

# Caring

February 20, 2003

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## Collaborative governance celebrates milestone 5-year anniversary



In foreground: members of the PCS Diversity Steering Committee stand to be recognized. Superimposed, are (l-r): Jeanette Ives Erickson, RN, senior vice president for Patient Care; Trish Gibbons, RN, associate chief, The Center for Clinical & Professional Development; and Dottie Jones, RN, senior nurse scientist.

## ‘Hope for Courage’

*A holiday keepsake; a credo  
for our times*

This past holiday season, I received a gift that, in addition to being beautiful, really gave me pause to reflect. Even now, weeks after packing it away, I’m still thinking about it. The gift was a crystal ornament engraved with the words, “Hope for Courage.”

As I thought about those powerful words etched into that delicately cut glass, it reminded me of the challenges we’re facing right now as a society. No one knows better than those of us who work in health care, the frailty and strength of the human spirit. No one sees it more vividly than we do. No one feels it more palpably than we do. It’s that combination of frailty and strength that gives birth to courage. It’s knowing you’re vulnerable, but stepping up anyway. It’s knowing you could fail, but taking the chance anyway.

I think of MGH and Patient Care Services, and I ask myself: Is this a place where courage resides? You bet it is!

The simple act of coming to work every day is courageous. Advocating for your patients, challenging the status quo, going that extra mile to ensure that every patient receives the best possible care.

Saying, “My patient is ready for discharge. Who will I care for next?” These are acts of courage.

I think of the members of our IMSuRT and DMAT teams (the International Medical-Surgical Response team and the Disaster Medical Assistance Team) who stand ready to answer unknown calls for help. They have selflessly volunteered to put themselves in harm’s way, without even asking what that harm may be. They have been called, they have responded well, and they will be called again.

friendship, to try to reconnect with a country and a people from whom we’ve been estranged for many years.

I recently attended an event here in the hospital that shed light on The Islam Project, a national initiative to promote understanding and education about Islamic beliefs and customs. Many of you joined me in learning about the Muslim culture. We heard sobering accounts of what it’s been like for Muslims living in our community in the days and months since September 11th.

MGH nurses are working in Africa, bring-

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**Courage is the price that Life exacts  
for granting peace.  
The soul that knows it not, knows no  
release from Little things.**

—Amelia Earhart

As I write this, a team of MGH employees, in concert with a local non-profit organization, is in Cuba on a humanitarian-aid visit bringing much-needed medical equipment, supplies, and books to replenish badly depleted schools and libraries. This team of health professionals, educators, business leaders and elected officials is on a mission of peace and

ing education and treatment to the areas hardest hit by the HIV/AIDS epidemic.

We are in the process of applying for magnet hospital certification, the highest recognition bestowed by the American Nurse Credentialing Center.

We have implemented a comprehensive, multi-disciplinary clinical recognition program that recognizes excel-



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

lence at all levels of clinical practice.

PCS leadership along with key individuals throughout the organization are working together to formulate a solution to capacity-management issues.

To date, 19 nurses have completed our New Graduate Critical Care Nurse curriculum, and 14 others are enrolled in the program right now.

To date, 36 nurses have completed the MGH-Northeastern University Perioperative Certification Program, and 8 others are currently enrolled.

Clinical narratives have become part of our professional culture. Every issue of *Caring Headlines* contains an exemplar written by a PCS clinician, and clinical narratives are an important component of our annual performance review process.

We are constantly exploring new ways to improve patient care. There’s no challenge we

shy away from when it comes to ensuring the safety and well-being of our patients.

What do all these examples have in common? Courage. They all require that strength of human spirit to which I referred earlier. They all reflect a fierce commitment of which we can be proud. And they all set a standard to which healthcare providers everywhere aspire.

We are navigating through uncertain times. As we continue to break new ground, set new standards, and face the challenges before us, I pray for peace... and ‘Hope for Courage.’

### Update

I’m pleased to announce that Walter Moulaison, RN, has been appointed co-director of the Anticoagulation Therapy Program along with Robert Hughes, MD, who had been sole director of the program. Walter will continue to serve as nurse manager for the White 9 General Medicine Unit.

## Fire safety and annual required training

*Question:* Why is it necessary to participate in quarterly fire drills? We all receive fire-safety training during orientation.

*Jeanette:* Familiarity with procedures ensures that we can perform them properly when needed. Fortunately, we rarely encounter a real fire emergency, so we don't have many opportunities to test our knowledge of those procedures. If we regularly review our fire-safety training, there's a much better chance that we will respond appropriately if/when the need arises. General fire-safety programs may cover fire extinguishers and evacuation principles, but department-specific training includes the location of extinguishers in your area and evacuation and other procedures specific to your work place.

*Question:* What types of safety training should employees receive?

*Jeanette:* This question needs to be answered according to each employee's work assignment. All employees should review fire, electrical, and infection-control training. But additional training may be required in chemical, radiation or mechanical hazards depending on an employee's specific work environment. It's important to remember that safety training is intended to give employees the knowledge and awareness they need to recognize and manage workplace hazards.

*Question:* How often do I need safety training?

*Jeanette:* Safety training should be undertaken as often as you feel you need it; certainly often enough to keep the information fresh in your mind. Once a year is a good estimate, that's why annual retraining requirements have been established within departments. However, more frequent training may be needed

as new risks or concerns are identified by you, your colleagues, or manager.

*Question:* How do I know what annual retraining I should be taking?

*Jeanette:* Specific requirements for safety and other types of required training are available from your manager and may also be found in your departmental Policy and Procedure Manual.

*Question:* If I identify a workplace hazard, whom should I contact?

*Jeanette:* It's always best to refer a safety concern to your manager, who in turn can refer it to one of the hospital committees or the department whose responsibility it is to address those issues. Occupational Health Services, infection Control, The Safety Office, and The Hazardous Drug Committee are just some of the groups who play a role in maintaining the safety of our work place.

## Run for a Reason!

### Join the MGH Team Durant 2003 in support of the Thomas S. Durant, MD, Fellowship in Refugee Medicine

Throughout his life, Dr. Tom Durant exemplified the importance of humanitarian service to refugees and victims of war and disasters. The Thomas S. Durant Fellowship was established to honor Dr. Durant's unique spirit of dedication and service. The Fellowship sponsors healthcare professionals who wish to serve refugee populations and victims of complex humanitarian disasters.

The 2003 Boston Marathon will be held on Monday, April 21, 2003. We invite you to run with us or sponsor one of our runners. Our goal is to raise \$5,000.00 per runner. Please indicate your interest in joining Team Durant (as a runner or donor) by contacting Laurence Ronan, MD, at [Ironan@partners.org](mailto:Ironan@partners.org) or calling Stacy Lewis at 617-724-3874.

Runners will be accepted on a first-come first-served basis.

## MGH-Timilty Science Fair

The MGH-Timilty Partnership Program is hosting its annual Science Connection Showcase.

Students from the James P. Timilty Middle School who have been working closely with their MGH mentors will present their science projects to the MGH Community.

The MGH-Timilty Partnership Program is part of the MGH Community Benefit Program.

**March 4, 2003; 9:00-11:00am  
Main Corridor**

## The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

### "Strategizing Your Financial Future"

Presented by Dee Lee, CFP, MBA

This seminar will help you manage all the components (investing, debt management, taxes and estate planning) of your financial plan. Tips will be provided for prioritizing your goals, identifying investment income, and minimizing debt.

**Thursday, March 13, 2003  
12:00-1:00pm  
Wellman Conference Room**

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

## Medical Grand Rounds

### Restraint-Free Care for Hospitalized Elders

Presented By

Neville E. Strumpf, RN, PhD, FAAN,  
Edith Clemmer Steinbright professor in Gerontology and director of the Center for Gerontologic Nursing Science  
University of Pennsylvania

Lois K. Evans, RN, DNSc, FAAN,  
Viola MacInnes/Independence professor in Nursing and division chair, Family and Community Health, University of Pennsylvania School of Nursing

**Thursday, February 27, 2003  
8:00 - 9:00am  
O'Keefe Auditorium  
and Haber Conference Room**

1.2 contact hours  
For more information, call 6-3111

## Patient Care Services unveils new website

—by Janet Madigan, RN, project manager

After a year of intensive planning, compiling, organizing and designing, the newly updated Patient Care Services website was unveiled earlier this month. The new PCS website can be found at: [www.mghpcs.org](http://www.mghpcs.org), and [www.mghnursing.org](http://www.mghnursing.org), or can be accessed from the MGH homepage at: [www.massgeneral.org](http://www.massgeneral.org), by clicking on Departments and Programs, and then Patient Care Services.

This website is the culmination of a pro-

cess that began with a mandate from Jeanette Ives Erickson, RN, senior vice president for Patient Care, to develop the, “best Patient Care Services website in the country.” A steering committee was convened in January of 2002, and began working with AlphaStrand Web, Inc. to develop a site that would achieve the following goals:

- assist in the recruitment of PCS staff
- showcase how care is delivered within PCS
- profile PCS departments and personnel

- provide a method of internal communications for PCS staff

The steering committee outlined the scope and timetable of the project, approved the design elements and navigational structure proposed by AlphaStrand, and developed a content outline for each section of the site. A sub-committee of nurse managers was asked to develop a format for the individual unit profiles and a template for the biographical sketches of each leadership triad. This group, led by The-

resa Gallivan, RN, included Eileen Flaherty, RN; Janet Quigley, RN; Wally Moulaison, RN; and Colleen Snyderman, RN.

The website is organized under 11 main headings. Content for each section was developed in collaboration with leadership and staff from each individual unit and/or department. Each unit page features profiles and photographs of the nursing leadership triad, and each department

page features profiles and photographs of leadership and/or staff from those departments. Some departments within PCS had existing websites, and in those cases, a link has been provided to the appropriate sites. The steering committee wanted to ensure that the website featured actual staff of MGH, not stock photos; so the homepage and banners were designed using photographs of MGH employees.

*continued on next page*

### Members of the PCS Website Steering Committee:

- Jess Beaham
- Megan Brown, HR
- Marianne Ditomassi, RN
- Ellen Forman, LICSW
- Theresa Gallivan, RN
- Trish Gibbons, RN
- Janet Madigan, RN (chair)
- Sally Millar, RN
- Steve Taranto, HR
- Carmen Vega-Barachowitz, SLP



**New Website**

*continued from page 4*

The end result is a website with more than 300 unique page locations, 5,100 links, 570 external links, 210 photographs; and 110 profiles of PCS staff members. Members of The PCS Website Steering Committee are confident they achieved their objective of creating a website that is, "Simply the Best!"

The new PCS website is structured as follows (with each major

- Nursing
  - ◆ Cardiology/Cardiac Surgery
  - ◆ Central Resources
  - ◆ Critical Care
  - ◆ Emergency Department
  - ◆ Medial
  - ◆ Neuroscience
  - ◆ Oncology
  - ◆ Orthopaedics
  - ◆ Perioperative
  - ◆ Psychiatry
  - ◆ Surgical
  - ◆ Women & Children's
- Health Professions
  - ◆ Chaplaincy (link to Chaplaincy website)
  - ◆ Occupational Therapy
  - ◆ Orthotics and Prosthetics
- Professional Resource Departments
  - ◆ Diversity Program
  - ◆ Information Systems
  - ◆ International Patient Center (link to International Patient Center website)
  - ◆ Management Systems
  - ◆ Medical Interpreters (link to Medical Interpreters website)
  - ◆ Office for Patient Advocacy
  - ◆ Office for Quality and Safety
  - ◆ Volunteer Department (link to Volunteer Department website)
- The Center for Clinical & Professional Development
  - ◆ Overview and Organizational Chart
  - ◆ Award, Recognition and Professional Certification
  - ◆ Blum Patient & Family Learning Center (link to PFLC website)
  - ◆ Clinical Affiliations
  - ◆ Clinical Recognition Program
  - ◆ Collaborative Governance Program
  - ◆ Continuing Education Offerings Calendar
  - ◆ Credentialing and Authorization
  - ◆ International Nurse Consultant Program
  - ◆ Leadership Development
  - ◆ Links
  - ◆ Orientation Programs
  - ◆ Policies and Procedures (link to Clinical P&P Manual in Trove)
- ◆ Yvonne L. Munn Research Program
- Clinical Recognition Program
  - ◆ Program Overview and Background
  - ◆ Describing Practice through Clinical Narratives
  - ◆ Application Packet for Clinicians and Clinical Scholars
  - ◆ Program Process
  - ◆ Levels of Practice
  - ◆ Frequently Asked Questions and Glossary of Terms
  - ◆ Information and Discussion Sessions
- Blum Patient & Family Learning Center (link to PFLC website)
- *Caring Headlines* (link to current and back issues)
- Careers/Employment Opportunities (link to MGH Jobs)
- What's New (listing of What's New topics)
- Calendar of Events (link to CCPD Calendar of Continuing Education Offerings)



heading accessible from the homepage):

- About Patient Care Services
  - ◆ Who We Are
  - ◆ Our Vision
  - ◆ Guiding Principles
  - ◆ Strategic Goals
  - ◆ Organizational Chart
  - ◆ Leadership Team Biographies
  - ◆ Collaborative Governance
  - ◆ Professional Practice Model
  - ◆ Policies and Procedures (link to Clinical P&P Manual in Trove)



- ◆ Physical Therapy
- ◆ Reading Disabilities
- ◆ Respiratory Care Services
- ◆ Social Services (link to Social Service website)
- ◆ Speech-Language Pathology



For more information about the PCS website, call Janet Madigan, RN, project manager, at 6-3109, or check it out for yourself at: [www.mgh.pcs.org](http://www.mgh.pcs.org).

## Collaborative governance kicks off year 6 with renewed commitment and some new faces

**O**n Monday, February 3, 2003, members of the seven collaborative governance committees came together for the 5th annual collaborative governance dinner to celebrate the accomplishments of 2002 and welcome new members to the committees.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed committee leaders and members to the grand ballroom of the Holiday Inn, saying, "In the wake of the shuttle tragedy, it is good to come together with this group. It's good to reaffirm our commitment

to excellence. It's good to spend time with kindred spirits."

Ives Erickson asked the members of each committee to stand and be recognized for their efforts over the past year and their willingness to remain focused as we respond to the issues that impact our patients and affect all who work in health care. "We can't work any harder," said Ives Erickson, "so we need to learn how to work smarter. Your commitment and positive energy is what keeps patients choosing MGH and what makes MGH the number one employer in Massachusetts."

Dorothy Jones, RN, senior nurse scientist, shared the results of the collaborative governance evaluation survey, which compared data collected in 1997, 2000, 2001, and 2002. The survey is designed to measure empowerment among collaborative governance committee members over time. Jones reported a statistically significant improvement in empowerment scores of committee members since the inception of collaborative governance and in subsequent years as well.

Some of the feedback received in the survey included comments like, "Collaborative governance has

increased my self-confidence... and my desire to contribute to society," and, "Committee members have an increased sense of involvement and control over their practice."

Trish Gibbons, RN, director of The Center for Clinical & Professional Development, took the opportunity to recognize Kim Chelf for her dedication and enthusiasm in providing seamless administrative support for the collaborative governance program. Gibbons presented Chelf with a bouquet of roses in appreciation.

January marked the beginning of a new term for committee members. The following individuals from all disciplines within Patient Care Services, will be serving on collaborative governance committees this year (see opposite page).



**Above:** Trish Gibbons, RN, associate chief nurse for The Center for Clinical & Professional Development, presents staff assistant, Kimberly Chelf, with bouquet of flowers;

**At right:** members of The Staff Nurse Advisory Committee, stand to be recognized at this year's annual collaborative governance celebration dinner.



## 2003 Collaborative Governance Committee Members and Leaders

### *Staff Nurse Advisory Committee*

Chair: Jeanette Ives  
Erickson, RN

#### *Members:*

Kevin Babcock, RN  
Wendylee Baer, RN  
Immacula Benjamin, RN  
Lynne Bozzi, RN  
Maureen Brecken, RN  
Kathy Callahan, RN  
Ed Ciesielski, RN  
Denise Coldwell, RN  
Susan Diehl, RN  
Kendra Dolloff, RN  
Fran Donovan, RN  
Beth Fortini, RN  
Agnes Froio, RN  
Charlene Gallagher-  
Cherwek, RN  
Laura Ghiglione, RN  
Steven Grondell, RN  
David Heitt, RN  
Rebecca Horr, RN  
Rebecca Johnston, RN  
Jane Kleinjian, RN  
Jacqueline Lally, RN  
Daria LeSanto, RN  
Anne LeTendre, RN  
Jamie Liu, RN  
Patricia Lynch, RN  
Mary MacLeod, RN  
Christine McCarthy, RN  
Joshua McGee  
Patricia McGrail, RN  
Mary McKinley, RN  
Hilda Morrison, RN  
Paula Nelson, RN  
Maura Neville, RN  
Gail Nilsson, RN  
Susan O'Brien, RN  
Charlene O'Connor, RN  
Gayle Peterson, RN  
Amanda Ramos, RN  
Erin Riley, RN  
Janet Roche, RN  
Julie Robinson, RN  
Brenda Girasella  
Schwartz, RN  
Nyla Shellito, RN  
Heidi Simpson, RN  
Patricia Simoes, RN  
Amie Sokolowski, RN  
Amy Sozanski, RN  
Erin Timoney, RN  
Susan Tower, RN  
Linda Younie, RN  
Karen Zoeller, RN

### *Diversity Steering Committee*

#### *Co-chairs:*

Beverly Cunningham  
(outgoing)  
Firdosh Pathan, RPh  
Lourdes Sanchez  
Coach:  
Deborah Washington, RN

#### *Members:*

Claribell Amaya, RN  
Christine Donahue  
Annese, RN  
Leila Carbutari, RN  
Charlie Ciano  
Beverley Cunningham  
Mary Cunningham  
Suzanne Curley, OT  
David Krebs  
Jacqueline Lynch  
June McMorrow, RN  
Kathleen Myers, RN  
Judith Newell, RN  
Ivonne Niles, RN  
Elisabeth Nolan  
Reverend Felix Ojimba  
Barbara Olson  
Georgia Peirce  
Donna Perry, RN  
Judith Pines  
Marianne Williams, RN

### *Nursing Research Committee*

#### *Co-chairs:*

Catherine Griffith, RN  
Kathy Grinke, RN  
Susan Jaster, RN (out-  
going)

#### *Coach:*

Joan Agretelis, RN

#### *Members:*

Mary Campbell, RN  
Elise Gettings, RN  
Annmarie Hayes, NP  
Donna Hills, RN  
Robin Holloway, RN  
Susan Jaster, RN  
Mary Lou Kelleher, RN  
Diane Ladd, RN  
Mary Larkin, RN  
Mary Lou Lyons, RN  
Talli McCormick, RN  
Donna Plunkett, RN  
Heather Vallent, RN

### *Ethics in Clinical Practice Committee*

#### *Co-chairs:*

Sharon Brackett, RN,  
(outgoing)  
Theresa Cantanno, RN  
Marilyn Wise, LICSW  
Coach:  
Ellen Robinson, RN

#### *Members:*

Nancy Balch, RPh  
Michelle Bedor, RN  
Sharon Brackett, RN  
Diann Burnham, RN  
Kristin Calheno, RN  
Leila Carbutari, RN  
Lin-Ti Chang, RN  
Alex FM Cist, MD  
Toby Coltin, LICSW  
Connie Dahlin, RN  
Nancy D'Antonio, RN  
Alexandra Detjens  
Pamela DiMack, RN  
Regina Doherty, OTR/L  
Danielle Doucette, RT  
Laurene Dynan, RN  
Kathy Evans, RN  
Jeanne Flannery, RN  
Barbara Guire, RN  
Regina Holdstock, RPh  
Jennifer Howard, RN  
Audrey Jasey, RN  
Sharon Kelly-Sammon, RN  
Cynthia LaSala, RN  
Martha Lynch, RD  
Deborah Lynch-Roden, RN  
Regis MacDonald, RN  
Phil McGaugh  
Brenda Miller, RN  
Christine Mitchell, RN  
Denise Montalto, PT  
Sally Morton, RN  
Rebecca Murphy, LICSW  
Jennifer Orcutt, RN  
Gayle Peterson, RN  
Susan Ricci, RN  
Lois Richards, RN  
Jo-Anne Riley, RN  
Joseph Roche, RN  
Naline Stewart, RN  
Maureen Thomassen, RN  
Althea Wagman-Bolster,  
SLP  
Susan Warchal, RN  
Brenda Woodbury, NP

### *Nursing Practice Committee*

#### *Co-chairs:*

Patricia Atkins, RN,  
(outgoing)  
Jennifer Kelliher, RN  
Catherine Mackinaw, RN  
Coach:  
Joanne Empoliti, RN

#### *Members:*

Susan Atamian, RN  
Patricia Atkins, RN  
Carolyn Bartlett, RN  
Cheri Boulanger, RN  
Diane Brindle, RN  
May Cadigan, RN  
Anita Carew, RN  
Diane Carroll, RN  
Patricia Fitzgerald, RN  
Eileen Flaherty, RN  
Dale Ford, RN  
Stephanie Fuller, RN  
Susan Gavaghan, RN  
Julie Goldman, RN  
Grace Good, RN  
Kathleen Gottbrecht, RN  
Pam Griffin, RN  
Mary Guanci, RN  
June Guarente, RN  
Amy Guillemine, RPh  
Judy Gullage, RN  
Sioban Haldeman, RN  
Margie Johnson, RN  
Patty McNamara, RN  
Ellen Pantzer, RN  
Kathy Pollara, RN  
Edna Riley, RN  
Jane Ritzenthaler, RN  
Martha Root, RN  
Emilia Rudowski, RN  
Joyce Saturley, RN  
Jayne Sexton, RN  
Rechelle Sprague, RN  
Jean Stewart, RN  
Amanda Todd, RN  
Aileen Tubridy, RN  
Barbara Walsh, RN

#### *Committee Leaders co-chairs:*

Trish Gibbons, RN, associate chief, CCPD  
Dorothy Jones, RN, senior nurse scientist, CCPD  
Staff Assistant: Kimberly Chelf

### *Patient Education Committee*

#### *Co-chairs:*

Carol Mahony, OTR/  
Lori Pugsley, RN  
Pamela Wrigley, RN  
(outgoing)

#### *Coach:*

Taryn Pittman, RN

#### *Members:*

Audrey Kurash Cohen,  
SLP  
Kathleen Creedon, RD  
Debbie Essig, LICSW  
Alyson Goodman  
Dean Haspela, RN, SN  
Deborah Jameson, RN  
Janet King  
Mary Elizabeth McAuley,  
RN  
Jacqueline Michaud, RN  
Donna Slicis, RN  
Angela Sorge, RN

### *Quality Committee*

#### *Co-chairs:*

Ann Eastman, RN  
Paige Nalipinski, SLP

#### *Coach:*

Lynda Tyer-Viola, RN

#### *Members:*

Maureen Buckley  
Dawn Crescitelli, RN  
Lindsay Davidson, RN  
Joan Fitzmaurice, RN  
Patricia Flanagan, RN  
Nancy J. Kelly, OT  
Mary Anne Killackey, RN  
Susan McKay, RN  
Linda Pelletier, RN  
Joanne Peters, RN  
Patricia Pires, RN  
Elena Pittel, RN  
Judy Sacco  
Sue Sheridan, RN  
Kimberly Smith  
Laura Sumner, RN  
Kathleen Tiberii, RN  
Julia Whelan  
Patricia Wright, RN

## Nurse's practice informed by being 'on the other side of the curtain'

My name is Barbara Sprole and I have been a staff nurse in the Medical Intensive Care Unit (MICU) for three years. I have seen many patients and families through the worst of times. Because of the high level of acuity in the MICU I am accustomed to working with patients near death, but I have not been desensitized by the losses I've seen people endure. Rather, I have been inspired in so many ways by my patients and their families. I have seen kindness and generosity in situations where anger and frustration would have been understandable. There is one family in particular that touched me both personally and professionally.

On an evening shift back in August, I was assigned to a patient who had just arrived from a community hospital. He was a 35-year-old man with cystic fibrosis, who had sustained a spontaneous pneumothorax while at the beach with his wife and 3-year-old son. He was taken to a hospital where they placed a chest tube, and shortly thereafter was transferred to MGH to be followed by his CF team

who knew him very well. That's when I met Roy and his amazing family.

Initially, I was nervous about taking care of a CF patient. I didn't know very much about the disease, especially in the adult population. I had taken care of other adult CF patients, but only after they'd been transplanted with new lungs. When I walked into his room and met Roy, it was clear that he was incredibly knowledgeable about his disease. He was friendly and talkative, despite the fact that he was often short of breath. He kept staring at the oxygen saturation levels on his monitor. He even took off his nasal cannula a few times to see what his saturation was on regular air. Roy had spent his whole life being in control of his disease, and being in the ICU was not going to change that.

I wondered why Roy was in the ICU, because he looked too healthy to be there. The majority of MICU patients are intubated and sedated, so I enjoyed having a patient I could have a conversation with. He told me about the events leading up to his hospital admission, including how scared he

was in the parking lot at the beach because he couldn't catch his breath. I remembered how hot it had been that day and I felt badly that he'd had to go through that. I met his wife, mom, dad and sister. They were all so supportive and gracious. I liked them right away.

I left for the day, not expecting to see Roy when I got back. I assumed he'd be transferred to a unit in my absence. The next day, I was shocked and upset to find that he was still in the MICU, and even more shocked to learn that he'd been intubated. I knew that intubation for a CF patient was bad because they are rarely able to be extubated. It was a horrible feeling to be talking to a patient one day and then see him so seriously ill the next. His family was absolutely devastated. Roy's parents, who were from out of state, had taken up residence at the Holiday Inn near the hospital. His parents and his wife were at his bedside day and night. I had never seen such dedication before. I did my best to accommodate them during their long stays in the MICU. I allowed them to stay in the room for as long as



Barbara Sprole, RN, staff nurse,  
Medical Intensive Care Unit

they wanted, even during procedures. I quickly got to know the whole family. We chatted about our families, restaurants, shopping, music, and anything else that was on our minds. I looked forward to seeing them every day. I enjoyed their company. And I shared some of my personal experiences with them as well.

My mother has been sick for two years with cancer. Last year after one of her many surgeries, she suffered complications and ended up in an ICU in a hospital in Pennsylvania. It was the worst experience I ever had. My mother was in an ICU bed just like one of my patients, and I was absolutely helpless. I wanted to have control, I wanted to take care of her, but I couldn't. I was no longer a nurse; I was a daughter, and I needed to let the nurses and doctors do their jobs. For the first time, I experienced what it felt like to be on the other side of the

curtain. It was horrible, but I learned something so valuable through that experience. The one thing I wanted most when my mom was ill was information. I wanted to be treated like I was an important part of the healing process. I vowed that I would do my best to treat the families of my patients with the respect and kindness that I wanted so desperately when my mother was sick. My nursing practice changed for the better as a result of that experience.

As the days, weeks, and months progressed, Roy had his share of ups and downs. He was extubated and re-intubated several times. He was on and off BiPap (a ventilation support system). Eventually, as options were exhausted, he received a tracheostomy after much consideration by his team and his family. His secretions were extremely difficult to manage. He required

*continued on next page*

vigorous chest PT three times a day, monitoring by physical therapists, nurses, and respiratory therapists. So much teamwork and collaboration went in to giving Roy the best care possible. The CF team was always available to help manage his care in collaboration with the medical team. We worked as hard as we could to get Roy better.

Our goal was to get Roy well enough to receive a lung transplant. He finally made it out of the MICU, and was transferred to the RACU on Bigelow 9. I remember giving report to his new primary nurse and specifically talking about his unique family dynamics. I told her how involved his family was, and how great they were. It had truly been a pleasure taking care of Roy and his family. I was sad to see them go, but I knew Roy would be in good hands. The nurses in the RACU were great. I was always welcomed for visits and they kept me updated on his progress.

In the RACU, Roy continued to have more complications. He returned to the MICU twice for various reasons. He suffered other pneumothoraces, had a very difficult time with anxiety management, and adequate nutrition was a constant issue. I visited him and his family frequently in the RACU.

It was wonderful, later, to see him finally able to get out of bed, walk around, and eat. It looked like he was going to make it to transplant after all, and it was no surprise to me that his family members were willing to risk their personal well being to be living donors for him.

I received a call from Roy's primary nurse one day in late October. Roy was not doing well. His blood gases were getting worse every day and no amount of chest PT or antibiotics could stop the downward spiral. I went up to see him, and things looked grim. For the first time since he arrived at MGH his heart, once consistently tachycardic, was down in the 60s. We thought this was the end. His family was exhausted. I recall his mom saying she felt like she was in a dream, nothing seemed real.

I tried to keep the conversation light. I mentioned that I was going to be running in the Cystic Fibrosis Foundation's Annual Halloween Run that night. And that night, as I ran through the streets of Boston in my fairy costume, I was greeted by Roy's mother and sister. It made my night! I was so touched that they waited out in the cold to cheer for me. I couldn't believe they were going through such a horrible time and still had the kindness to think of someone else. And that's just one example

of the generosity and warmth this family showed me during their time at MGH.

In November, Roy rallied again. With some finely tuned changes in ventilator settings and sedation, he was back on track. He was more alert and able to work with physical therapy. I ran into his family in the cafeteria one day and they invited me up to his room for a birthday party for his son who was turning four. Roy looked weak and emaciated but was determined to get into the chair for the party. His son was so excited about a train set he had received. He handed it to Roy, and I remember how heartbroken I felt that he could barely lift it. We all continued to hope that Roy was on his way to getting a transplant.

Nutrition continued to be a problem for Roy. He was down to less than 100 pounds and was in constant need of tube feeding. The decision was made to place a gastric tube. None of us knew that this would be the beginning of the end for Roy.

I received a call from Roy's primary nurse letting me know he was not doing well. We feared he wouldn't rally again. When I visited Roy, it looked to me as though he'd already left this world. He hadn't regained consciousness since receiving the gastric tube. His eyes were

glazed, and he was back on maximum ventilator support. I sat down with Roy's dad and we talked. We both knew this was it. The next morning I called and spoke to Roy's primary nurse, but he had already passed.

That night was the annual holiday party for the nurses, doctors and staff of the MICU and RACU. I talked to Roy's nurses for a long time. We toasted him and his family. It was a bittersweet event. We were really going to miss them.

Roy's memorial service was held at the country club where he had celebrated his 35th birthday just last year. So many people came to celebrate his life that there was standing room only. His sister spoke eloquently about Roy and his many talents, strengths and his determination to live his life without the constraints of a chronic illness. I learned about the person he had been before he became so ill. His dad thanked me for taking care of all of them while Roy was sick. He went on and on about how I made a difference, and how much they appreciated my kindness. I told him I had only reciprocated the kindness they had shown me. Roy's family is such an inspiration. If love, commitment, and compassion were medicine, Roy's family surely could have saved his life.

I have taken so much away from my experience with Roy and his wonderful family. The importance of family involvement in the critical care environment is paramount to healing and relieves some of the helplessness that is inevitable when loved ones are critically ill. The human connections I have made in situations of hardship and pain have been invaluable. Although I deal with the inevitable loss of human life in the MICU, I continue to be encouraged and resolved that I have the ability to make a difference.

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

This is a wonderful narrative about teamwork in the delivery of patient care. And not just teamwork among caregivers, but partnering with the patient and family to maximize the support and involvement of the entire team.

Barbara's experience with her own mother informed her practice as she cared for this family at this critical time in Roy's illness. She knew first-hand the importance of keeping them informed, and she maintained that level of communication even after Roy was transferred to the RACU, creating a seamless support system for Roy and his family.

Thank-you, Barbara.

## Articulating our professional practice model

—submitted by the Magnet Steering Committee

As we move forward in our preparations for the Magnet site visit in the spring, it's important that we be able to articulate the many facets of our practice. One topic the Magnet appraisers will want to hear about is our professional practice model and how we translate the components of that model into our practice.

As you may recall, Jeanette Ives Erickson, RN, senior vice president for Patient Care Services, first described

our professional practice model in (the September 19, 1996) issue of *Caring Headlines*. She explained that the model encompasses all the important work being done within Patient Care Services, but maintains the identity and integrity of each of the individual professional disciplines. A professional practice model is not a stagnant thing; it is designed to evolve over time as clinicians continue to learn and develop as professionals.

Through our professional practice model, we:

- delineate the knowledge embedded in our practice and answer the question, "How do we acknowledge and capture clinical expertise?"
- describe our process of skill acquisition and answer the question, "How do we create an environment for continuous learning and capture opportunities to teach and share our knowledge?"

- identify and resolve impediments to clinical practice and answer the question, "What systems need further refinement, and what resources are needed for the advancement of expertise in clinical practice?"
- define strategies that encourage and celebrate professional development and answer the question, "How do we acknowledge, celebrate, and reward clinical expertise?"

More than six years after the first iteration of our professional practice model, we can truly say that our clinical

practice is a rich and living manifestation of our professional practice model.

To help clinicians better articulate the finer points of their practice, we are providing a review of our professional practice model along with some sample questions you might expect when the Magnet appraisers visit your unit (see opposite page). Please use this review as a springboard for discussions with your colleagues and the Magnet champions on your unit. The more we talk about our practice, the better able we are to capture the intricacies and complexities of the important work we do.

Continued on next page



Lauren Holm, RN, staff specialist (standing), facilitates group discussion with staff nurses at recent Magnet Champion Retreat.

**Values**

Our values are derived from our vision statement, a statement that was shaped by nurses who practice at MGH. As clinicians, we ensure that our practice is *car-ing, innovative, scientific, empowering, and based on a foundation of leadership and entrepreneurial teamwork.*

**Philosophy**

Our philosophy statement is a formal expression of the values, principles, and beliefs that support the individualized work of each discipline within Patient Care Services. A draft of our philosophy statement was originally shared in *Caring Headlines* at which time all staff had an opportunity to comment on, and help craft, the paragraph that would become a lasting statement of our philosophy of care. Our philosophy statement is

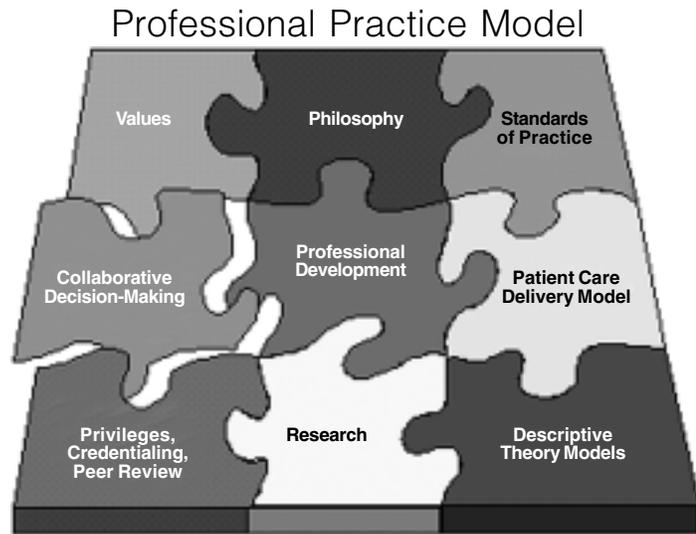
a comprehensive description of what we believe, and it helps us articulate our practice to others.

- Share our philosophy with your nursing and non-nursing colleagues.

**Standards of Practice**

Standards of Practice exist to ensure that the highest quality of care is maintained regardless of the number of professionals providing care, or the experience of those professionals.

- Can you identify some of our standards of practice? One example would be our Nursing Practice Guideline for Risk for Impaired Skin Integrity
- Do you know where to find our standards of practice?
- Are there any standards specific to the patients you care for on your unit?



**Collaborative Governance**

By participating on the seven committees that currently comprise our staff-led collaborative governance structure, nurses at MGH have a strong voice in decisions that affect their practice.

- Can you name the seven committees?
- Who are the representatives on your unit who serve on committees?
- How do you share your concerns and stay informed through committee representatives.

**Patient Care Delivery Model**

The foundation of the care we provide is an interdisciplinary, patient- and family-centered model.

- What does this look like on your unit?

**Professional Development**

Professional Development is essential to our ability to provide quality care.

- How do staff on your unit use the resources available from The Center for Clinical & Professional Development?
- How do nurses on your unit share information with colleagues when they return from professional conferences?

**Privileging, Credentialing, and Peer Review**

Our requirements around privileging, credentialing, and peer review ensure that our patients and their families receive quality care from competent providers.

- Why is it important to have a system of privileging, credentialing, and peer review?
- How does this system support nurses and protect patients?

**Research**

Nursing practice is based on scientific research. A ‘spirit of inquiry’ advances our knowledge and enhances the quality of the care we deliver.

- What research studies have influenced your practice?
- Are any nurses on your unit currently participating in a research study?
- Did you know that there are 21 doctorally prepared nurses at MGH? They are an invaluable resource in an environment that values research-based practice.

**Descriptive Theory Models**

At MGH, we’re always looking for new ways to inform our practice. We subscribe to a variety of theories in support of our nursing care.

- Can you identify any theories of practice that inspire the way you deliver care on your unit?

**Our philosophy statement**

We believe that the essence of nursing practice is caring. Caring that is  
 ... a science and an art  
 ...deliverable, teachable, researchable  
 ...accomplished with wisdom, knowledge, compassion, and competence.

We believe the clinical practice of nursing is built on a scientific base  
 ...evaluation of nursing practice is a professional responsibility  
 ... critical thinking and scientific inquiry are essential to the improvement of practice.

We believe we have the responsibility to  
 ...educate ourselves and others  
 ...expand our knowledge and expertise  
 ...share our growing body of knowledge, and  
 ...provide such opportunities to the greater healthcare community.

## Clinical nurse specialist as collaborator

—by Patricia M. Connors, RNC, MS, WHNP

The role of clinical nurse specialist has been described as one of educator, consultant, researcher, and collaborator. On any given day, a CNS may perform in any or all of these roles. It is a diverse and often challenging position helping staff carry out the most appropriate plan of care for their patients. As a perinatal clinical nurse specialist, I have found it necessary to seek the advice of my colleagues who specialize in areas less familiar to me. In so doing, I have been able to demonstrate to staff the importance of collaborating with other disciplines.

Occasionally, patients are re-admitted to the OB Unit with wound infections following a Cesarean section. Most of the time, patients respond well to antibiotics and prescribed wound care. However, when a wound shows resistance to healing properly and the integrity of the surrounding tissue becomes vulnerable to further breakdown, it has been necessary to seek the expertise of other CNSs. Wound care specialists, Joan Gallagher, RN, and Ann Martin, RN, have shared their knowledge with me and my staff. Vacuum-assisted closure

(VAC) therapy has been called for in a few instances, and since this is not a treatment commonly used on obstetrical units, Ann has explained the physiology of the healing process with this technique and supported staff as they cared for patients. It has been a great learning experience for all involved and an example of how we sometimes need to pool our knowledge to facilitate the best outcome.

Last summer, pain-management was an issue for an antepartal patient despite the involvement of the Pain Management Team. This patient was having difficulty understanding the plan of care and didn't think people fully appreciated the level of discomfort she was experiencing. She reacted angrily to caregivers when attempts were made to discuss her pain-management. It's not often that staff on the obstetrical unit encounter this kind of challenging behavior. Staff was frustrated and the patient only became more resistant. Several times she wouldn't allow a nurse to enter her room because she was tired of 'retelling her story' and trying to convince people she needed more medica-

tion. It's worth noting that this patient had been under psychiatric care, but substance abuse had never been an issue, and her psychiatrist had always found her to be compliant.

In talking with the staff and trying to offer some guidance, I decided to consult with a psychiatric CNS to help formulate a plan for how best to care for this patient. Tina Gulliver, RN, responded and within an hour we had an impromptu meeting, which resulted in staff verbalizing their frustrations and Tina providing a greater understanding of the patient's behavior. She stressed the importance of continuity and consistency in the message being given to this patient concerning the management of her medications. It was decided that the patient was to be included in the plan, and if she deviated from what had been mutually agreed upon, she would be reminded of the agreement. Staff became more confident in their approach to this patient, and, I believe, more secure in their nursing care since they had a better understanding of the dynamics behind the patient's behavior and a concrete plan of care.



Patricia Connors, RN,  
clinical nurse specialist

Lynda Tyer-Viola, RN, Marylou Lyons, RN, and I are perinatal clinical nurse specialists for the Obstetrical Service, and we are often called upon when pregnant women are hospitalized on other units. We have been asked to visit patients on Oncology, Neurology and in the medical and surgical intensive care units. In this way, we share our expertise with other members of the health-care team. We may be called on to assess a fetal heart, teach a patient about what to expect when she goes into labor and prepare her for delivery. Educating staff about the anatomical, physiological and emotional changes of pregnancy is important as these changes can greatly affect the recovery process when a comorbid situation exists.

The Coronary Care Unit was home for several weeks for a woman who was pregnant with her second child. During

her third trimester she was admitted with ventricular tachycardia, which was monitored in the 200+ range. She described lightheadedness with these episodes that had become progressively worse. The patient was visited every day by a member of the obstetrical medical and nursing team, and as her delivery date drew closer, her plan of care and delivery was discussed by her nurses, obstetrician, cardiologist, anesthesiologist, and neonatologist. We provided patient education to prepare her for a Caesarean section, which was to be the mode of delivery. The patient had labored and delivered her first child vaginally, but due to her cardiac status during this pregnancy, she was scheduled to have an operative delivery. I met several times with the patient as did my colleagues, and we discussed not only the different procedures she

*continued on next page*

## Raising awareness about fire safety and burn prevention

Nurses from the Bigelow 13 Burn Unit took turns staffing an educational booth in the Main Lobby on Wednesday, February 12, 2003, in an effort to raise awareness about fire safety and burn prevention.

"It's only a couple of days before Valentine's Day," said Gina Cenzano, RN. "We want to make sure everyone is well informed of the dangers before they cuddle up in front of a roaring fire or sit down to a candlelight dinner."

Some tips included: staying in the same room whenever candles are lit; placing candles out of reach of children and pets; and keeping all matches and lighters in high, locked cabinets where children won't be tempted to play with them.



Bigelow 13 nurses, Gina Cenzano, RN, (left) and Brook Morgan, RN, staff Burn Safety table in the Main Lobby during Burn Prevention Awareness Week.

### CNS

*continued from previous page*

would need prior to surgery (prep, foley catheter, intravenous placement with a potential arterial line), but also the support she would receive during her time on the labor and delivery unit. The patient was appropriately concerned about her well-being and that of her unborn baby and needed reassurance that the whole team was aware of her status and what needed to be accomplished for the optimal outcome.

Her successful, uneventful delivery of a healthy baby boy was the culmination of all of our efforts.

It has been my experience in my seven years at MGH that clinicians here possess a wealth of talent and expertise that they are unselfishly willing to share. Providing the best possible patient care is our primary goal and that is so obvious when I call upon my colleagues or they seek my assistance. The CNS fosters collaboration and in so doing serves as a role model for the next generation of nurses.

### The MGH Nursing Alumnae Association presents Nursing Update 2003

The Operating Room of The Future  
Framingham Heart Study  
MGH and Disaster  
Childhood Cancer  
Gerontology/Psychiatry

**March 28, 2003  
8:00am-4:30pm  
O'Keefe Auditorium**

7.2 contact hours.  
Cost: \$40

For more information,  
call 617-726-3144

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#### Publisher

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

#### Managing Editor/Writer

Susan Sabia

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and LVC Retail Services  
Pat Rowell

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#### Submission of Articles

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Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746.

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## Students get up-close look at careers in health care

Gayle Peterson, RN, staff nurse on Phillips House 21, has been a member of The Staff Nurse Advisory Committee since its inception in 1997. Says Peterson, "Retention and recruitment are

regular topics at our meetings. Jeanette [Ives Erickson] has always promoted the idea of student outreach and educating our youth about careers in health care. So when I saw the e-mail about Job Shadow Day, I jumped at the

chance to bring students to our unit."

Peterson planned a whole morning of educational activities for the students and enlisted the aid of her colleagues, Michael Flynn, RN, and Janice Cameron-Calef, RN.

Peterson invited occupational therapist, Daniel Kerls,

OTR/L, to speak with the students about what it's like to work as an occupational therapist, what level of education is required, and the impact that occupational therapy can have on patients after injury or illness.

Students had a chance to observe nurses working with patients. They visited the Ether Dome, the MGH Chapel, and the Back-Up Day Care Unit.

Says Peterson, "Everyone was so helpful. I think the students were given a realistic look at what it's like to work in health care. And I think they liked what they saw."

Students, Monet Evans, Kelen Silva, and Shannon Sousa, came from East Boston High School as part of the MGH-Boston Public School Partnerships Program coordinated by the MGH Community Benefit Program.



(Clockwise from top left): Flynn and Cameron-Calef with students in Ether Dome; Kerls (third from left) talks to group about occupational therapy; Cameron-Calef and Peterson with students in Ether Dome Museum; Peterson and student, Monet Evans, with patient, Paul Mousseau, on Phillips House 21.



# Educational Offerings

February 20, 2003

When/Where	Description	Contact Hours
February 19 1:30–2:30pm	<b>USA Educational Series</b> Bigelow 4 Amphitheater	---
February 20 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2
February 20 10:00–11:30am	<b>Social Services Grand Rounds</b> “Children from Families with Alcoholism and Substance Abuse.” For more information, call 724-9115.	CEUs for social workers only
February 21 (Day 1) 8:00–4:30pm	<b>End-of-Life Nursing Education Program</b> O’Keeffe Auditorium	TBA
February 26 8:00–4:30pm	<b>Workforce Dynamics: Skills for Success</b> Training Department, Charles River Plaza	TBA
February 26 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
February 26, 27, March 3, 4, 10, and 11 7:30am–4:00pm	<b>ICU Consortium Critical Care in the New Millennium: Core Program</b> BWH	45.1 for completing all six days
February 27 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
February 27 7:30–11:30am; and 12:30–4:30pm	<b>Pediatric Trauma Update</b> Wellman Conference Room	---
February 27 7:00am–12:00pm	<b>CVVH Core Program</b> VBK 601	6.3
February 27 1:00–2:30pm	<b>Conflict Management for OAs and PCAs</b> VBK 601	---
February 28 8:00–4:30pm	<b>Cancer Nursing Update 2003</b> O’Keeffe Auditorium	TBA
March 4 8:00am–4:30pm	<b>Chemotherapy Consortium Core Program</b> Wolff Auditorium, NEMC	TBA
March 6 7:30–11:00am, 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
March 6 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2
March 6 1:30–2:30pm	<b>Shared Vision—New Pathways: A New Approach to Joint Commission Accreditation</b> Habber Conference Room	---
March 7 (Day 1) 8:00–4:00pm	<b>CCRN Review Day</b> O’Keeffe Auditorium	TBA
March 12 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
March 12 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
March 13 8:00am–4:30pm	<b>Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other</b> Training Department, Charles River Plaza	7.2

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>.

## Perleberg turns 50; staff nominate him for Nurse of the Year

In a packed visitor's lounge on Phillips House 21, on Thursday, February 13, 2003, staff surprised nurse manager, Keith Perleberg, RN, with a surprise 50th birthday party and news that they had nominated him for *Nursing Spectrum's* Nurse of the Year award.

Staff nurse, Nicole, Filosa, RN, read the letter of nomination, which captured many of the qualities and reasons they chose this means to observe Perleberg's 'coming of age.'

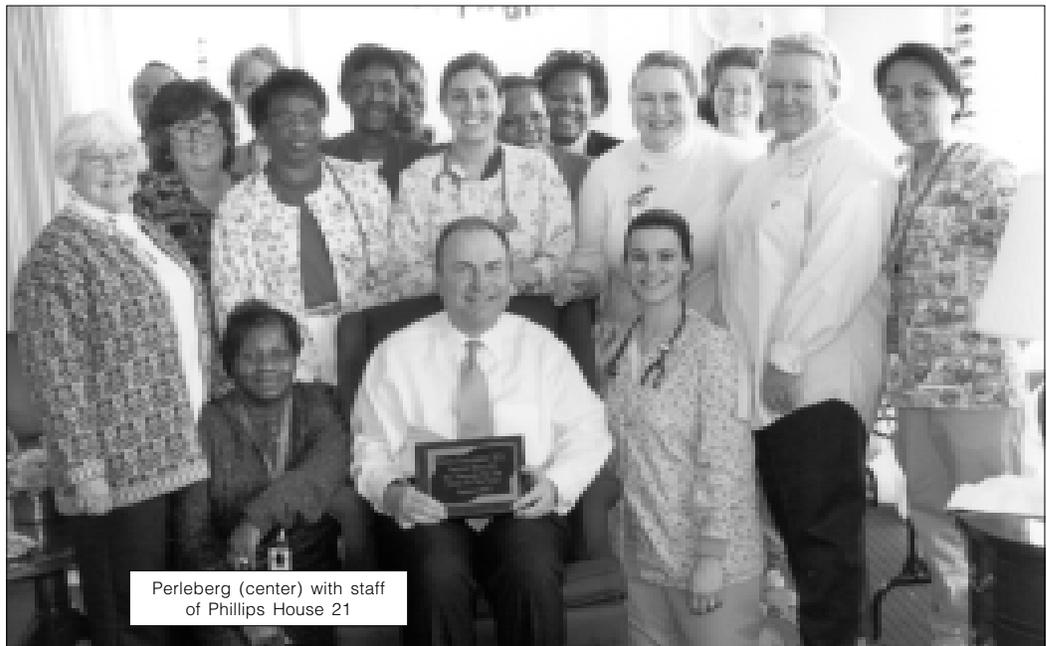
Said Filosa, reading from the letter, "Keith creates an environment that focuses on what is best for the patient. His frequent presence and knowledge of the patient help us achieve the goals we set. His creative thinking and ability to seek out resources allow us to give the best possible care to our patients and their fam-

ilies... Keith says that 'Nursing is not just a profession, it is a calling.' To have our work framed that way is inspiring, and so is our nurse manager."

A genuinely surprised Perleberg thanked his staff, not just for the party and the nomina-

tion, but for their ongoing commitment to nursing and to the patients of Phillips House 21. He thanked Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Theresa Gallivan, RN, associate chief nurse, for their support and guidance, and for the confidence they placed in him in asking him to be nurse manager of Phillips 21.

Happy birthday, Keith!



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