

November 20, 2003

Caring

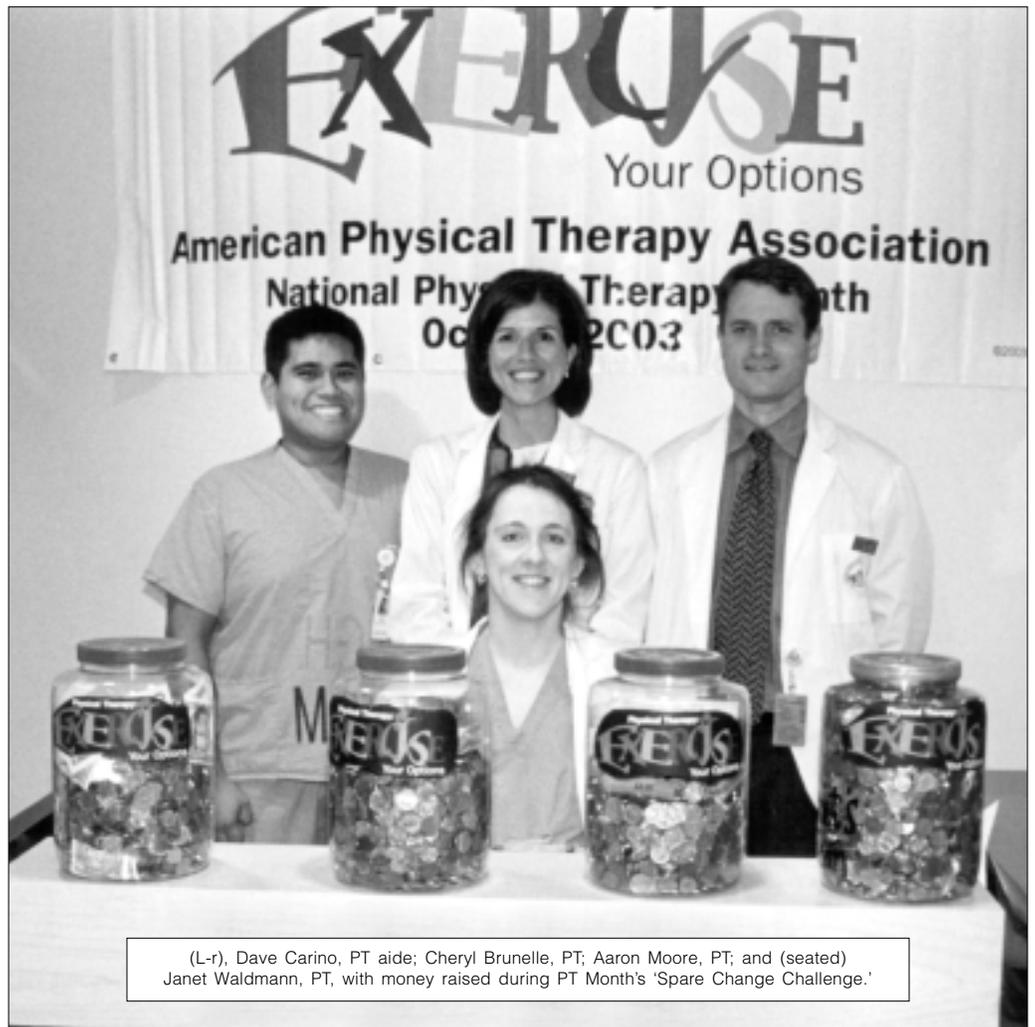
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Physical Therapy Department celebrates National PT Month with spirit of giving

(See page 4)



(L-r), Dave Carino, PT aide; Cheryl Brunelle, PT; Aaron Moore, PT; and (seated) Janet Waldmann, PT, with money raised during PT Month's 'Spare Change Challenge.'

MGH Patient Care Services
Working together to shape the future

Creating an environment that fosters disclosure

So many issues in health care today are complex, far-reaching, and highly sensitive. Creating an environment that fosters the disclosure of adverse events falls squarely into that category. At MGH and across the country, important discourse is taking place about errors in the medical setting—how to address them, how to communicate about them, and how to prevent them. The subject has been addressed in a number of books, like *Crossing the Quality Chasm: a New Health System for the 21st Century* and *To Err is Hu-*

man: *Building a Safer Health System*, published by the Institute of Medicine. And as an organization, MGH fully endorses disclosure of adverse events. The good news is: people are talking about it. My own feelings about the disclosure of medical errors are based on three basic concepts. The first is that nothing is more important than the delivery of safe,

high-quality care to our patients. The second is that trust is at the core of the caregiver-patient relationship. And third is my firm belief that when errors occur in a clinical setting, it is more often due to a breakdown in systems than a breakdown in the critical thinking, actions, or intent of a single individual. We all know there are formidable barriers to an organizational culture of free and open disclosure—blame, punitive action, financial liability, harm to reputation, legal and regulatory repercussions, and loss of professional credibility.

There are many reasons to support a model of health care that embraces disclosure of adverse medical events.

Perhaps the most compelling is the opportunity to learn from our mistakes.

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Is there an up-side? Disclosure of medical errors is the right thing to do, it is the ethical thing to do. And while there is certainly merit to that thinking, there are many other reasons to support a model of health care that embraces disclosure of adverse medical events. Perhaps the most compelling is the opportunity to learn from our mistakes. That opportunity only exists when we know a

mistake has been made. Changes in practice and procedures can occur when errors are reported. Systems can be adapted, updated, and improved based on information learned from negative outcomes. When considered in this light, disclosure of adverse events actually contributes to patient safety and enhances professional development. It's in the best interest of the patient, the caregiver, and the organization.

Disclosure strengthens the bond of trust between patients and caregivers; it demonstrates our commitment to putting the patient's needs before our own. We know that patients and families want honesty, respect, and open communication. Disclosure of adverse events, though

difficult, reinforces patients' and families' faith in us as professionals and often discourages legal action. It has been documented that patients often forgive mistakes when they are disclosed forthrightly.

Any discussion of disclosure, I think, must also take into account the impact it has on the caregiver. By admitting a mistake we take accountability for our ac-



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

countability for our actions; we begin to ease our own emotional strife, and we create an opportunity to apologize. Something as simple as an apology can have an enormous positive impact on the patient as well as the caregiver.

As I said at the outset, disclosure of adverse events is a complex, far-reaching, and highly sensitive subject. Strategies and solutions are being discussed on many fronts. I think it's fair to say that our ideas about educating staff and the public, and creating a culture that fosters disclosure will continue to evolve. Whenever intelligent, caring people give serious thought to serious issues, it's a good thing.

As we move through the process of updating our policy on disclosure of adverse events, I ask each of you to give serious thought to the matter. Think about the trust that exists between patients and caregivers;

think about what's required in order to provide the best possible care to our patients; think about what you would want if you or a loved one was hospitalized; and think about systems—systems that can be implemented to reduce the occurrence of adverse events and ensure that we learn from any mistakes that are made in the clinical setting.

I look forward to hearing your thoughts and ideas.

Update

I'm pleased to announce the appointment of Colleen Snyderman, RN, to the position of nurse manager for the Ellison 9 Cardiac Intensive Care Unit. Colleen will no longer be nurse manager for Ellison 19 but will continue her nurse manager responsibilities in the RACU. This role change will take effect as soon as new leadership is identified for Ellison 19.

REAL encourages you to recycle!

—submitted by the Raising Environmental Awareness League

Did you know that paper accounts for more than 50% of all solid waste disposed of at MGH?

Last year we saved more than \$56,000 by recycling 574 tons (or 11%) of paper and cardboard. Imagine how much we could save if we recycled 20% of the paper we discard, not to mention trees and landfill space. Imagine what

we could do if we recycled 50%!

All white paper that is being discarded at MGH should be recycled. Every unit, setting, and department should have blue recycling bins for white paper. If your department does not have a recycling bin, please contact Environmental Services at 6-2445 to have one delivered. Bins are also available for recycling colored

paper and newspapers.

Batteries, which are extremely toxic to the environment if not disposed of properly, may be recycled at MGH. Look for appropriate containers and avoid throwing batteries in the trash. If you need a battery disposal receptacle, please call the Safety Office at 6-2425.

Currently, there is no way to recycle aluminum or plastic at MGH,

but most communities have recycling programs that accept aluminum and plastic. So instead of throwing away your cans and plastic bottles at MGH, take them home and recycle them through your community programs.

If every MGH employee makes an effort to reduce the amount of

waste accrued at MGH, it will save the hospital money and reduce the negative impact we have on our environment. It doesn't take much. Just remember: reduce, reuse, recycle.

If you have questions, comments, or concerns please e-mail them to: REAL@partners.org.

Get REAL!

Have you ever thought about the impact MGH has on the environment?

REAL (Raising Environmental Awareness League) is a newly formed environmental group at MGH seeking new members.

For more information, e-mail: peaceout@quik.com or rhorr@partners.org

MGH Institute of Health Professions Spring Semester

Register for January classes by December 12, 2003 to receive 10% discount

The MGH Institute of Health Professions' spring 2004 session begins January 12, 2004. More than 30 evening, day, and on-line classes are available to nurses, physical therapists, speech-language pathologists, and other clinicians.

On-line classes:

- Advanced Pharmacology (nurses only)
- Diagnostic Imaging
- Principles of Genetics for Health Professionals
- Introduction to Clinical Investigation
- Treatment Approaches to the Neurologically Impaired (physical therapists only)

On-site classes at the Charlestown Navy Yard:

- Applied Clinical Research
- Cardiopulmonary Clinical Laboratory
- Clinical Neurology
- Living with Death and Grief: a Clinician's Perspective
- Tracheostomy and Ventilation Issues (speech and communication specialists)

For complete list of courses go to:
<http://www.mghihp.edu/Admissions/nondegree.html>

Partners Discount: full-time employees working within Partners may take their first 3-credit course at half-price. For more information, e-mail registrar@mghihp.edu or call (617) 726-3140.

Educational Offerings available on-line

The Center for Clinical & Professional Development lists educational offerings on-line at: <http://pcs.mgh.harvard.edu>

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

Annual Thanksgiving Interfaith Service

Get your spirit ready for Thanksgiving! The MGH Chaplaincy invites you to a half hour of giving thanks and reflection at our annual Thanksgiving Interfaith Service. All are invited.

**Monday, November 24, 2003
12:15–12:45pm**

Hear readings from individual faith traditions and communal reflections.

Staff and patients are welcome to attend.

For information, call the Chaplaincy at 6-2220.

MGH celebrates National Physical Therapy Month

—submitted by Nancy Goode, DPT,
inpatient physical therapy coordinator

October was National Physical Therapy Month, and the theme of this year's celebration, put forth by the American Physical Therapy Association (APTA) was, "Exercise Your Options." In a series of special events and educational presentations, The MGH Physical Therapy Department did just that. On Wednesday, October 15th, physical therapists staffed a booth in the Main Corridor providing information to staff and visitors about physical therapy, exercise

prescriptions, and proper posture. Staff therapists participated in the MGH Women's Health Fair providing information about osteoporosis and tips for prevention.

There was a strong desire within the department to engage in a community-service project that would benefit MGH patients. Toward that end, for the first time this year, the department sponsored The Spare Change Challenge. Throughout the month of October, special fund-raising jars were placed at key loca-

tions throughout the hospital. Physical therapists divided into four

teams and challenged each other to raise the most money. With a little (some would say a lot!) of friendly competition, they raised more than \$1,000 to support the MGH Social Services food voucher program

for patients and families in need. The donation was presented to Evelyn Bonander, ACSW, director of Social Services at the annual Physical Therapy Recognition Luncheon, on October 20th. *continued on next page*



October was National Physical Therapy Month and the MGH department of Physical Therapy celebrated with a number of events and educational offerings.

Above: senior physical therapist, Melanie Struzzi, PT, staffs the PT booth in the Main Corridor during PT Month.

At left: senior physical therapist, Denise Montalto, PT (foreground), recruits a future therapist, while physical therapy intern, Michelle McCune, looks on.

Physical Therapy Month

continued from previous page

tober 30th. Bonander expressed her sincere appreciation, both for the money and the spi-

rit of generosity that made the gift possible.

Senior vice president for Patient Care, Jean-

ette Ives Erickson, RN, was on hand to congratulate physical therapists and applaud the important work they do for patients every day.

Ives Erickson suggested that Physical Therapy challenge the rest of the hospital to be as creative and giving when it comes time to celebrate their professions.

The annual Recognition Luncheon is always a highlight of PT Month. This year, four therapists shared their insights and experiences in informal presentations. Each of their talks, though very different, was marked by humor, poignancy, compassion, and an undeniable com-

mitment to the profession. Presenters were: Alison Bates, PT, clinical specialist; Aimee Klein, PT, clinical associate; Jean O'Toole, PT, clinical specialist; and Bill Waddell, PT, senior physical therapist.

Director of Physical Therapy, Michael Sullivan, DPT, took advantage of the occasion to thank his staff for their dedication, teamwork, and unparalleled enthusiasm as they con-

tinually provide the best care and treatment to MGH patients. Individuals were recognized for achieving board certification; receiving advanced clinical and academic degrees; participating in research, publications, and presentations; and receiving professional awards.

The luncheon concluded on a fun note with a PT version of the TV game show, *The Weakest Link*.



Director of Physical Therapy, Michael Sullivan, DPT, presents Evelyn Bonander, ACSW, director of Social Services, with check for money collected in the 'Spare Change Challenge.'

Did you know...?

- MGH Physical Therapy professional staff is comprised of 109 FTEs
- MGH Physical Therapy has 27 board-certified clinical specialists on staff (in pediatrics, geriatrics, neurology, orthopedics, sports, and cardiopulmonary physical therapy)
- MGH Physical Therapy provides 52,053 ambulatory patient visits per year between the MGH main campus, Chelsea, Revere, Charlestown, and MGH West.



At annual Physical Therapy Recognition Luncheon, members of the department play a home-grown, MGH version of the TV game show, *The Weakest Link*.



ProTech students showcase their MGH experience

—by Galia Kagan, ProTech program manager,
and Mary McAdams, RN, clinical educator

Eleven ProTech interns, all seniors at East Boston High School, had an opportunity to share their MGH internship experience with families, school administrators, MGH employees, and guests during parent night at East Boston High School on October 16, 2003. The students told about their ProTech experiences as a PowerPoint presentation displayed images of their worksite activities.

Ashleigh Fitzgerald, who is interning on Blake 8, observed, "I've become more interested in nursing since I started working at the hospital. Being at MGH has taught me many

important lessons such as time-management and the need for patient confidentiality. But the most valuable lesson is how to work well with others. Working in the Surgical ICU, I see so many interesting things. Every once in a while there's a code blue on my unit and I'm amazed at how quickly the nurses respond to the situation and how well they work together at such a stressful time."

Alicia DeStefano, who is interning on Blake 6, said, "Working at MGH has shown me that life is precious. I work in the Transplant Clinic, and we see miracles every day. I feel like I'm ready to take on the job of being a

nurse. A highlight for me while working at MGH is learning and observing how nurses do their jobs. The people I work with are not only co-workers but

mentors. I've been able to make a decision about becoming a nurse because I want to make a difference in people's lives. I see meaningful moments every day in the Transplant Clinic. The most amazing ones are when I see little kids go home after having a

transplant and seeing their parents overcome with joy."

An intern in the department of Radiology Avon Breast Center, Carla Casaletto, said, "The dedication required to work in health care is tremendous. I've learned that to work in a hospital you must be determined to get the

"The most important thing I've learned is how to get along with people who are different from me in age and attitude. This has been one of the most important experiences of my life..."

— Melissa Diaz

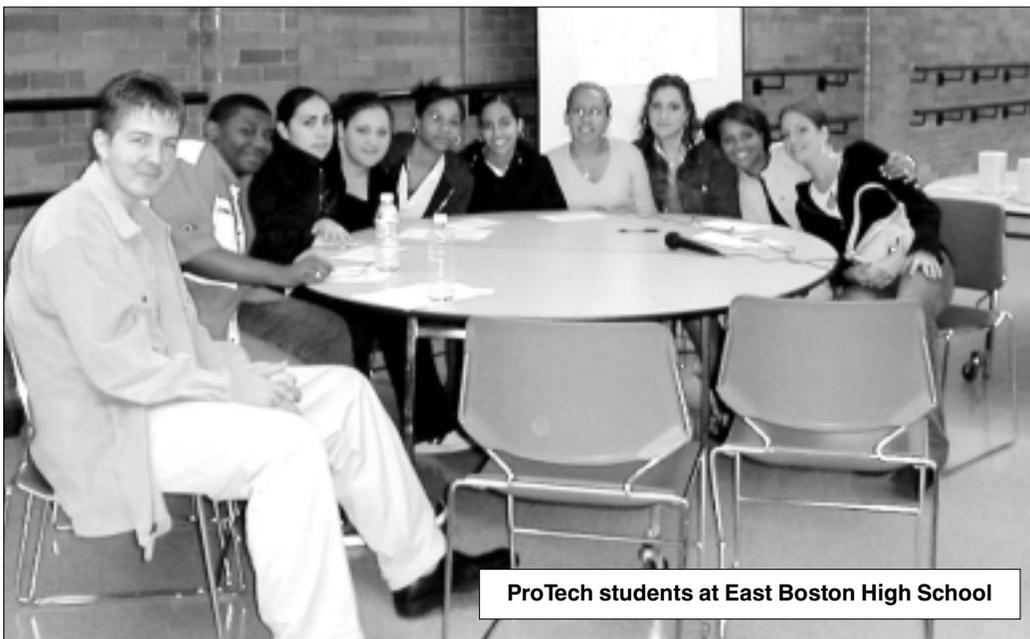
job done and prepared to take whatever comes your way. I've gained so much information that I can use to shape my future. I feel like the ProTech program has given me the determination to succeed."

Interning on the White 11 Medical Unit, Melissa Diaz, said, "The most important thing I've learned is how to get along with people who are different from me in age and attitude. This has been one of the most important experiences of my life and I hope all the students in the program have the same opportunity to discover themselves, discover what they want for the future and what they can give to the people around them."

The ProTech Program introduces and prepares East Boston High School students for challenging and rewarding careers in health care through a variety of career-exploration activities and paid internships at MGH.

The ProTech Showcase was not only a fun and educational experience for the interns, it was a great way to get parents involved in their children's educational activities. In preparation for the showcase, students attended monthly student planning sessions. These sessions gave them a chance to share stories from their work settings and exchange best practices in a peer-led setting.

The ProTech Program is a school partnership initiative coordinated through the MGH Community Benefit Program. For more information, call the MGH/EBHS Partnership office at 4-8326.



ProTech students at East Boston High School

MRI, CT scans now available at Mass General Imaging Chelsea

—by Kristen Dean, department of Radiology

In response to growing community demand, MGH Radiology is pleased to announce the opening of its new state-of-the-art community imaging center in Chelsea. Keeping pace with its ever-expanding role within the patient care model, the department of Radiology has relocated to a larger site. Formerly located at 100 Everett Avenue, Mass General Imaging Chelsea, operated by the Massachusetts General Physicians Organization (MGPO) Radiology Associates,

is now located directly across the parking lot at 80 Everett Avenue.

The new facility offers magnetic resonance imaging (MRI) and computed tomography (CT) technology that, until now, has only been available at some teaching hospitals. The advanced imaging technology offers shorter scan times and finely detailed images, providing enhanced information for physicians and a better experience for patients.

Mass General Imaging Chelsea is conveni-

ently located to serve the local patient community. It is easily ac-

cessible from the MGH main campus and the MGH Revere Health Center, and only 100 yards from the MGH Chelsea Health Center.

Designed with patient comfort in mind, the spacious reception area features a self-service coffee bar, a computer with access to the Internet, and a telephone that can be used for local calls. Right now, a series of original seascapes by local artist,

to clinicians is that all exams are interpreted by MGH radiologists, and all images and reports are available electronically to MGPO physicians via the Picture Archiving and Communication System (PACS).

Says Denise Palumbo, RN, administrative director for the department of Radiology, “The role of Radiology is integral to the patient-care process. We continue to be diligent in monitoring the imaging needs of our patients and referring physicians. We’re able to provide our patients with a wonderful clinical experience and foster peace of mind at the same time. Our new facility in Chelsea was designed for patient comfort, and our MRI and CT imaging capabilities and world-renowned interpretive expertise are truly cutting-edge.”

Mass General Imaging Chelsea has offered CT scanning since 1999 at its original location. The department of Radiology operates a community imaging center in Waltham at Mass General West that offers CT, MRI, screening mammography, nuclear medicine, ultrasound, and pediatric services. Both facilities offer same-day appointments, evening and weekend hours, free parking, and shuttle service to and from the MGH main campus.

For more information or a tour of Mass General Imaging Chelsea, contact David Spinale at 617-726-1467.

“We continue to be diligent in monitoring the imaging needs of our patients and referring physicians. We’re able to provide our patients with a wonderful clinical experience and foster peace of mind at the same time.”

— Denise Palumbo, RN

Charles Margeson, is on display and will remain until April, 2004, when another local artist’s work will be exhibited.

Of particular interest



Mass General Imaging Chelsea’s new MRI, the GE 1.5T Horizon LX with Excite 11.0 Software

MGH participates in National Disabilities Mentoring Day

—submitted by the Disabilities Mentoring Day Planning Committee

On October 15, 2003, MGH joined scores of other companies across the country to participate in National Disabilities Mentoring Day, hosted by Human Resources and the Community Benefit School Partnership Program.

The day provided an opportunity for students and adults with disabilities to shadow MGH

employees to learn more about careers in health care. Twelve participants spent the morning with employees who had volunteered to be mentors. They were paired according to each participant's interests and experience.

Participants came from The Career Place in Woburn, the Massachusetts Rehabilitation Commission, Partners for Youth with Disabili-

ties, and East Boston High School. Mentors volunteered from Nursing; Training and Development; Human Resources; Speech Language Pathology; Medicine; Volunteer, Interpreter, and Ambassador Services; The Gillette

Center for Women's Cancers; MGH Clubs at Charles River Park; Radiology; and Internal Medical Associates.

Participants were welcomed to the hospital by Jeff Davis, senior vice president for Human Resources, before embarking on their individual job-shadowing experiences. The day concluded with a presentation by Steven Gardner, MD, of Bea-

con Hill Health Associates, and a panel discussion on, "Health Care Careers and Recruitment," moderated by Oswald Mondejar, Human Resources manager. It was a rare and important opportunity for individuals with disabilities to engage in meaningful dialogue about the issues and policies that impact the employment of people with disabilities.



Above: clinical educator, Mary McAdams, RN (left), and patient care associate, Theresa MacDonnel (center), with program participant during job-shadowing experience on Ellison 14.



Above right: director of Speech-Language Pathology, Carmen-Vega Barachowitz, SLP (center), and speech-language pathologist, Allison Holman, SLP (right), review radiographic study of a modified barium swallow with participants.



At right: on Phillips 21, participant sits in on weekly leadership meeting with operations coordinator, Beverley Cunningham (center), and nurse manager, Keith Perleberg, RN,

(Photos by Paul Batista)

Comfort and Support after Loss Program holds 12th Annual Pediatric Memorial Service



Above: Kathryn Beauchamp, RN, Fredda Zuckerman, LICSW, with parent who attended the memorial service.

Below: A passer-by stops to view quilt in the Ellison Corridor.

The first Sunday in November has special meaning for some parents and families of the Mass-General Hospital for Children. Twelve years ago a multi-disciplinary bereavement committee was formed to come up with strategies to help families cope after the death of a child. One idea that came out of that group was an annual memorial service in remembrance of every child who has died at MGH. Since that idea was first voiced, an annual pediatric memorial service has been held every year on the first Sunday in November.

This year, the service was held on November 2nd. As part of the service the Comfort and Support after Loss Committee invited family and friends to decorate fabric to be used in the making of a memorial quilt. The Memorial Quilts from 2001 and 2002 were on display outside the MGH General Store for the first few weeks of November.

For more information about the Comfort and Support after Loss Program or the memorial quilts, please contact Kathryn Beauchamp, RN, at 4-3888, or Fredda Zuckerman, LICSW, at 4-3177.



(Photos by Michelle Rose)

Compassion, spirit of inquiry keep physical therapist fighting for young man's dignity

My name is Janet Callahan and I have been a physical therapist for more than 25 years. My practice has involved caring for a diverse patient population from pediatrics to geriatrics, and in a number of different settings including schools, home care, inpatient rehabilitation, outpatient clinics, and research. I have practiced at MGH in both a part-time and full-time capacity for the past three years. During that time, I've had the challenge and opportunity to provide care for patients whose motor-control deficits have yet to be adequately explained.

I first met JM in January of 2002. He was 18 years old; he had been recently diagnosed with chronic inflammatory demyelinating polyneuropathy (CIDP); and had been referred for physical therapy by his neurologist for gait training with a cane due to repeated falls. JM came to MGH from an outlying community when his local physicians were unable to delineate the cause of his repeated falls. His past medical history was not significant with the exception of frequent falls that he described as a sudden loss of balance. He had un-

dergone nerve conduction studies that confirmed a diffuse sensorimotor demyelinating polyneuropathy.

I performed a physical therapy examination that revealed weakness throughout the lower extremities, greater on the left side than the right, and brisk DTRs (deep tendon reflexes) at the knees and ankles. Balance assessment revealed diminished effectiveness of postural response strategies of an exaggerated magnitude with a prolonged response time. JM demonstrated postural insecurity and exaggerated balance reactions, which I thought could be associated with his fear of falling. His gait was characterized by decreased step length, decreased knee extension at heel strike, and diminished arm swing. At this point in time, the only unusual finding was the presence of brisk DTRs in the presence of CIDP. He had been given a standard cane to help compensate for sensory deficits found during nerve conduction studies. Sensory deficits were not found during the initial PT exam, but often measures obtained as part of a standard PT exam aren't sensitive enough to detect subtle changes. JM felt the cane gave

him an added sense of security. Although some examination findings were not consistent with balance impairment due to CIDP, I thought it would be appropriate to implement a conventional balance re-training program at this time. The goal of treatment was to improve JM's limits of stability and postural-response strategies with the hope of reducing his falls. JM and his family wanted to pursue PT at MGH but due to the long distance they had to travel, he could only be seen once a month. JM was conscientious about exercising, and it was agreed that this plan could meet his needs.

JM was seen twice over a three-month period and demonstrated significant improvement in strength and balance. He was still experiencing frequent falls but didn't wish to pursue further PT at this time. He continued to see his neurologist at MGH on a regular basis.

JM returned to PT in March of 2003, his diagnosis unchanged. A review of his history revealed he'd had a seizure in December of 2002, had an abnormal EEG, and was started on dilantin for seizure control. JM had been started on intravenous immunoglobulin for



Janet Callahan, PT
physical therapist

treatment of his CIDP that was thought to be somewhat effective.

JM was now 19 years old and walked into the PT clinic with his cane, holding his mother's hand. During this visit, as a result of in-depth questioning, JM characterized his falls as more like total collapses, occurring suddenly and without warning. The onset of falls was unpredictable and there did not seem to be any discernible provoking factors. The only common factor seemed to be a response to being startled. JM could collapse while standing still if he was surprised. This had occurred at least twice in the hospital elevators. Injuries were generally minor, consisting of black eyes, lacerations to his face and extremities, or multiple bumps and bruises. This new information about his fall behavior caused me to think JM's falls were not simply due to a loss of balance. I performed

a re-evaluation that revealed hyper-reflexia, mild left-extremity weakness, moderate scapular weakness, and ineffective postural response strategies. Also, upper-extremity weight-bearing during transitional movements was accompanied by a postural tremor of the trunk/scapular musculature.

At this point, JM's falls did not appear entirely consistent with a diagnosis of CIDP. Typically, balance deficits associated with a severe sensorimotor polyneuropathy are characterized by increased sway when attempting static postures and frequent small steps to re-establish the base of support as needed. The stepping strategy remains intact although sometimes ineffective. Falls most often result from tripping due to foot drop (weakness) or diminished dorsiflexion in gait resulting from timing deficits associated with the sensory impairments.

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Exemplar

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JM's balance deficits were most significant for an exaggerated proximal jerking motion in the absence of small increases in ankle motion to control small amounts of sway.

I discussed these inconsistencies with JM and his mother to help them understand the intended course of treatment. My concern surrounding the inconsistencies made me wonder if a traditional approach would adequately address his falls. I thought it was reasonable to expect some improvement in balance and strength as his limited function over the past three years would have resulted in a great deal of secondary weakness and self-imposed limitations. Once these had been addressed it might be easier to delineate the underlying deficits.

They were both agreeable to my plan to try to improve his situation, but I felt it only fair to admit my concerns and uncertainty at the outset.

In an attempt to improve JM's tolerance for movement, we began working on balance re-training and strengthening his hips and scapular musculature. He demonstrated improvements in strength that I had anticipated as he had become quite deconditioned from a total lack of exercise. During this time I had been actively discussing his case with a clinical specialist and had arranged a consultation for a subsequent visit. As treatment continued, JM began tolerating increased amounts of sway in his stance, and I encouraged him to self-initiate perturbations to his balance by shifting his weight forward and backward from heels to toes. I felt that self-

perturbations would minimize the element of surprise and allow JM a sense of control, enhancing his ability to push his limits of stability.

During one visit, as he initiated a posterior sway, he suddenly collapsed, without any warning or protective balance responses. Fortunately, his mother and I were able to support him and prevent any injury. The most interesting part of this event was what occurred while he tried to regain his footing. His motor behavior became characterized by a rapid succession of total-body rhythmic jerks involving his trunk, extremities, and head. His behavior appeared almost seizure-like, but JM was totally conscious and afterward able to describe his perception of the event as a feeling of trying to make his muscles work but not being able to get them to contract. He and his mother confirmed that this was a typical fall for JM but that he usually hit the floor before being able to try to regain his footing. Other family members had observed these jerking motions in the past.

These falls were not typical of a loss of balance due to CIDP but possibly the result of some as yet unexplained central nervous system (CNS) dysfunction. I had known there was something unusual about his falls, but witnessing

this event first-hand encouraged a whole new line of thought. Was this seizure-like behavior? Was there a physiological change at the level of the neuromuscular junction? I had many questions but no answers. I e-mailed JM's neurologist and described the event and elucidated my concerns. He appreciated the feedback as he had never witnessed one of these falls either.

JM's co-visit with the clinical specialist occurred at his next appointment. My hope was that a fresh set of eyes might help identify impairments I had overlooked that would explain JM's problems. Unfortunately, there were no new revelations regarding JM's condition. The possibility that a psychiatric disorder might be underlying his behavior was raised. Although this had been a part of my 'rule-out' process, I

didn't feel I had adequately investigated all aspects of JM's problems yet to default to that explanation. The suggestion was made to employ a lite-gait device (a body-weight support system) as a safety tool and videotape JM's performance. This would allow many more eyes to observe his fall behavior and hopefully see some similarity to something they had seen in the past. JM was amenable to this plan so we arranged a videotaping session for his next visit.

The session was fruitful in that we were able to destabilize JM adequately enough to replicate his 'collapse' and rhythmic jerking behavior four or five times. I showed the tape to a number of clinical specialists and to JM's neurologist. Unfortunately, no one had seen behavior quite like this before. His

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The Yvonne L. Munn Nursing Research Award

The Center for Clinical & Professional Development is now accepting proposals for The Yvonne L. Munn Nursing Research Award.

Proposals must be received by February 15, 2004, in order to be eligible for the 2004 award.

Recipients receive a \$1,500 grant to fund their research studies.

Eligibility requirements and guidelines for proposal development are available in The Center for Clinical & Professional Development on Founders 6.

For more information, contact Brian French at 4-7842.

The Employee Assistance Program Work-Life Lunchtime Seminar Series presents

"Holiday Resource Table"

We all look forward to the holidays as a time to celebrate and enjoy. But it can also be a stressful time as we deal with conflicting feelings and demands.

Visit the Holiday Resource Table for information and suggestions on how to manage holiday stress, set realistic goals, and take better care of yourself at this time of year.

**Tuesday, December 4, 2003
11:00am-1:00pm
MGH Eat Street Café**

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

Respiratory therapists: an integral part of the patient care team

—by Dean Hess, RRT, assistant director,
Respiratory Care Services

There are more than 120,000 respiratory therapists in the United States.

About 80 of them practice at MGH. Respiratory therapists are licensed clinicians who evaluate, treat, and care for patients with breathing disorders. About half the RRTs at MGH have baccalaureate or graduate degrees and have completed Advanced Cardiac Life Support training; some have completed the Neonatal Resuscitation Program and Pediatric Advanced Life Support. Respiratory therapists are an integral part of the patient care team at MGH and their responsibilities are diverse. Although their

clinical activities are greatest in the intensive care units, respiratory therapists' skills are utilized in virtually every clinical area of the hospital. Respiratory therapists are involved in adult, pediatric, and neonatal care. They are present in the hospital

24 hours a day, every day of the year.

Mechanical ventilation and airway management

Much of the clinical work of respiratory therapists at MGH revolves around the care of mechanically ventilated patients. Respira-

tory therapists' responsibilities include selection of appropriate settings on the ventilator, monitoring the patient's response to mechanical ventilation, and interacting with other health-care professionals related to the respiratory care of patients. In some instances, noninvasive ventilation is provided using a facemask rather than an artificial airway. For babies transferred to MGH on a ventilator, respiratory therapists are involved in stabilization at the outside hospital and transfer to our Neonatal ICU.

Respiratory therapists are very involved in the care of artificial airways (endotracheal tubes and tracheostomy tubes). This includes intubating the airway, assisting physicians with intubation, monitoring the tube for proper function and placement, and changing tracheostomy tubes when necessary. Airway care involves procedures performed by respiratory therapists to remove mucus from the patient's lungs.

Specialized gas delivery

Respiratory therapists occasionally administer specialized gases to patients. These include nitric oxide and heliox. Nitric oxide is administered by inhalation to improve the blood oxygen levels of patients with respiratory failure. The use of inhaled nitric oxide is approved by

the FDA for use in full-term babies. It is also used in select adult patients with severe respiratory failure. Heliox is a mixture of oxygen and helium. It is used in the care of patients with severe asthma or those with a partial obstruction of their upper respiratory tract.

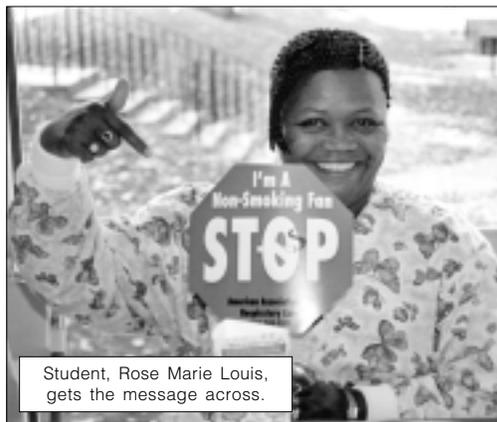
Bronchoscopy assistance

Bronchoscopy is a procedure performed by a physician in which a small tube is inserted into the lungs to observe abnormalities and remove mucus. Respiratory therapists assist physicians by preparing the patient and equipment prior to the procedure, monitoring the patient during the procedure, and caring for the patient and equipment after the procedure.

Extracorporeal life support

Extracorporeal life support is used for infants (and some adults) who have severe respiratory failure. Blood is removed from the body via catheter; oxygen is added to the blood, carbon dioxide is removed from the blood, and the blood is returned to the patient through another catheter. This procedure is lifesaving for some patients. During this procedure, which often lasts for days or weeks, a respiratory therapist is present at all times to

continued on next page



Student, Rose Marie Louis, gets the message across.



Respiratory therapist, Jesslyn Lenox, RRT (right), explains airway management to passer-by.

Respiratory Care Week

continued from previous page

care for the patient and ensure proper adjustment of equipment to meet the needs of the patient.

Asthma education

The incidence of asthma has increased in recent years. Respiratory therapists provide education for many asthma patients in the Emergency Department or following admission to the hospital. This includes instruction in the recognition of asthma triggers, the correct use of inhalers and other breathing medicines, and the importance of monitoring peak expiratory flow. The asthma education program provided by the Respiratory Care Department is an integral part of the care provided for these patients.

Educational and consultative responsibilities

The Respiratory Care Department provides clinical education for the respiratory care program at Massasoit Community College. The department provides educational experiences in respiratory therapy for practicing clinicians, including therapists and physicians from around the world. There is a very active continuing education program within the Respiratory Care Department to maintain the

clinical expertise of staff.

Much routine respiratory care such as aerosol drug delivery and oxygen-administration is provided by nurses. Respiratory therapists frequently serve in a consultative role to assist with specific issues that arise in the care of these patients. Respiratory therapists provide formal and informal teaching to many disciplines throughout the hospital, including nurses and physicians.

The Respiratory Care Department is actively involved in providing physician education, particularly for residents and fellows. Respiratory therapists frequently interact with physicians during patient rounds and scheduled conferences. The Respiratory Care Department is intimately involved in teaching the principles of mechanical ventilation to physicians in training.

Research and other academic activities

The Respiratory Care research laboratory is actively involved in the study of many new approaches to respiratory care. These include techniques of mechanical

ventilation, aerosol therapy, and others. Several physicians from other countries are currently working as research fellows in the respiratory care laboratory. Opportunities are also available for respiratory therapists to participate in research in a laboratory setting.

The Respiratory Care Department at MGH is recognized as one of the foremost academic departments in the country. Many scientific papers are written by members of the Respiratory Care Department and published in the peer-reviewed literature every year. Members of the department speak at conferences across the country and around the world. Many textbooks used in respiratory therapy educational programs have been written

by members of our department. Several members of the department hold faculty appointments at the Harvard Medical School.

Community and professional service

Members of the Respiratory Care Department are active in the community. Each summer, respiratory therapists plan and direct an asthma camp in conjunction with the American Lung Association. Respiratory therapists plan an annual summer picnic for patients who have received extracorporeal life support therapy at MGH. A team of respiratory therapists from MGH participated in a golf tournament to provide scholarship money for students interested in becoming respiratory therapists. Respiratory therapists at MGH are active in

professional societies, locally and nationally. Several therapists are active in the Massachusetts Society for Respiratory Care. Others have been active at the national level, including a former president of the National Board for Respiratory Care.

Respiratory Care Week

Staff of the Respiratory Care Department hosted an information table in the Central Lobby during Respiratory Care Week, October 20-22, 2003. Information was available on asthma education, sleep apnea ventilation, and smoking and pulmonary disease. Staff performed pulmonary function screenings and showed a video created by Michael Underwood, RRT. These activities were coordinated by Pam Brown-Early, RRT, and other staff members.



Respiratory therapist, Neila Altobelli, RRT (left), performs pulmonary function test as students (l-r), Connie Labady and Dieula Francois, look on.

Hospital Fun

Halloween spirit is alive and well at MGH



NICU



Blake 4 Endoscopy



Trick-or-treaters rest in the Warren Lobby

Exemplar

continued from page 11

neurologist concurred that the nature of his falls and the rhythmic jerking was probably not consistent with a conversion type disorder and that this behavior was not typical for patients with CIDP. He requested a copy of the tape to show to other neurologists in an effort to find an explanation.

I wish I could say that our work together has proved beneficial in delineating the cause of JM's falls and more importantly in identifying an effective treatment modality. Unfortunately, at this time, I cannot. Experience has taught me that many of the motor-control problems we observe as a result of CNS dysfunction are not diagnosed by standard methods. As a PT, I am in the unique position of being able to collaborate with JM's neurologist and chronicle JM's motor behavior to provide him with information that might ultimately help in identifying the cause of his specific problems. Experience has afforded me the ability to recognize that my role is a multi-faceted one and that there are innumerable opportunities for me as a PT to use my expertise in motor control to help individuals in many different ways.

JM has started at-

tending college but needs to hold someone's hand as he walks from class to class. He has obtained information about how to get a wheelchair if he feels his risk of injury is too great. We continue to work together to try to maximize his control and independence, and hopefully help him maintain his sense of dignity.

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

Janet's significant knowledge and years of experience inform her care of this patient at every step. Her treatment is thorough and compassionate. Instinct tells her to question the diagnosis; she looks at JM and his symptoms and intuitively knows something beyond the original diagnosis is at work. Janet is confident enough in her own practice to seek consultation from other clinical specialists. She uses every resource available to her, including videotaping JM's behavior, to allow all members of the team to observe his falls. She informs JM's neurologist of her findings and suspicions to ensure continuity of care across disciplines.

Though the cause of JM's problems remain unclear, I'm confident that Janet will continue to be vigilant in exploring every possible treatment.

Thank-you, Janet.

Eat Street Café



Same Day Surgical Unit



Psychiatric CNSs implementing creative solutions in the ED

—by MaryJo Cappuccilli, RN; Gail Leslie, RN; Tricia Mian, RN; and Suzanne O'Connor, RN

Interesting things are happening in advance practice psychiatric nursing within the Emergency Department. Long a mainstay of patient and family care, the psychiatric clinical nurse specialist's work is increasingly focused on managing high patient volume and longer waiting times, improving access to care, and strengthening family-centered care.

The development of the advance practice nurse Urgent Care Clinic (UCC) within the Acute Psychiatry Service (APS) allows patients in need of rapid psychiatric evaluation and treatment to be referred by their primary care physicians and be seen quickly in a sched-

uled appointment. UCC has improved access for people who don't necessarily need emergency care but do need an urgent evaluation and can't wait for a scheduled outpatient appointment. Gail Leslie, RNCS, and clinical supervisor, Larry Park, MD, chief of APS, coordinate services for this urgent-care population.

Patients are evaluated by Gail Leslie and prescribed medication, if needed, or instructed to continue with their existing medication. The one-to-three session treatment provides a 'bridge' for patients to sustain continuity of care and lessen their anxiety about waiting for longer-term treatment. The focus is on facilitating patients'

referral to ongoing psychiatric care after timely evaluation. Staff from primary care, the health centers, and specialty clinics refer patients with urgent psychiatric needs, and the UCC also provides interim care to patients newly discharged from the Blake 11 inpatient Psychiatry Unit and the Psychiatric Consult Service. The goal is to ensure continuity of care as patients wait for follow-up appointments.

Family-centered care has always been a guiding value in the ED. The role of psychiatric clinical nurse specialists in the ED consists largely of direct care to patients and families in crisis. When research demonstrated that the presence of family members during resuscitation and invasive procedures was of benefit to families, Tricia Mian, RNCS, working with interested staff nurses, and David Tancredi, ED attending physician, developed a

EMERGENCY



ED Psychiatric CNSs (l-r): Suzanne O'Connor, RN; MaryJo Cappuccilli, RN; Tricia Mian, RN; and Gail Leslie, RN;

protocol to allow families to be present during resuscitations and invasive procedures. Their research study to understand ED nurses and physicians' attitudes toward families being present was awarded the Yvonne Munn Nursing Research Grant. Data from this year-long study, which was also geared to determine if education or clinical experience would influence these attitudes, is currently being analyzed. The ED has instituted a pilot program where families accompanied by a psychiatric CNS or trained staff nurse have been present during resuscitations and invasive procedures. Family members have expressed appreciation at being able to see, touch, and talk to their loved ones during these critical times. Some ED staff who had concerns

about family members being present initially have reported a shift in attitude after being part of these clinical experiences. One theme echoed over and over by families is the recognition of the efforts of ED staff who worked so hard to save the patient. Seeing the commitment and determination of caregivers was a great comfort to families in their grief.

The ED Ethics Forum was initiated by MaryJo Cappuccilli, RN, in response to staff recognition of a need for models of ethical decision-making that take into account the unique dynamics of a high-volume, high-acuity emergency department. ED staff meet regularly to discuss such topics as patient autonomy, life-sustaining treatment, decision-making, *continued on next page*

Staff contributing to creative solutions in the ED

Family Presence Research

Susan Warchal, RN
Susan Whitney, RN
Debbianne Shahidi, RN
David Tancredi, MD
Tricia Mian, RN, CS

Surviving Triage Island

Dianne Farley, RN
Joanne Joyce, RN
Brenda Parrelli, RN
Linda Redd, RN
Suzanne O'Connor, RN, CS

Palliative Care Committee

Elena Clifford, RN
Erin Croft-Graves, RN
Andra Diephus, RN
Tracy McPhee, RN
Tricia Mian, RN, CS
Claire Moore, RN
Mary Ellen Robertson, RN
Susan Warchal, RN
David Tancredi, MD
MaryJo Cappuccilli, RN, CS

ED Ethics Forum

Susan Warchal, RN, Chair
June Guarente, RN
MaryJo Cappuccilli, RN, CS

MGH Fingernail Policy

—by Paula Wright RN, BSN, CIC,
director, Infection Control Unit

You may not think of fingernails as a potentially dangerous health care threat, but in fact, with what we now know about hand hygiene, long and/or artificial fingernails can be potentially harmful in some clinical situations. For that reason, the Infection Control Committee recently approved a new policy addressing fingernail guidelines in the clinical setting.

In response to recommendations by the CDC in the 2002 *Guidelines for Hand Hygiene in HealthCare Settings*, an MGH Fingernail Policy was developed, which prohibits artificial and/or long natural nails to be worn by specific healthcare workers. It has been shown that healthcare workers with artificial and/or long nat-

ural nails are more likely to carry pathogens (organisms capable of transmitting infection) on their fingertips both before and after hand hygiene. The policy, was reviewed by Human Resources, the Patient Care Services Executive Committee, and the Infection Control Committee. The new policy is posted on the MGH Infection Control website at <http://phsweb3/icu/> and in *The Green Book, An Employee Health and Safety Guide*, which is distributed to new employees.

Implementation of this policy is timely as we approach the January, 2004, date for compliance to JCAHO Patient Safety Goal # 7: "Reducing the Risk of Hospital-Acquired Infections." Improving hand hygiene continues to be a priority at MGH.

Employees affected by the policy include:

- direct patient-care providers
- employees who handle or prepare medications
- employees who handle blood, body fluids, or tissues, and who have patient contact.
- employees who handle or reprocess equipment or instruments
- food service workers

The Policy

- Artificial nails *may not* be worn.
- Nail jewelry *may not* be worn.
- Natural nails must be well maintained, clean, and short (no longer than ¼ inch long).
- If nail polish is worn, clear polish is preferred. Nail polish must be maintained regularly so that it is not cracked, chipped, or scratched.

For more information, please contact Infection Control at 6-2036.

Clinical Nurse Specialists

continued from previous page

pain-management for addicted patients, and allocation of resources

The ED Ethics Forum spurred two 'spin-off' projects also coordinated by MaryJo Cappuccilli. The first is the ED Palliative Care Guidelines, which were written to educate ED staff about how to provide the best care to patients making treatment decisions at the end of life. The guidelines are used to stimulate interdisciplinary discussion about issues such as pain- and symptom-management, advance directives, communicating with patients to clarify values, learning about resources, and enhancing collaboration within MGH treatment areas.

The second project is a multidisciplinary task force to identify patients, who because of complex medical issues or poor coping skills, are unable to manage their care effectively on their own. The purpose of the task force is to collaborate with patients and their care providers in the community to meet care goals more effectively.

Psych CNSs are acutely aware of the increased volume and long waits in emergency departments around the country. To enhance the skills of MGH staff in handling patient stress while waiting, Suzanne O'Connor, RNCS, coordinated several workshops for staff entitled, "How to Survive Tri-

age Island." Several expert triage nurses, along with Suzanne, provided helpful strategies to reduce anxiety, improve communication and set realistic expectations for patients, families, and staff. Staff have learned many creative ways to gain trust and cooperation, maintain safety, and diffuse stress. One important strategy is taking advantage of the many, varied resources available in the ED to help manage patients waiting for long periods of time. Because of the success of this program in the ED, Suzanne O'Connor presented the triage workshop at the Boston Consortium of Emergency Nurses.

These are just some of the challenges and innovations being explored by advance practice psychiatric nurses in the ED.

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Publisher

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

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Distribution

Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

Submission of Articles

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

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Next Publication Date:

December 4, 2003



MGH celebrates National Surgical Technologist Week

—by Ted Todd, surgical technologist

On Thursday, September 25, 2003, a standing-room only crowd of perioperative nurses from the Main OR and Same Day Surgical Unit gathered in the Potts Conference Room to acknowledge and celebrate MGH surgical technologists.

The program began with presentations by

April Cheney, ST; Deb DiNuzzio, ST; Cindy McLernon, CST; Ataquay Peters, ST; and Paula Rooney, ST, surgical techs who had attended the National Conference of the Association of Surgical Technologists in New Orleans last May. Each individual shared a different aspect of the con-

ference, and all reports were very well received.

Everyone enjoyed a sumptuous breakfast and tokens of appreciation were distributed to surgical techs in recognition of their contributions to the care of patients at MGH. Techs used the occasion to express their appreciation to their colleagues

in the instrument rooms and the Endoscopy processing areas.

Jeanette Ives Erickson, RN, senior vice president for Patient Care was in attendance. Ives Erickson congratulated surgical techs on their many achievements and remarked that surgical techs were all but 'invisible' a decade ago. She applauded the considerable advancement of the profession and the fact that surgical techs are now considered an integral

part of the surgical and perioperative teams.

Later in the day, box meals and two enormous cakes were delivered to surgical techs so that those working the later shifts could enjoy the celebration.

To capture the moment on film, surgical techs gathered for a group photo on the Bullfinch lawn.

The MGH community joins Ives Erickson in acknowledging the important work of MGH surgical techs.



MGH surgical technologists on the Bullfinch steps

Educational Offerings

November 20, 2003

When/Where	Description	Contact Hours
December 1 and 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
December 1 7:00am–12:00pm	CVVH Core Program VBK 601	6.3
December 1 1:00–2:30pm	Conflict Management for OAs and PCAs VBK 601	---
December 2 8:00am–4:30pm	Chemotherapy Consortium Core Program Wolf Auditorium, NEMC	TBA
December 3 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements Clinics 262	1.8
December 4 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
December 4 1:30–2:30pm	Nursing Grand Rounds “Ethical Dilemmas in Clinical Practice: a Case Presentation.” O’Keeffe Auditorium	1.2
December 5 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
December 5 8:00am–4:00pm	Managing Patients with Psychiatric Illness in the General-Care Setting O’Keeffe Auditorium	TBA
December 8 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
December 10 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
December 10 8:00–11:45am	Intermediate Arrhythmias Haber Conference Room	3.9
December 10 12:15–4:30pm	Pacing: Advanced Concepts Haber Conference Room	4.5
December 11 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
December 11 1:30–2:30pm	OA/PCA/USA Connections “Teamwork.” Burr Conference Rooms 5 & 6	---
December 12 8:00am–4:30pm	Coronary Syndrome O’Keeffe Auditorium	TBA
December 12 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
December 15 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
December 17 and 8 8:00am–4:30pm	Advances in Caring for Polytraumatized Patients O’Keeffe Auditorium	TBA
December 18 1:00–2:30pm	The Joint Commission Satellite Network presents: “Performance Improvement: Achieving Results.” Haber Conference Room	---

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>.

Some holiday gift ideas for children

The following list was compiled by our pediatric care team and is provided as an aid to holiday shopping for children. Some suggestions for age-appropriate gifts include:

1-3 years old

- Picture books
- Blocks
- Balls
- Dolls or puppets
- Toy kitchens with dishes
- Riding toys
- Thick, non-toxic crayons and paper

3-5 years old

- Dolls
- Dress-up clothes

- Puzzles (25-35 pieces)
- Books
- Wipe-off boards, chalk boards, etc.
- Paint, paper, glue, crayons, coloring books, child-safe scissors, stamp pads, stickers
- Musical toys and instruments
- Cassettes and CDs
- Card games
- Wagons, tricycles, and other riding vehicles (helmets are important at this age too!)

6-8 years old

- Books (and books with cassettes)
- Subscription to children's magazines

- Craft or science kits
- Puzzles (50-100 pieces)
- Computer toys, games, and software
- Bikes (helmets are a must!)
- Sports equipment
- Board and card games
- Watches
- Trucks and dolls

9-12 years old

- Books
- Craft kits, science kits and models
- Sports equipment
- Construction sets or Lego type blocks
- Puzzles (100+ pieces or 3D)
- Games requiring strategy, concentration and skill

- Computer games and software
- Bikes, scooters (helmets a must at this age!)

Toys should be colorful, well constructed,

and durable, and above all safe. Be certain when purchasing toys to make sure they are made of non-toxic materials. Most of all, enjoy playing with your children over the holidays.

Annual Holiday Celebration and Gift-Giving Event

The PCS Diversity Committee will hold its annual holiday celebration on December 11, 2003. Come learn about the many different holiday traditions around the world.

The committee will also hold its annual Gift-Giving Event for families of the HAVEN program and MGH health centers. If you would like to participate by 'adopting' a family for holiday gift-giving, please contact Beverley Cunningham at 4-6225 or e-mail: bcunningham2@partners.org. (Please include the number of people who will be participating from your area and the size of the family you can accommodate.)

Spread the joy!



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