October 3, 2002

Caring HEADLINES

An inside look at Radiation Oncology

Inside:

—by Katie Mannix, RN, nurse manager, and Kathy Bruce RTT, technical director, Radiation Oncology

Radiation therapy is one of the primary weapons in the treatment of cancer. Approximately 60% of all patients diagnosed with cancer receive radiation treatment at some point during the course of their disease. And yet, there is still a great deal of misunderstanding about what radiation therapy actually is. Radiation therapy utilizes high-energy x-rays, electrons, protons, or other sources of ionizing radiation to destroy tumor cells or prevent them from reproducing. The goal of radiation therapy is to maximize the destruction of cancerous cells while minimizing injury to the surrounding tissues and organs.

Radiation therapy is similar to surgery in that it precisely targets the tumor and any surrounding tissue that may be at risk for tumor involvement. It is not systemic therapy like chemotherapy. Radiation therapy can be given alone as a primary treatment, but it is frequently used in combination with other forms of cancer therapy, such as chemotherapy and surgery. Radiation therapy can be geared toward cure, tumor-control, or palliation of symptoms such as pain, obstruction, bleeding, or neurological deficit due to a compression of the spinal cord by the tumor.

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At the Northeast Proton Therapy Center, (l-r) staff nurse, Pat McManus, RN; radiation therapist, Jim Matthews, RTT; pediatric anesthesiologist, Mei Sang, MD; and radiation therapist, Ann Eliachar, RTT, prepare 4-year-old, Logan Shafer, for proton treatment.

MGH Patient Care Services

Working together to shape the future

Magnet Hospital Recognition: an important and coveted certification

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

I would like to take this opportunity to tell you about an exciting process we're undertaking that involves each and every one of us.

Many of you already know what a Magnet hospital is, but for those of you who don't, let me give you a brief explanation. In the early 1980s, in response to a serious nursing shortage, research was conducted to determine what factors characterized those hospitals that were best able to attract and retain nurses despite the shortage. Hospitals that successfully attracted and retained nurses were termed 'Magnet' hospitals.

In 1993, the American Nurse Credentialing Center, a subsidiary of the American Nurses Association, introduced The Magnet Nursing Services Recognition Program, a certification process that recognizes excellence in patient care based on excellence throughout the organization in key areas such as professional practice, professional development, quality, inter-disciplinary teamwork, our ability to provide culturally competent care, leadership, and documentation.

Some characteristics of Magnet hospitals include:

- Nurses identify the hospital as a good place to work and practice
- Hospital has a reputation for quality nursing as rated by patients.
- Increased retention of qualified nurses.
- Lower turnover
- Lower burn-out rate
- Use of supplemental staff virtually non-existent
- Increased percentage of registered nurses
- Staff are more educated
- Flexible staffing strategies
- High degree of teamwork
- Staff work where their work has meaning and they feel good about what they do.

I'm happy to tell you that MGH is in the process of preparing to apply for Magnet hospital certification. As many of you know, earning Magnet hospital status is as formidable a task as earning JCAHO accreditation; and the processes are similar in many ways. In both cases we are provided with a list of standards that must be met, and in both cases preparation culminates with an intensive, multi-day site visit by the certifying board.

To guide us in our preparation, I have convened a Magnet Nursing Services Recognition Steering Committee, co-chaired by Lori Clark Carson, RN, and Marianne Ditomassi, RN, with staff support provided by Lauren Holm, RN, and Ed Coakley, RN. The Steering Committee is responsible for the oversight, implementation, and evaluation of the entire process, including communication, marketing, and education.

Within the Steering Committee, four workgroups have been established to guide specific aspects of our work (see shaded box below). The application process is comprised of two components: evidence collection to document our alignment with Magnet standards, and a site visit, which will encompass several days of on- and off-shift visits to patient care units and other settings throughout the hospital.

More and more, Magnet hospital certification is being recognized by patients and the public as an important factor when choosing their healthcare providers. It is recognized by clinicians,

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MGH Guiding Principles in preparing for the Magnet Nursing Services Recognition Program

- Reflective leadership should be evidenced by reflective nursing practice
- The process of the Magnet Nursing Services Recognition Program application is, in and of itself, an outcome; it is an iterative process
- Every nurse is an active participant in this journey
- Enrollment of all nurses and departments in the process is key
- Think conceptually—translate concepts into practical and simple actions
- Maximize use of existing groups
- The Magnet Nursing Services Recognition Program application process dovetails the JCAHO process, although it uniquely highlights the contributions of nursing to the patient care team

Magnet Work Groups

- *Inter-Disciplinary Team Workgroup*; chaired by Theresa Gallivan, RN, and Judy Newell, RN
- *Professional Practice Workgroup*; chaired by Jackie Somerville, RN, and Marie LeBlanc, RN
- *Professional Development Workgroup*; chaired by Trish Gibbons, RN, and Keith Perlberg, RN
- *Knowledge Management Workgroup*; chaired by Dawn Tenney, RN, and Sally Millar, RN

Hospital Emergency Incident Command System (HEICS)

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: What is HEICS?

Jeanette: HEICS stands for Hospital Emergency Incident Command System. It is an emergency response system that uses a standardized management and communication structure to assist with the operation of the hospital in the event of a crisis. For example, there are generic roles and responsibilities within the Incident Command System that allow for maximum flexibility in responding internally. Everyone knows what they're responsible for and whom they report to during an emergency. HEICS utilizes a clear chain of command and a common language to allow hospitals and other emergency responders to communicate effectively with one another.

Question: Why is it necessary?

Jeanette: Given the current world situation, it is imperative that we are prepared to protect our patients and employees in the event of a crisis. Adopting HEICS standards and integrating this approach into our emergency preparedness plan allows us to communicate effectively with other hospitals and agencies if necessary.

Question: Where did the HEICS originate?

Jeanette: In the 1980s, a fire-protection initiative in the state of California led to the development of a management system that has become standard operating procedure for fire departments across the country. This system, called FIRESCOPE, facilitates inter-state assistance. Many fire departments across the United States and Canada have implemented this system. In 1987, the Hospital Council of Northern California adapted the system to fit hospital emergency response systems and became the original HEICS model. For consistency, HEICS is being integrated into other civil service areas and the private sector as well.

Question: Where are we in planning for HEICS?

Jeanette: Senior administrators and managers from throughout the Partners system have attended training sessions to learn more about HEICS. An MGH Steering Committee has been working to:

- incorporate the incident command system (HEICS) into our current emergency response plan.
- integrate response plans for internal and external emergencies
- revise/update policies and procedures
- add specific response plans for biological, chemical and nuclear events

In October, there will be a tabletop drill to test the system. This drill will involve members of the Steering Committee and designated others and is designed to test our new emergency response plan. Once the plan is approved, each department will need to update their emergency plans and training for all staff.

Question: Will this change my role in responding to an emergency?

Jeanette: When the emergency response plan is completed, you will need to review it to become familiar with the new language, roles, and communication strategies. Some staff may need to be trained in more specific tasks, as well. In general, you will need to be ready to respond as you do now—to follow the direction of your manager or supervisor.

Question: Are other Partners hospitals doing the same?

All acute-care hospitals in the Partners System are adopting HEICS.

Jeanette Ives Erickson

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insurers, politicians and legislators across the country as a symbol of excellence in patient care delivery.

Of the more than 5,000 hospitals in the United States, fewer than 1% have received Magnet certification, and none in Massachusetts at this time.

Because so many of our values and guiding principles echo those of the Magnet Nursing Services Recognition Program, I knew we were ready to seek this coveted certification. And the results of our annual survey (Staff Perceptions of the Professional Practice Environment) reinforce my belief that this certification is within our reach.

As we proceed with the application process, I'll keep you informed of our progress, including the important work of our MGH Magnet hospital champions, the four Magnet workgroups, and the many other groups and individuals throughout the hospital who are working hard to help us prepare.

Again, although Magnet certification is bestowed by the American Nurses Association, it reflects and recognizes the contributions of all clinicians and all departments throughout the hospital. Excellence in patient care can only be achieved with the kind of day-to-day collaboration and teamwork that is the hallmark of practice at MGH.

The MGH ProTech Program

For more than a decade, with support from the Boston Private Industry Council and the Boston Public School System, the MGH ProTech Program has helped prepare minority students for careers in health care.

Open your doors for just one hour to a young person interested in learning about careers in health care. The ProTech Program is looking for staff to share their work experience by having small groups of students visit their departments on the morning of October 24, 2002.

If you are is interested in providing a tour, please e-mail Galia Kagan, program manager, at gkagan@partners.org or call 4-8326 by October 15, 2002.

Opportunity is a terrible thing to waste

Radiation Oncology

continued from front cover

Part of the MGH Cancer Center, the department of Radiation Oncology is located on the lower level of the Cox Building. On a typical day, we see numerous new patients and conduct follow-up exams, perform a variety of specialized procedures and simulations, and provide 200 or more radiation treatments.

We offer a broad range of treatment options. External beam treatment (EBRT) is the most common method of delivery. EBRT utilizes high-energy x-ray or electron beams generated by linear accelerators to treat a wide variety of tumor types and sites. Our five linear accelerators are fixed pieces of expensive and highly complex equipment, housed in heavily shielded 'vaults' that prevent radiation exposure to visitors and staff. Our linear accelerators generate beams from 4 *million* electron volts (MeV) to 18 MeV. To understand the power of these machines, compare these values to those of x-ray machines used in diagnostic radiology, where high-quality images are obtained using between 40 *thousand* electron volts (KeV) and 120 KeV. Through the science of Radiation Biology we know that normal cells have a greater ability to recover from radiation damage than tumor cells, this allows us to eradicate many tumors knowing that the side effects of radiation will diminish over time.

Another area of treatment is called brachytherapy, or implant therapy. The prefix, 'brachy' is from the Greek word for short. In brachytherapy, radioactive implants deliver a dose of radiation from a short distance, thus the name. In this type of treatment, sealed radiation sources are placed directly into or adjacent to the tumor. This is done in the operating room under anesthesia, or in a procedure room. Implants are either permanent, as in prostate seed implants, or temporary, like those used for certain gynecological cancers.

Another technique available at MGH (and in only a few other hospitals in the country) is intra-operative radiation therapy. Room 43 of the Blake Operating Suite houses a linear accelerator dedicated exclusively to this specialized technique. Patients with certain types of malignancies have benefited from a single high dose of radiation that is delivered 'intra-operatively,' i.e., during the course of a surgical procedure. The surgeon, pathologist, and radiation oncologist confer on the need for, and potential benefit of, this kind of treatment. If the decision is to proceed, a highly focused electron beam is aimed at the tumor bed while literally moving normal organs and tissues, such as the small bowel, out of the way of the beam. This treatment is most often used in the treatment of pancreatic cancer, rectal cancer, some gynecological cancers, and connective-tissue tumors.

Our most publicized treatment is probably proton therapy. The Northeast Proton Therapy Center (NPTC) is located directly across from the Clinics Building and will become the lower level of the new Yawkey Center, currently under construction. There are only two proton centers in the country at this time. This is due to the high cost of building the machines themselves, called cyclotrons, and the complex structures needed to contain them. Over the past 25 years, MGH clinicians have demonstrated the efficacy of proton therapy in the treatment of rare tumors called, chordomas or chondro-sarcomas, that arise at the base of the skull or in the spine.

We have also been successful in treating malignant melanomas of the eye, avoiding enucleation and in many cases also preserving vision. This is possible due to the physical properties of protons (positively charged particles)—specifically that protons stop; and x-rays don't. When conventional x-rays are used, part of the beam's energy remains in the patient, and part of it keeps going. If this weren't the case, x-ray images would not be possible because no radiation would emerge to strike the film. Protons, on the other hand, will

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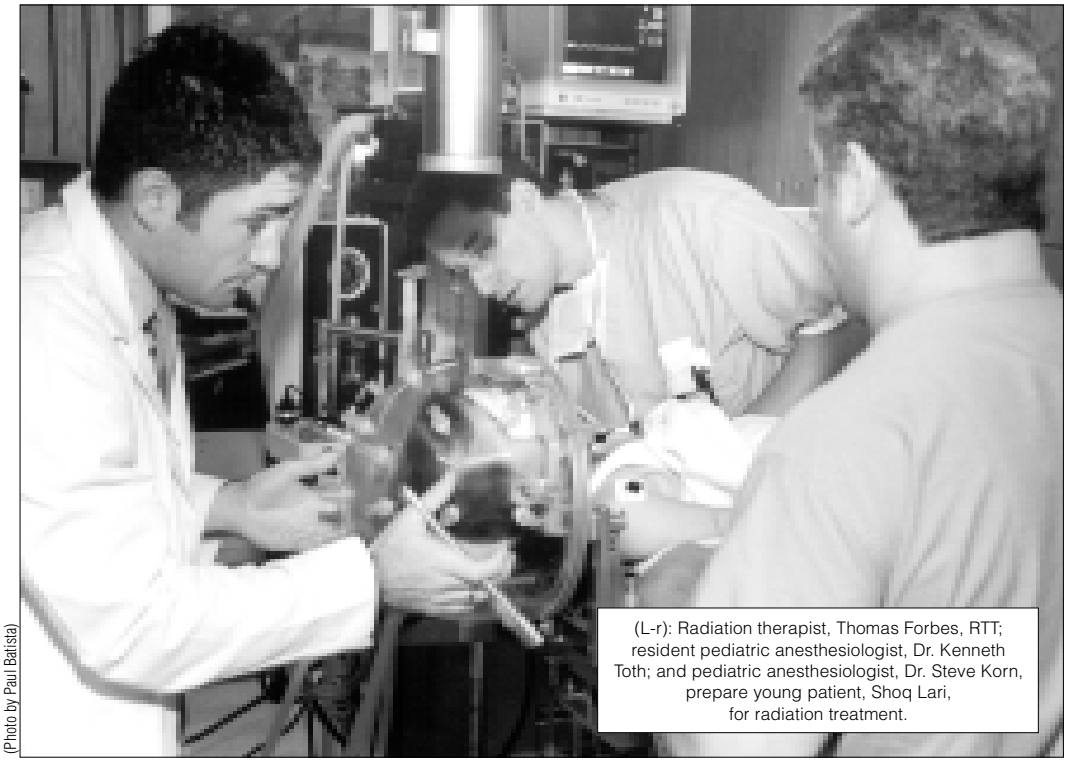

(Photo by Paul Batista)

(L-r): Radiation therapist, Thomas Forbes, RTT; resident pediatric anesthesiologist, Dr. Kenneth Toth; and pediatric anesthesiologist, Dr. Steve Korn, prepare young patient, Shoq Lari, for radiation treatment.

Radiation Oncology

continued from previous page

travel a certain distance into tissue, then literally stop, depositing all their energy. This property is valuable when treating tumors situated close to sensitive normal tissue or organs. As the proton program grows, we will be able to expand treatment to include many new anatomic sites. This modality is especially attractive for pediatric solid tumors, where currently used technology can result in impaired growth or other undesirable long-term effects.

One of the most challenging and stimulating aspects of our work is the level of diversity among the patients we treat. We see patients from throughout New England and around the world representing a rich blend of cultures and ethnicities. Our patients range in age from pediatric to geriatric with corresponding age-specific needs. Because of this great diversity among our patient population, close collaboration with our colleagues in Social Services, Interpreter Services, and the International Office is a must.

A typical course of radiation therapy requires treatment once or twice a day, Monday through Friday, for up to eight weeks. The actual treatment can take from 15 minutes to more than an hour, depending on the complexity of the treatment. Computers have enhanced so many areas of our lives, and that is especially true in Radiation Oncology. Our ability to obtain superbly detailed images of tumors utilizing CT, MRI, and PET (and then fusing these images) enables highly 'conformal' treatment (treatment doses are shaped and aimed to conform to the shape of the tumor). Of course, the success of radiation therapy relies upon precise delivery to the tumor every session. Thus, various positioning and immobilization devices are used to ensure the accuracy of patients' positioning and beam alignment. Patients with brain tumors or other tumors of the head and neck are usually immobilized using a custom-made perforated mask affixed to the treatment table. Some intra-cranial lesions are treated using removable neuro head frames. Other mold and casting techniques are employed for other parts of the body.

Most patients receive small tattoos to mark key reference points on the skin. These permanent marks are needed to eliminate repeated visits to the treatment planning suite and extensive reworking of their plan. One of the most challenging situations arises in the treatment of young children who may require general anesthesia for daily treatments to ensure correct positioning is maintained.

As technology has advanced, the roles of nurses and radiation therapists have grown as well. Collaboration between the two is a key component of care in our department. Both roles require fundamental knowledge of the disease process and radiobiology (the response of the tumor and normal tissues to radiation).

The Radiation Oncology Team

The Radiation Oncology Treatment Team consists of nurses, physicians, radiation therapists, physicists, dosimetrists, and mold room technicians, as well as front-desk and office-support staff. It takes a multi-disciplinary approach to deliver treatment in a safe, effective and individualized manner. Collaboration between all members of the team is vital to ensure seamless, quality patient care.

The radiation oncology nurse practices in an oncology sub-specialty and has a solid oncology foundation in order to understand the relationship and potential impact that chemotherapy and surgery have on a patient's course of treatment (e.g., skin reactions, tissue healing, and the risk for lowered blood counts). The scope of nursing practice in Radiation Oncology includes the assessment of every patient; providing education about the disease, course of treatment, potential side-effects, and any procedures the patient will undergo. The nurse assists in procedures such as implants, trans-rectal ultrasounds, neuro frame placement, and post-anesthesia recovery. The nurse evaluates the patient on an ongoing basis throughout the course of treatment to provide appropriate symptom-management for side-effects such as nausea, vomiting, and fatigue. Pain-assessment and management are essential aspects of patient care as they impact patients' ability to lie on a treatment table and affect their quality of life. Many of our patients present with medically complex situations that combine physical, cultural, psycho-social and age-specific needs and concerns that can impact treatment. The nurse must be knowledg-

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Radiation oncology staff nurse, Donna Stamatis, RN, assists neurosurgeon, Paul Chapman, MD, in placing immobilization head frame on patient, Roger Ladurantaye.

Compassion, continuity and collaboration drive care for radiation oncology patient

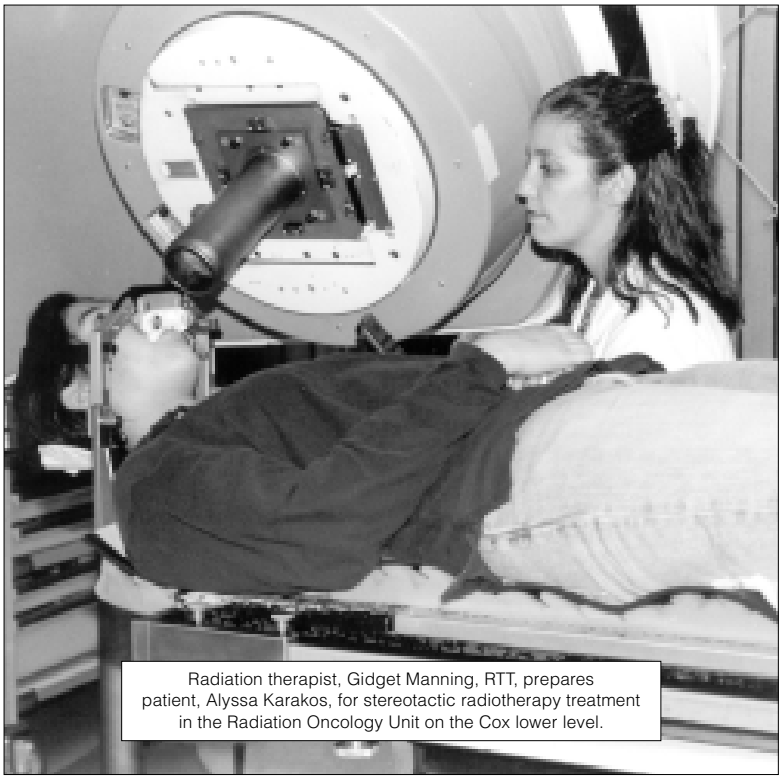
Sheila Brown, RN
Radiation Oncology

My name is Sheila Brown and I am a nurse in Radiation Oncology. Before coming to Radiation Oncology, I worked on adult and pediatric inpatient units and spent 12 years in the Pediatric Hematology-Oncology Outpatient Clinic.

It was in 1991, in the Pedi Hem-Onc Clinic, that I first met Greg, a 7-year-old boy with a pineal germ cell tumor. I was drawn to this young boy, who had a wonderful sense of humor and an incredibly supportive family who were naturally devastated by this diagnosis.

Initially, Greg's brain tumor was treated surgically with a sub-total resection. Over time, Greg's beta HCG levels (a marker for his tumor) became elevated. A subsequent MRI of his brain showed that there was tumor recurrence. Greg underwent a course of radiation treatment to his brain and spine. Once again, Greg was closely followed with serial MRIs, and in 1997 he experienced another relapse. This time, a more intensive course of chemotherapy combined with a peripheral blood stem cell transplant was needed, followed by another surgical resection.

It was during Greg's multiple hospitalizations and subsequent visits to the clinic that I came to really know him and his family, especially his mother Ann, an intelligent strong woman. She was by his side constantly, staying overnight during admissions, asking questions about his treatments, and always advocating for her son. At times, this advocacy presented challenges to staff. I came to realize how desperately Ann wanted to maintain her son's sense of independence despite the many obstacles in his path. I became a resource person for Ann, someone she was comfortable calling with her questions and concerns, someone to confide in.



Radiation therapist, Gidget Manning, RTT, prepares patient, Alyssa Karakos, for stereotactic radiotherapy treatment in the Radiation Oncology Unit on the Cox lower level.

Last year, after I transferred to Radiation Oncology, I received a call from a nurse in Pediatrics informing me that Greg had experienced another relapse, which required a right-sided occipital craniotomy. He was at Spaulding Rehabilitation Hospital for extensive rehabilitation and was scheduled for a course of radiation. When Greg arrived on our unit for treatment, he had no strength or control of his lower extremities; he was unable to communicate; and it was not clear whether he comprehended or recognized his environment. Despite his severe physical condition, he was in a wheelchair with his mother by his side.

Ann greeted me with, "I'm so glad you're here." She was upset and proceeded to tell me she'd been informed that Greg would have to come for his treatments on a stretcher. She had been told it would make Greg's transfer to the treatment table easier, and that Greg's safety was also a concern.

I knew immediately what this meant to Ann: a loss of normalcy and independence, a reversal. She knew that Greg had a sense of awareness and she wanted to preserve his sense of independence and dignity. I needed to communicate Greg's history and Ann's feelings and concerns to the therapists who would be treating him.

A team meeting with all Greg's caregivers would be important in ensuring continuity and a consistent plan of care.

story continues with exemplar on next page

Karen Reed, RTT, and Gidget Manning, RTT, senior radiation therapists

My name is Karen Reed and I am a senior radiation therapist in the department of Radiation Oncology. I have been employed at MGH for four years and have worked in various radiation oncology departments throughout the United States and New Zealand for more than 12 years.

I am Gidget Manning, senior radiation therapist and MGH employee for more than 11 years. Together, we are part of the Stereotactic Radiotherapy and Radiosurgery team in the department of Radiation Oncology.

Greg was scheduled to begin stereotactic radiotherapy for his pineal tumor recurrence. In Greg's case, stereotactic radiotherapy was the treatment of choice because it would optimally minimize the dose to the areas that had been previously treated, while giving a high dose to the area now involved.

Stereotactic radiotherapy is a 3-dimensional radiation therapy used to treat various benign and malignant brain tumors using multiple, small, highly conformal beams of high-energy x-rays. The goal of radiation therapy is to deliver therapeutic doses of radiation to the target, while minimizing the dose to surrounding tissues. Stereotactic radiotherapy is ideal for small intracranial lesions, benign auditory lesions, and orbital tumors in both adult and pediatric patients.

During the team meeting prior to Greg's first treatment, we discussed the emotional impact that this type of recurrence can have on the patient and family, and the issues related to a child who had been treated many years ago and presents with disease in later life. Although Greg's family, in particular his mother, Ann, were very supportive and involved in his care, we felt the need to support them all the more in this difficult time. During the meeting, we, the radiation therapists, expressed our concerns about Greg's candidacy for stereotactic radiotherapy. The treatment involves the use of a customized head frame, placed daily for 4-6 weeks. Given Greg's poor physical condition after surgery, and his lack of mobility and response, we didn't feel he was an ideal candidate for this complex treatment regimen.

We also had concerns about Greg's safety and the safety of those involved in his care. It was important to Greg to come to his daily treatments in a wheelchair; important for his independence and maintaining his sense of self. Could we safely transfer him to the treatment table each day when he had very little use of his legs? It was decided that given Greg's history of treatment and recent disease progression, this would be the best option for him at this time.

Transferring Greg from the wheelchair to the treatment table required the help of at least five people. Nurses, therapists and residents all pitched in to ensure a safe transfer and proper positioning of his body on the table.

With the help of his mother, we began Greg's treatment and learned in a very short time what an amazing family this was. Their strong desire to take their son home and resume normalcy in their lives was a driving force in his recovery. Our reservations about this treatment regimen for Greg diminished quickly as his physical limitations and challenges decreased.

The 18-year-old young man who had come into our department in a near-lethargic state was now walking, talking, even dancing! We grew to love him, his remarkable family, and his wonderful personality, which was emerging more and more each day.

Radiation Oncology sees more than 200 patients each day. The pace is often hurried, if not some days frantic, yet over a 4-6 week period we get to know our patients on a personal level. In a department that witnesses so much grief and sadness, people often ask if we find our job depressing. With the advances in technology and cancer care, Greg's story is just one of many happy endings we see. We are thrilled with the outcome, and the team effort that made it possible.

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

These narratives, which so beautifully complement each other, are an extension of the teamwork and collaboration that made this patient's story such a success. It wasn't just 'knowing' Greg that led to this positive outcome. It was caring for and about him, understanding his needs even when he was unable to voice them, and respecting this family's desire to support their son in a way that preserved his dignity and independence. This story is about risk-taking, strong patient advocacy, and a willingness to learn and grow as clinicians. This is a wonderful example of teamwork and commitment.

Thank-you, Sheila, Karen, and Gidget.

"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

"Depression: What You Should Know"

Presented by John B. Herman, MD

This seminar will provide information on the signs, symptoms and treatment of depression.

October 11, 2002
12:30–1:30pm
Wellman Conference Room

For more information, call 726-6976.

NERBNA celebrates 30th anniversary; Ives Erickson receives President's Award

Celebrating its 30th anniversary as an organization and three decades of service to the community, The New England Regional Black Nurses Association (NERBNA) held its annual meeting and luncheon at the Quincy Marriott, Sunday, September 22, 2002. It was a day of festivities, good food, and friendship as black nurses from all over New England came together to celebrate this milestone occasion.

Keynote speaker and past NERBNA president, Dr. Marcia I. Wells, spoke about the great strides made by nurses of color in the past 30 years. She spoke of the importance of having a vision, thinking outside the box, and in fact, getting to a place where 'there is no box' because boxes are limiting. Advocacy, activism and empowerment, said Wells, are the keys to continued advancement.

Ron Greene, RN, MGH case manager and president of NERBNA, recognized several individuals with special awards. Among them, Jeanette Ives Erickson, RN, senior vice president for Patient Care, was honored for her outstanding leadership and commitment to diversity.

Said Greene, "Jeanette has been recognized as a nursing leader locally and nationally; she has worked hard to give nurses the professional respect they so rightly deserve. When it comes to diversity, Jeanette does more than talk the talk; she walks the walk. Due largely to her efforts, MGH is becoming a more diverse hospital, and under her leadership, the department of Nursing is leading the way for change."

Ives Erickson was unable to attend the event. Associate chief nurse, Theresa Gallivan, RN, accepted the award on her behalf.

Associate chief nurse, Theresa Gallivan, RN, accepts award for Ives Erickson as NERBNA president, Ron Greene, RN, looks on.

Cover Story

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eable about all of these elements.

The radiation therapist's role is truly an extension of the radiation oncologist. Radiation therapists operate the linear accelerators to precisely deliver the prescribed radiation dose according to the oncologist's treatment plan. The therapist also participates in the 'simulation' or planning procedure, generating x-rays of the treatment 'fields.' Contemporary radiation therapy is endlessly challenging as we add sophisticated new treatment techniques to our program while participating in complex multi-disciplinary protocols. Working in teams that change semi-annually, radiation therapists deliver most, if not all, treatments to any given patient. This continuity of care enables us to build trust and meaningful relationships with our patients.

No individual takes lightly the need for high-energy radiation to be directed at his or her body. It is critical that therapists earn the confidence of their patients and work to preserve that trust for the duration of the program. Radiation therapists are licensed practitioners, with either an associate's or baccalaureate degree. Special areas of study include radiation physics and biology, radiation safety, computer-aided biophysics, and medical imaging. MGH is the single clinical education site for student therapists enrolled in the BS degree program in Radiation Therapy Technology at Suffolk University.

How nurses and therapists interact has direct bearing on the care that patients receive. We use a primary-practice model for both nursing and treatment delivery to ensure consistency and continuity of care. With a high level of collaboration and sharing of information, nurses and therapists coordinate treatments and identify the resources needed by each patient. Therapists providing daily care are able to recognize physical and emotional changes and communicate them to the nurse. Because a course of radiation can be lengthy, we get to know patients and families over a long period of time. Providing physical care as well as emotional support is an integral part of our practice. Developing relationships through the course of treatment enables us to better evaluate and respond to individual needs.

In addition to the specialized skills and services provided by nurses and therapists in Radiation Oncology, there's no way to adequately describe the human factor that is provided in the form of ongoing support, compassion, understanding, communication, and just being present to our patients. We are privileged to share intimate and emotional moments with our patients and their families.

Patient observers: frequently asked questions

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, which includes a high-quality Patient Observer Program.

This column, provided by the Office of Quality & Safety, highlights some frequently asked question about our Patient Observer Program.

Question: What is the MGH Patient Observation Program?

Answer: When a patient is determined to be at risk for injury, appropriate nursing strategies are implemented to ensure patient safety. When these strategies are ineffective and the patient remains at risk, observation of the patient may be an option. Nurses, in consultation with unit leadership, identify the need for, and determine the level of, observation necessary for each individual patient.

Question: If an observer sees a patient getting out of bed, can he or she physically help redirect the patient to stay in bed?

Answer: If a patient is getting out of bed, a Bulfinch Temporary observer should call for assistance. Patient care associates acting in the role of patient observers, are allowed to perform these duties within the scope of their job responsibilities, and would be able to redirect the patient back to bed.

Question: What do patient observers document on the Patient at Risk for Injury flowsheets?

Answer: Observers document patients' actions every 15 minutes. This documentation emphasizes the dynamic nature of the observer role. It is used by staff nurses along with their own assessments to determine whether or not there is a need for ongoing observation.

Question: Is using the observer worksheet optional?

Answer: In order to maintain consistency and appropriately support Bulfinch Temporary observers and patient care associates who have been trained in these procedures, it is important to use the observer worksheets the way they were designed to be used. The observer worksheets are used for all patients for whom observation is deemed necessary, and are maintained with the nursing assignment sheets on the unit.

The Employee Assistance Program

presents

National Depression Screening Day

The Employee Assistance Program (EAP) is participating in a nationwide program to provide information about the signs, symptoms, and treatment of depression. As part of the effort to heighten awareness about depression in the workplace, the EAP will offer free, anonymous, confidential screenings to all employees. Employees may walk in for a 15-minute, self-administered test. Mental health professionals will be on hand to review and discuss the tests. Employees will have an opportunity to speak confidentially about concerns they may have about friends and family.

October 10, 2002
MGH employees: 9:00am–4:00pm
VBK427

General public: 9:00am–1:00pm
4th floor, 50 Staniford St.

For more information, call 726-6976.

MGH celebrates Case Management Week October 7–11, 2002

Educational Booth in the Main Corridor
Tuesday, October 8th and Thursday, October 10th

1st Annual Case Management Change Show
Our very own *Saturday Night Live*!
Wednesday, October 9th
2:00–3:30pm
O'Keeffe Auditorium

Nursing Grand Rounds: "Case Management"
Thursday, October 10th
1:30-2:30pm
O'Keeffe Auditorium

Case Management Presentation:
"Dealing with the Changing Healthcare Times:
It's Time to Break the Rules"
presented by Louis Feuer, MA, MSW,
nationally rcognized lecturer, author, and healthcare management consultant; leading customer service expert in the healthcare industry.
Tuesday, October 15th
10:00–11:00am
O'Keeffe Auditorium.
(CEUs pending)

For more information, call Leah Wolf 4-8561 or Ron Greene at 4-8252.

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Written contributions should be submitted directly to Susan Sabia **as far in advance as possible.** *Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas may be submitted by telephone: 617.724.1746
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Please recycle

AMMP recognizes scholarship recipients; bids farewell to outgoing chair

Always an uplifting event, this year's celebration was especially moving as AMMP (the Association of Multicultural Members of Partners) recognized its annual scholarship recipients and said good-bye to out-going chairperson, Ron Greene, RN, at a special luncheon in the Wallcott Conference Room, on September 12, 2002.

Vice president for Human Resources, Jeff Davis, addressed the gathering, saying, "AMMP has done outstanding work in funding scholarships for minority employees; helping them to improve their skills, continue their education, and hopefully stay on at MGH as valued members of our community." Davis commended Greene for his participation and commitment over the years. "Ron has been a great sounding board and an effective leader. With his creativity, drive, and positive attitude, it has been a real pleasure working with him."

Said Greene, "It's been an unbelievable ride! I'm grateful to have had the opportunity to meet the people I've met, and work with the people I worked with. But don't worry," he added. "I'm not going anywhere. I'm always going to be here, helping, pitching in, supporting you all. That's what I do."

Note: if it ever becomes necessary for an organization to have an officer who doubles as a powerhouse diva, AMMP will be in good shape with secretary, Jennifer Jackson, who blew the walls off the Wallcott Conference Room with her a cappella rendition of *God Bless America*.

For more information about AMMP, contact Loretta Holliday, at lholliday1@partners.org, or Gilbert Arenaza at 6-3395.

(Photos by Paul Batista)

Future midwife, Marianne Williams, accepts scholarship award from Wanda Velazquez and Ron Greene, RN, out-going chair of AMMP.

Ana Ruth Higbee-Barzola accepts certificate of recognition from committee chair, David Wise.

2003 AMMP executive board members (l-r): Loretta Holliday (chair); Jacquelyn Flowers (vice-chair); Wanda Velazquez (public relations chair); Jennifer Jackson (secretary); and Gilbert Arenaza (membership chair). Maria Bloch (treasurer) and Oswald Mondejar (advisor) not pictured.

Ellison 16 staff nurse, Audrey Jasey, RN, addresses the gathering after accepting her scholarship award.

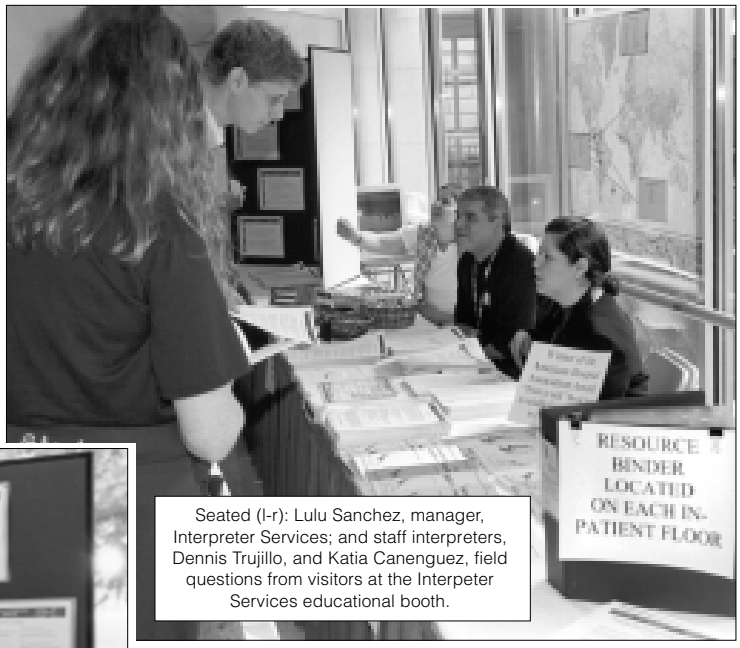
When/Where	Description	Contact Hours
October 3 12:00–1:00pm	**Diversity Considerations in Responding to Domestic Violence** Walcott Conference Room	---
October 10 12:00–1:00pm	**The African American Community Responds to Domestic Violence** Wellman Conference Room	---
October 11 8:00am–4:00pm	**Managing Patients with Psychiatric Illness in the General-Care Setting** O'Keeffe Auditorium	TBA
October 15 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
October 16 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
October 16 1:30–2:30pm	**USA Educational Series** Bigelow 4 Amphitheater	- - -
October 17 10:00–11:30am	**Social Services Grand Rounds** "The Mind-Body Connection: Learning and Leading Relaxation Exercises." O'Keeffe Auditorium. For more information, call 617-726-8673.	CEUs for social workers only
October 17 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
October 21 7:30–11:30am, and 12:30–4:30pm	**Pediatric Trauma–Part VI** Wellman Conference Room	---
October 23 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
October 23 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
Oct. 28: 7:30am–4:30pm Oct. 29: 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: Wellman Conference Room. Day 2: VBK607	14.4 for completing both days
October 30 8:00am–4:30pm	**Preceptor Development Program: Level II** Training Department, Charles River Plaza	7.8
October 31 8:00–11:30am	**Intermediate Arrhythmias** Haber Conference Room	3.9
October 31 12:15–4:30pm	**Pacing : Advanced Concepts** Haber Conference Room	5.1
November 1 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
November 1 8:00am–4:30pm	**Care of the Person with Cancer: Back to Basics** O'Keeffe Auditorium	TBA
November 4 and November 15 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
November 6 4:00–6:00pm	**Deb Wing Memorial Lecture** Haber Conference Room	---
November 7 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -

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.

MGH celebrates Interpreter Services Week

MGH interpreters were out in force, September 16–20, 2002, staffing an educational booth in the Main Corridor, disseminating information and answering questions for staff, patients and visitors. Medical interpreters provide an important service at MGH, ensuring that patients from all backgrounds and cultures can communicate effectively with their healthcare providers.

The Interpreter Services office is located in Clinics Room 141; they are open from 7:00am–12:00am Monday through Friday, and 10:00am–10:00pm on weekends. For more information, call 726-6966.



Seated (l-r): Lulu Sanchez, manager, Interpreter Services; and staff interpreters, Dennis Trujillo, and Katia Canenguez, field questions from visitors at the Interpeter Services educational booth.

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