August 15, 2002

Caring HEADLINES

SummerWorks

a program designed to raise awareness among students entering high-school about careers in health care

SummerWorks intern, George Thomas, with mentor, Celeste Peters

At left: SummerWorks intern, George Thomas, a graduate of the Timilty Middle School in Roxbury, shares insights about his experience working in, and learning about, Information and Ambassador Services, under the guidance of WACC front-desk information ambassador, Celeste Peters. Says Thomas, "Celeste and I had a great time. She's a terrific supervisor. She taught me a lot about the job, about the hospital, and about life in general. They say the mind is a terrible thing to waste. Celeste taught me that a smile is a terrible thing to waste, too."

Inside:

MGH Patient Care Services

Working together to shape the future

Restraints

An interview with Joan Fitzmaurice, RN, director, Office of Quality & Safety; and Sally Millar, RN, director, Office of Patient Advocacy

Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

Jeanette: Sally, we've seen an increase recently in communication about restraints and our policy on restraint use. Can you tell us what's driving this communication?

Sally: We are always concerned about protecting our patients and their rights. But there has been renewed interest on the national level around restraint use, especially as it relates to patients with behavioral problems. We're using this as an opportunity to strengthen and clarify our commitment to protecting all patients.

Jeanette: Joan, when we talk about restraints, are we talking about a large percentage of our patient population.

Joan: Absolutely not. We know that clinicians exhaust all alternative interventions to protect patient safety before even considering restraints. Restraints are used only if less restrictive measures would pose a greater risk to the patient than using restraints.

We're talking about a very small percentage of our total patient population—less than ten percent. And of that number, we're talking primarily about minimal restraints, such as side rails or geri tables with locked trays.

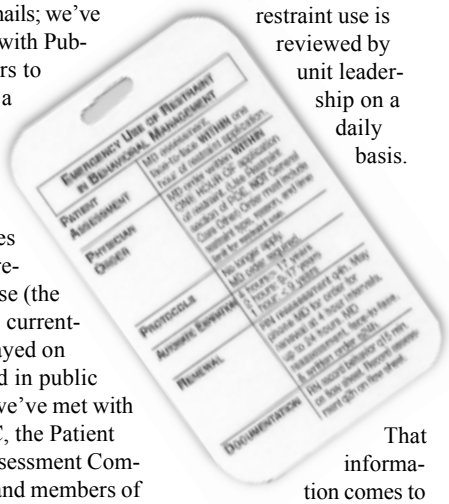
Jeanette: What avenues are we using to communicate with staff about this important topic?

Sally: We have run, and will continue to run, articles in *Caring Headlines*; we've sent out All-User e-mails; we've worked with Public Affairs to develop a poster describing our guiding principles around restraint use (the poster is currently displayed on units and in public areas); we've met with the GEC, the Patient Care Assessment Committee, and members of the house staff to educate and inform them about changes in our restraint policy.

Joan: And we've created a special card that staff can wear along with their ID badges as a quick reference to our guidelines on restraint use.

Jeanette: What steps are we taking to ensure that staff are aware of, and understand, our current policy?

Joan: We have implemented a 'review of practice' system whereby restraint use is reviewed by unit leadership on a daily basis.



That information comes to the Office of Quality & Safety where we use it to generate reports, which we then share with nurses, physicians and staff on the units. This lets us see how well we're doing, and gives us an opportunity to coach and mentor staff around appropriate use of restraints.

Sally: We've also made some preliminary changes to the Provider Order Entry (POE) system that reflect the recent changes in our restraint policy. Staff can now access excerpts of the restraint policy in POE at the time restraints are ordered. Other changes to POE will be made later in the year.

I think it's important to note that although the emphasis is on physicians' ordering restraints, nurse practitioners and physician assistants also have the authority to order restraints.

Joan: Another aid we've implemented is a new flow sheet. This is a documentation tool to assist staff in the initial assessment and ongoing evaluation of patients in restraints. The new flow sheet makes it easier for staff to document restraint use, and at the same time ensures a cohesive understanding of the policy.

Jeanette: Sally and Joan, thank-you, this has been very helpful. Who can staff call if they have any questions?

Joan: Staff should call the Office of Quality & Safety at 6-9282 if they have any questions.

Patients at risk for injury

Our mission is to provide the highest quality patient care in an environment that is safe for all patients, families, visitors, and employees. MGH is committed to maintaining the rights, dignity, and well-being of all patients. Below are our guiding principles regarding the use of restraints:

- MGH is committed to the minimal use of restraint and seclusion
- Alternative strategies to reduce risk of injury are tried prior to restraint use
- Restraints are used only when the use of less restrictive measures poses a greater risk than using restraints
- All orders for restraints are time-limited
- The patient and family are involved in the decision to use restraints whenever possible
- Patients are re-evaluated at regular intervals to assess the need for continued restraint.

New defibrillators

The Fielding the Issues section of Caring Headlines *is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions or concerns presented by staff at meetings and venues throughout the hospital.*

Question: Is the hospital converting to a new defibrillator?

Jeanette: The hospital has already begun converting to the Phillips biphasic (two-way current) automated external defibrillator (AED) in the Perioperatve Service (including the Main OR, the SDSU, the Cardiac OR, the PACU), the Cardiac Surgical and Arrhythmia services. Phase 2 of the conversion, which will begin in the fall, will include the remaining intensive and special care units (where staff are already trained to defibrillate), The ED, Dialysis, Ellison 11, and the Knight Cath Lab. Phase 3 will include general care units; and phase 4 will involve the outpatient clinics and health centers.

AED is the same technology currently used in public areas, at airports, on airplanes, etc.

Question: Why are we making this change?

Jeanette: Bi-phasic technology utilizes a more advanced energy wave that self-adjusts according to the impedance factors of every patient, thereby delivering a more even discharge of energy regardless of a patient's size. Using an appropriate amount of energy to defibrillate provides optimal protection to the myocardium. The success rate for converting lethal arrhythmias into stable rhythms is significantly higher using biphasic technology.

Staff nurses will be trained to defibrillate using an advisory alert function and external pads. The advisory alert warns if defibrillation is indicated based on cardiac rhythm, which is sensed through the external pads.

An educational plan has been developed by The Center for Clinical & Professional Development to help prepare staff.

Complementary and alternative medicine:

Program will look at acupuncture, meditation, and therapeutic touch. Case studies will help demonstrate the impact of complementary healing modalities.

November 22, 2002
8:00am–4:00pm
O'Keeffe Auditorium

For more information, call 6-3111

The Joint Commission Satellite Network

presents:

"Patient Safety: Achieving Measurable Results"

September 12, 2002
1:00–2:30pm
Haber Conference Room

For more information, call 6-3111

Call for Portfolios

PCS Clinical Recognition Program

The Patient Care Services Clinical Recognition Program is now accepting portfolios for advanced clinicians and clinical scholars. Portfolios may be submitted at any time; determinations will be made within three months of submission. Refer to the http://pcs.mgh.harvard.edu/ website for more details and application materials, or speak with your manager or director.

Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6.

For more information, call 6-3111.

Call for Nominations

The Anthony Kirvilaitis Jr. Partnership in Caring award

In January, 2002, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Anthony Kirvilaitis Jr. Partnership in Caring Award. The purpose of the award is to recognize and celebrate staff in non-clinical roles within PCS who exemplify the values and qualities that made Tony so successful and appreciated in his work as training development specialist in The Center for Clinical & Professional Development.
Those values include *reliability, responsiveness, creativity, assurance, collaboration, and flexibility.*

The award will be given annually to a maximum of two individuals. Nominations are now being accepted for recipients to be selected in October, 2002.

Eligibility

Operations associates, unit service associates, operating room assistants, unit assistants, patient service coordinators, Emergency Department admitting assistants and patient care information associates are eligible for the award.

Nomination and selection process

- Nominations are due by August 23, 2002.
- Any employee, manager, physician, patient or family may nominate a candidate.
- Those nominating may do so by completing a brief nomination form accompanied by a letter of support. Nomination forms will be available on patient care units, in the Emergency Department, Operating Room, the Bigelow 10 PCS Management Office and at the Gray Information Desk.
- Nominees will be asked to submit a letter of support from their manager. If their manager was the nominating party, then the nominee will need to provide a second letter from a co-worker.
- A selection committee convened specifically for this purpose will review all letters and select the award recipients.

Award and award-related activities

Each recipient will receive an award of $1,500 and will be acknowledged at a ceremony and reception among colleagues and family. Their names will be added to a plaque honoring The Anthony Kirvilaitis Jr. Partnership in Caring Award recipients.

For more information, or assistance with the nomination process, please contact Nancy DeCoste, training specialist, at 4-7841, or Carolyn Washington, operations coordinator, at 4-7275.

MGH nurses bring important AIDS education to South Africa

Chris Shaw, RN, and Sheila Davis, RN

Chris Shaw, RN, and Sheila Davis, RN, participants in the Nursing Partners AIDS Project (NPAP), a joint undertaking with the Partners AIDS Research Center, are currently working as part of a two-year humanitarian assistance program in South Africa. NPAP sends clinicians to areas hardest-hit by the AIDS epidemic to implement and coordinate services to help alleviate the suffering caused by this devastating disease. Shaw and Davis have agreed to share their experiences with readers of Caring Headlines*. Below is a recent correspondence from Shaw..*

July 22, 2002

A three-day HIV/AIDS Nursing Conference, coordinated by Sheila Davis, RN, adult nurse practitioner, Partners AIDS Research Center, and hosted by the University of Natal Nursing Program, was held recently here in Durban, South Africa. Along with Sheila, presenters included our colleagues Donna Gallagher, RN, Brianne Fitzgerald, RN, and IHP student, Jamie Zagorski, RN, whom Sheila had recently precepted. Sheila has traveled back to the United States and other parts of the world in her efforts to educate, advocate for, mentor, and provide education to nurses in the field, not only in the United States, but here in South Africa, where the need for education grows daily. Seventy nurses from Kwa-Zulu Natal and other provinces came together to gain knowledge about the virus that is filling South African clinics with patients suffering its devastating effects.

In Kwa-Zulu Natal, one of the hardest hit areas of the world, HIV/AIDS has been a growing cause of concern for nurses. One conference attendee put the situation into perspective when she said she could go back to her practice and, even though she may not have the means to cure people, having the information she learned at the workshop de-mystified the disease and gave her hope.

Conference presenter and IHP student, Jamie Zagorski, RN, shares a moment with conference attendee, Mazwi (pronounced Mar-zway) a community organizer and outreach worker.

For local nurses at the bedside it is a great mystery indeed to see so many young patients dying in the prime of their lives. Sr. Christa Mary, a well respected nurse leader in the province, reports that recruiters are luring nurses away from South Africa for jobs everywhere from Dubai to Australia. But she stresses it's wrong to think nurses are running away from their people. Nurses are paid an average of 5,000 to 8,000 rand per month, the equivalent of $500 to $800 US dollars, and expected to support families. They are often the only employed person in their extended family, not astonishing in a country where the unemployment rate falls consistently between 50 and 70%.

No single issue can be attributed to the cause for burnout and flight from the nursing profession.

The three-day HIV/AIDS Nursing Conference provided important knowledge delivered to nurses by nurses in a format that was open, caring and respectful. Participants shared their rich and often misunderstood cultural practices and beliefs, and challenged each other to open their hearts and minds to understand patients from cultures and beliefs not familiar to them. Topics discussed included the ritual circumcision of adolescent males who sometimes die of septic infection. Instead of judging these practices, discussion focused on the need for clinicians to teach traditional doctors the principles of sterile technique and antibiotics. One South African nurse spoke of a local team of healthcare workers who helped educate a camp where circumcision rituals take place and because of the mutual in-

continued on next page

AIDS Education in South Africa

continued from previous page

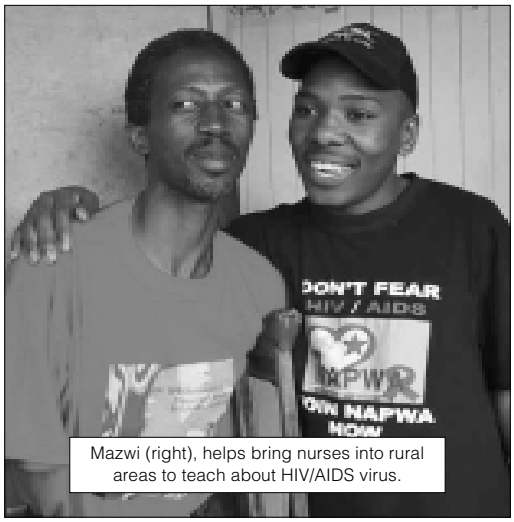
volvement of traditional culture and modern medicine, the rate of infection has decreased significantly.

There were discussions about race and culture which have the potential to be charged with accusations of blame, but within the setting of this conference, discussions were respectful and thoughtful. Nurses in attendance reflected much of the rich diversity of South Africa. They recognized that the struggles of the past contribute to many of the current misunderstandings.

Brianne Fitzgerald, RN, a nurse who has cared for HIV patients in a wide variety of venues, opened her presentation on psycho-social issues with the quote, "Go in search of your people, love them, meet them where they are, and listen to them." It was the perfect opening for our invited guest speaker, Arthur Jonkweni, a 22-year-old Zulu youth volunteer coordinator and outreach worker for the Treatment Action Campaign here in Kwa-Zulu Natal. Arthur shared personal stories of encounters he's had with young people in rural and urban areas and challenged nurses to reach out to people in communities where HIV/AIDS patients are 'invisible.' It is a sad fact that many people who live in South Africa never see the heartbreaking devastation of HIV/AIDS. But for Arthur it is his daily mission to listen to the voices of those who are unheard, and deliver their message to the rest of us.

For nurses, it's impossible not to encounter those infected by HIV/AIDS as the rate of infection stands somewhere between 70 to 80%.

New England AIDS training director, Donna Gallagher, RN, closed the conference with an interactive presentation on "Care for the Carer," a personal perspective of her years of experience as an HIV/AIDS specialist in the United States and a global lecturer in places hardest hit by the pandemic. Her talk emphasized the need for nursing education to include comprehensive workshops on HIV/AIDS to de-mystify, de-stigmatize, and provide hope at a time when hope is in short supply.



Mazwi (right), helps bring nurses into rural areas to teach about HIV/AIDS virus.

Sheila has returned home, but will continue to fund-raise and prepare for the next series of workshops scheduled for February, 2003. It is a privilege to be living and working here with nurses on the front lines and have the support and expertise of fellow nurses, educators and clinicians like Sheila, Donna, and Brianne, and the indirect support of nurses at MGH who share their knowledge, experience, and hope with me in correspondences and prayer. Your strength and support are allowing me to help nurses who need it most.

Sister Christa Mary has told me she wishes she could keep Sheila, Donna, Brianne, and Jamie here to continue educating nurses in Kwa-Zulu Natal. From the land of the Zulu whose love, good will, and humor is balm for the soul, I share this with you and ask for your continued support and prayers.

Chris

(Photos from Africa provided by Chris Shaw and Sheila Davis)


At a support group/training session, Sheila Davis, RN, conducts workshop on antiretrovirals for people living with HIV/AIDS.

Caring for patients in times of crisis, a privilege for ED nurse

Barbara Rossi, RN,
staff nurse, Emergency Department

My name is Barbara Rossi, and I have been a nurse for 33 years, an MGH Emergency Department (ED) staff nurse for the last two years. As a member of the ED resuscitation team, I recently cared for a young woman who presented to the ED in pulseless electrical activity arrest (PEA). Being involved in this team effort reminded me of why I became a nurse and why I love this profession.

The mutual decision-making, trust, and teamwork during this critical and extremely difficult situation was outstanding, and I feel made a difference in the outcome for this patient. I also feel that everyone involved made valuable contributions to the critical thinking and process of care for this patient. All thoughts and ideas were considered; everyone participated in a cohesive decision-making process.

Mrs. R was a 42-year-old, married, mother of three, who was at home with her family on the evening of her admission. She had recently fractured her left ankle. Over the previous few days, she had complained of increased discomfort with less activity. Her husband reported that her primary care physician was concerned about the possibility of a DVT (blood clot in her leg) but an MRI had been negative. Mrs. R had been taking aspirin once a day. Her medical history was significant for varicose veins and oral contraceptives.

According to her family, Mrs. R had been sitting on the couch when she stood up and complained of pleuritic chest discomfort, and then collapsed. Her husband said she appeared to be seizing with rhythmic movements of her extremities. He immediately called 911. When the paramedics arrived she had agonal (strained) respirations and a heart rate in the 140s. She was immediately intubated. Following intubation, her heart rate dropped and CPR was started. Mrs. R was then transported to MGH.

When Mrs. R arrived in the ED, we all felt the situation was tense because we were aware that a young and fragile life hung in the balance. Mrs. R had a rapid heart rate of 140-150, and she was not perfusing (getting blood to her extremities). Chest compressions were continued. She received IV fluids as well as atropine; epinephrine; D50; NaHCO3; and dopamine and levophed via continuous infusion. Her oxygen saturation was 70-80% and her initial blood gas levels were critically low.

In spite of our efforts, Mrs. R's condition did not improve. The team suspected pulmonary emboli (PE). For that reason, it was decided that Mrs. R should receive a dose of TPA (a clot-breaking agent); a bolus was given followed by continuous infusion. Once Mrs. R received the TPA, her color improved and her perfusion was maintained. We sensed hope in one another and a feeling that maybe Mrs. R would survive.

Mrs. R soon developed hematuria (blood in her urine) and a nose bleed, but her oxygen saturation and blood gas levels improved dramatically. She had some purposeful movement on the right side. Again, I sensed that the entire team was feeling hopeful.

Mrs. R's husband and family came in to see her. We explained the gravity of her situation. They cried, and I cried. I tried to support Mrs. R's family and encourage them to talk to her, hold her hand, and let her know they were there. Years of emergency nursing experience told me the situation and prognosis were bleak. However, because of my experience, I also knew that caring for the family is an important part of emergency nursing, especially during critical situations.

Once Mrs. R was stabilized in the ED, she was transferred to the CCU. Her prognosis did not look hopeful given her recent resuscitation, which included intermittent CPR for almost an hour, hypoxia (low oxygen level), and critical blood gas values.

When I returned to work the following Monday, I was greeted by one of the team doctors who said, "You must go to the CCU. You won't believe it."

I gathered myself together and off to the CCU I went. Staff there told me that, remarkably, Mrs. R was able to follow commands, although she was a little slow to respond. I cried when I left. I felt humbled by her recovery, and an essential part of it.

I later visited Mrs. R on one of the medical units. Again, I was overwhelmed by her astonishing recovery. Although she had no recollection of the events, she told me that her husband had finally shared what happened with her. "It was time," she said.

continued on next page

Educational Offerings and Event Calendar Now Available On-Line

The Center for Clinical &Professional Development now lists educational offerings on-line at

http://pcs.mgh.harvard.edu

To access the calendar, click on the link to CCPD Educational Offerings.

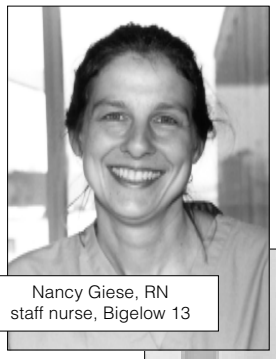
For more information or to register for any program, call the Center at 6-3111.

Employee Referral Program: bringing quality clinicians to MGH

"It was the New Graduate Critical Care Nurse Program that really attracted me to MGH," says Kate Garrigan, RN, who has two weeks left of her orientation in the Pediatric Intensive Care Unit. Garrigan is one of almost a hundred clinicians who has come to MGH since July, 2001, through the MGH Employee Referral Program.

Garrigan was referred by staff nurse, Nancy Giese, RN, of the Bigelow 13 Burn Unit. Garrigan's mom met Giese at a Christmas party, the two got to talking, and Giese suggested she have Kate call her.

Says Garrigan, "We talked for about an hour. I knew I wanted to work in Pediatrics, but being a new nurse, I didn't think critical care would be an option for me. So when I heard about the New Graduate Critical Care Nurse Program, it really sparked my interest."



Nancy Giese, RN
staff nurse, Bigelow 13

The program involves a six-month orientation period, during which the new nurse works closely with a preceptor. Says Garrigan, "It is such a great learning experience. I've been exposed to so many different situations that you just don't get in nursing school. It's a unique opportunity to learn in a very complex setting with the support of an experienced nurse and mentor."

Garrigan graduated from Simmons College with a nursing degree in December, 2001, and started working at MGH in February, 2002. Says Garrigan, "I'm in the process of getting my master's degree, and both Brenda Miller (nurse manager) and Kathryn Beauchamp (clinical nurse specialist) have been very supportive. I have to say… I feel like I have the support of the whole staff. I love the pace, the environment, and the people. It's a great unit."

Giese, who is herself a preceptor for the New Graduate Critical Care Nurse Program on her unit, has been a nurse for 13 years.

Talk about a win-win situation. Giese received a $1,000 referral bonus, which she generously split with Garrigan. Says Giese, "I know how hard it is when you're just getting started and going to school. I thought it was only fair that she got half."

New graduate nurse, Kate Garrigan, RN (left), and preceptor, Lisa Henderson, RN, in the PICU

Bigelow 13 is a 22-bed adult patient care unit with 12 beds designated for plastic surgery, 10 beds for burn patients (5 of those dedicated to critically ill burn patients).

The PICU is an 8-bed, critical care unit for children from newborn to age 19.

Exemplar

continued from page 6

Even though the ED can be a very stressful environment in which to work, caring for Mrs. R in such a critical situation, and seeing the positive outcome, makes being a nurse and a member of this dynamic team worthwhile. Mrs. R's recovery has renewed for me the meaning and privilege of being a nurse. I am fortunate to be part of a team of professionals who care for patients and their families in times of crisis.

Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

This narrative gives us a wonderful glimpse into the high-tech, fast-paced, life-and-death decision-making that epitomizes ED nursing practice. Barbara's account of teamwork in this critical situation is more than people just working side by side; it's a team of clinicians so united in purpose, they *feel* each other's hope, determination, and commitment. That is a special kind of teamwork.

The combined wisdom, skill and experience of this team enabled them to assess, diagnose and treat this gravely ill woman about whom they initally knew very little. Barbara understood the fear and anxiety of Mrs. R's family, waiting helplessly for news. Despite the critical nature of Mrs. R's condition, Barbara included the family as soon as it was safe to do so.

Despite the fact that Mrs. R was unconscious during the time she spent in the ED, a connection was made; a connection between Barbara and Mrs. R, and between Barbara and Mrs. R's family. Barbara's visits to Mrs. R in the CCU and medical unit speak to the strength of that connection.

Thank-you, Barbara, this is a wonderful story.

New strides in nursing research: a report on the Cooperative Group Cancer Nursing Research Summit

Joan Agretelis, RN
clinical nurse specialist

Recently, Karleen Habin, RN, research nurse manager for the Gillette Center for Women's Cancers, and I attended the first Cooperative Group Cancer Nursing Research Summit, which brought together nationally recognized nurse researchers and nurse leaders representing the National Cancer Institute (NCI), the National Institute of Nursing Research (NINR), the Komen Foundation, the American Cancer Society (ACS), and the Oncology Nursing Society (ONS), as well as representatives from several cooperative research groups.

A number of key nurse leaders attended the summit including Drs. Claudette Varricchio and Ann O'Mara of the NINR.

The goal of the summit was to exchange information and form collaborations to facilitate multi-site nursing research. Five objectives were identified:

- To understand the nursing research structure and culture of other organizations
- To investigate funding opportunities for collaborative group nursing research
- To develop strategies to integrate nursing research into cooperative group research agendas
- To establish a collaborative, national network through which nursing studies can be conducted
- To increase national awareness of nursing research opportunities within cooperative group settings.

To appreciate the magnitude and relevance of this unique gathering of nurse leaders, it is important to understand the historical barriers that have influenced nursing research in the past. Unlike medical research, most nursing research has been conducted at single institutions, utilizing small, minimally diverse patient populations, thereby limiting the generalizability of nursing knowledge to the broader population. Large, multi-center nursing research has taken place only rarely.

By gaining access to a larger source of scientific expertise, and a larger, more diverse patient population, nurses at all levels can facilitate scientifically credible nursing research. This summit was a first step in what could be a monumental change in how nursing research is conducted in this country.

The current state of cooperative group nursing research spans a wide range. Of the nine groups represented at the summit, nursing research studies have been conducted in all but three groups. However, only a handful of nursing studies have been completed over the past 50 years compared to thousands of medical studies. Additional studies are currently accruing patients or have been approved but are pending funding. And other studies are still in the development phase. In the groups that have not yet developed nursing studies, facilitation of nursing research was clearly identified as a goal for the future.

In addition to nurse-initiated studies, nurses at all levels have made significant contributions to the design and execution of medical and behavioral-science-focused studies, functioning as consultants, study coordinators, clinical research associates, and co-investigators. Nurses are beginning to identify nursing-specific outcomes from these non-nurse-initiated studies. Dissemination of these findings through publication of results in peer-reviewed journals will be important.

Several areas of scientific focus where identified by participants at the summit. Claudette Varricchio, RN, reported that funding is available for cancer nurse researchers targeting clinical-trial development in several areas, including:

- Health promotion in diverse populations
- Neuro-function and sensory conditions
- Immune responses and oncology
- End of life
- Disease prevention
- Symptom management
- Minority health issues.

One presentation provided evidence supporting the lack of improvement in overall survival for cancer patients between the ages of 25-39, primarily due to poor clinical trial participation among this group. The presenter challenged summit nurse leaders to target this young adult and older adolescent population when designing research agendas.

Several challenges were identified that need to be considered when developing strategies to advance a nursing research agenda within cooperative group settings. The following list summarizes areas for future focus by summit participants:

- Funding is needed for clinical-trial execution, travel for nurse researchers and clinical experts to attend cooperative group meetings, and future summits
- Need to educate academically focused nurses regarding strategies for navigating within cooperative group systems and on important, yet subtle, requirements within grant applications that will lead to funding
- Need to educate/mentor clinical nurse experts regarding research methodology
- Linkage of nurse researchers with clinical nurse experts
- Education within cooperative groups regarding the contributions of nurse researchers-clinical nurse dyads
- Consider concerns regarding who owns the data and paper authorship

continued on next page

Professional Achievements

Bilodeau certified critical care clinical nurse specialist

On June 21, 2002, Bigelow 13 clinical nurse specialist and nurse practitioner of the MGH Burn Service, MaryLiz Bilodeau, RN, became certified as a critical care clinical nurse specialist by the American Association of Critical Care Nurses.

Madigan receives MONE's Sherwood Service Award

Janet Madigan, RN, project manager for Nursing Information Systems, received the Elaine K. Sherwood Service Award at the Massachusetts Organization of Nurse Executives (MONE) annual meeting, May 23, 2002. The award recognizes outstanding commitment and contributions to the work of MONE, including longevity of service, project management, leadership, dependability, and support of peers developing within the organization.

Whitaker presents poster at ANNA conference

Blake 6 staff nurse, Debra Whitaker, RN, was lead author of the poster, "A Collaborative Protocol for the Transplant of Multiple Myeloma," at the American Nephrology Nursing Association's annual conference in May, 2002. The poster described the team approach used in successful, simultaneous, combined renal and bone-marrow transplants. Contributing authors include: MaryLiz Bilodeau, RN, Loretta Godfrey, RN, Lisa Sohl, RN, and Nina Tolkoff-Rubin, MD.

Lawson receives med-surg certification

Donna Lawson, RN, staff nurse, Bigelow 11, is the first nurse on her unit to receive medical-surgical certification.

Morton presents at Burn and Wound Care Symposium

Sally Morton, RN, Bigelow 13 staff nurse and member of the MGH DMAT Team, presented, "Burn Team Response to a National Disaster," at the John A. Boswick, MD, Burn and Wound Care Symposium, on February 18–20, 2002, in Maui, Hawaii.

Noska presents at Transplant Management Forum

Susan Noska, RN, Blake 6 transplant coordinator, presented, "Transplantation," at the 10th annual United Network for Organ Sharing's Transplant Management Forum, on May 20, 2002. The presentation was a broad-based overview of organ and tissue transplantation, including a history of organ transplatation and a discussion of anticipated future enhancements.

The Employee Assistance Program

presents

"Stress Management in Today's World"

Presented by Stacey Drubner, JD, LICSW

Seminar will educate staff on the causes of stress and help participants adapt coping styles to more effectively respond to stressful situations.

September 12, 2002
12:00–1:00pm
Wellman Conference Room

For more information, call 726-6976.

CNS

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- Develop a common language when articulating our vision
- Merge nursing science into cooperative group agendas
- Identify and establish connections with nurse researchers not present at the summit.

Next steps identified by the group include:

- Disseminate summit outcomes via journals, publications, press releases and presentations
- Educate all cooperative group nursing committees.
- Obtain funding
- Continue networking to enlist participation of more nurse researchers

I hope this overview helps shed some light on the future role of nurses in cooperative oncology research groups. I was recently appointed to the Cancer and Leukemia Group B (CALGB) Oncology Nursing Committee as the nurse researcher for symptom management, so this was a great opportunity for me to get a glimpse into nursing research on the national level before going to Nurse Scientist Training at NIH.

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ProTech Program spotlights healthcare careers for high school students

—by Carol Camooso Markus, RN and Mary McAdams, RN

The ProTech Program, a collaborative venture involving MGH, East Boston High School, and the Private Industry Council, provides opportunities for juniors and seniors at East Boston High School to gain knowledge about jobs and careers in a hospital setting. Through participation in the program, students become familiar with the roles of nurses, therapists, pharmacists, dieticians, technicians, secretaries, and environmental service workers.

The ProTech Program is coordinated through the MGH Community Benefits Office. Within Patient Care Services, the program is coordinated by The Center for Clinical & Professional Development. ProTech offers students a chance to:

- gain awareness of their talents and career interests
- develop work habits to promote future success
- learn skills that can be brought back to the classroom
- have a paid work experience while still in school.

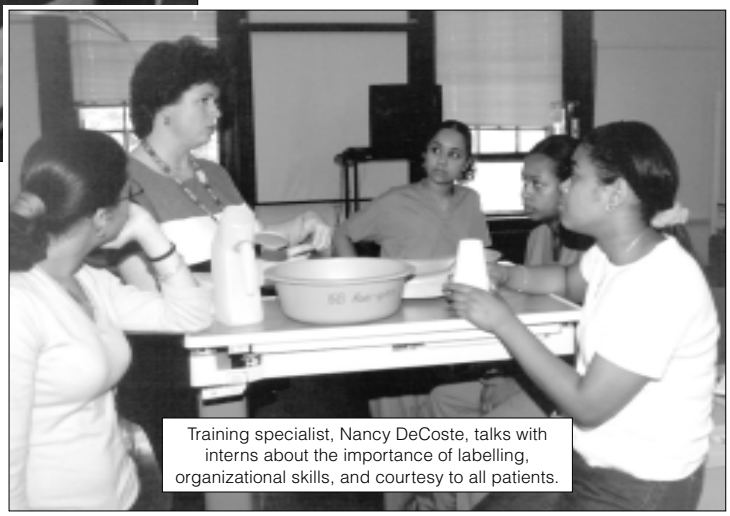
This year, we have one ProTech intern on each of the following units: Bigelow 7, Bigelow 11, Ellison 3, White 7, White 9, Ellison 7, and in the department of Occupational Therapy.

ProTech interns (l-r): Lillian Gonzalez (White 7); Victoria Fernandes (Bigelow 11); Filomena Barros (White 9); and Nancy Ventura (Ellison 7)

In Nursing, there are two levels of ProTech interns. Level 1 interns are trained in specific skills such as filing medical records, creating inventories, maintaining the nurse-station work area, and doing specific projects under the direction of the operations coordinator and nurse manager. Level 2 training includes assisting nurses in the transfer of patients, making beds, filling water pitchers, and assisting patients with menus.

ProTech students work 15 hours a week during the school year and 40 hours a week during the summer. For more information about the ProTech Program, please contact Carol Camooso Markus RN, professional development coordinator, at 4-7306.

Mary McAdams, RN, clinical educator, trains interns in proper bed-making techniques.



Training specialist, Nancy DeCoste, talks with interns about the importance of labelling, organizational skills, and courtesy to all patients.

In memory of September 11th

The MGH Chaplaincy will offer a special service on the one-year anniversary of September 11th. The service will include participants of many religious traditions and will be tele-conferenced to the Haber Conference Room.

Wednesday, September 11, 2002
11:30am–12:00pm
O'Keeffe Auditorium.

When/Where	Description	Contact Hours
August 26 8:00–11:30am	**Intermediate Arrhythmias** Wellman Conference Room	3.9
August 26 12:15–4:30pm	**Pacing : Advanced Concepts** Wellman Conference Room	5.1
August 27 (and September 19) 8:00am–4:15pm	**Neuroscience Nursing Review 2002 (Day 1)** BWH	TBA
August 28 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
September 3 8:00am–4:30pm	**Chemotherapy Consortium Core Program** Wolff Auditorium, NEMC	TBA
September 4 8:00am–4:00pm	**CVVH Core Program** VBK601	6.3
September 5 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
September 5 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
September 6 8:00am–4:30pm	**Heart Failure: Management Strategies in the New Millennium** O'Keeffe Auditorium	TBA
September 6 8:00am–4:30pm	**OA Preceptor Development** Training Department, Charles River Plaza	- - -
September 10 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
September 11 8:00am–2:30pm	**Mentor/New Graduate RN Development Seminar I** Training Department, Charles River Plaza	6.0 (mentors only)
September 11 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
September 12 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
September 12 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Patient Safety: Achieving Measurable Results." Haber Conference Room	---
September 13 8:00am–4:30pm	**Staying on Top of Your Game: Advanced Cancer Nursing** O'Keeffe Auditorium	---
September 17 1:00–3:00pm	**Pacing: Basic Concepts** Haber Conference Room	---
September 18 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
September 19 10:00–11:30am	**Social Services Grand Rounds** "An Overview and Application for DBT." O'Keeffe Auditorium. For more information, call 724-9115.	CEUs for social workers only
September 19 8:00am–4:15pm	**Neuroscience Nursing Review 2002 (Day 2)** Wellman Conference Room	TBA

For detailed information about educational offerings, visit our web calendar at http://pcs.mgh.harvard.edu. To register, call (617)726-3111.
For information about Risk Management Foundation programs, check the Internet at http://www.hrm.harvard.edu.

"Wrap it up, We'll take it to go!"

special painting goes home with special patient

(L-r):Jerry and Jane Lapriore, the painting, "Morning Light," and Teresa McCue (the artist).

(Photo provided by Beth Homicki)

Jane Lapriore got more than great care at MGH. She got *Morning Light*, a painting by local artist, Teresa McCue. The painting was part of the Illuminations art exhibit that was on display in the MGH Cancer Center. Illuminations is a rotating art exhibit, made possible with funding from the Friends of the MGH Cancer Center, that uses art to create a healing and comforting environment for patients and families.

When Jane was diagnosed with cancer, she began an aggressive regimen of radiation and chemotherapy. Jane's husband, Jerry, recalls, "It was a terrible time for us; a very difficult time for my wife. When we came to MGH for treatment and we sat in the waiting area on Cox two, we were drawn to this painting called, *Evening Light*. It brought both of us such peace. We found ourselves gravitating to it whenever we came here."

Says Jerry, "As my wife neared the end of her treatment, I thought she deserved a major present! So I got in touch with the artist, Teresa McCue, and arranged to buy it and have it delivered the day Jane finished her treatment."

The Lapriores have since renamed the painting, *Morning Light*, and have it in their home, where it occupies a place of distinction. Says Jerry, "It has a very special place in our hearts, and still brings us a sense of peace and comfort."

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