February 21, 2002

Caring HEADLINES

African American Pinning Ceremony

Celebrating the rich culture and invaluable contributions of African American employees

—by Deborah Washington, RN director of PCS Diversity

Inside:

On February 1, 2002, in O'Keeffe Auditorium, Patient Care Services and the MGH community celebrated Black History Month with the third annual African American Pinning Ceremony. The ceremony was created as a means of reflection for African American women and men to celebrate their organizational contributions, their cultural history, and their vision for the future.

Guest speaker and consultant, Ralph Frazier, presented, "Mentoring, the Gift of Relationships," in which he described mentoring as a transfer of wisdom in a way that helps individuals build abilities and self-confidence. The message fit perfectly with the day's observance.

(Photo by Michelle Rose of the Bulfinch Photo Lab)

Director of PCS Diversity Program, Deborah Washington, RN, pins White 6 staff nurse, Ivonny Niles, RN, at this year's African American Pinning Ceremony.

The theme of this year's celebration, "Hidden Treasures," captured the essence of this program that honors the quiet, capable individuals who consistently impact MGH through the effect they have on the lives of others. Honorees for 2002 were: Carol Washington, Bigelow 13 operations coordinator; Alfreda Whyte, RN, Blake 6 staff nurse; Dorothy Bowers, RN, staff nurse on the Ellison 8 Cardiac Step-Down Unit; Helen Warwick, patient care associate in the Emergency Department; Edna Gavin, Bigelow 13 critical care tech; and Ivonny Niles, RN, White 6 staff nurse.

Each honoree was introduced by the person paying her tribute. Dawn Moore, RN, spoke about Carol Washington, the operations coordinator on Bigelow 13. Moore was first hired by Washington when she was a Protech student. "I was surprised she even gave me a chance," said Moore, "because I was dressed in jeans and sneakers and had a flip attitude at the time." Washington mentored

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PCS diversity initiatives: creating an infrastructure that works!

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

Each year when I sit down to write Patient Care Services' report on Diversity, I am amazed at how far we've come in such a short amount of time. It reinforces my belief that we were right to take the time necessary to educate ourselves and really create a solid infrastructure to support this important work.

Our diversity initiatives are broad and all-encompassing; they mirror the definition of diversity that we crafted to guide our efforts. Our operating assumptions reflect the wisdom and thoughtfulness of a sensitive and informed organization. They are the guideposts that ensure we remain true to our values as we move forward in our journey. The operating assumptions that drive our diversity program are:

- Cultural competence is a process, not a destination
- The journey begins with each individual knowing his/her own cultural values, beliefs, and lifestyle as they influence our actions.
- It is critical to recognize the intra-cultural variation among ethnic and diverse groups.
- We must be patient in our learning and knowing processes, including integrating social cultural factors within a cultural context.
- Knowing and improving are inseparable. We must learn about the illness and wellness states of diverse cultures to be able to provide care that is culturally competent.

PCS definition of diversity encompasses:

- Race
- Ethnicity
- Gender
- Education
- Sexuality
- Religion
- Age
- Culture
- Physical ability
- Personal belief system
- Stage of life/career
- Opinion

Though MGH has always welcomed people and cultures from all over the world, it wasn't until we really focused our efforts, identified specific goals, and committed resources that we started to achieve measurable outcomes in our work around diversity. Some recent outcomes include:

- incorporating diversity-assessment questions into the Staff Perceptions Survey
- collaborating with U.Mass Boston to enhance clinical affiliation experiences
- designing processes and interventions to enhance the career success of diverse employees
- working with Human Resources and Community Benefits to conduct focus groups to gain insight into other perspectives about the care delivered at MGH
- developing strategies to positively impact youth-service groups such as The Girl Scouts, to raise awareness a bout careers in health care

And our goals for the future are equally ambitious. We are currently working to:

- implement a Foreign-Born Nurses Licensure Program (see question on page 3)
- create strategic alliances with academic institutions to support new graduate nurses' transition into practice
- improve access to diversity trend data
- revise the PCS Diversity Leadership Fellowship
- design an MGH Nursing Image Campaign that captures the diversity of our workforce and the opportunities available at MGH

Providing competent medical interpreters for our non-English-speaking patients has become a top priority (see article on page 5). The number of requests for interpreter services has tripled in the past five years. To meet the demand, we now employ 18 full-time interpreters who provide competent medical interpreter services in Spanish, Khmer, Portuguese, Arabic, Vietnamese, Cantonese, Mandarin, French-Creole, Russian, and Italian. Over and above that, there are 83 interpreters on call supporting 34 languages. Interpreter services are available 24 hours a day, seven days a week.

We truly have created a new reality at MGH, a reality where diversity is one of the many interwoven threads in the fabric of Patient Care Services. Isn't it wonderful that at any given time we can attend an educational offering on:

- Caring for Gay & Lesbian Patients
- Gender Roles in the Muslim Culture
- Communicating Effectively with Deaf and Hearing-Impaired Patients
- Special Issues in Healthcare for Jehovah's Witnesses and Christian Scientists

We have come far. I commend each and every one of you for your commitment to, and support of, our diversity initiatives. The more we do… the more we achieve together… the stronger we become. It's exhilarating to think what we will accomplish in the *next* 5 years!

Medical equipment and on-going diversity initiatives

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 questions presented by staff at meetings and venues throughout the hospital.*

Question: I heard about an incident recently (at another hospital) where a patient died after receiving a dose of nitrous oxide. Is it advisable for oxygen-delivery equipment to be modified for use with other gas mixtures?

Jeanette: This is a question that relates to all medical equipment in all areas of the hospital. Under *no* circumstances should patient-care equipment be modified or used for any purpose other than its intended use. We have a lot of very sophisticated machinery that enables us to utilize the latest in healthcare technology. We use this equipment according to manufacturer's specifications, and only the manufacturer is qualified to modify or adapt that equipment.

This is particularly important in the case of gas-delivery equipment. In the United States in the past 12 months two patient deaths have occurred as a result of modification of gas-delivery equipment. Machines designed for use with a specific gas should never be modified or used with substances other than those they were intended for.

Question: We've been talking about making a difference with diversity for a long time. I do see changes, but what exactly is the hospital doing?

Jeanette: I think the changes you're referring to have to do with our increasingly multi-cultural, multi-ethnic staff, and our on-going efforts to ensure that all staff deliver care that is culturally competent and sensitive. Increasing the diversity of our staff has been a long-held priority of Patient Care Services. We have made great strides in providing and supporting educational opportunities with grants and scholarships. We celebrate employee contributions through recognition and award ceremonies. Through school and other affiliations, we promote MGH as the healthcare employer of choice. It is encouraging to hear that our many efforts are being noticed.

Question: Did I hear that there's a mentoring program for foreign-born nurses interested in pursuing a license to practice in the United States?

Jeanette: Yes, we are piloting a program to assist nurses licensed in other countries to fulfill the necessary requirements to obtain a professional license in this country. Many MGH employees working in assistive roles are fully licensed to practice nursing in their own countries. These individuals have been valuable employees, and it's important that they be supported in their efforts to maximize their own potential and continue to make valuable contributions to our patients and their families.

Above: Wong at reception with senior vice president for Patient Care, Jeanette Ives Erickson, RN.

Above right: Wong with Washington and Waithe.

At right: Wong with Tyrrell and Greene.

(Photos by Michelle Rose)

Multi-Cultural Student Mentoring Program Welcome Reception

Teresa Wong received a royal welcome as the first nursing student accepted into the MGH-U Mass Boston Multi-Cultural Nursing Student Mentoring Program at a special reception held in her honor on February 1, 2002. Speakers at the reception included: Rosalie Tyrrell, RN, MS, project manager; Marion Winfrey, RN, EdD, associate dean for Undergraduate Studies, U Mass Boston School of Nursing and Health Sciences; Deborah Washington, RN, director of PCS Diversity; and Ron Greene, RN, chair of AMMP (and a volunteer mentor).

Associate chief for The Center for Clinical & Professional Development, Trish Gibbons, RN, DNSc, presented the scholarship to Wong. Several nurses who have volunteered to be mentors for the program were present, including: Rischa Mayes, RN; Philip Waithe, RN; Angelleen Peters-Lewis, RN; and Mary Williams, RN.

Wong has begun her orientation to become a part-time patient care associate on Phillips House 21.

Cover Story

continued from front cover

Moore throughout high school, attended Protech meetings with her, and helped her prepare for college. Moore, who is a member of the International Medical Disaster Team, started as an assistant on the unit ten years ago, and in June of this year will graduate with a master's degree in Science as a family nurse practitioner. Said Moore, "I have achieved these goals and much more because of Carol."

Alfreda Whyte, RN, was honored by Ronald Greene, RN, who said in his introduction, "When Alfreda decided to go to nursing school, she worked full time and went to school full time. When I asked her what the hardest thing was during that time in her life she said, 'It was the exhaustion.'" Whyte graduated two years ago and is now working as a nurse on Blake 6. What's her greatest challenge these days? Says Whyte, "It's the whole idea that now I'm the responsible one. There's no nurse to go to anymore. I'm the nurse."

Helen Warwick, patient care associate in the ED (unable to attend), was also recognized by Greene. "Helen's job title has changed several times in her thirty years at MGH," said Greene. "But no matter what hat she wears, she always makes a difference whether it's mentoring new employees, helping interns get oriented, or just generally helping patients and families feel more comfortable."

Dorothy Bowers, RN, staff nurse on the Ellison 8 Cardiac Step-Down Unit, was introduced by Lois Masters, RN, who shared that, "Dorothy came to us as a new graduate nurse, then she worked as a patient care associate. It was easy to see her potential. 'Excellence' is the word that best describes her."

Edna Gavin, critical care tech on Bigelow 13, was introduced by Mary Williams, RN. Gavin, who has worked at MGH since 1969, was the first person to become a burn technician when the role was initially created. Said Williams, "When you think of the Burn Unit, the first person who comes to mind is Edna. She is firm but gentle. She has a great sense of humor. And sometimes you may even hear her singing!"

Ivonny Niles, RN, who started as a phlebotomist at MGH in 1979, was introduced by Deborah Washington, RN. Niles, who is now a staff nurse on White 6, proudly self-identifies as a Latina and an African American. Said Niles, "Being honored at this African American Pinning Ceremony means I'm somebody. It's easy to get lost in such a large hospital, but this pin says: 'this person exists … this person has something to offer.'"

Indeed, each of these individuals has much to offer. We're happy to have the opportunity to recognize them and make their contributions a little less 'hidden.'

Lois Masters pins Dorothy Bowers

(Photos by Michelle Rose)

2002 Pinning Ceremony honorees (l-r): Dorothy Bowers, Ivonny Niles, Edna Gavin, Carol Washington, and Alfreda Whyte.

MGH Cancer Center Music and Healing Program

Wednesday, March 6, 2002

11:00–11:45am	(harpist) Radiation Oncology (Cox LL)
12:00–12:45pm	(staff in-service) Cox 8 (Social Work office suite)
1:00–1:45pm	(harpist) Cox 2 Waiting Area

Thursday, March 7, 2002

11:00–11:45am	(harpist) Bigelow 12 Infusion Unit
12:00–12:45pm	(staff in-service) Radiation staff lounge
1:00–1:45pm	(harpist) Blake 2 Infusion Unit

For more information call Joelle Reed at 6-2689

Medically speaking: the importance of using medical interpreters

—By Andrea Beloff, administrative fellow

Going to a hospital as a patient can be unsettling under the best of circumstances, but being in a hospital and unable to communicate with anyone can be absolutely terrifying. This is the unfortunate reality for many non-English speaking patients and their families across the country.

In July of 2001, the Massachusetts legislature passed a new state law ensuring effective communication between healthcare providers and all non-English-speaking patients. The law specifies that competent interpreter services be available at no cost to all non-English speaking emergency and psychiatric patients. Because MGH is committed to providing the highest-quality culturally competent care, our policy calls for the provision of competent interpreter services to *all* patients.

The US Civil Rights Act prohibits discrimination by federally funded entities based on race, color, or national origin, particularly as it pertains to individuals with limited English proficiency. Hospitals and individual healthcare providers could face serious legal charges for treating patients with whom they cannot effectively communicate.

Qualified medical interpreters improve understanding between patients and caregivers. It has been shown that enhanced communication and understanding improves compliance with the care plan and treatment regimen, and ultimately results in better outcomes. Using medical interpreters also ensures that patients are aware of ancillary tests and follow-up appointments, reducing the amount of missed appointments.

It can be tempting to ask family members or other staff members to interpret during encounters with non-English speaking patients. State law and MGH policy prohibit the use of unqualified staff or family members as a replacement for competent medical interpreters. Family and staff are often unfamiliar with medical terminology and may have difficulty remaining unbiased and unemotional when interpreting medical information. Family members especially may subconsciously screen the patient's answers, add their own information, or contribute medical advice that did not come from the provider. This jeopardizes the accuracy of communication and severely undermines patient confidentiality. Using bi-lingual staff as interpreters contributes to decreased productivity, resentment among staff who must cover for them in their absence, and increased turnover among bi-lingual staff.

MGH medical interpreters follow the standards of practice established by the Massachusetts Medical Interpreters Association and are trained to be accurate and unbiased.

Patients have the right to choose who will interpret for them, but all patients must be given the option of using a trained MGH medical interpreter. Only the patient has the right to accept or refuse a qualified medical interpreter. Providers should document in the patient's medical record when a medical interpreter is used or refused by the patient.

The MGH Interpreter Services Office is open weekdays from 7:00am to midnight, and weekends from 10:00am to 10:00pm. Not all interpreters are on-site when the office is open, so it is strongly recommended that you request an interpreter in advance.

During office hours, call 6-6966 to request an interpreter. After hours, please call 4-5700 and enter pager number:

- 3-0001 for a Spanish interpreter
- 3-0003 for a Portuguese interpreter
- 3-0005 for an Arabic interpreter
- 3-0009 for all other languages or authorization to use telephone services

Look for another article focusing on the important work of medical interpreters in the March 21st issue of *Caring Headlines*.

Spanish-speaking medical interpreter, Isa Maria Deputy, assists pediatric pulmonologist, Bernard Kinane, MD, in communicating with 2-year-old, patient, Sonia Henriquez and her mom.

Long-term nurse-patient relationship, a treasured gift for Blake 2 nurse

Heather Kuberski, RN, BSN
staff nurse, Blake 2

My name is Heather Kuberski, and I am a staff nurse on the Blake 2 Infusion Unit. When I began caring for Beth, I was a new graduate nurse, only 22 years old. I was a newcomer to nursing and to Oncology. Beth was only 18 years old when I first met her (at that time, I was nurse on Ellison 14). She had been newly diagnosed with a rare form of cancer, called sarcoma, that was believed to have started in her left groin and spread to her lungs. She had been admitted to the hospital for her first round of chemotherapy.

I'll admit, I was a little intimidated at the idea of treating a patient so young, practically my own age. I'll never forget the frightened look in her eyes when I first met her—that fear of the unknown. Her parents were with her and seemed very supportive of their daughter, who was their only child. I introduced myself to them and told them I'd be their 'primary nurse.' They seemed grateful to know that they would be seeing a familiar face with each of Beth's admissions… and there would be a lot of them over the next four and a half years.

The first memory I have of developing a trusting nurse-patient relationship with Beth was when her hair began to fall out from the chemotherapy treatments. She was devastated by her hair loss. She described it as, "really seeing herself as sick." I comforted her and assured her that when her treatments were completed her hair would grow back. I even helped her shave what was left of her hair, as she said it was "itching her." Beth and I had begun a bond that would continue throughout her fight with cancer.

Beth tolerated the first two years of her chemotherapy treatments quite well. She would come to the hospital with her midnight snacks to share with the nursing staff and entertain us late at night with her wonderful sense of humor. Never during this time did she think she would not get better. She coped with her illness by sleeping through her treatments. We all knew not to disturb her, unless of course, her favorite show, *Days of our Lives*, was on.

As time went on, Beth's disease continued to win. She would have her rounds of different inpatient chemotherapies and CAT scans. Though certain chemotherapies worked for a little while, and her lung disease would get better, after a while treatments stopped helping and her disease started to grow again. Beth would plead with her oncologist, asking, "When am I going to be better? When am I going to be able to live a normal life?" Of course her doctor had no answers for her. He didn't know if or when her disease would ever fully respond to treatments. In addition to the grueling chemotherapy treatments, Beth had been through two surgeries on her left groin and leg where doctors believed her primary cancer site was.

After standard chemotherapy had ceased working, Beth went on to try investigational protocols on an outpatient basis. Coincidentally, that's when I transferred from the inpatient Oncology unit to the outpatient unit, so I was able to remain her primary nurse. These protocols kept the disease in her lungs stable for a period of time.

One day I received a phone call that Beth had been taken to the emergency room. She was somnolent and confused, and doctors weren't sure of the cause. She was taken to Ellison 14, where she remained for more than six weeks. We all thought this would be the end of Beth's long battle with cancer. We said our good-byes, and her parents kept a vigil at her bedside. Beth was mostly unresponsive. As a last resort, her oncologist decided to try one last medicine, Decadron. Miraculously, Beth woke up! I was amazed when I came to visit her and found her sitting up in bed asking for a ham and cheese sub. She said, "Heather, what did you expect? You know I love to eat." I smile now at the memory. Everyone was ecstatic at her recovery. She was transferred to rehab, where she remained for several months. But Beth's remission was short-lived

When Beth returned to MGH, we continued to try different chemotherapy treatments, which weren't effective against her aggressive disease. She would continue to come to the clinic to see me for hydration, blood products and lab work. Every time I saw her, she looked a little thinner, a little more pale, and most importantly, a little more sad. She would tell me, with tears rolling down her face, how much she hated coming into the hospital.

Her parents remained supportive of Beth, but it became obvious that Beth's care was taking a toll on them as well, emotionally and physically. Beth could no longer walk, she could only stand and pivot with a walker. She had been sleeping in her living room at home, as she was unable to go up stairs to her bedroom. I thought it was time for a discussion about palliative care with Beth and her family.

I met with Beth's social worker (who had

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Exemplar

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been there throughout Beth's entire illness) and her oncologist. We discussed Beth's care and when we thought it would be appropriate to mention, 'hospice.' Up until this time, Beth and her family had been unwilling to accept the fact that she was nearing the end of her illness. After all, she had come back after having been given only six months to live. We knew we had to approach this subject with great care. We slowly introduced the Palliative Care team back into their lives (they had been involved when Beth had had her previous crisis). They reluctantly accepted this. Beth and her family did not like "all this talk about death and dying." They wanted to focus on the positive, which we could understand. Beth was an only child and part of a very close circle of friends and relatives.

In the months that followed, Beth went through an array of emotions, ranging from anger to sadness. She would ask, "Why me? I see everybody around me getting good news and getting better. When is it my turn to get a break? When am I going to get my life back? I am so sick of being sick." I would comfort Beth during these times and try to cheer her up. Sometimes, I would succeed and other times I would fail, but I never stopped trying. I had been there for Beth since the beginning, and I wasn't going to stop now.

One day, Beth came into the clinic, as she did every week, but this time was different. Beth had had a bad fall over the weekend, and was bruised and in severe pain. I immediately called her doctor and we arranged to have some x-rays taken. Luckily, nothing was broken, but the pain in her left leg would not stop. The decision was made to admit her for pain management and physical therapy as she had almost no movement in her left leg. I helped her to the inpatient unit. I felt terrible leaving that night, as she pleaded with me not to leave her. I promised that I would be back to see her the next day and assured her that she was in good hands.

When I came back the next day, I was relieved to see her looking much more comfortable. They had started continuous pain medicine. She was very glad to see me, and assured me that she was feeling much better. Then, something happened that had never happened between us in the past. She began to open up to me in a way she never had before. She told me she thanked God every day that I was her nurse. She told me it was comforting to have a nurse her own age to confide in. She reminded me of the fact that I had begun treating her when I was the age she was now, 22. She told me she considered me one of her best friends, as we had spent so much time together over the past four years. She told me she had been talking to God a lot lately, asking Him why she was still here, what His purpose was for her. She said He must have a reason to have kept her here so long, when others with her diagnosis had already passed away. She told me she was tired of being in pain, she wanted to feel normal again, wear her hip clothes and put on makeup. I listened to her words with a full heart. I knew I should go back downstairs, but I stayed. Somehow, I knew that this visit was very important.

When she finished talking, her parents and some family friends came in to visit. They brought pastries, and Beth asked for a cheese danish. She hadn't eaten anything in more than a month, so this request was a surprise. We asked if she only wanted half, but she exclaimed, "No! I'm going to eat the whole thing!" I had a wonderful visit that day with Beth. I told her I would be off the next day, but I would see her soon. I gave her a hug good-bye and headed back down to care for my other patients.

When I came back to work four days later, Beth was gone. She had died peacefully just a few hours before my shift started. I was shocked. How could the 'cat with nine lives' have died? I broke down in tears. I felt in my heart as if I had lost a very dear friend. Then I realized, I had. I felt terrible that I hadn't seen her again before she died. But as I pondered, I realized that we had said all that needed to be said in our last visit. And I began to feel good about how we had left things with each other.

I attended Beth's funeral service and was overwhelmed by the number of people who were there. Beth's parents told me that day that I was like part of their family, and I realized just how important I had been to them. Caring for a long-term patient is not only about treating their medical needs, it's about meeting their social and emotional needs as well. I will never forget Beth and her family. Our relationship will always hold a special place in my heart.

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

I'm sure this narrative brought back memories for a lot of clinicians—remembering the first time we cared for a terminally ill patient, perhaps a patient, like Beth, who was close to our own age. These are precious experiences in our development as caregivers, learning how to integrate our human responses with our professional acumen.

Heather's four-year journey with Beth was a gift for both these young women. Beth received the benefit of Heather's compassion and nursing skill. And Heather experienced for the first time the true power of being present as a nurse.

Thank-you, Heather.

MGH-Timilty Partnership seeks pen pals for Timilty students

Through letter-writing, The Promising Pen Pals Program bridges generations, matching Timilty students with adult pen pals at MGH. The Promising Pen Pals Program helps enhance literacy and writing skills, and provides an opportunity for young people to meet positive role models. Students and their adult pen pals commit to correspond by letter or e-mail at least four times from January through May.

For more information contact Norma Soto at nsoto@timilty.boston.k12.ma.us or call 617-635-8109.

CNS as researcher

—by Diane L. Carroll, RN, PhD
clinical nurse specialist

The main focus of a clinical nurse specialist (CNS) is nursing practice and its primary goal of delivering optimal patient care. In order to advance nursing practice, a CNS needs to develop a deep understanding of the context of nursing practice, identify the elements that influence patient care, and foster the changes that need to be made to improve the quality of patient care.

As a CNS, I utilize research methods every day to evaluate nursing practice and patient outcomes, and identify or generate knowledge to solve problems that occur in practice. I attempt to reduce the practice-research gap and assist staff in the generation of new knowledge to support excellent patient care. The development of knowledge relevant to nursing practice has had many roots. Much of nursing practice is based on tradition, trial and error, expert opinion, and logical reasoning. Therefore a lot of what nurses do in practice has had very little systematic evidence, until recently.

As a profession, nursing needs to move toward a practice that is grounded in scientific evidence that has been developed through research. This means that our clinical practice must be systemically evaluated to provide evidence that a particular practice is appropriate. Over the past few decades, more and more nursing practice is supported by evidence generated from nursing research. This research is used by CNSs to support current practice or as an impetus for change.

Every CNS can help promote the use of nursing research. For example, nursing research has provided us with empirical evidence regarding the practice of instillation of saline lavage prior to suctioning patients. Nurse researchers from the University of Rochester, found that saline lavage caused an adverse effect on oxygen saturation (O_2 sat) compared to no instillation, and this reduction in O_2 sat lasted for up to ten minutes after instillation. There was little evidence that saline instillation loosened secretions or that saline actually mixed with secretions to thin them. Others learned that saline lavage and a suction catheter dislodged a significantly large number of bacteria compared to just a suction catheter. This dislodgment of bacteria from the upper airway into the lungs using saline lavage again demonstrated that saline lavage should not be routinely performed. CNSs, through review and presentation of these findings, have led the effort to reduce the use of routine saline lavage in nursing practice.

CNSs assist nurses in finding answers to the questions that arise from practice. To begin, a literature review may be appropriate. Treadwell Library is an excellent resource for searching and scanning literature. CNSs can assist in evaluating the literature and assessing the strength of the evidence that supports practice. In cases where there is no evidence, you might decide to generate a research proposal to further investigate your question. The CNS can assist in this process.

For years on Ellison 9, the Coronary Care Unit, iced injectate was used to measure cardiac index (CI). There was a desire to move to a room-temperature injectate because it was less cumbersome and less costly. In 1993, nurse researchers from Texas determined that for patients with a high or low CI, use of iced injectate for measurement of CI was, in fact, needed. This recommendation was based on a small sample, so the authors recommended further research. A group of MGH staff nurses led by Maryanne Kiely, RN, with a CNS as a mentor, took up this question to validate the need for iced injectate to measure CI in patients with low CI.

Diane Carroll, RN, PhD,
clinical nurse specialist

The American Association of Critical Care Nurses funded the study and the results were published in 1998, in the *American Journal of Critical Care.* We found no difference in results using iced or room-temperature injectate in our sample of 50 subjects with low CI. These results supported the nursing practice of using room-temperature injectate to measure CI even in patients with low CI. Therefore, iced injectate is no longer used on Ellison 9 to measure CI.

Two groups of staff nurses interested in alternative therapies to improve patients' experience developed clinical trials to measure the effects of music and back massage on cardiac patients on strict bedrest. With the CNS as mentor, one group of nurses, led by May Cadigan, RN, found that patients who received 30 minutes of music as a treatment, had significantly lower blood pressure, respiratory rate and psychological distress scores.

Another group led by MaryEllen McNamara, RN, looked at the effects of back massage and found a significant decrease in blood pressure. Based on these studies, music and back massage appear to be successful nursing interventions to manage negative human responses to hospitalization. The music-therapy results were published in *Progress in Cardiovascular Nursing* and the back-massage results are being published in *Alternative Therapies in Health and Illness.*

A CNS with special preparation in research, based in a practice setting, is focused on identifying and solving clinical problems that arise in nursing practice. This research-prepared CNS can offer assistance in identifying evidence that supports practice, can formulate the clinical questions and design the protocol to answer the clinical questions, and then promote the dissemination of this new nursing knowledge through presentation and publication.

Professional Achievements

Ives Erickson recognized by MONE

Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care Services, and chief nurse, received The Mary B. Concesion Award from the Massachusetts Organization of Nurse Leaders on June 7, 2001. The award honors nursing leaders who are recognized by colleagues, physicians, and healthcare executives for implementing collaborative and innovative professional practice, who are articulate spokespersons on healthcare issues, and for developing future nursing leaders.

Duffy, Reilly and Whitaker co-author monograph

Sheila Duffy, RN, BSN, staff nurse, Central Resource Team, Jayne Reilly, RN, BSN, and Deb Whitaker, RN, BSN, CNN, staff nurses on the Blake 6 Transplant Unit, were contributing authors on a monograph for the Palliative Nurses Association in November, 2001. The monograph dealt with "The Treatment of End-Stage Non-Cancer Diagnoses," as they relate to liver disease.

Magee presents poster

Kristine Magee, RN, BSN, CPSN, staff nurse, Bigelow 13 Plastic and Reconstructive Surgical Unit Poster, presented a poster at the American Society of Plastic Surgical Nurses, in November, 2001, in Orlando, Florida. The presentation was called, "The Use of Medical Leaches with Plastic Surgical Patients."

Whitaker certified

Deb Whitaker, RN, BSN, CNN, staff nurse, Blake 6 Transplant Unit, received her certification in Nephrology Nursing in June, 2001.

Giese certified

Nancy Giese, RN, BSN, Staff Nurse, Bigelow 13, Burns and Plastic Reconstructive Surgical Unit, received her certification in Plastic Surgical Nursing (CPSN) in November, 2001.

Matthews receives Mary Malone Award

Margaret Matthews, RN, White 11, received the Mary Malone Award for the Pursuit of Excellence, on October 19, 2001, at the Blue Hills Country Club in Canton, MA. The award recognizes individuals who have set the highest standards for themselves, and who are committed to excellence in the professional service they provide.

Giampapa, Mott and Smith certified

Ellison 12 staff nurse, Heather Smith, CNRN, and White 12 staff nurses, Mary Mott, CNS, CNRN, and Deborah Giampapa, CNRN, all have received their Neuroscience certification.

McGrath certified

Julie Ann McGrath, RN, staff nurse, Bigelow 13 Burn Unit, received her CCRN, Critical Care Nurse certification in January, 2002.

Carroll appointed to editorial board

Diane Carroll, RN, PhD, clinical nurse specialist, has been appointed to the editorial board of the *Journal of Cardiovascular Nursing*. Carroll will review submissions and have input into journal content.

Dahlin publishes

Constance Dahlin, RN, facilitated the Fourth Monograph by the Hospice and Palliative Nurses Association, called "End-Stage Treatment of Non-Cancer Diagnoses. Contributors from the MGH Cancer Center included: Noreen Leahy, NP, Ellison 12; Dottie Noyes, NP, CHF; and Debra Whitaker, Blake 6.

Dahlin co-authored a chapter with Tessa Goldsmith, SLP, entitled, "Dysphagia, Dry Mouth, and Hiccups," for the *Oxford Textbook of Palliative Nursing*.

Dahlin's article, "Supporting Alternative Families," appeared in the May/June, 2001, issue of *Clinical Journal of Oncology Nursing*.

Capasso, Jones, Kwiatanowski and Martin receive grant

Virginia Capasso, RN, PhD, Dorothy Jones, RN, EdD, Karen Kwiatansowski, RN, BSN, and Ann Martin, RN, MSN, received a grant for $750 from the Harvard Institute for Nursing Healthcare Leadership to fund a qualitative research study entitled, "The Lived Experience of the VAC Dressing."

Ellison 12 nurses present poster

A poster has been accepted for presentation at the AANN Annual Meeting in March. The poster, entitled, "Invasive Epilepsy Monitoring: Nursing Excellence with Assessment and Safe Monitoring of the Seizure Patient," was created by Jean Fahey, RN, MSN, CNRN; Nancy J. Meehan, RN, BSN; Holley Engel, RN, BSN; Sandra Iarossi, RN, BSN; Julie Cafasso, RN, CNRN; and Colleen Gonzalez, RN, MSN.

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or by e-mail: ssabia @partners.org

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Welcome to the MGH International Patient Center

—by Sarah Jay
international patient coordinator

In your travels throughout MGH, you may have noticed a little office on Blake 1 across from O'Keeffe Auditorium. It's a small, unassuming office, set back from the main corridor, but its doors open a portal to a very special place; a place that is alive with different languages and dialects. Exotic clothing, headdresses and jewelry tell of a vast array of origins and cultures. People gather here from all over the world. You have just entered the MGH International Patient Center (IPC).

On one couch a couple from The United Arab Emirates fills out a form that will allow an international patient coordinator to complete their registration process.

A family from Argentina speaks with an international billing coordinator to help process their financial records.

A woman drops off x-rays for her cousin who lives in Greece. She asks if the IPC can arrange for a physician to review the films and let her know if MGH can help her.

A billing coordinator explains to a young Canadian woman how her insurance coverage will be handled at MGH.

A family from India shakes hands with the concierge coordinator, and thanks him for helping them find affordable housing in Boston while their father recovers from surgery.

A coordinator escorts a Saudi Arabian patient to his doctor's appointment where a medical interpreter will meet them. Another coordinator goes to visit a patient from Kuwait on an inpatient unit, and another returns from walking two Colombian patients to the subway station, where she helped them purchase tokens and explained how to get to Harvard Square.

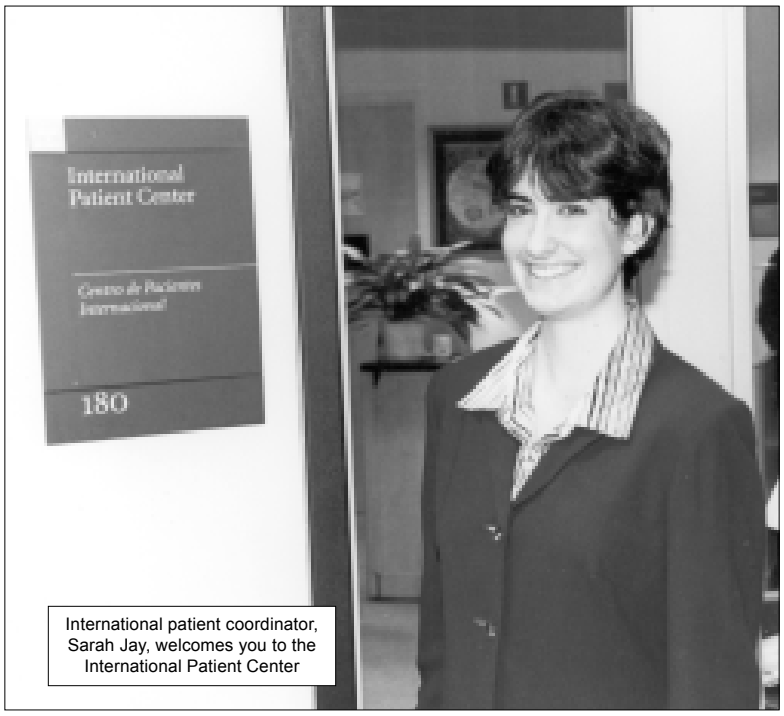
The International Patient Center has created a thriving, functional, world-friendly community within the walls of MGH. Patients from all nations are greeted by IPC staff members. Children rush to show their IPC coordinator the toys they got from one of their nurses. Parents settle on a couch and read a newspaper printed in their native language. An IPC staff member compliments a Japanese cancer patient on her new wig, and a Venezuelan family comes in and starts chatting with a Brazilian family with whom they've become friends.

Staff of the IPC know these patients, their families and their children. The IPC is a place where international families can seek help, information, and understanding, or just to relax in a caring environment.

In the IPC the term, 'caring environment' goes far beyond its clinical interpretation. Anyone who has ever been sick or in need of help knows how overwhelming the healthcare system can be. Even for an English-speaking American citizen, the process is daunting: the initial search for a doctor, planning a visit to the doctor's office, finding the office, waiting for test results, treatments, not to mention rehabilitation and the expense of treatment and insurance coverage. Now imagine that you must travel to another country and navigate a complex healthcare system where you don't even speak the same language. This gives you some sense of the challenges and obstacles that international patients face every day.

The International Patient Center is designed to help international patients move more easily through a very complex system. IPC staff understand that while patients are coping with the fear and stress of illness, they need to focus their energy on healing, not worrying. We are their advocates.

So the next time you're in the neighborhood, stop by the International Patient Center. You may be surprised at the 'world' you find there.



International patient coordinator, Sarah Jay, welcomes you to the International Patient Center

When/Where	Description	Contact Hours
March 1 8:00am–4:30pm	**A Diabetic Odyssey** O'Keeffe Auditorium	7.8
March 4 and March 11 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
March 4 1:30–2:30pm	**Conflict Management for OAs and PCAs** Pre-registration is required. VBK 607	---
March 5 8:00am–4:30pm	**Chemotherapy Consortium Core Program** Wolff Auditorium, NEMC	TBA
March 7 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
March 7 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
March 8 8:00am–4:30pm	**Care of the Person with Cancer: Back to Basics** O'Keeffe Auditorium	TBA
March 13 8:00am–2:30pm	**Mentor/New Graduate RN Development Seminar I** Training Department, Charles River Plaza	6.0 (mentors only)
March 13 1:30–2:30pm	**OA/PCA/USA Connections** "Safety & Self Care: Taking Care of Ourselves in Times of Stress." Bigelow 4 Amphitheater	- - -
March 13 5:30–7:00pm	**Advanced Practice Nurse Millennium Series** O'Keeffe Auditorium	1.2
March 14 8:00am–4:30pm	**Caregiver Skills for the New Millennium** Training Department, Charles River Plaza	7.2
March 15 7:30–11:30am and 12:30–4:30pm	**Pediatric Cardiac Series II** VBK 601	---
March 18 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
March 21 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
March 21 8:00am–4:30pm	**Operations Associate Preceptor Development Program** Training Department, Charles River Plaza	---
March 21 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
March 22 8:00am–4:30pm	**Taking Care of the Cardiac Patient: Knowing the Basics** O'Keeffe Auditorium	TBA
March 25, 27, 28 (Note: days not consecutive) and April 1, 2, 3 7:30am–4:00pm	**ICU Consortium Critical Care in the New Millennium: Core Program** Mount Auburn Hospital	45.1 for completing all six days
March 25 8:00–11:00am and 12:00–3:00pm	**Care for Patients at the End of Life: Clinical & Ethical Considerations** Wellman Conference Room	4.5

For more information about any of the above-listed educational offerings, please call 726-3111.
For information about Risk Management Foundation educational programs, please check the Internet at http://www.hrm.harvard.edu

Timilty students present scientific posters

Timilty 7th-grader, Steve Fleureus, explains his science project, "Which Breath Mint Fights Germs Best?" at the Scientific Advisory Committee poster session held Wednesday, February 6, 2002, in the Wellman Conference Room.
Other Timilty students who displayed posters were: Sherilee Joyner (8th grade); Sashida Rodriguez (8th grade); Jean Paul Morais (8th grade); Alexander Mestre (7th grade); and Jesse Winfrey (7th grade).

Call for Nominations!

The Susan and Arthur Durante Award for Exemplary Care And Service with Cancer Patients

The MGH Cancer Center is now accepting nominations for the 2002 Susan and Arthur Durante Award for Exemplary Care and Service with Cancer Patients. The award recognizes clinical caregivers and support staff whose work with cancer patients reflects compassion, caring, exemplary performance, and outstanding work.

Eligibility

Non-physician staff and leadership who interact with cancer patients throughout MGH are eligible for this award. Awards are granted annually to recognize one clinical person and one support staff member.

Recipients receive $1,000 each *(award may be subject to taxes)* to be used for activities that promote their own relaxation and respite.

Deadline for nominations is
Friday, March 15, 2002

For more information or assistance with the nomination process, please contact
Joelle Reed at 6-2689.

Caring HEADLINES

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