B G Y N unit that the, the company was in, in, concerned that they were going to lose their government contract. And it was their first government contract, multimillion dollar contract. And so the person who had called me to go down and take over the directorship of the maternity area down there, I said, "But I'm not a maternity nurse." But she said, "Remember what you did at Jeff-, what you did at Saint Mary's? Get the nurses who are good and work with them." So that's what I did. And they actually wanted me to stay down and be the director. I said, "No, this is not my cup of tea" {LG}. I said, "I, I, I, like I'm that critical care person. I want to be all over the place, you know." So anyway, but I did that, and, you know, I remember driving down there thinking, "You have to be out of your mind. You know, you don't know anybody." I mean, they put me up in a bed and breakfast for the time that I was there, which was great. Got -- I worked with the military command, I worked with the civilian group, and I was like, "Oh my god." You know, and you're like, you keep saying to yourself, you pinch yourself, are you really doing this, you know? But other people believe in you and you just, you know, uh, that's what you have to do. You have to surround yourself with people who believe in you, you know, and encourage you, who don't put you down and go, "Oh, you can't do that," you know. And then the, the, you call them on the phone and say, "Look, you know I have this problem. This is what I think I should do. What do you think? You know, am I on the right track?" And bounce the ideas off of. Because otherwise um, you're not growing yourself. The other aspect, and I've said this to many new nurses and I've said it even to my other staff, staff nurses that I've been over, is that while it is great for hospitals to support continuing education for nurses, um, and particularly in the areas of where they're working, especially in those areas, there's a whole subset of continuing education that we as professionals should take on, um, whether or not a hospital or an organization supports it. Those things that help support your, uh, supervisory skills, your listening skills, your communication skills, your teambuilding skills. Getting out there into other programs where there are other healthcare professionals so that you see that it's not just nursing that is experiencing this, and hear what other people have to say, and share with each other and learn from each other. I've, I've done that throughout my entire career, continuing education outside of what anybody else has ever done for me before they ever made it mandatory. Because to me, while Jefferson School of Nursing, Diploma School of Nursing, gave us a certain amount, there's a lot more that you have to continue to build on as you go through your life and your career. Uh, even at Villanova, the same thing. They give you certain things, but you have to keep building on it. And you have to practice it. Uh, you don't get up and, and do a presentation in front of the class the very first time and do it perfect. You have to keep practicing and trying new skills and listening to other people of how they do it. Um, and then try it, you know. So I think really for, for my career, you know, when I left hospital care, um, it was because the hospital I worked in, Sacred Heart, in Norristown, um, closed in um May nineteenth nineteen ninety four. And when they closed um, it was a real eye opener to realize that even though I had my Master's, in our tri-county area it is extremely difficult to get a job because the jobs are tight. Uh, and two jobsthat I wanted to get, if I had gotten them, I would have been laid off in another six months. One was down here at Pennsylvania Hospital and one was at Medical College of Pennsylvania. I was thinking, "Somebody's trying to watch out for me, even though it's not fun being unemployed." So then, somebody said, "Why don't you think about doing something else? Teaching, whatever?" I said, "Well,

yeah, I like to teach, but I don't want to be like a full-time teacher. I want to still have some clinical roles and whatever." So, I was living up in, I had moved from South Philly, I was living up in Blue Bell Pennsylvania, right near Montgomery County Community College, that I knew nothing about. And I saw a little ad in our Nursing Spectrum magazine for a college nurse, and I thought, "Uh, let me check that out." So I called and I, I applied. So they told me what the salary was. It was half of what I was making as a professional nurse in the hospital. I said, "But it's better than nothing, right?" I went for an interview. I was interviewed by nine people. I said, and I said to them, I had to laugh, I said, "You're all here to interview me for this position?" I said, "That's interesting." I said, "I didn't even have that many people for my vice president position." So, they were, they were concerned that because of my career that I had and all of the experience that I would get bored there. And I said to them, "Have you looked at your population of students? Have you looked at your population of employees?" I said, "You're a haven for health and wellness. You're a haven for reaching out, you know, reaching out, doing community work here, you know, um." I said, "If, if you hire me and you come back to me in a year and I tell you I'm bored, then something's not getting done." I said, "There's more than enough work for me and probably another five nurses to do." But I said, "I know you're not going to hire five more nurses." I said, "With my background, what I need from you is help me navigate the academic system, um, and I will give you whatever I can from all of my job experiences, work experiences, because I've had a lot of different things. Strategic planning, um, community service, um, edu-, you know, doing, teaching myself." I said, "You know, you know, whether it's for students, credit courses, but health and wellness, whatever it may be." So anyway, I did, I got hired, and again, I got my, I had my hire notice, I got in on my birthday. They called me on the phone and said, "You have the position." I said, "You just gave me the best birthday gift." I said, "I will not disappoint you." Um, I was there for twelve and a half years, but I still stay connected with folks in the hospital setting, I still was doing continuing education. And it still wasn't required, trying to keep up with what was going on, 'cause I thought maybe someday I'll go back to the hospital. But then I thought, after twelve and a half years, who would want me? Who would want me? Until a friend of mine had gotten a call from a vice president from down here at Jefferson who wanted her to come. And she was going to come, but then she developed a health issue, and so the vice president said, "Do you know any other good nurses out there?" She said, "I really need to build my team up, this perioperative surgical team." She said, "Well you know, my friend Grace is working at the College but she has all this experience, maybe you should talk to her." So I said to my friend, I said, "Did you tell her I've been out for twelve and a half years?" And she said, "Yeah, but she still wants to talk to you." I came down with my resume, it was two thousand seven, March seventeenth. We were having an ice storm following me all the way from Norristown all the way down to Jefferson. I was like, "I have to be out of my mind." But I was excited. I said, "Oh my god." I was getting that Jefferson feeling, like maybe I might end my career at Jefferson. What a way! Begin it and end it! Right? So I drive in, I meet her, we sit down have coffee, we look, she's looking at my resume, she says, "Where have you been hiding?" I said, "I haven't been hiding, I've been working very hard." I said, "I've been keeping up-to-date with a lot of things, but I've been working very hard." So she took me up to meet the Vice President, who I already knew, but she didn't know that {LG}, and while I'm waiting for Sue to get me coffee and, and we're going to go in, Mary Ann McGinley comes around the corner and says, "Grace, what are you doing here?" I said, "Oh, I'm interviewing for the PAC U nurse manager position." So she said, "Come on in the office." So Sue comes back with the coffee, "Where's Grace?" And I'm in the

office, and she comes in and she didn't realize like -- she was wondering like how I got in there. So Mary Ann says to her, "You didn't tell me Grace Spena was coming out." She said, "I didn't know you knew her." She said, "Oh my god," she said, "I want you to come work here." And I said, "Woah, woah, woah. Wait a minute, wait a minute." I said, "That's really nice, but," I said, "Let's talk about what you need, you know" And uh, we talked about the PAC U and the needs of the PAC U and I said, you know, I said, "I know it's something I can do. Uh," I said, "but I need to talk with the staff, I need to talk with the anesthesia folks and, and some of the surgeons to really get a feel for what is going on here that you f-, that needs to be fixed. And I said, but I also need the staff to know that I'm not at the clinical level that I was years ago. I'm willing to learn. I'm willing to re-, brush up, but I'm not going to be at the same level they are at." And uh, and I said, "If they're willing to understand that," I said, "I will come in here and work with them to get this back to being a premier PAC U unit, uh, PAC U service, because it wasn't just one area." So, long and short, I got hired, and in the interview, the nurse, the nurses said to me, "We don't want you for your clinical, we want you for your leadership." I said, "Well that I can do." So. So uh, I was here two years, and the funny part was, is, as the first day I came in, you know, they were taking me around, showing all my different areas. "This is your area." "OK, I know that one. I know that one. And I have this one. And this one." I said {LG}, "Anything else you're giving me?" And it turned out that the Thompson PAC U was the old surgical I C U {LG}.

KD: Oh wow.

GS: It was reconfigured. And I'm like, I'm walking in there, and I'm saying, "This like, looks familiar, but it's like, it's like set up different." And then I'm like thinking, "Oh my god. Those are the doors I almost took out with the uh, the BAX machine when we used to have a BAX machine for codes." We would put the patient on and it had a thumper and everything. And I'm like, "Oh my god, I can't believe it like it's really." So I really thought that I would finish my career here. But in two thousand nine my mom, who I had moved up from South Philly to Blue Bell before I knew I was coming here, was getting progressively more sick. And it was very difficult to have the time that I needed. So I really needed to make a decision. And as it turned out, the person who replaced me at the college left abruptly in October of uh, two thousand eight, and they called me to see if I would come back. I said, "Well," I said, "You know, I'm, I'm happy with what I am doing," I said, "but I was thinking about maybe coming back to a hospital in the area because I needed to be closer because of my mom." And uh, so I went up to interview with them, and they wanted to restructure the position that I had before, they really wanted to make it a director level health and wellness initiative position, bringing in more responsibility. Actually, it was identifying all of what I was doing before into a real job description and, and paying more for it. So I, and told them, "You're not going to be able to pay me what I'm getting down at Jefferson, but," I said, "you know, what I was making before, I need to make more." And I said, "And if you're going to restructure the job description, add more into it, fine," I said, "I'll do it." You know. So, Mary Ann McGinley didn't talk to me for three days she was so upset that I was leaving. And I really, I told her, I said, "You know, if there was any other way to manage everything," I said, "But PAC U is a twenty four seven, um, responsibility." And I said, and I said, I said, "I know you know. Parents have to come first, you know, family's got to come first, so." And uh, I said, "I'm just glad that I had an opportunity to, that came up that I wasn't actually having to go look for something, or that my mom got real sick and then, you know, I needed to take time

off, and then what do I do, you know. So um, so I was doing that. So I've been back at the college. I was back at the college five and a half years, so I actually totaled, I was at the college almost eighteen years. And in acute hospital care twenty seven years. Yeah. It's a thirty, forty five. And so when I retired in two thousand fourteen, they weren't replacing my position at the time because of budget, so um, I was going to look for a part-time staff nurse position somewhere. And they said, "Well would you consider doing some part-time here and helping us to continue all of our wellness initiatives?" So they restructured it to be more for working with the employees, but I still try to squeeze the students in once in and while in the timeframe that I have.

KD: Sure.

GS: So. So, I really have to say that, uh, and I've told many staff nurses, many students nurses, 'cause whenever I work very closely with our students at the college because I, I, as one nurse, I told them, "There's only so much I can do. But I can multiply what I do if we could get the students nurses into a community-based option on campus." So, they had a new nursing director that came uh, shortly after, a few years after I started at the college back in ninety five. Um, Dr. Bev Welhan, and she was on the same page, and she wrote a grant and got a uh, a funded grant for a on-campus community, um, uh, nursing promotion center. And so then what I did was I worked with the nursing students and created the opportunities on campus for community service. So instead of me doing five blood pressures in my office, we would have maybe a hundred blood pressures done on the campus that day.

KD: Wow.

GS: And then if they had an issue with somebody's blood pressure, I'm a resource to send them to, and if they needed some type of consultation, I'd help them get that. And we did that and it really, and we established community day events and wellness expo events that we got the students all involved with, um, sometimes there were programs I went out to that I invited them to. I said, "Do you want to come out and do this with me, you know, and, and have that." So um, so there was really a major emphasis of community service, community education, and getting the nurses some immediate feedback, the students nurses, immediate feedback from the very folks that are on-campus, you know. So, so it was really nice. I've enjoyed that, I've enjoyed the ability to take what started out with Jefferson telling us, "When you leave here, and you get, your wings are flying, and you're doing your job, remember the folks that are coming up after you. Treat them as though you would have wanted to be treated. Bring them into the fold. Nurture them. Guide them. Give them ideas and suggestions, you know, help them stay in the profession, not get out of it. Help them realize that there are many opportunities, and today there's even so many more opportunities for nurses with informatics, uh, with the community based organizations, um, you know, the pharmaceuticals even more so, um, you know, training other, you know, learning something and training other staff with, with new things. As well as your on, on-site hospital-based programs." But the fact that patients typically, you know, come into the hospital sicker and usually go home still needing help, that realizing that the community nurses out there and you can partner to make sure that that patient once they get home gets what they need. It's not just you're out the door and now it's somebody else's responsibility.

KD: Yeah.

GS: There has to be that transition occurring. In the assisted living facilities, uh, independent care facilities, there's opportunity to have registered nurses leading some of those, uh, and realizing that, you know, um, you're dealing just as you would, as you would be with a medical-surgical patient on a, on a med-surg floor, you know, you have to still be aware of what it is you are seeing, being attentive. As someone said to me the other day, "You can have all monitors in the world, all the computers in the world. If you're not looking at your patient you're going to miss something because the numbers don't always tell you the truth about how a patient's going to be."

[End of recording from January 29, 2016]

[Start of recording from February 15, 2016]

KD: OK. So, thank you for coming back. Um, we last time we talked ended with, um, your working at Jefferson and then going back to Mont- Montgomery County Community College.

GS: Mm hm.

KD: And so what have you been doing since you retired from that position?

GS: Uh, basically um, I've been doing a lot of different special projects. They, what they wound up doing was is, for budget reasons they put the original director of health and wellness initiatives position on hold, um, because the College is developing a new health sciences center. And so they want to look and see how maybe they could incorporate that role possibly through that area, combination econ- academics as well as, you know, the main part of the um College in terms of human resources for both employees and students. So um, but there were a lot of programs that I was running before I retired that dealt with employee wellness, um, dealt with ergonomics, uh, my community, uh, my relations with the community, uh, agencies. So they really didn't want to see that go by the wayside, and um, I actually was planning to get a part-time job in nursing so they asked if I would do it, work for them on a part-time basis. So I worked some, what I call limited hours {LG}, but it's actually a little more than the limited hours because the amount of hours in a day, there's just not enough time to get everything done. An duh, as my boss said to me the other day, she said "You and I look at five o'clock and go 'Oh my god there's not enough hours to get it done.' And people look at five o'clock and say, 'Oh, it's time to go home.'" {LG}

KD: {LG}

GS: So anyway, um, but I enjoy what I do because it's, it's um, still using a lot of the different skills and backgrounds that I've developed over the years, and um, and still able to in some way help maybe not as much as broadly, but still particularly the employees. And I said, I still see students, um, in passing who, you know, they run into a question or whatever. And I say, well, if somebody just has a question, you know, I'm here, you know, to help, you know. So what I've been doing recently is um basically, like for

example with the Zika virus outbreak. Um, the uh, it's not as, as, in terms of contagiousness, it's not as bad as we had last year with the Ebola outbreak, umm, but they asked me for, to do resource materials, and how can we best communicate to our college community what they need to know about the Zika virus and what impact it may have on them or their loved ones, where they can go for information. So I pull all of that together for them and then um, it goes up the chain of command, and then somebody else will put it out, but I'm beh- I'm like the behind-the-scenes person, but um, the college community pretty much knows that when my touch has been placed on something, which, which is nice, because then I get, I get some nice feedback. But um, but I try to work collaboratively with folks, and if they don't think of it, I'll say, "Have you thought about, and you know, do you want me to do something to help out?" You know. So, um, and then um, I'm still doing ergonomic assessments because you know when you have people doing a lot of computer work, um, there are issues that come up in terms of back strain, um, carpal tunnel issues, eye strain. So I've, I've been trained on how to do basic ergonomic assessments. So I'll go through, look at their work station, work and ask them how they're doing, if they do have any medical issues and try to see where we could adjust things. And most times it is some fine tuning that makes a world of difference, and um, so um, there might be some pieces of equipment we need to get, but again, it's not like spending hundreds of thousands of dollars to help somebody to feel better at their work because when they are able to do the work, the work itself has its own level of stress, but if you can minimize the um impact that having an incorrect work station set up, that makes a lot of difference for, for people. Um, I still try to maintain a lot of relationships with the community, uh, you know, we have a great health department in Montgomery County. Philadelphia has a great health department and I get information from them all the time because thirty miles difference is not really that big when it comes to communicable diseases or health issues, so when you stay connected with the, uh, the different groups, if something comes up, then that way I could advise the folks at the College as to whether this is something they should be concerned about or who they, who they have as a resource out there, um, so that um, when I'm not there, they know what to do, you know. So. Um, so I think it's been, it's been real helpful to the College, it's helped, kept me in, um, doing things that I like to do, and also keeping me current, because I think one of the things for nurses is that uh you can't underestimate the need for staying current. And in today's world, you know, when you go to school a lot of people think, "Well I'm finally done." And that's not the way it is in nursing, or in any really healthcare professional field. Uh, you have to stay current, and, and it's not always necessarily the going back to school, but it's staying in touch with what's happening in the local area and in the more global area so that way you can see what influence you might have. Uh, and if you need to work with others to come up with policies to look at your own personal training, um, you know, is there more work that needs to be done to keep your skills up. And, and nursing, from when I first started back in nineteen seventy one, and if you go back to nineteen sixty eight when I first went to nursing school, a lot has changed. Uh, the technology is unbelievable, the medication, prescription medications and over the counter medications are expansive, so that you need to find ways to make sure that when you're caring for someone you have the best knowledge you can possibly have to do the right job for that individual. Because if not, that person's life is in your hands. An error on a medication or not doing um, a procedure correctly. Doing it an old way because that was the way it was years ago may not be the way it should be today. So, and I think the other area that um, and I'm focused with nursing, is that a lot of nurses are very self-directed. Um, they don't need other people to tell them to, uh, go learn this topic, you know. Um, they

will go on their own to do that. But there are still nurses who feel that, “Well, if their employer doesn’t pay for it, then I’m not doing it.” And we can’t look at it that way. Because the bottom line is, that information, if you need it, even if where you work does not pay for you, pay for it, you need to get it somehow. Because if it’s going to influence how you’re providing your care, that’s what the important aspect is to it. So, um, so today it’s, it’s really um, looking at how are people being educated in nursing, what information are they being given, compared to maybe what we had in the past. And I know that when I was here at Jefferson, um, our nursing faculty, um, many of them were very, very stringent about their expectations. Um, and I think they wanted it that way and they were that way because they realized that when a nurse comes out of school you don’t have a whole lot more leeway time in terms of developing. You, you get in there and, you know, your very first day on the job, you might encounter a patient, and you need to know what you need to do. And you need to know what you don’t know so you can go find out so that when you go to do for this patient what needs to be done, you do it the right way. Because the potential consequences are somebody’s life.

KD: Sure.

GS: Or it may not even be necessarily a loss of life, but it could be, um, a damage, it could be an insult to that patient. You know, if you don’t put an I V in the right way or the medication you, you have an infiltrating I V and that medication gets into the skin of the patient, they could lose an extremity. Um, there’s all different aspects. So I, I, one of the messages I like to give new nurse today, or new nurses even in training is that if you have faculty who are not challenging you, who are not wanting you to be the best, who are not demanding that you know your stuff, then that’s not the faculty that you want to have teaching nursing because they’re not doing right by you. If a program seems to be easy it can’t possibly be right {LG}. Because nursing is difficult. It’s challenging. There’s a lot to know. The one good thing that nurses have is they have a lot more access to information very quickly. So where technology, we didn’t have, you know, the computers, we didn’t have the internet. So anything you needed to go learn, you had to pick it up in a book. And, you know, we had the Physician’s Desk Reference, which by the time it comes out, it’s somewhat antiquated. So you can get a lot more information and a lot more current information today, but do you use the technology for that purpose, or do you just really kind of take it for granted. So use it so that way before you go in to see a patient, within five minutes before seeing that patient, you can get a pretty good idea of what’s going on and, and if you’re not sure what’s happening, do a little quick research, you know. That way when you go in you can feel a little more comfortable about what might be going on with the patient. And if a patient asks you a question and you don’t know the answer, don’t fudge it. Just say, “Listen, you know, I’m not really sure, but that is a good question. I’m going to go find out and I’ll be back.” And go and find out and then come back {LG}, you know, because, you know, if you try to fudge it, patients know. And uh, I had a friend of mine,her, a relative of hers say, we were talking and, and he was saying, “Oh, these people here, they’re just so young, they can’t possibly know.” And I said, to him, I said, “Well, you know, as we get older everybody else looks younger. You know,” I said, “I was young one day.” I said, “I wasn’t even twenty-one when I graduated from nursing school.” And I said, “All the patients that I went in to their rooms, you know, I called them by their, their name, whether it was Mr. this or Mrs. that. Asked them how they wanted to be called, to give them that opportunity. Told them that I’m their nurse for the day, I’m a registered

nurse, and I'm caring for them for the day. And um, you know, we're going to make sure that they get what they need, and then try to go about my business with them." And I said, "When you enter in with a professional attitude, and not calling somebody 'honey' um, you know, or uh, you know, calling them by their first name when they may not really want that, you know, you're setting yourself up for having someone look at you as being a child caring for them rather than someone who comes in and says, 'Wow, she seems like she really does know what she's doing.' Or 'He knows, he knows what he's doing.'" So there's a lot of different ways to how to approach that interview process or that connective process with a patient, and um, you know, and, and the challenge for nurses today is that so many of them, uh, are not, they don't, they're not able to just focus on nursing. They're coming in either second career, they're coming in with families, so they're not even necessarily living at school, like we did back in the day. And back in the day we thought we had it hard, but we lived it every single day. So I admire the new nurses that are trying to do this in the midst of trying to raise children, you know, have other jobs, because it's expensive to go to nursing school. Um, so that they need to be very organized and very on top of their game. The problem is is a lot of them aren't because they haven't really developed in that way over time because things have kind of gotten very, maybe, relaxed. And so when they are trying to do all this work, it is extremely overwhelming. So that when somebody does make it through nursing school and they graduate and they're doing well, I applaud them, because I don't know if I could have done it to the level that they do, because of all of the other distractions that they have in their life. So, and I think nursing programs, the educational programs, have to realize that they have to find ways to be adaptive for the nursing students in order so that it's, it's, if I could put it this way, if you took all the nursing faculty that I had, who were excellent, alright, they were driven, and they wanted you to do well, for you, for the patient, for them, and obviously here at Jefferson, for Jefferson. Because all, we all represent something. If they had to take today's nursing students and try to do the job the same way, it wouldn't work. They'd have to become more flexible, the programs have to become more flexible, um, there has to be a little bit more give and take, um, and not just have it as it was in the past. So today, we have to be more creative. Um, I find that um, and I think that I might have mentioned this earlier, that when I went back for my Bachelor's when I was at Villanova, um, over the years Villanova has developed its nursing lab into what looks like a mini-hospital right on campus, to give the nursing students every possible angle in which they can work to make it as real as possible, because they can't even get all of the clinical time in the hospitals anymore. So you have to find alternative ways. So technology has helped.

KD: Mm hm. Sure.

GS: You know. I mean, you have mannequins that basically mimic a human person, um, you've got computer programs where faculty could be in another room, giving you information about changes in the patient's condition that you have to think about, you know, so, it, to me it's like, we did it on the real patient {LG}, they get to do it on a simulated patient, which probably is safer. But again, you can make it work, you can make it work. And that way when then you come out into the real world, as I would call it, into a hospital or into a clinic or whatever and now you're faced with the real patient, um, you have more of a sense of what you need to do. Um, the one concern, one concern that I do have is that in the previous program, in the programs I, I was in, and many of the nurse that are in my age group, you had

to learn how to talk to patients. Uh, you had to learn how to listen. Um, and you would carry that over with you outside of your work area. Today with the way technology is, so much communication is done through electronics. Cell phones, computers, um, so that you don't get to see the reaction of the person that you've just sent this message to. When you're doing it for the first time between two people face-to-face, you're not, you may not understand the reaction, you may not, um, respond correctly to the reaction, and when that's a patient, that could definitely interfere with the relationship you have with that patient. So that's why even more so today, um, every nurse should really, beyond what they get in nursing school, whether it's a um, still a hospital based program, an Associate degree program, a Bachelor program, you need to take more course on listening skills, communication skills, dealing with difficult people, understanding how you respond to things, what are your triggers, how do you intercept a situation before it gets out of control. Um, and, because, if not, you're going to wind up being in battles all of the time. Or you're going to wind up thinking a patient is a nasty patient, or they're uncooperative, or their family, or, you know, P I A's, you know, where they, where they seem to be more of a bother. We can't afford to do that as professionals. Our job is to bring calm. Our job is to bring awareness. Our job is to bring something to that relationship that allows the patient hopefully to get better from whatever it is that they're dealing with, or at least deal with it in a more dignified fashion.

KD: Mm hm. Alright. So, I think we touched on this some already, but do you have any other thoughts on how nursing has changed since you've been in the field?

GS: Well, the one thing is, is that it has certainly expanded out more to the community. Um, for years, um, the only way that you would think a nurse might be able to get his or her experience is to work in a hospital. And we realize now that that's necessarily the full picture. Um, and in part it, it's partly like that because the way, um, some of the hospitals have gone, where, you know, you um, with the magnet accreditation process, it puts more pressure on the hospitals to have a higher level of education among its workforth, workforce. Which is good, however what that does then do is those nurses who are graduating from Associate degree programs or hospital based programs who have not yet reached their Bachelor's, they may not be able to get jobs in the acute care hospital setting. So that experience, which I think is valuable, um, and lends itself to then if you want to move into other fields of nursing, you take that experience with you. But because many of those nurses are not able to get jobs, they look elsewhere. So they're going into the homecare settings, they're going into assisted living facilities, or nursing home settings. Um, and not that they can't learn from those settings, but the thought years ago would be is you would not go to that setting until you really had your own skillsets well honed, had your knowledge base well broadened out, because when you go to those settings you might be the only R N. And so now you have really nobody else to rely on, um, in the sense of mentorship. So that that, it, you, once you get into those settings, if you want to go back into the hospital setting you're sort of like maybe not viewed as um, acceptable because you don't have the acute care experience. So we've kind of developed this system which on one end they're trying to move nursing forward in terms of the educational process as long as nursing, the profession of nursing, does not require every nurse to graduate with a Bachelor's degree, as long as it still allows nurses to graduate from hospital programs and Associate degree programs, we, I believe, are doing a tremendous disservice to those nurses who may, because of financial reasons can't go to a four year school, who because of maybe the lack of

accessibility can't go to a four year school, or who may not at that point feel that they can manage a four year school. Like myself. When I started, I didn't think I could go to a four year school, more because I didn't think educational-wise I would be able to do well. And I might have done well, I may not have done well, but thank god for Jefferson I did become a nurse and I was able to move forward. So I think that, um, nursing has not bitten the bullet yet in terms of what it wants and so it's, it's, it's using another process in which to, uh, screen out a whole area of nurses that can do very well and many of them are motivated to go on forward but are are going to be stifled simply because they can't get jobs in the acute care healthcare field. And, and, to me, I think my message to nurses or anyone going into nursing, anything and all that you can do to get on to get that, your Bachelor's degree as soon as possible. You know, try to do that, because ultimately if you want to go work in an acute care setting or a, excuse me, an assisted living facility or a homecare situation or anything outside of the hospital, you want to know that when you go to that, those areas that you really have a solid foundation both in knowledge and skill because once you get there you're going to have to self-motivate yourself to keep up, a lot more than you would necessarily in a hospital setting where hospitals do require certain educational requirements. Um, so I think um, the challenge for, for all of us is to remember that when any nurse at any level of education comes out of that program they still have a learning curve. And regardless of where we are, whether it's me now retired or someone else who's working as a head nurse or nurse manager or director somewhere else, uh, and they have their years of experience, find these people, take them under your wing, nurture them, help them progress further. Because if we don't we are more likely to lose them from nursing than keep them.

KD: Mm hm. Yeah, so {CG} one of the things you've been mentioning a lot is the need for growth and further education for anybody in nursing, and I think probably for most people in most careers.

GS: Yes.

KD: Um, but looking back to your time starting at Jefferson in nursing, how would you say your time at Jefferson has influenced where you've gone since?

GS: Well, I think um, the second year that I was in nursing school Jefferson, um, Jefferson, uh, the uh, Jefferson became a university status, and so some of the courses that we were taking actually became credit courses. And then they uh started offering some credit courses at the camp-, on campus that we could do, so I actually, I took three, over the course of the remaining two years I took three different courses, so I had nine college credits {LG} when I came out. But just that little bit was interesting because I thought, "Wow, you know, maybe I could do this." So when I did go to apply to college, you know, those credits were acknowledged. And so, I think Jefferson back then knew that the Jefferson nurses would eventually need to go back to college, um, you know, and to to grow their overall knowledge and broadness of nursing. Jefferson I believe felt that it was educating its nurses to the highest level, but they also knew there was something beyond that, OK? And they instilled in us that you never stopped learning. And so um, and I guess I was mentored, even beyond my years at Jefferson, from others who said, "Yes, you need to keep going." OK? And it wasn't just keep going degree-wise, but it was going and reinforcing all your skills, getting things current. So um, there was a strong emphasis from Jefferson way back in the day that you just don't graduate from school and that's it. You have to

keep going and, and, and. But they also wanted you to know that you needed to do with others. You didn't do what you, you -- we don't become good nurses in isolation. We do it together. And um, and that message resonated with me early. Um, I was also very fortunate in my career that I could identify several key people in my mind that were mentors to me even before the mentor word came up. Um, and you know, folks who would challenge me to do more, you know, challenge me to learn more, challenge me to go back to school. What that would mean for me in terms of not only my professional life but my career as a nurse, you know, and, and um my career that would expand beyond myself but would take in other people. Because when you start to take on leadership roles you really become more responsible for other people's growth and, and sometimes I've seen over the years where um, some folks in administrative positions, um, who are, have subordinates under them, don't encourage them. Don't want them to go above because there's a fear factor that they're going to know more than me, OK? Well you know what? There are a lot of people out there that know more than me and I want to know what that is so I can learn, because it's exciting. It's exciting to know that you could have someone come in with a new idea that you didn't think about and you could work with it and make it better. So uh, for for newer nurses coming out, always look to try to improve yourself but improve others around you. Particularly those who you may see as not being necessarily as good as a nurse as they should. How can you influence that? Sometimes you know, you just can't go up to them and say, "You know what, you're really not that good of a nurse," because you're going to get blown away. And particularly if you're a younger nurse age-wise, they'll just you think you're some, you know, wet behind the ears person coming out trying to tell, so you have to find ways in which to do this so part of doing that is getting those other trainings that I talked about where you uh, integrate your, your knowledge with those from other health fields and other professions. Because all of us, no matter what field you're working in have to work with people, and so part of it is is development, development of others. When you rise up and you become a leader, whether it's a director, a vice president, um, a consultant, whatever it may be, it's incumbent upon you to help others learn how to move themselves forward too. Because who's going to be there when you leave? And so I always think about, you know, when I've left the positions I've left, um, did I have to worry about who was going to take over, who would continue it? And I didn't really have to worry about that. The only place I worried about that was at the college, because when they said they weren't replacing the position I'm like, "Who's going to do all this? You wanted me to do all this stuff, now who's going to do it?" But in my other positions, there were other people there who I felt very comfortable with because we were on the same wave length. We, we learned together, we worked together. We did the joint commission accreditation processes multiple times and tried to make it, in a way, fun, to the extent, to the extent that you can make it fun, realizing that it was -- everybody needs sometimes a scorecard. How you doing, you know? And if we could give our nurses feedback, or the hospitals feedback, to say, "Hey we did this well," or, "You know what, we didn't do this well, somebody else called it on us, we need to get it straightened out. Let's do it and let's get them back here to give us the new scorecard." And, when you can show that improvement, and you can acknowledge it among your staff to say, "We did this. You know, we made a difference. This is a 'we' situation, not an 'I' situation," and I think it makes a big difference in, in how nursing can continue to move itself forward over the years to come and allow for quality care, exciting care. You know, there's nothing more exciting than to see a patient who comes in who you may think is beyond help and have them come back and walk out the door. There's also an excitement even when a patient passes, that if

you could be there for that patient and the family. And even though there is emotion involved, that you were there for them. You didn't go and leave. Or a patient's having a difficult day and so is one of your colleagues, and they've just gotten into it, saying to your colleague, "Listen, why don't you go get a cup of coffee?" And then you sit down with this person and say, "Listen, tell me what's going on. I want to hear because we do care. It's not just me that, but we do care. Tell me what's going on." And really actively listen and say, "Well what can we do to make it better? How can we fix this?" And every now and then you're going to get somebody who really doesn't want to get it fixed. But at least you know you tried. But I will guarantee you this, if that person comes back to your institution and they see you, they're going to remember that you tried. And maybe, just maybe, you see them and say, "Hey, I remember you, how you doing today? What's the matter? Let's try to get this right this time, OK?" And it does make a difference, and, and to me I get emotional because in the course of the time that I've been a nurse there's been so many different times where we have done it right and we've had times where it wasn't. And I'll tell you, you can spend a lot more time trying to fix things, you can spend less time doing it right the first time and then be able to have the time you really wanted you to have a really good relationship with the patient, with the family, whoever it may be. So.

KD: Alright. Well thank you for that. So those are all of my questions, but what would you like to bring up? Any other topics that haven't been mentioned so far?

GS: Um, just that I, I really think that um, people need to remember that the essence of nursing is what we put into it. And that if we do it as a team and, and because our circumstances day-to-day may vary, one of the other things that I did want to mention is that the one thing that Jefferson did for us when we were, back in the day in our training, was to get us to think about the different ways that you have to function in different circumstances. And to give us that flexibility to deal with, for example, you have a unit, five nurses are scheduled to work. You have a couple of nursing assistants, um, maybe if you're lucky you might have a licensed practical nurse. Most of them are not even in the hospital settings anymore. Two of the nurses call out, two of the R N's call out. The nursing office says, "I don't have any-, we don't have anybody." OK? Well, you have some choices to make. You can rant and rave and whatever. You could panic. You can say, "Well, I can't do this." Well you know you can't leave your patients, you can't abandon them. So what do you do? And I believe that one of the things, one of the strong things that Jefferson did for its nurses was to train them in how to adapt. You wouldn't want to work in that situation every day, but sometimes things happen. You can pull it together if you work as a team. And, and you may not do the same process of working, but you work together. So one of the things they did, and it's, it's interesting, because the terminology has changed over the years. We used to have total patient care, where the nurses did everything. Then you had team nursing where you had your R N's and you had your licensed practical nurses and your nursing assistants. So the R N's did certain things and these folks did other things. Um, and then you had functional, where you did a specific task, OK, to get the job done. And I remember, um, being in a situation, working in the I C U, where a couple of the R N's had called out, and it was myself, another R N, and a licensed practical nurse. And that was it for eleven patients in I C U. And we like looked at each other and they told us there was absolutely -- this was night shift -- there was absolutely nobody else. And I'm like, "Oh my god." And I was only out of school like not even a year, right? And the senior staff nurse who was only a

year and a half more experienced than I was said, “Well this is what we’re going to do. We’re going to start from one patient and we’re going to do the absolute tasks that have to be done and just keep going down the line, coming back and going down and coming back. We made it through the night, everybody got what they needed, nobody died, uh, thank god, uh, and as a team, it was the first time the first three of us worked together as a team like that. And when the staff came in the next morning they were like, “How did you do it?” And we said, “We went into a different mode of operation.” Uh, working on a nursing floor, or a patient care floor, um, you can have primary nursing, which basically back in the day was more like total patient care nursing, but primary nursing where you had all the R N’s. Um, they did everything and then one day, couple R N’s call out, the other three R N’s could not manage because there was too much of a load, so the nursing department says, “Well, I’m going to send you a licensed practical nurse and a nursing assistant.” You can have a choice and say, “Well what am I going to do with them?” Or you can say, “Wait a minute, they’ve got certain skills, we go into a team function.” Alright? So that you work that way. So it’s not something you want to have to do every single day because for safety reasons and, you know, it may not always, you know, if situations stay stable, you can work it out, OK? But the bottom line is, is that when you, when you have been taught how to adjust, it lessens the panic, doesn’t mean you’re not afraid, let me tell you, because nobody wants to see a patient compromised because of not having adequate staffing, um, but, you know, you can have a snow storm, an unexpected situation happens, and you’ve got to adapt. So, I think nurses need to be adaptable, need to realize that within the group that they are working that there is more capability than they may realize if everybody just gives a little bit more.

KD: Mm hm.

GS: OK? And so when you do that all in the name of patient care, you can make things happen. You don’t want the hospital to expect it all the time, in that -- because that’s not the way it should be, but there are times where it is necessary and people do rise to the occasion. Uh, I always say you can have five R N’s working on a unit doing primary nursing and not get as much done if you had, you could have them doing their job, and you could have another unit with two R N’s, two L P N’s , and two nursing assistants, and have better care getting done because they’re working together, OK? When you isolate yourself out and say, “Well these are just my patients, that’s your patient, go answer the call light yourself,” you can’t have that in nursing. And people say, “Oh well that doesn’t happen.” Oh yes it does {LG}. It does, OK? So you wind up wanting to really nurture the idea that more can be done when people are working together even if that number is less than more here, that might have a lot more educational background or whatever, um, because they’re not working together, OK? So I’ve, I’ve seen a lot of situations in my time where people have rallied, they’ve worked together, and you want to acknowledge them for that work that they’ve done. You know, if you’re a director or a vice-president, whatever it may be, to say that, well, it’s expected to be done. On the other end, it’s rewarding to truly see it happen, when people rise to the occasion, um, and patients can say, “You know what? I never would have known we had a problem. Um, no nurse came in here and said, ‘Well we’re short. I can’t do this.’” You know, or, “I’m too busy, you’ll have to wait.” Patients should never have to hear that, they should never have to hear that. Our problems are our problems, we can’t put them onto the patient. And with that, I’m done.

KD: Alright, any last reflections, memories, thoughts?

GS: I think this is a wonderful project.

KD: Oh, thank you.

GS: I think that uh hopefully that nurses or future nurses who might listen to some of these recordings, hopefully maybe you'll get a little chuckle here and there and you'll wonder, "What is that that she just said or he said?" But that you'll, you'll realize that you are coming into a profession that is extremely rewarding, extremely challenging, but extremely life-fulfilling, and always remember, once a nurse you're never a nurse, uh, unless you choose to not be a nurse. So always choose to be a nurse, uh, regardless of where you are, what you're doing, and um, be that person who might reach out to help someone in need, because that's really what the essence of nursing is. Thank you.

KD: Yeah, thank you.

[End of recording from February 15, 2016]