October 2, 2003

Caring HEADLINES

Revere Health Center offers therapy with a view!

—by Rebecca Fishbein, PT, OCS, and Jane Evans, OTR/L

On Monday, September 8, 2003, MGH Physical and Occupational Therapy Services officially opened their newly renovated clinical space at the MGH Revere HealthCare Center. On hand to celebrate were, MGH president, Peter Slavin, MD; chief medical officer for the MGPO, Gregg Meyer, MD; senior vice president for Patient Care, Jeanette Ives Erickson, RN;

continued on page 4

Physical therapist, Ellen Tighe Ventola, PT, works with patient, Edith Sartorelli, in one of the new examination rooms at the Revere HealthCare Center. A calming ocean view adds to the therapeutic experience.

Inside:

MGH Patient Care Services

Working together to shape the future

An update on the hospital's strategic plan

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

MGH is constantly engaged in some form of strategic planning—whether it's identifying opportunities to improve care, implementing new initiatives, or monitoring existing programs and services. We engage in these efforts to ensure that we're providing the highest quality care to our patients, and to maintain a competitive edge in the healthcare marketplace.

Shortly after Peter Slavin, MD, assumed the role of MGH president in 2003, he and David Torchiana, MD, the newly appointed chief executive officer and chairman of the MGPO, embarked on a new strategic planning process. Anne Dubitzky, vice president of Managed Care Contracting & Marketing for MGH and the MGPO, and Allison Rimm, vice president of MGH External Affairs, are spearheading the initiative.

To ensure continuity with previous planning efforts, the Steering Committee re-visited the strategic plan put forth in 1995. They assessed the current reality to get a sense of what factors were impacting our human, clinical, and financial resources. That assessment showed that:

- the hospital is nearly full (inpatient beds, ORs, and the ED)
- outpatient practices are at or near capacity
- inpatient volume for the first quarter of fiscal year 2003 was below budget and nearly flat (versus fiscal year 2002) largely due to capacity restraints
- federal and state budgets are creating serious downward revenue pressure
- there have been double-digit premium increases for private insurance
- employers are distressed about premium increases and are consequently shifting costs to employees
- there is a strong focus, both internally and externally, on quality and safety

On May 15, 2003, a strategic planning leadership retreat was held to discuss ways that MGH can continue to provide high-quality care and services in a cost-effective way, without compromising quality or safety. Many constructive ideas came from that retreat, which helped sharpen the focus of our strategic-planning direction. The new focus became to develop clinical strategies that allow us to:

- better meet the needs of our patients
- maintain and enhance clinical excellence
- improve quality and patient safety
- achieve our margin targets

Toward that end, a number of task forces were formed and charged with generating proposals for specific strategic initiatives to help achieve our goals. The seven strategic planning task forces and their primary charges are:

The Clinical Growth Task Force (chaired by Peter Slavin, MD, and David Torchiana, MD):

- Develop a proposal for an optimal service-mix strategy balancing patient care priorities, financial concerns, opportunities to deliver services in community-based locations, and the most appropriate use for limited main-campus capacity
- Develop a plan for optimal use of campus assets
- Recommend the optimal size and reach of MGH clinical activities
- Develop a strategy for off-campus clinical program-development

The Quality & Patient Safety Task Force (chaired by Jeanette Ives Erickson, RN, Gregg Meyer, MD, and Brit Nicholson, MD):

- Develop strategic initiatives that distinguish MGH on the basis of quality and safety.
- Update priorities for The Office of Quality & Safety
- Set clear quality and safety goals
- Determine how to measure quality

The Clinical Innovation Task Force (chaired by David Rattner, MD):

- Identify clinical innovations that could affect the way MGH delivers care over the next several years
- Identify next-generation clinical innovations that will shape the future of health care
- Identify processes by which clinical innovations can become a systematic part of the way the MGH functions

The Expense Management Task Force (chaired by Jean Elrick, MD, and Sally Iles):

- Develop plans to eliminate $15 million from the MGH cost base in fiscal year 2004 by focusing on product-standardization and opportunities for process-improvements, streamlining workflow and documentation, etc.

continued on page 7

REMINDER!

The Staff Perceptions of the Professional Practice Environment Surveys must be returned by October 24, 2003.

If you have not received a survey, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are confidential. Please complete and return your survey by October 24th.

Your voice is important!

Confidentiality and performance-improvement

Question: I know our policies on patient confidentiality and HIPAA regulations prohibit inappropriate discussion of patient information? Does that include casually talking about a patient while waiting in line in a public area?

Jeanette: Yes, it most certainly does. Information about patients is highly confidential. All employees have received HIPAA training and should understand the importance of safeguarding health information. Clinicians should never discuss patients in areas such as elevators, the cafeteria, or waiting in line. Clinicians are responsible for ensuring the privacy and security of all patients and their health information.

Question: Where can I refer people for more information on HIPAA regulations and our policies on confidentiality?

Jeanette: Eileen Bryan is the MGH HIPAA privacy and security manager. She can be reached at 6-6360 or by e-mail. Eileen is responsible for issuing the HIPAA*lerts* in All User Messages. Confidentiality policies can be referenced in the Human Resources and Clinical Policy and Procedure Manuals, found on-line at http://healthcare.partners.org/mgh/policies/default.htm.

Question: I recently saw a flier describing a new performance improvement approach at MGH. Can you tell me more about this?

Jeanette: MGH has introduced a new Performance Improvement Standards Goal to ensure that we are designing processes in the best possible way, and that we systematically monitor, analyze, and improve performance to ensure continuous improvement in patient outcomes. What's new about this standard is the approach, or method, we're using to improve performance. It is a clearly delineated process of design, monitoring, analysis, and improvement that focuses on sustaining improved performance.

Question: Everyone uses a different language when talking about performance improvement. Why does it have to be so confusing?

Jeanette: That is an excellent question. Experience has taught us that having a common language with which to communicate about quality encourages teamwork and increases success. MGH has always had a strong commitment to performance-improvement, especially as it relates to patient care. Now we do have a common language with which to talk about our performance-improvement efforts.

PDCA is an acronym that stands for Plan, Do, Check, Act, the four phases of our performance-improvement approach. The PLAN phase is comprised of: identifying an opportunity for improvement; selecting a team of stakeholders to participate in the project; quantifying the current performance level; analyzing the root causes; setting measurable goals to monitor the success of the project; and developing a plan for improvement.

The DO phase is where we develop an implementation plan; identify resources; and pilot the proposed solution.

During the CHECK phase, we verify whether or not the solution is successful by analyzing the data collected in the PLAN and DO phases.

The ACT phase is when we standardize the solution; communicate the solution to others; and establish a plan for how to monitor sustained improvements.

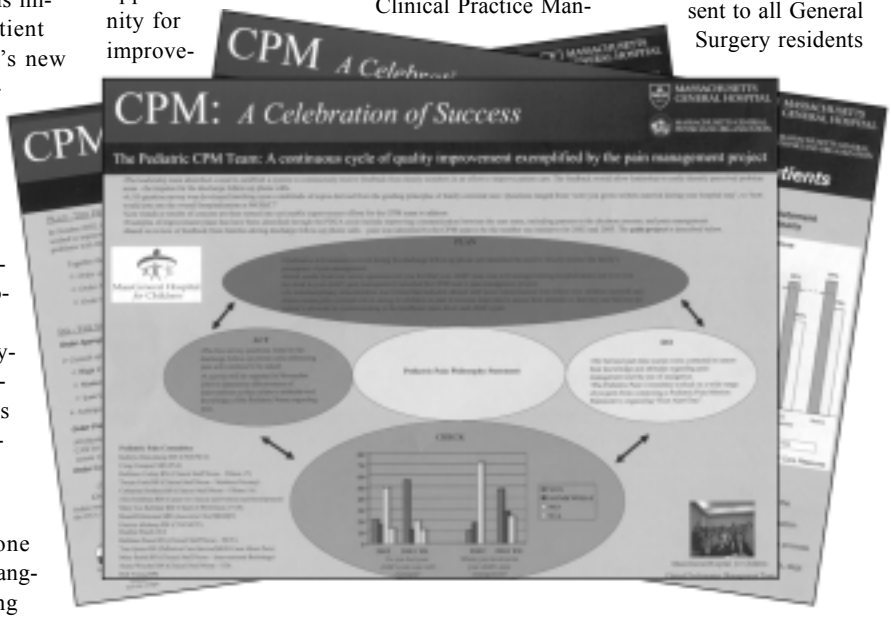
Question: Can you give an example of how PDCA works?

Jeanette: The Surgical Clinical Practice Management (CPM) team wanted to enhance the quality of practice life for clinicians. They conducted focus groups with nurses and residents to solicit ideas about how to improve their practice life. Through this process they discovered that improving communication between nurses and doctors via the page system would improve their quality of practice life (PLAN).

They updated and standardized PRN meds for sleep, pain, and post-op nausea in the POE templates; they developed nursing protocols for routine problems; they re-introduced The Problem List; and they set up monthly orientations for residents new to the Vascular and General Surgery rotation (DO).

Then they monitored the volume of text pages sent to interns for house and private surgeries; they reviewed text pages sent to all General Surgery residents for two weeks and asked nurses and residents for feedback on The Problem List (CHECK).

After that, they modified their existing approach, adding low-urine output to the list of nursing protocols to be developed, and they developed new paging guidelines (ACT).



Therapy with a View

continued from front cover

Revere mayor, Thomas Ambrosino; director of MGH Physical and Occupational Therapy Services, Michael Sullivan, DPT, and many happy therapists.

Marie Brownrigg, MS, PT, clinical specialist, recalls when the original practice space opened at the Revere Health Center eight years ago. PT and OT began as part-time practices sharing space with many other specialties. Increased demand resulted in expanded hours and services, and additional staff, but before long it became clear that more space would be required to adequately

continued on next page

(Photo by Paul Batista)

Above left: Physical therapist, Joanne Clifford, DPT, shows patient, Francis Puleio, the ropes at the new, expanded therapy area at the Revere Health Center.
Above: Occupational therapist, Carol Harmon Mahony, OTR/L, works with patient, Sean Whelan, taking full advantage of the waterfront view.
At left: Cutting the ribbon at the Revere HealthCare Center PT/OT Open House are (l-r): Peter Slavin, MD; Gregg Meyer, MD; Jeanette Ives Erickson, RN; Marie Brownrigg, PT; Roger Pasinski, MD; and Michael Sullivan, DPT.

Therapy with a View

continued from previous page

meet the needs of the Revere community.

Through the efforts of Roger Pasinski, MD, medical director of the Revere Health Center, Ives Erickson, and many others, the dream of a new therapy area became a reality.

The clinic overlooks Revere Beach, providing a scenic work area and a peaceful, soothing patient-care environment. Said occupational therapist, Suzanne Curley, OTR/L, CHT, "I was overwhelmed. The beautiful rooms and large space were universally applauded by patients, family members, therapists, and interpreters. I think the ocean view is therapeutic for patients and therapists alike."

Said patient, Joan Magno, "It's so beautiful! It doesn't compare with the old space. This is so bright and airy, and with the view of the ocean—I could live here!"

"It has been our hope to be able to expand rehabilitative services for patients in Revere and other north shore communities," said Sullivan. "This space affords us the opportunity to provide services closer to patients' homes improving access to care. Patients can now receive the same high-quality rehabilitative care in their own community without having to travel to the main campus in Boston. We're grateful for the support we received from MGH leadership. It's another example of the hospital's commitment to the communities we serve."

Along with the physical expansion, services have been expanded to offer two full evenings a week for patients with orthopaedic, neurological, post-surgical, and chronic conditions. The PT/OT Clinic is located at 300 Ocean Avenue in Revere. For more information, or to make an appointment, please call 781-485-6222.

The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

"Nourishing your Newborn"

Presented by Germaine Lambergs, RN

If you're an expectant parent, a new parent, or an imployee considering haveing children, come hear the latest tips and current information on breastfeeding.

Tuesday, October 14, 2003
1:00–2:00pm
VBK401

For more information, call the EAP at 726-6976.

Infection Control Week Awareness Fair

Sponsored by the MGH Infection Control Unit

October 21–23, 2003
11:30am–1:30pm.
East dining room

The Infection Control Unit joins The Association for Professionals in Infection Control and Epidemiology (APIC) in recognizing National Infection Control Week.

Please stop by our table to pick up the latest information on disease prevention.

Nurses, public invited to comment on IHP Graduate Nursing Program

As part of an accreditation visit by the National League for Nursing Accreditation, the MGH Institute of Health Professions Graduate Program in Nursing, invites public comment on issues such as curriculum, clinical sites, faculty, and the student experience. Comments may be submitted in writing, or in person on October 15, 2003.

E-mail comments to:
mchisholm@mghihp.edu
Fax comments to: 617-724-6321
or directly to the NLNAC at:
212-812-0390

The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

"Women and Depression"

Presented by Adele Viguera, MD

Clinical depression affects mood, mind, body, and behavior. Research shows that in the US, approximately 19 million people experience depression each year.

This session will address the unique causes and factors contributing to depression in women today.

Wednesday, October 8, 2003
12:00–1:00pm
Clinics Amphitheater

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

The ProTech Program

The ProTech program is recruiting departments and staff to share their job experience with small groups of students from East Boston High School. Visits will take place on the morning of October 29, 2003.

Open your doors to a young person interested in learning about health careers.

For information, please e-mail gkagan@partners.org or call the ProTech office at 617-724-8326.

The ProTech Program is offered through the MGH Community Benefit Office.

The Healing Arts Fair: Bridging our Communities through Art and Medicine

All members of the MGH family are invited to attend a unique art exhibit and talent show dedicated to the children who inspire us every day

Friday, October 3, 2003
5:30–8:30pm
Under the Bullfinch Tent

Come and enjoy the Nick Ressler Musical Instrument Library, the Child-Caregiver Tile Wall, children's crafts, book signings, art and music.

They don't call it healing arts for nothing!

Cool heads and quick wits contribute to life-saving care in the PICU

Steve Mason, RRT, respiratory therapist

My name is Steven Mason and I have been a respiratory therapist for 20 years at MGH, 15 of them in the Neonatal and Pediatric ICUs.

I had just arrived to work for the night shift and reported to my assigned area. Tonight it was the Pediatric Intensive Care Unit (PICU). As I got report from the previous respiratory therapist, he said, "Steve, we have a sick baby coming in via Coast Guard chopper. The Med-Flight helicopter is out of service, so the Coast Guard was the only option."

This was a baby our ground team had gone to pick up earlier in the day at an outlying hospital. Unfortunately, the baby's condition had deteriorated to the extent that ground transport was no longer an option; air return was the baby's best chance for survival. Upon completing report, I quickly went to the bedside and checked all the equipment to make sure it was in working order and ready to go when the baby arrived. I was informed that the transport team had just left the outlying hospital and would arrive at MGH in approximately thirty minutes. I completed some of my other work and went to the bedside of my new admit to wait for his arrival.

A few moments later I was told that the helicopter had just landed on the helipad and that the baby was on his way to the unit. Very shortly thereafter, the doors to the PICU opened and in wheeled our new patient, or what I could see of him. He was completely enmeshed in tubes and wires and other associated equipment. It was difficult to tell there was a baby beneath the 'spaghetti' of tubing. This is not an unusual way for sick babies to arrive on our unit.

After a brief stabilization, we prepared to move our new patient to his isolette, an important but potentially hazardous part of his admission to the unit. He was disconnected from his life support and moved to his warming table. I quickly set him up on a ventilator and stood back to observe his response. Initially, he did well with an oxygen saturation level of 97%. Unfortunately, that didn't last very long, and over the next thirty minutes his condition began to deteriorate. His oxygen saturations dwindled to 84% with little or no response to either conventional or manual ventilation.

It was at this time that the surgeon and fellow turned to me and said we'd better prepare this baby for ECMO (extracorporeal membrane oxygenation). They asked me to assemble a circuit as quickly as possible. I called another therapist to the bedside to relieve me, and I made my way to an empty room at the rear of the PICU to prepare the ECMO circuit for this baby. Another therapist joined me and helped me assemble the circuit as quickly as possible without making any costly errors that might spell doom for this baby in distress. A few minutes later one of the residents peeked his head in and asked us to hurry as the circuit was needed ASAP for this baby who was now rapidly deteriorating. I told him we were doing the best we could and that we'd be finished in just a few minutes.

A minute later the fellow peeked her head in and reiterated the urgency of the situation. I assured her I was fully aware of the urgency of the situation and asked her not to distract us from the task at hand.

We completed assembly, primed the circuit, and wheeled it to the baby's bedside. I prepared for the cannulation and attachment of the ECMO circuit to this critically ill infant whose oxygen saturations were now in the 20s. Chest compressions had been initiated secondary to cardiac failure. There was much commotion at the bedside as we plugged the oxygen and air hoses into the wall. The surgeon looked at me and calmly asked how I was doing and when we'd be ready to 'go on.' I told him it would be just another minute.

The baby was doing very poorly and needed ECMO now! I handed the cannulas to the surgeon who cut them away using sterile technique. He attached them to the special cannula protruding from the baby's neck. CPR was still being performed but that did not deter us. I slowly adjusted the pump flow on the circuit from 50 to 100 to 200ccs. After about a minute the baby's oxygen saturation level slowly started to climb. In the next fifteen minutes it reached an acceptable 89%. His heart rate normalized and compressions were stopped. We all looked at each other with a collective sigh of relief as this patient finally stabilized. I stepped back and wiped away the sweat that was dripping into my eyes.

Over the next several hours we continued to work on and stabilize this critically ill baby. All of his IV lines had to be switched over to the circuit, the heparin had to be titrated to an acceptable level, and the circuit flow had to be fine tuned to support the baby's oxygenation and cardiac output. I happened to catch a glimpse of the clock and noticed it was 5:00 in the morning. Gee, I said to myself, wasn't it midnight just a few minutes ago?

continued on next page

Exemplar

continued from page 6

When things settled down, the surgeon walked over to me and said, "Thanks for all your help, Steve."

"No problem," I said, half jokingly, "It's all in a night's work."

One of the PICU nurses approached me and said, "Nice job, Steve. That baby would have died if you hadn't been here." I just looked at her and shrugged in agreement. I didn't know how to respond to that.

Over the next several days the baby did well, but remained in critical condition. We were in wait-and-see mode as the outcomes of these 'crashing onto ECMO' scenarios are very uncertain. Amazingly, on day four, the baby showed signs of improvement. The circuit flows were weaned as his chest x-ray cleared. On day five, he was weaned off ECMO completely and put back on a conventional ventilator. The big question now was: What would this baby's neurological status be after such a severe insult to his system. We were very happy to observe a baby who opened both eyes, tracked well, and responded well to both verbal and tactile stimuli. It appeared that this lucky infant had not sustained any appreciable neurological damage at all.

The baby was weaned off the mechanical ventilator several days later. Both mom and dad were ecstatic at the progress their baby had made. They couldn't thank us enough.

It's through experiences like this that we learn to appreciate the value of life. The time I've spent in the pediatric arena has taught me that there's no resiliency or will to live like that of a newborn. Most people think newborns are fragile and need to be handled with 'kid gloves.' While this may be the case on some occasions, other times the opposite is true. I have observed this phenomenon many times while working in the world of pediatrics. While most people never see this side of the spectrum, it has been something I've observed and marveled at throughout my entire career.

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

Steve's level of comfort at managing this critically ill child and the complex technology required to support him are evident throughout this narrative. He remained calm and focused. He was attentive and responsive in this rapidly changing clinical situation. And when thanked for his 'heroic' efforts, his response was that it was all in a night's work.

Indeed, for a clinician of his skill and experience, it *is* all in a night's work. It's easy to see why he continues to find joy in his work in the pediatric arena.

Thank-you, Steve.

Jeanette Ives Erickson

continued from page 2

- Develop a plan to reduce the MGH cost base by $75 million over the next five years
- Set priorities for funding and implementing cost-reduction measures
- Develop expense-management tools to set targets and measure results

The New Business Opportunities Task Force (chaired by Jim Thrall, MD):

- Identify potential new lines of business
- Prioritize opportunities and recommend quick hits for early implementation
- Undertake study of long-term opportunities

The Optimal Use of Campus Capacity Task Force (chaired by Andy Warshaw, MD, and Rick Bringhurst, MD):

- Develop recommendations for length-of-stay reductions and other improvements in clinical operations focused on efficient use of campus resources
- Analyze patient-flow from operating room to bed-placement, and develop a model of optimal utilization to maximize bed capacity

The Workforce Issues Task Force (chaired by Nancy Gagliano, MD, and Marianne Ditomassi, RN):

- Define what it means to be the employer of choice
- Develop strategies to address current and projected workforce shortages
- Develop strategies to improve the quality of practice life for clinicians
- Address career-advancement for clinically focused faculty
- Address diversity and career-advancement issues

All task forces will present their proposals to the Steering Committee later this month and a time frame will be established to begin implementation of initiatives.

It's important to realize that strategic planning is not some distant process that involves just a few key decision-makers. Strategic planning affects everyone, and everyone has a vested interest in participating in the process. If you have ideas or suggestions related to any of the above focus areas, I encourage you to contact the appropriate chairperson(s) to make your comments known, or visit the strategic planning website at: http://is.partners.org/mghstrategicplan. And I will keep you informed as we move forward in our strategic planning efforts.

Update

I would like to take this opportunity to congratulate Michael Sullivan and the departments of Physical and Occupational Therapy on their wonderful new space at the Revere Health Center. This is the culmination of many years of hard work. I know this new therapy area will have an enormous impact on patients and staff alike as we continue to improve access to quality care in our communities.

National Depression Screeing Day

The Employee Assistance Program will offer free, anonymous, and confidential screenings to all MGH employees

Thursday, October 9, 2003

For information on times and locations, call the EAP office at 726-6976

Unit-based ethics rounds on Phillips 20 and 21

—by Gayle Peterson, RN

Marion Parker, RN, and I are staff nurses on Phillips House 20 and 21 respectively. Together we have 74 years of clinical nursing experience. Phillips 20 is a 20-bed medical unit. Phillips 21 transitioned recently from an ortho-neuro-medical unit to medical only. This change united Phillips 20 and 21 under one leadership triad, and this relationship has given staff a wonderful opportunity to share interests and collaborate on projects.

Marion and I are passionate about ethics and health care. When we learned that Ellen Robinson, RN, PhD, ethics clinical nurse specialist, had organized a program to educate staff about how to develop interdisciplinary ethics resources at the unit level, Marion, Beverley Cunningham, our operations coordinator, Shoshanna Savitz, our social worker, and I decided to attend.

The program, modeled after Dr. Terry Fulmer's program in geriatric care, is intended to create a model for recognizing unit-based individuals who can assume the role of 'first-line resources.' First-line resources are individuals who can assist fellow clinicians in identifying ethical issues, and help them employ preventive and early-intervention strategies. The program familiarizes unit-based staff with the network of ethics resources available at MGH.

Marion and I were inspired by the initial day-long workshop, and decided it would benefit both our units to establish a unit-based ethics forum. Our nurse manager, Keith Perleberg, RN, and clinical nurse specialist, Theresa Cantanno Evans, RN, shared our enthusiasm. Ellen Robinson and ethicist, Christine Mitchell, agreed to join us as coach and consultant. Shoshanna and Beverley were active participants in the planning process.

We all recognized that we're confronted with ethical issues on a daily basis. We were

continued on next page

Phillips 20 & 21 Ethics Rounds

October 9, 2003 (Phillips 20)
"Care of the Dying Patient"
presented by:
Connie Dahlin, Marion Parker, and Gayle Peterson

November 13, 2003 (Phillips 21)
"Advance Directives"
presented by:
Gayle Peterson and Theresa Cantanno Evans

December 11, 2003 (Phillips 20)
"Religion at the End of Life: Cultural Differences"
presented by:
Beverley Cunningham and others TBA

January 8, 2004 (Phillips 21)
"Post Mortem Care"
presented by:
Marion Parker and Gayle Peterson

February 12, 2004 (Phillips 20)
"Working with Family Conflict at End of Life"
presented by:
Ellen Robinson and Shoshanna Savitz

March 11, 2004 (Phillips 21)
"Leaving a Legacy"
presented by:
Betty Ann Burns-Britton and others TBA

April 8, 2004 (Phillips 20)
"Pain at End of Life: the Double Effect"
presented by:
Gayle Peterson and Ellen Robinson

May 13, 2004 (Phillips 21)
"Dignity"
presented by:
Keith Perleberg and Marion Parker

(all sessions are held from 12:00–1:00pm)

(L-r): Marion Parker, RN; Gayle Peterson, RN; Rosalie Tyrrell, RN; and Ellen Robinson, RN, listen as Betty Ann Britton, RN, and Janice Cameron-Calf, RN, present case at unit-based ethics rounds on Phillips 21.

MGH celebrates National Case Management Week

MGH celebrates National Case Management Week October 5–11, 2003. This annual event is an opportunity to recognize case managers and provide information to the hospital community and the public about the important role they play in delivering patient care. The theme of this year's celebration is 'collaboration.'

Several activities are planned, including an educational booth in the White lobby staffed by MGH case managers. The second annual Case Management Change Show will be held on October 9th at 3:30pm in O'Keeffe Auditorium. All staff are welcome.

On October 30th, from 12:00–100pm, an educational program entitled, "Case Management: What it is and What it is Not," will be presented by MGH Emergency Department case manager, Peter Moran, RNC, BSN, MS, CCM. Moran is the national vice president of the Case Management Society of America (CMSA) and chair of the CMSA Industry Council. The presentation will be held in O'Keeffe Auditorium. All are welcome. For more information, call 6-3665.

MGH case managers

(Photo by Paul Batista)

Ethics Rounds

continued from previous page

eager to bring our interests and concerns to this complex subject. We started meeting in the spring of 2003, with rich discussions around the ethical concerns of staff. One discussion resulted in an important follow-up strategy that affirmed the importance of advocacy by nurses in our practice area.

We will continue to meet monthly and have put together a program for the academic year 2003-2004. Several sessions will address topics identified by staff, and CEUs will be offered. Other sessions will provide a forum for current and post-case discussion.

Meetings take place on Phillips 20 or 21, and all disciplines providing patient care on our units are welcome to attend. Any clinicians interested in observing our unit-based ethics rounds model are also welcome.

Marion, Beverley, Soshanna and I are pleased that so many of our colleagues share our interest in seeking optimal strategies, guided by ethical sensitivity through dialogue with our peers. It is satisfying to know that our efforts have resulted in the creation of a forum where staff can meet to discuss ethical concerns and explore creative solutions for our patients and their families.

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Managing Editor

Susan Sabia

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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.

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

Next Publication Date:
October 16, 2003

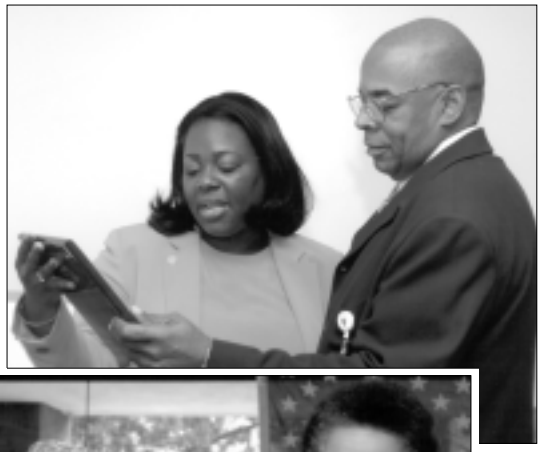
Annual AMMP scholarship awards and recognition luncheon

On Thursday, September 18, 2003, AMMP (The Association of Multicultural Members of Partners) held its annual scholarship and recognition luncheon in the Walcott Conference Room.

Chairperson, Loretta Holliday, presided over the event that included recognition of several AMMP members as well as the presentation of scholarships to:

- Ileana Arocho, on-call coordinator for Interpreter Services
- Judith Voufo, patient care associate on Ellison 12
- Steven Hernandez, senior attending technician in the Pharmacy
- Jennifer Kim, program coordinator, Partners Research and Ventures
- LaNeia Mahaffey, administrative assistant in The Clinical Research Center
- Jacqueline McNeil, budget analyst at the Institute for Health Policy

AMMP is committed to the recruitment, retention, development, and advancement of minority professionals throughout the organization and awards a number of scholarships each year to assist and support employees in continuing their education. For more information, visit their website at phsammp@partners.org.



(Photos by Abram Bekker)

Top: Ron Greene, RN, receives special recognition award from AMMP chairperson, Loretta Holliday.
Above: Scholarship recipient, Judith Voufo, patient care associate on Ellison 12 (and her son) with nurse manager Ann Kennedy, RN (left) and Deb Washington, RN, director of the PCS Diversity Program,
At left: Scholarship recipients (l-r): LaNeia Mahaffey, Judith Voufo, Ileana Arocho, Jennifer Kim, Jacqueline McNeil, and Steven Hernandez.

When/Where	Description	Contact Hours
October 15 1:30–2:30pm	**USA Educational Series** "Work-Related Injuries." Bigelow 4 Amphitheater	- - -
October 16 1:30–2:30pm	**Nursing Grand Rounds** "New Nursing Graduate Critical Care Program." O'Keeffe Auditorium	1.2
October 16 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Realizing the Vision: Effective Leadership." Haber Conference Room	- - -
October 17 8:00am–4:00pm	**CCRN Review Day I** O'Keeffe Auditorium	TBA
October 17 7:00–11:am and 12:00–4:00pm	**Congenital Heart Disease** Haber Conference Room	4.5
October 20 8:00am–12:00pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Wellman Conference Room	---
October 21 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
October 21 8:00am–4:00pm	**Intermediate Respiratory Care** Ellison 401	TBA
October 21 and 22 8:00am–4:30pm	**BLS Instructor Program** VBK601	- - -
October 22 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
October 22 4:00–5:30pm	**Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements** Clinics 262	1.8
October 23 1:30–2:30pm	**Nursing Grand Rounds** "Collaborative Governance." O'Keeffe Auditorium	1.2
October 23 8:00am–4:00pm	**CCRN Review Day II** Wellman Conference Room	TBA
October 23 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
October 24 8:00am–4:00pm	**Psychological Type & Personal Style: Maximizing Your Effectiveness** Training Department, Charles River Plaza	8.1
October 24 7:00am–12:00pm	**CVVH Core Program** VBK 601	6.3
October 24 1:00–2:30pm	**Conflict Management for OAs and PCAs** VBK 601	- - -
October 27 and 28 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: New England Medical Center. Day 2: (VBK607)	14.4 for completing both days
October 27 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)	- - -
October 30 1:30–2:30pm	**Nursing Grand Rounds** "An Overview of Case Management." O'Keeffe Auditorium	1.2
October 31 8:00am–4:30pm	**Wound Skin Care Update: 2003** O'Keeffe Auditorium	TBA

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

The Norman Knight Nurse Preceptor of Distinction Award

Through the generosity of Mr. Norman Knight, the MGH department of Nursing is pleased to announce the first annual award to honor staff nurses who serve as preceptors to other nurses.

The Norman Knight Nurse Preceptor of Distinction Award recognizes clinical staff nurses who consistently demonstrate excellence in educating, mentoring, and coaching fellow nurses; who are committed to the preceptor role, who seek opportunities as life-long learners to enhance their own knowledge and skills, and who work to create a responsive and respectful practice environment.

Nurses can nominate nurse colleagues whom they know to be strong educators, preceptors, mentors and coaches (to other nurses). Nomination forms will be available on all inpatient units and in The Center for Clinical & Professional Development on Founders 6.

Nominations are due by October 27, 2003.

The Norman Knight Nurse Preceptor of Distinction Award will be presented annually by Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Mr. Norman Knight for whom the award is named.

The first Norman Knight Preceptor of Distinction Award will be given on January 29, 2004. For more information, call The Center for Clinical & Professional Development at 6-3111.

The MGH Chaplaincy offers the blessing of the hands

In celebration of Pastoral Care Week, the Chaplaincy Department will offer The Blessing of the Hands on Wednesday, October 22, 2003. All patients, families, staff, visitors and volunteers are welcome.

The blessing will be offered in the MGH Chapel on Ellison 1
Wednesday, October 22, 2003
6:30–8:00am
11:30am–1:00pm
3:00–5:00pm

Blessing the hands with water is a gesture of grace. Because we use our hands to bring healing and hope to those in need, this blessing is a means of recognizing and reaffirming the true meaning of who we are. Whether we are typing words at a computer, preparing meals for our patients, checking blood pressure, or holding a newborn baby, our hands are instruments of healing and hope. The Chaplaincy offers this blessing as affirmation and appreciation for the many tasks our hands do to provide comfort and care for one another.

(Photo by Paul Batista)

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