April 7, 2005

Caring HEADLINES

Inside:

National Youth Leadership Forum: grooming nurses of the future

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Staff nurse, Amy Webster, RN, delivers bedside care to pediatric patient while student from the National Youth Leadership Forum looks on

MGH Patient Care Services

Working together to shape the future

A look at the complex issue of capacity management

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

Across the country successful hospitals, especially teaching hospitals, are struggling to balance quality patient care with today's unprecedented demand for healthcare services. Capacity management is the term hospitals use to describe their ability to admit, provide appropriate care to, and discharge patients in a timely, efficient manner. It may sound simple, but believe me, it's not.

Countless factors affect a hospital's ability to optimally utilize available resources, thereby moving patients through the system in a way that is both clinically and financially sound. Patient safety is always the primary consideration, but a host of other factors come into play. Bed availability, patient-specific needs, gender, medical rounds, scheduling, de-centralized resources, the ability to clean patients' rooms, as well as organizational policies and procedures, state-mandated regulations, and JCAHO standards, all influence a hospital's ability to manage the flow of patients through its doors. And those are just a few of the factors competing for consideration.

At MGH, there is a comprehensive effort under way to address the issues affecting capacity management. I'd like to tell you about some of the work going on, much of which falls under the scope of the Capacity Management Committee, which I chair with Rick Bringhurst, MD, as part of Dr. Slavin's Strategic Planning Initiatives.

Capacity management is the term hospitals use to describe their ability to admit, provide appropriate care to, and discharge patients in a timely, efficient manner.

In addition to exploring ways to optimize the use of existing rooms and facilities, we're looking at opportunities to utilize human resources differently in ways that favorably impact the flow of patients through the system. The Rapid Response Team is one example. The Rapid Response Team, an offshoot of the Central Resource Team, deploys highly skilled, broadly trained nurses to units to assist with short-term emergencies, transport critically ill patients, help with the admission process, and generally support staff to ensure smooth, efficient operations.

Nursing supervisors are another example. Nursing supervisors provide 24/7 coverage of the hospital, constantly monitoring and expediting the safe and efficient movement of patients as beds become available. In addition to a triage nursing supervisor and a resource nursing supervisor, there will soon be a non-ICU access nursing supervisor to facilitate placement of patients into non-ICU beds.

Capacity management is an ongoing, moment-by-moment process that requires the attention of every invested clinician and support staff member. To ensure that the best decisions are made to accommodate all patients, early reporting of bed availability is key. Our Admitting Department has implemented a proactive communication system to alert units about potential 'back-ups.' Color-coded reports are sent twice a day to apprise key personnel of the current status of patients waiting to be placed and bed availability.

There's no question that improved technology will have an enormous impact on our ability to move patients through the system safely and efficiently. Toward that end, we are exploring a new function in the Provider Order Entry (POE) system that will dramatically improve our ability to communicate imminent discharges. The POE Anticipated Discharge Communication function will allow more people on units (and in Admitting) to be aware of impending discharges, enabling more people to get involved with the discharge process. Being able to make this information available electronically in a timely fashion to a broad cross-section of staff will ensure that patients are placed where they will receive the best possible care at the earliest possible time.

Another technological advancement under consideration is an electronic bed-management system that would allow hospital-wide monitoring of bed availability. This project is still in the early stages, but we're looking forward to piloting the software as soon as it becomes feasible.

Another branch of work related to capacity management involves studying existing systems related to patient flow and identifying strategies to improve the discharge process. Again with patient safety as the prime concern, this group is looking at ways to

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Bar-coded wristbands: an important new safety initiative

Question: Is it true that MGH will soon be introducing a new patient wristband?

Jeanette: This summer, as part of a quality and safety initiative, MGH will introduce a new wristband specially designed for ease of reading and legibility. Beginning on June 1, 2005, all inpatient and procedural wristbands will be white (blue and red wristbands will no longer be used).

This change will lay the foundation for a variety of patient-safety initiatives in the future. The new wristbands will be bar-coded so staff will be able to scan patients' wristbands when monitoring glucose levels. Eventually, vital medical and health information, such as blood types and/or allergies, can be embedded in the bar-coding. Bar-coded wristbands could one day be used as a means of ensuring that the right patients are receiving the right medications. The possibilities are endless.

Question: Why is it necessary to have a bar-coded patient wristband?

Jeanette: Bar-coded wristbands facilitate the accurate and automated identification of every patient. The introduction of bar-coding opens the door to a number of other patient-safety initiatives, including many technological advances currently being developed.

Question: How will the new wristbands be used?

Jeanette: Beginning in June, bar-coded wristbands will be able to be used with glucometers. Staff will be able to scan the wristband, which electronically stores the medical record number. Patients' medical record numbers will no longer need to be typed manually.

Question: How will the new wristbands be made?

Jeanette: Wristband-specific printers are currently being installed on units. Operations associates and other staff who have access to PATCOM will have the ability to print wristbands. Training sessions are starting this month.

Question: Will bar-coded wristbands be available for all patients?

Jeanette: Bar-coded wristbands will be available for adult inpatients and in some procedural areas.

Vendors do not yet offer a wristband small enough for babies or very young pediatric patients. We are working with vendors to correct this; more information will be available soon.

Question: How accurate is bar-coding?

Jeanette: In the pilot program where we tested bar-coded wristbands with glucometers, there was 100% accuracy in patient identification. The manual system of entering medical record numbers showed a 5% error rate.

Question: Why are we switching to white-only wristbands?

Jeanette: Red and blue wristbands could potentially lead to inaccurate identification of allergy status. White-only wristbands reinforce the practice of obtaining allergy information from the most reliable source — patients' medical records.

Jeanette Ives Erickson

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improve inter-disciplinary communication, enhance transitions of care during hospitalization, and ensure accessibility to resources.

To support this work, we are enlisting the aid of a consulting firm to conduct an on-site assessment of our patient-flow and discharge practices, identify areas for improvement, and provide recommendations on how to implement a 'transformation methodology.'

In addition to these long-term solutions, we are implementing a number of short-term measures to help reduce bed demand in the immediate future. On April 4, 2005, the Trauma Rapid Admission Care Unit (TRACU) opened on Ellison 7. It will serve trauma and emergency surgical patients for short-term observational stays.

Bigelow 12, recently vacated by the outpatient Infusion Unit, which relocated to the Yawkey Center, is being used in a couple of creative ways. We're piloting two different concepts. One is a discharge lounge, the other is a pre-admission area for patients awaiting bed placement.

Capacity management has captured the imagination and ingenuity of some of our most talented people. As long as patients continue to seek care at MGH, we will continue to commit the time, money, and resources necessary to tackle the difficult questions, including the complex issue of capacity management.

Updates

I'm pleased to announce that Carla Welsh has accepted the position of senior project specialist for Patient Care Services Systems Improvement. She will be working closely with George Reardon, director of Systems Improvement, on a number of projects, including capacity management.

I'm happy to inform you that Lilian Dayan-Cimadoro, PT, has accepted the position of inpatient PT clinical specialist for the Pediatric Service, the RACU, and the MICU.

IMSuRT team receives Department of Homeland Security Under Secretary Award

At a special ceremony in O'Keeffe Auditorium, on March 11, 2005, The Boston-based International Medical Surgical Response Team (IMSuRT) was honored with a Department of Homeland Security Under Secretary Award. The award is one of only nine presented for outstanding work in emergency management.

The IMSuRT team, sponsored by MGH and affiliated with the Federal Emergency Management Agency under the Department of Homeland Security, was deployed to Bam, Iran, on December 27, 2003, to assist earthquake victims with medical relief. More than 30,000 people died and another 40,000 injured in what, at the time, was the worst earthquake in the world in the past 25 years. It was the first official US delegation to set foot in Iran in almost a quarter century.

"We are honored to receive the Under Secretary Award. It is great recognition for this team that worked under extremely difficulty conditions to provide life-saving care to earthquake victims," said Dr. Susan Briggs, IMSuRT-East team commander, and associate professor of Surgery at MGH.

FEMA officials, Kenneth Horak, acting regional director; Marty Bahamonde, public relations liaison, and Jack Beall, the director of the National Disaster Medical System attended the event.

Sue Briggs, MD, speaks at award ceremony

Said Beall, "The passion for this kind of work starts in your heart. What is most important is what we leave behind. On behalf of the entire organization, we thank you for your contributions."

Said Briggs, "The whole MGH community is part of what we do. We're all members of the IMSuRT family, whether we go, or whether we stay."

Above: staff nurse, Pamela Griffin, RN, is congratulated by FEMA representatives, Ken Horak and Jack Beall.
Below, respiratory therapist, Robert Goulet, RRT, accepts his award.

MGH IMSuRT team members:

Jennifer Albert, RN
Susan Briggs, MD
Kathryn Brush, RN
Sheila Burke, RN
Lin-Ti Chang, RN
Tony Forgione, LPN
Ron Gaudette, RPH
Edward George, MD
Robert Goulet, RRT
Pamela Griffin, RN
Annekathryn Goodman, MD
Patrick Kadilak, RN
David Lawlor, MD
Jesslyn Lenox, RRT
Barbara McGee, RN
Tom MacGillivray, MD
Leandra McClean, RN
Patricia Owens, RN
Joseph Roche, RN
Maryalyce Romano, RN
Jay Schnitzer, MD
Joan Tafe, RN
Barbara Walsh, RN
Brenda Whelan, RN
Marie LeBlanc, RN
(home team liason)

Advance care planning: planting the seeds of awareness

—by Gayle Peterson, RN, and Linda Ryan, RN

The Ethics in Clinical Practice Committee (EICPC) has always been concerned with the ethical issues facing clinicians. In discussions at our meetings, through our Polls of Peers, and from staff responses to the Staff Perception Survey, members of the EICPC have long known that decisions about end-of-life treatment are difficult. In part, this is because clinicians and families aren't clear about the wishes of their loved ones who aren't able to speak on their own behalf. Efforts to educate clinicians around this issue began with our first Advance Directives Booth in 2002. Response was overwhelming—more than 1,000 packets were disseminated to clinicians, patients, and employees.

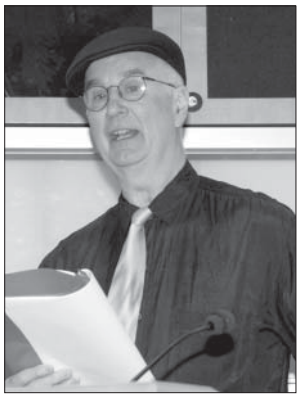
We recently held our 4th annual Advance Directives Booth in collaboration with the Patient Education Committee and the Patient & Family Learning Center. The theme was, "Have a heart-to-heart." Interest has grown since 2002, leading to the creation of our multi-disciplinary Advance Care Planning Task Force, chaired by Sharon Brackett, RN, former co-chair of the EICPC. The task force was responsible for bringing the Respecting Choices Program to MGH in November, which resulted in the certification of 39 advance care planning facilitators and eight instructors, so the program could be self-sustaining at MGH.

Recently, the EICPC presented the educational program, "Advance Care Planning: Hard Facts, Humor, and How Tos." The 'Hard Facts' segment was presented by clinical nurse specialist, Theresa Cantanno-Evans, RN, who is a fellow in the Harvard Medical School's Division of Medical Ethics Fellowship Program. Cantanno-Evans' expertise in ethics and advance care planning has been an asset to the committee.

The 'Humor' segment was a crowd-pleaser as the Ethical Players enacted a skit conceived, written, and directed by Regina Holdstock, RPh, co-chair of the EICPC. While entertaining, the skit carried a very important message about what can happen to patients in the absence of advance directives.

The 'How To' segment offered advice from a panel of experts that included certified advance care planners: Paul Montgomery, Linda Ryan, Marion Parker, Gayle Peterson, Ellen Robinson, Theresa Cantanno-Evans, and Annie LeTendre.

More than 75 people attended the three-hour program, and evaluations were extremely positive. The EICPC and the Care Planning Task Force look forward to continuing our work in educating clinicians, patients, families, and employees about this very important topic.



The Not-Ready-for-Prime-Time Ethical Players present skit depicting the importance of securing advance directives

National Youth Leadership Forum: grooming the nurses of the future

—by Lauren Holm, RN, staff specialist

The National Youth Leadership Forum on Nursing is a program designed to provide high school students with a formal introduction to the nursing profession. Students from all over the country participated in week-long sessions February 15–20, and February 22–27, 2005. All participants were strong academic achievers and active in community service.

Kicking off the week at MGH, executive director to the office of senior vice president for Patient Care, Marianne Ditomassi, RN, set the stage by showing a videotape of *Nursing Diaries*, a nursing documentary that was filmed at MGH. Ditomassi used the video as a springboard for questions she wanted students to consider during their time shadowing nurses.

Of the 334 students who participated in the National Youth Leadership Forum, 202 had an opportunity to shadow MGH nurses on patient care units and in clinical settings. A total of 210 staff nurses volunteered to share their knowledge and experience with nearly every nursing specialty represented.

Students spent time in two different clinical areas and were impressed with the critical thinking of the nurses they observed, the respect nurses received from their colleagues, and the high level of teamwork they witnessed.

In a panel discussion moderated by Mary Ellin Smith, RN, professional development coordinator, staff nurses shared why they chose nursing as a career, how they selected a nursing school, and tips on how to determine the best place to practice. Representatives from Human Resources invited students to consider MGH when they graduate.

Students heard from guest speakers, including patients and nurses who described a variety of nursing roles and practice areas.

Feedback from students was extremely positive. One student posted this message on the NYLF website, "I had a great time. The best part was when I went to the Mass. General Hospital because I was able to go to a patient unit. Everything was wonderful."

Ditomassi thanked the planning team, nurse managers, clinical nurse specialists, preceptors, Nutrition & Food Services, and all who helped make the NYLF experience such a success. For many students, participating in the NYLF program, particularly shadowing nurses in clinical settings, sealed their decision to pursue a career in nursing.

Special thanks to the following preceptors:

Jenn Albert, RN
Angela Altobel, RN
Julie Angueira, RN
Alexis Auger, RN
Georgette Azar, RN
Vicki Bain, RN
Deanna Banyai, RN
Kristin Baronas, RN
Jim Barone, RN
Melissa Barrett, RN
Lynn Bellavia, RN
Kiki Benjamin, RN
Marianne Benoit, RN
Tony Bianco, RN
Kathi Blais, RN
Karen Bolden, RN
Sharon Bolton, RN
Katie Botelho, RN
Diana Boye, RN
Jennifer Burns, RN
BettyAnn Burns-Britton, RN
Katrina Cabral, RN
Lisa Califano, RN
Caitlin Callahan, RN
Pauline Cameron, RN
Tammy Carnevale, RN
Natalya Carney, RN
Jennifer Carr, RN
Lisa Carter, RN
Rhianna Casale, RN
Michelle Catrambone, RN
Lynda Center, RN
Gina Cenzano, RN
Tina Chirgwin, RN
Linda Choute, RN
Beth Coe, RN
Colleen Comeford, RN
Greg Conklin, RN
Patty Conners, RN
Nuala Conroy, RN
Judy Corbett, RN
Elizabeth Costigan, RN
Catie Crook, RN
Shannon Dacunha, RN
Jackie Davis, RN
Kara Davis, RN
Jyl Dedier, RN
Robin Delaney, RN
Nicole DiFrinzo, RN
Carolyn DiMaggio, RN
Andy Dinardo, RN
Katie D'Mare, RN
Karen Donahue, RN
Maureen Donovan, RN
Jennifer Doolin, RN
Terry Doyle-Creamer, RN
Jackie D'Silva, RN
Alice Edmonds, RN
Kathleen Egan, RN
Laurie Eiermann, RN
Janice Erlandson, RN
Kathy Evans, RN
Melisssa Fantasia, RN
Victoria Feenstra, RN
Brenda Fletcher, RN
Meg Flight, RN
Marie Flood, RN
Alison Flynn, RN
Jenn Fong, RN
Beth Fortini, RN
Agnes Froio, RN
Monique Gauthier, RN
Sue Goguen, RN
Cheryl Gomes, RN
Ana Gomes-DaCosta, RN
Pat Gorham, RN
Kathleen Gorman, RN
Christie Granfield, RN
Jessica Gray, RN
Deb Greenberg, RN
Judy Gullage, RN
Sarah Guyette, RN
Colleen Halley, RN
Andrea Hansen, RN
Nancy Harkness, RN
Shauna Harris, RN
Julie Hazelton, RN
Beth Hennessey, RN
Robin Herrman, RN
Dave Hiett, RN
Helen Ann Higgins, RN
Maura Hines, RN
Brook Holmes, RN
Vicki Hubacheck, RN
Audrey Jasey, RN
Becky Johnston, RN
Lauren Kattany, RN
Kristen Knapp, RN
Kathy Kryzanek, RN
Liza Kuchar, RN
Brittany Kupferberg, RN
Holly Kurisko, RN
Lucy Langenkamp, RN
Sheryl Larson, RN
Marissa Legare, RN
Robin Leone, RN
Ann Letendre, RN
Amy Levine, RN
Annette Levitt, RN
George Lillie, RN
Lori Lucas, RN
Michelle Lussier, RN
Corinne Luxama, RN
Jamie Macintyre, RN
Jose Madelon, RN
Fareeda Mahmoud, RN
Steph Mahoney, RN
Trisha Mahoney, RN
Maryann Mantville, RN
Amy McCarthy, RN
Lee McCloskey, RN
Mary McKinley, RN
Kathy McLaughlin, RN

Opposite page: Staff nurse, Ana Gomes-Decosta, RN (right), explains IV technology to NYLF student on Bigelow 11

Above: Blake 6 staff nurse, Debra Whitaker, RN (right), conducts patient-education with patient, Lisa Bracken, while student observes

Above right: Ellison 14 staff nurse, Lisa Skayne, RN, shows student how to read a medical record

At right: Staff nurses (l-r): Debra Spain, RN; Karla Farrer, RN; and Frankie Allen, RN, explain EKG monitoring system to student on White 11

Roseann McNamara, RN
Arlene Meara, RN
Ann Menna, RN
Anastasia Michaelidis, RN
Jacqueline Michaud, RN
Laurie Miller, RN
Meredith Minchello, RN
Gwen Mitchell, RN
Patricia Moran, RN
Chelsea Morello, RN
Cyndi Moriera, RN
Kathy Mortimer, RN
Nilanthi Motsenigos, RN
Jennifer Murray, RN
Lorraine Nazzaro, RN
Kim Nolan, RN
Greg Nuzzo-Mueller, RN
Kerin O'Grady, RN
Cathy O'Leary, RN
Kerri O'Meara, RN
Molly O'Neil, RN
Emily Olmstead, RN
Karen Orband, RN
Jane Oulette, RN
Nikki Ouelette, RN
Erin Pacocha, RN
Ellen Pantzer, RN
Joanne Parhilia, RN
Erin Pelletier, RN
Gayle Peterson, RN
Eileen Picazio, RN
Kelly Pike, RN
Julie Piotrowski, RN
Patty Pires, RN
Pat Powell, RN
Daisy Powers, RN
Cami Pucci, RN
Kathleen Pullen-Norris, RN
Steph Pusti, RN
Linda Reed, RN
Patricia Reilly, RN
Danielle Rochette, RN
Lauren Rodrigues, RN
Martha Root, RN
Sarah Rowley, RN
Lori Ruskin, RN
Laura Ryan, RN
Erin Salisbury, RN
Genevieve Salvacion, RN
Steve Sampang, RN
Beth Sawyer, RN
J.J. Sayler, RN
Deborah Scannel, RN
Jill Scarry, RN
Kathy Selleck
Bridget Shaughnessy, RN
Lauren Shea, RN
Kristina Shultz, RN
Lisa Skayne, RN
Barbara Smith, RN
Kim Smith, RN
Pam Smith, RN
Richard Soria, RN
Jean Stewart, RN
Kristin St. Pierre, RN
Denise Studley, RN
Lily Sullivan, RN
Chris Swanson, RN
Mary Theroux, RN
Kitman Tsang, RN
Lisa Tufts, RN
Maureen Tully, RN
Kathleen Twomey, RN
Bridget Valeri, RN
Elizabeth Viano, RN
Elene Viscosi, RN
Tim Wages, RN
Bernie Warren, RN
Amy Webster, RN
Andrew Whetstone, RN
Debra Whitaker, RN
Jane White-App, RN
Gayle Wholley, RN
Alfreda Whyte, RN
Joy Williams, RN
Jody Wolf, RN
Sarah Wood, RN

Respiratory therapist's calm, controlled approach helps baby, parents, colleagues

Clorinda Buenafe, RRT
respiratory therapist

My name is Clorinda Buenafe, and I am a registered respiratory therapist. I work predominantly in Pediatrics. I have been a member of the Pediatric transport team for seven years, which involves transporting critically ill infants via ambulance, helicopter, or airplane.

A community hospital contacted our Neonatal Intensive Care Unit (NICU) regarding a critically ill, full-term infant who had been born with meconium aspiration syndrome. The hospital wasn't ready to send the child yet but wanted to know, if the infant's condition worsened, that we would be able to accept her as a possible ECMO (extra corporeal membrane oxygenation) patient. We had a bed available and were put on alert.

The patient was managed for another five days at the community hospital before becoming extremely unstable. Staff at the hospital didn't feel comfortable transporting such a critically ill child by ground. To expedite transport, it was decided that this infant should be med-flighted to MGH. Because of weight restrictions and other considerations, helicopter transports require a NICU fellow, a respiratory therapist, and two med-flight team members (usually a nurse and a paramedic) to accompany the patient. The team was mobilized minutes after we got the call.

En route to the referring hospital, our four-person transport team discussed the patient's pertinent data and our plan for care. We knew the patient was on a high-frequency oscillator ventilator (HFOV) and would need to be converted to conventional ventilation in order to be transported. We also knew when we departed, that the patient was becoming extremely unstable. We agreed we'd need to stabilize the infant and get back to MGH as quickly as possible. I reminded the NICU fellow that he'd need to obtain consent from the parents for the transport as well as for potential treatments.

We arrived at the referring hospital and, after introductions, I started my assessment of the infant. I listened to bilateral breath sounds (BBS) and confirmed equal and coarse BBS with good aeration. We looked at the most recent chest X-ray, taken an hour earlier that showed significant meconium aspiration as well as a small pneumothorax at the left base. The respiratory therapist from the referring hospital had taken the infant off the HFOV ventilator and was manually ventilating her because the baby had started showing differences in her pre- and post-ductal saturations. Her pre-ductal saturation was 95%; post-ductal was 88%. I knew that with this degree of shunting, the infant most likely had significant pulmonary hypertension.

The NICU fellow, only in his first year of practice, asked my opinion on the best management of this patient. I responded that the baby could benefit by optimizing her blood pressure. Although her mean arterial pressure was within normal limits for a healthy term baby, increasing cardiovascular support might help decrease the severity of her pulmonary hypertension. I noticed right away that her last arterial blood gas revealed a mild respiratory acidosis and knew the pulmonary hypertension could benefit from some alkalinization. The fellow was hesitant at first, so I encouraged him to contact our attending in the NICU for support. At this point, the baby's saturations hadn't changed, and I asked the respiratory therapist if I could take over the manual ventilating (or 'bagging').

I began to hand ventilate with an anesthesia bag. I started at pressures of about 25/6 and noted excellent chest movement. It took a few seconds to find the proper inspiratory time and pressures, but the infant responded well to pressures of 30-32/6-8. The fellow, after a detailed discussion with our attending, started some inotropic support to increase her blood pressure.

With the change in ventilatory support and the increase in mean arterial pressure, the pre- to post-ductal oxygen saturation difference decreased, and both saturations rose to >96%. I was confident the degree of pulmonary hypertension had lessened.

At this point, I asked the respiratory therapist to take over bagging and simulate what I was doing so I could ready the transport ventilator for travel. I suggested a follow-up chest X-ray before leaving because I was concerned about the pneumothorax. There was potential for it to increase as we climbed to higher altitudes, and I wanted to assess it before we left the ground. The follow-up showed that the pneumothorax had resolved, and we were ready to go.

I set the transport ventilation system to mimic what I had been doing while hand-ventilating and felt comfortable enough to place the infant in the transporter. The med-flight nurse and paramedic provided great support in transitioning the infant from the nursery isolette to the transport isolette. They responded to medication adjustments we requested, arranged the lines for ease of access during transport, and helped minimize the transition time, keeping the infant's temperature stable. The fellow and I continuously conferred on management of the patient and were in agreement with every move.

We realized how difficult this must be for the patient's mother. Now that we had a more stable

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Clinical Narrative

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situation, we were able to let mom kiss her baby good-bye, reassure her that we'd take good care of her, and let her know how to contact the NICU at MGH.

The fellow secured all the necessary consents and I conveyed to the parents that they were welcome to call or visit the NICU any time to be with their daughter, as soon as we had her settled in. They asked if we would be caring for their child at MGH, and the fellow and I were happy to tell her we would be.

I chose to write about this event because this infant was originally a candidate for ECMO. By making adjustments in ventilator support and improving the infant's cardiac output for transport to our NICU, we were able to avoid using ECMO altogether. I was able to demonstrate my knowledge and ability to care for infants with pulmonary hypertension to the NICU fellow, and he quickly relied on my suggestions for managing this infant. We employed proper ventilation and optimal blood-pressure support along with appropriate sedation and were able to stabilize this infant, resulting in a less risky transport to MGH. She remained critical for a few days before being weaned off of nitrous oxide. It was never necessary for her to be cannulated for ECMO.

I think my extensive experience in the NICU and with ECMO kept me calm and focused on the appropriate management of this baby. When mom arrived, she remembered me and asked me to help orient her to the NICU. I introduced her to the primary nurse, the attending physician, and reintroduce her to the fellow. Together, we assured her that her baby was doing fine and improving every day. Years of experience as an ECMO therapist have taught me that the stress and anxiety parents feel can be minimized by a calm and controlled approach. It was important for me to reassure them that although the situation was still critical, we were comfortable working with severely ill infants and we would continue to work collaboratively to give their child the best possible care.

I took the initiative with the medical management of this infant by assessing her needs and suggesting the appropriate therapy. Though authoritative, I didn't overstep my bounds and continued to encourage teamwork, involvement, and coordination with the NICU team. I'm always learning from the team—nurses, fellows, therapists, pharmacists. It felt good to be able to contribute to a positive learning experience for this new NICU fellow and, hopefully, staff at the referring institution as well.

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

It is clear from this narrative that Clorinda is comfortable practicing in critical, rapidly changing, clinical situations. She is completely present in the moment, anticipating anything that could happen and compensating for anything that does. She proactively coaches the NICU fellow through the clinical management of this child and shares her expertise with the respiratory therapist at the referring hospital.

Clorinda knew this baby was a cherished member of a family who worried for her safety. She addressed their needs as soon as the situation was clinically under control.

It was an uneventful flight for this baby thanks to the calm, confident, and competent care Clorinda and the team provided.

Thank-you, Clorinda.

MGH Perioperative Nursing Education and Orientation Program

Are you interested in becoming an OR nurse?

If you are currently an experienced nurse and have an interest in working in the Operating Room, the Perioperative Nursing Education and Orientation Program may be for you. The program begins June 6, 2005. You must be a registered nurse with experience in an acute-care setting. For more information, contact Michele Andrews at 617-724-6052

April is Organ & Tissue Awareness Month

April is National Organ & Tissue Awareness Month. MGH will observe this important occasion with a special presentation and information table in the Main Corridor.

"Realize the power of giving life"
12:00pm, April 25, 2005
O'Keeffe Auditorium

Organ recipients, organ donors, donor families, and patients waiting for organs will share their experiences. Visit the information table to learn more about the need for organ and tissue donation and how you can make a difference today.

April Vacation Club at the MGH Backup Childcare Center

Tentative schedule for 6-12 year-olds:
Monday: Basketball City
Tuesday: tour of Fenway Park
Wednesday: papermaking
Thursday: bowling
Friday: swimming

April 18–22, 2005
7:30am–5:45pm
Cost: $275 for 5 days
($60 per day per child)

For reservations call 617-724-7100
The Backup Center will also be providing care for younger children, aged 15 months–5 years old.

Making materials easy to access and easy to use

—by MaryElizabeth McAuley, RN; Donna Slicis, RN; and Ruth Dempsey, RN, for the PCS Patient Education Committee

Education in the Pre-Admission Testing Area (PATA) is geared toward supporting patient advocacy; ensuring that patients understand their procedure, recovery, and discharge needs; and minimizing anxiety through patient- and family-education. Recently, a project evolved between The Blum Patient & Family Learning Center (PFLC) and PATA to help facilitate peri-operative patient- and family-teaching. The following interview describes this collaborative project.

Mary: Donna and Ruth, what can you tell people about this collaborative effort to facilitate patient education?

Ruth: It began as an MGH "Making a Difference" grant proposal from the Surgical CPM team. Representatives from the PFLC, the Surgical CPM team, and PATA worked together to identify patient-education materials appropriate for patients having thoracic, vascular, or general surgical procedures. Materials were gathered and approved for more than 20 surgical procedures in both easy-to-read and more sophisticated formats. Initially, PATA nurses verbally explained surgical procedure to patients then gave them an 'information prescription,' which they could take to the PFLC and exchange for a packet of educational materials to reinforce their teaching.

Donna: After four months, we evaluated the process and found that of 300 patients who received information prescriptions only 12 actually went to the PFLC to claim them. We tried a number of incentives, but ultimately patients felt burdened by a long day of testing and saw the PFLC as an additional stop.

Ruth: Teaching materials were readily available in the PFLC. We just needed to figure out the best way to get them to patients. The decision was made to send teaching materials to the PATA so they could be available to patients at the point of care. Patients are assessed by nurses in the PATA and often have questions about topics covered in the teaching materials.

Mary: What were the teaching materials and how were they used?

Donna: Ruth and I saw a great opportunity, not only to bring teaching materials to PATA, but to separate the materials into three groups. The first group would include easy-to-read picture booklets that reviewed pain-control, anesthesia, recovering from surgery, and medications. These were placed in a central pamphlet rack in the patient waiting area. Patients could select the appropriate materials as needed.

The second group included picture booklets describing specific surgical procedures to be used by PATA nurses during patient-education sessions. The third group contained materials with fewer graphics, written at a higher reading level, to be made available to patients wanting more detailed information about their surgery and recovery.

Ruth: We documented the usage of these teaching tools, but also wanted to understand the reasons why some tools were used and others weren't. PATA used staff meetings as focus groups to find out how the tools were working for nurses and patients. Anecdotal information was collected to document staff perceptions and help plan the future direction of the project.

Mary: What did staff think of the project?

Donna: Nurses were very excited and happy to have access to the teaching materials. Staff liked using the easy-to-read materials. Explaining a laparoscopic procedure was much easier

continued on next page

Good for patients; good for staff

At left, patient in the PATA waiting area accesses patient-education materials; at right, PATA staff nurse, Peter Hayes, RN, chooses the appropriate teaching materials for his patient.

Breaking the silence: a response to sexual assault

—by Alexandra Detjens, HAVEN Program

Talking about sexual assault is difficult, but if clinicians aren't comfortable talking about it, those in need may be denied help. As hospital staff and employees, we need to find ways to ask the difficult questions. For many people affected by domestic violence, shame, embarrassment, and fear of reprisal keep them silent.

Sexual assault is a broad term that includes rape, attempted rape, and any act of unwanted sexual contact. Over the years, people have become more savvy about protecting themselves against sexual assault. Unfortunately so have sexual predators:

- Eight out of every ten rape victims know their attackers
- 35% of those rapes take place in the victims' homes
- 44% of rape victims are under the age of 18
- only 7% of those offenders were strangers to their victims
- 93% of those perpetrators were family members or acquaintances.

Sexual assault is one of the most under-reported forms of domestic violence because many victims don't recognize it as a crime. A marriage license is not a license to have unwanted sex with your partner. Sexual violence in an intimate relationship can mean forced sex, being forced into prostitution, pornography, and/or watching your partner have sexual relations with others. Whatever form it takes, sexual violence can have long-term psychological and physical consequences.

We are fortunate at MGH to have qualified staff who respond to sexual assaults. Patients and employees have access to experts. The MGH HAVEN Program, Police & Security, the Employee Assistance Program, SANE and the Child Protection Consultation Team all work individually and collectively to ensure the best possible response to every situation.

We can make a difference. Help blow the whistle on sexual assault. Come to the sexual assault educational booth in the Main Corridor on April 7, 2005, from 11:00am–2:00pm.

For more information about sexual assault, visit the Rape, Abuse & Incest National Network website at: http://www.rainn.org.

Ethics Forum

Faith perspectives in caring for the dying

Panelists:
Firdosh Pathan, RPh (Muslim Perspective)
Rabbi Ben Lanckton (Jewish Perspective)
Chaplain Susan Bridge (Buddhist Perspective)
Reverend Ann Haywood (Protestant Perspective)
Bishop Michael Marcheschi (Church of Jesus Christ of Latter-day Saints)
Reverend Paul Ogoke (Catholic Perspective)
Sister Joanne Lappetito (Catholic Perspective)

Friday, April 8, 2005
12:00–1:30 PM
Sweet Conference Room

Feel free to bring a lunch
For more information, e-mail erobinson1@partners.org

Patient Education Materials

continued from previous page

when they could use pictures and diagrams.

Staff reported an improvement in patients' understanding of their procedures. They felt patients were better able to verbalize their surgical procedures and post-operative care.

Patients also preferred the teaching materials with graphics. One patient noted, "I didn't understand how they were going to take my gallbladder out through my belly button, but now I get it."

Ruth: It was cumbersome for staff to look through filing cabinets for teaching materials. So I got another rack that could be placed near where staff conducted patient teaching. We found that when teaching materials were centrally located, utilization by staff increased significantly. With increased visibility and accessibility, utilization of teaching materials tripled. Ease of use was as much a factor for staff as it was for patients.

Mary: What's happening with your project now?

Ruth: We're in our third year and see opportunities to branch out into other areas. We're looking at other needs identified by patients in PATA, and continue to try to match educational materials to patients' needs. We have expanded the scope of our teaching materials to include other surgical procedures requested by staff. Donna is looking at frequent diagnoses and is in the process of acquiring information to support teaching on pain control, anxiety-management, sleep disorders, and other topics. We continually document how teaching materials are being used.

Donna: We would like to enable patients to learn ways to partner with their healthcare providers to manage their health and life-style issues. For example, PATA nurses now have the opportunity to give patients information about how to quit smoking.

I'm auditing nursing assessment forms to identify other common patient-learning needs and acquire materials to address them. I'm finding that teaching materials work best when they meet the needs of both the provider and the patient.

Ruth: Donna and I have presented a poster on our initial findings at the Association of Operating Room Nurses (AORN) annual conference. Easy access and easy-to-read patient-education materials make for an optimal patient-education experience.

For more information about easy-access, easy-to-use patient-education materials, contact Donna Slicis, RN, at 4-1668.

Clinical Recognition Program: a unique opportunity for self-reflection

My name is Kathleen (Kassie) Lopez, and I became a registered nurse in 1978. Most of my nursing career has been spent at MGH. Practicing on a variety of units has been exciting and challenging, always offering new opportunities for growth and discovery. Recently, my nurse manager encouraged me to seek out information on, and apply for, the Clinical Recognition Program.

Thinking about applying for the Clinical Recognition Program was intimidating. As a staff nurse with a diploma in Nursing, I wasn't sure I had the required credentials. But the Clinical Recognition Program at MGH is not degree-based; it's based on clinical expertise, knowledge, and practice. With my nurse manager's support, I decided to give it a try.

The first step was self-examination, looking at where I'd been as a nurse and where I was going. My nursing career was like a tapestry of clinical experiences. I had developed an advanced level of practice almost without realizing it. Skills identified as advanced clinician criteria were second nature to me. I began to view my practice with new eyes.

I have a substantial knowledge base that I use when precepting new staff to help them grow into competent, confident nurses. The process of self-examination helped me understand why I see patient concerns and problems the way I do. I realized how comfortable I had become managing the conflicts that sometimes arise when many talented clinicians work together to care for patients and families. Experience allows me to take sound clinical risks and be a resource for others.

I participated in an internship in the Patient & Family Learning Center last year that opened the door to a new source of knowledge for me. It not only influenced my nursing practice, it allowed me to influence other nurses on my unit in the way they educate patients and families.

Realizing how much I loved being a nurse, I couldn't imagine working in any other profession. The challenge for me was to express those feelings in my application for advanced clinician. As nurses, we're not always adept at articulating how well we do our jobs, or what makes us good nurses. Sometimes the most influential and life-changing events are not able to be measured by conventional standards. I decided to try to capture that snapshot of my practice in my portfolio.

After sketching out my educational experiences, my resume was a journey down memory lane. Remembering all the interesting places I've worked and the wonderful, talented people I've worked with was very rewarding.

Nursing care and equipment have changed so much in 25 years. For example, changing from glass IV bottles in the 70s to bags of IV fluids in the 90s. My clinical nurse specialist helped me arrange all the information into an organized, professional package.

The cover letter was next on my agenda. I used the cover letter to tell the story of my practice—where I'd been and how I felt about nursing. The PCS Clinical Recognition Program web page offers some good advice on how to write a cover letter. One of the themes I chose to focus on was the cultural diversity of our patients and how that impacts our care. This was an opportunity to highlight my advocacy skills and my ability to develop relationships with patients and their families.

I talked about my role as a resource nurse for

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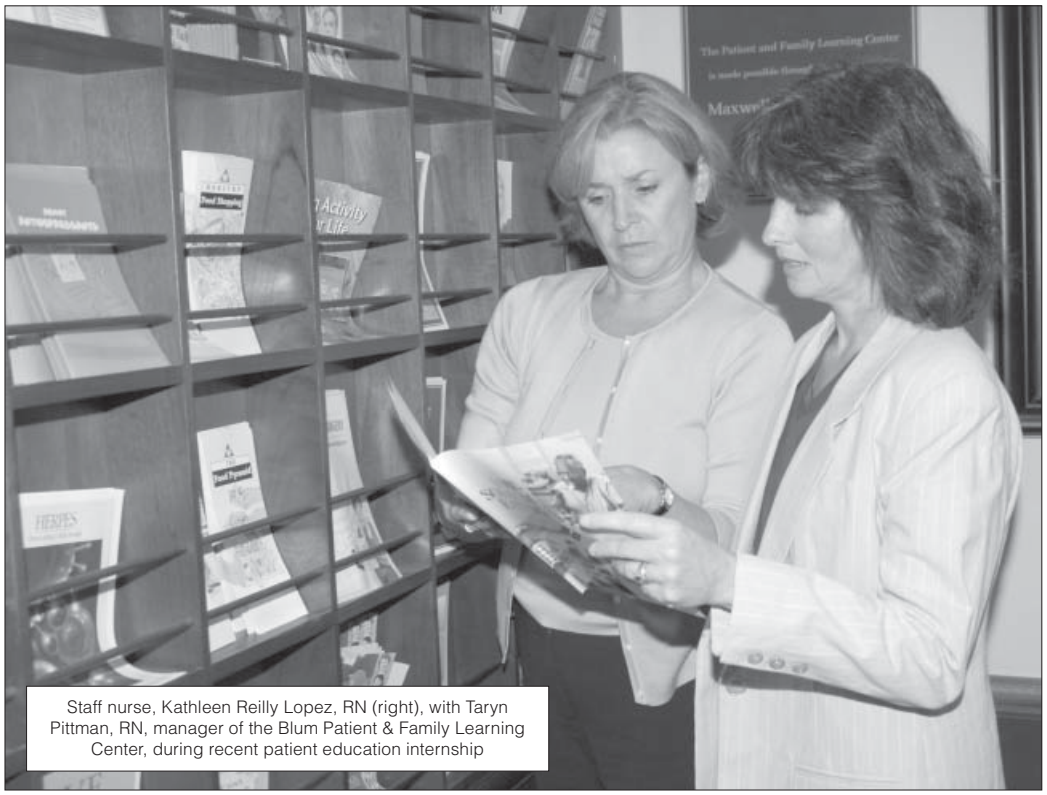

Staff nurse, Kathleen Reilly Lopez, RN (right), with Taryn Pittman, RN, manager of the Blum Patient & Family Learning Center, during recent patient education internship

Clinical Recognition Program

continued from previous page

other staff nurses. I emphasized my ability to develop collaborative relationships with other caregivers by using examples of interactions and interventions that showcased that area of my expertise.

I needed to obtain three letters of recommendation (two from colleagues in my field and one from someone outside of Nursing). It was important to ask colleagues who knew my practice or who had worked with me in particularly challenging patient-care situations. I needed to find clinicians who could describe my effectiveness during critical situations and attest to how well I collaborated with other members of the team. I chose two nurses I work with on a consistent basis. We discussed a few patient and family situations and decided on which one to highlight in each of their letters.

I asked a physician to write my third letter of recommendation. The physician had collaborated closely with me in caring for a number of patients, including the patient I wrote about in my clinical narrative. We discussed that patient's hospital course, which helped us remember how challenging and rewarding the experience had been.

Writing the clinical narrative took on new meaning. I wanted it to be an accurate picture of my daily life as a nurse, to capture the intensity I bring to nursing and the joy nursing affords me. I paid attention to details like clinical risk-taking, patient-advocacy, and collaboration with other disciplines, which I have overlooked in previous narratives. Those are the details that make up the fabric of our practice. Clinical narratives give readers a glimpse into our thought processes as nurses. Capturing that on paper was a difficult but rewarding experience.

When it came time for my interview, I was extremely anxious about the prospect of sitting before the interview team and talking about my practice. It was helpful to spend some time beforehand reviewing practice questions and specific challenging situations with my nurse manager and CNS. It helped me feel more confident and prepared for the interview. I also reviewed my narrative, cover letter, and letters of recommendation to keep them fresh in my mind.

During the interview, the team asked specific questions about elements of my portfolio in an effort to assess whether my reasoning and decision-making skills fit the advanced clinician criteria. Talking about my skills and strengths as a nurse was the most difficult part of the process for me. I had never considered my practice in terms of an individual having an impact on nursing units, and focusing on myself made me uncomfortable. But this experience showed me the value I bring to my unit. The interview team helped me reflect on my practice in a very positive way that made me extremely proud to be a nurse. And oddly enough, this process of self-examination helped me realize the strengths my fellow clinicians bring to patient care, aswell.

The Clinical Recognition Program helped me reaffirm why I am a nurse. I didn't have to leave bedside nursing to be recognized as the skilled clinician I know I am. There are opportunities at all levels of practice for self-reflection, affirmation, and celebration. As nurses, we are an integral part of the delivery of excellent patient care, and the Clinical Recognition Program is one way we are encouraged to shine. Having received the recognition of advanced clinician, I want to encourage other staff members to apply to the Clinical Recognition Program. On my unit, we've started support groups to mentor clinicians as they embark on their clinical-recognition journeys. Through mentoring, we all grow in our practice.

For more information about the Clinical Recognition Program, visit the Patient Care Services website at http://pcs.mgh.harvard.edu (no spaces).

Strategic Leadership Course

Learn how to maximize your potential to influence teams and workgroups within your organization. This dynamic course led by Bonnie Michelman, director of MGH Police & Security, will provide proven leadership styles and strategies and present characteristics of successful leaders.

Course is open to all Leadership Academy members (those in management roles with supervisory responsibilities).

Wednesday, April 13, 2005, 1:00–2:30pm
100 Charles River Plaza

For more information, visit the Leadership Academy website at: http://www.massgeneral.org/leadershipacademy
To register, e-mail: mghleadershipacademy@partners.org.

Published by:
Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

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

Articles/ideas 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:
April 21, 2005

Munoz appointed to Review Board

In January, 2005, Lauro Munoz, MOT, OTR, occupational therapist, was appointed to the Editorial Review Board of the *American Journal of Occupational Therapy*.

Peirce presents in D.C.

Georgia Peirce, director of Promotional Communication and Publicity, presented, "Creating Cultures of Safety: the Leadership Imperative," on February 23, 2005, as part of the National Patient Safety Audio Conference broadcast from Washington, D.C.

Kelleher presents in San Diego

Mary Lou Kelleher, RN, pediatric clinical nurse specialist, presented, "Creating a Pediatric Center of Excellence within a Large Adult Medical Center," at the National Initiative for Children's Healthcare Quality (NICHQ) in San Diego, California, February 25–March 3, 2005.

Seitz presents in New Orleans

Amee Seitz, PT, MS, OCS, physical therapist, presented "Rehabilitation of Partial Scapulectomy in Recreational Athletes," at the American Physical Therapy Association Combined Sections Meeting–Sports Physical Therapy Section in New Orleans, Louisiana, February 24-27, 2005.

Choosing a Nursing Program

A new web page that focuses on Choosing a Nursing Program has been added to the Patient Care Services website. The page was developed to help meet the learning needs of staff at all levels and includes resources to assist staff in choosing or advancing a nursing career.

Visit: http://pcs.mgh.harvard.edu/abt_Health_Career.asp

For more information, call Janet Madigan, RN, at 6-3109.

Law appointed to Committee

In February, 2005, Suy-Sinh Law, PT, OCS, M-AC, physical therapist, was appointed as a member of the Public Affairs Committee of the American Physical Therapy Association.

Tenney presents in Phoenix

Dawn Tenney, RN, MSN, associate chief nurse, presented, "The MGH OR of the Future," on February 21, 2005, in Phoenix to the AORN Executive Nursing Surgical Summit.

Pazola publishes in *Oncology Times*

The poem, "Special Kind of Magic," written by Kathie Pazola, RN, MSN, CPON, pediatric staff nurse, was published in the February 10, 2005, issue of *Oncology Times*.

Kent, Pazola, and Stakes present at APON

On January 20, 2005, Patricia Kent, RN, MSN, CPNP, Kathie Pazola, RN, MSN, CPON, and Kate Stakes, RN, MSN, presented, "A Palette of Professional Practice," at the Boston Chapter of the Association of Pediatric Nurses (APON).

Byrne, Catone, and Palmer certified

Endoscopy nurses, Maureen Byrne, RN, GCRN; Cecilia Catone, RN, GCRN, and Deborah Palmer, RN, GCRN, were recently certified by the Certifying Board of the Gastroenterology Nurses Association, Inc.

Popular Diets

presented by the EAP and Suzanne Landry, RD, Ambulatory Nutritional Services

Come hear the pros and cons of popular low-carbohydrate diets and how to live a nutritious, healthy life style.

April 26, 2005
12:00–1:00pm
Anesthesia Conference Room

For information, call 726-6976.

Brien, Lavieri, publish in *Advance for Nurses*

Barbara Brien, RN, BS, staff nurse, and Mary Lavieri, RN, MS, CCRN, clinical nurse specialist, Medical Intensive Care Unit, co-authored the article, "Making a Change: Implementation of Evidence-Based Practices in Critical Care," in the February 14, 2005, issue of *Advance for Nurses*.

Michel publishes in *Diabetics*

Theresa Michel, PT, DPT, MS, DSc, CCS, physical therapist, wrote, "How to Exercise and the Importance of Exercise in Weight Management and Diabetic Control," in *Diabetics,* published by the National Institutes of Health, 2005.

McNamara certified

Roseann McNamara, RN, BSN, CMSRN, clinical research nurse, was certified as a medical-surgical nurse by the Medical-Surgical Certification Board of the Academy of Medical-Surgical Nurses.

Gavaghan, Haldeman, and Jeffries certified

Susan Gavaghan MSN, RN, CCRN, BC, Sioban Haldeman, RN, MSN, MS, BC, and Marian Jeffries MSN RN FNP-C, BC, were certified by the American Nurses Credentialing Center (ANCC) as medical-surgical clinical nurse specialists.

Elder Care Monthly Discussion Groups

presented by

The Employee Assistance Program, and facilitated by Barbara Moscowitz, LICSW, geriatric social worker

Caring for an aging loved one can be challenging. Join us for monthly meetings to discuss legal, medical, coping and other issues.

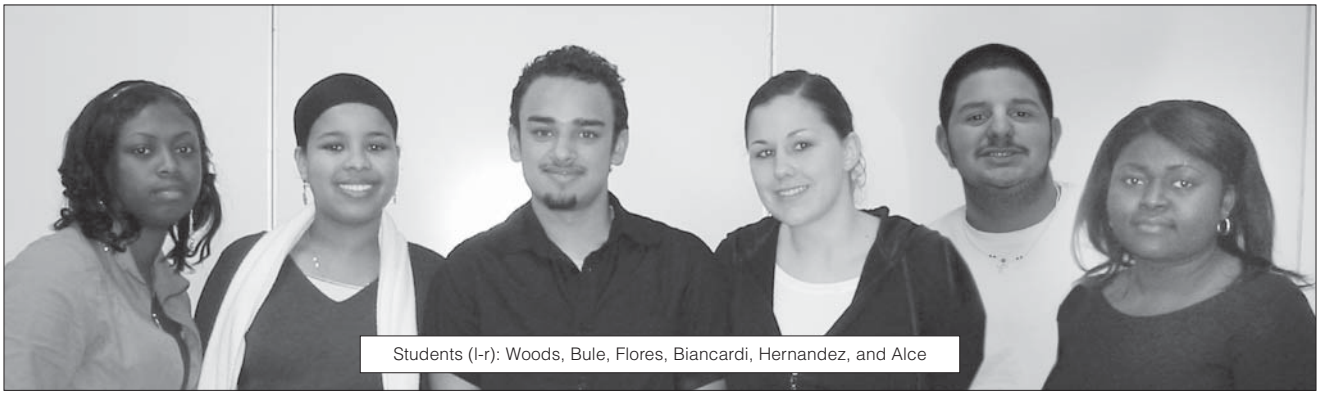
Next meeting: April 12, 2005
12:00–1:00pm
Bulfinch 225A Conference Room

For more information, contact the EAP Office at 726-6976.

Educational Offerings

When/Where	Description	Contact Hours
April 13 11:00am–12:00pm	**Nursing Grand Rounds** "Child Abuse and Neglect." Sweet Conference Room GRB 432	1.2
April 15 8:00–11:00am	**On-Line Clinical Resources for Nurses** Founders 626	- - -
April 21 and 22 7:30am–4:30pm	**Pain-Relief Champion Workshops** Wellman Conference Room	TBA
April 25 and 26 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: VABHCS; Day 2: VBK601	14.4 for completing both days
April 26 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
April 27 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
April 27 8:00–4:30pm	**Caring for the Compromised Obstetrical Patient** Shriners' Auditorium	TBA
April 28 1:30–2:30pm	**Nursing Grand Rounds** "Quality & Safety Update." O'Keeffe Auditorium	1.2
April 29 8:00am–4:15pm	**Advances in Anti-Coagulation** O'Keeffe Auditorium	TBA
April 29 12:00–4:00pm	**Basic Respiratory Nursing Care** Ellison 19 Conference Room (1919)	- - -
May 3 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
May 4 4:00–5:30pm	**Natural Medicines: Helpful or Harmful?** Founders 626	1.8
May 5 7:30am–12:30pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Wellman Conference Room	- - -
May 5 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
May 9 8:00am–4:30pm	**A Diabetic Odyssey** O'Keeffe Auditorium	TBA
May 10 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)	- - -
May 11 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
May 11 7:30–11:30am and 12:30–4:30pm	**Congenital Heart Disease** Haber Conference Room	4.5
May 11 1:30–2:30pm	**OA/PCA/USA Connections** "Food and Nutrition." Bigelow 4 Amphitheater	- - -
May 11 11:00am–12:00pm	**Nursing Grand Rounds** "Infection Control Update." Sweet Conference Room GRB 432	1.2
May 11 4:00–5:00pm	**More than Just a Journal Club** Wellman Conference Room	- - -
May 19 8:00am–4:30pm	**Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other** Training Department, Charles River Plaza	7.2

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



Students (l-r): Woods, Bule, Flores, Biancardi, Hernandez, and Alce

Six MGH students participate in National Youth Leadership Forum on Nursing

Six students from East Boston High School currently doing Pro Tech internships at MGH, participated in the recent National Youth Leadership Forum on Nursing (see story on page 6). The students are Marielle Alce, Shannon Biancardi, Sadiya Bule, Julian Flores, Jesse Hernandez, and Juanita Woods. At a time when health care is facing a daunting shortage of nurses and other health-care workers, the response of these six students to the experiences they had learning about nursing is encouraging.

Said Bule, "The program was an eye-opener for me. Nurses really have an opportunity to further their education and practice in a number of different roles."

One student who might have been vacillating on whether to become a nurse shored up his decision as a result of the program. Said Hernandez, "Before participating in the forum, I was getting a lot of flak from friends and family that nursing was a woman's job. But what struck me was how great it is to work with patients. I didn't realize how involved nurses are. I have so much more respect for them now. Nursing is an awesome field."

Woods observed that, "The program is especially good for students who haven't made up their minds yet. It really showed me what nursing is all about and helped me decide."

Others were struck by the flexibility and opportunities nurses have. Said Alce, "Being a nurse can mean so many things—there are so many different roles and specialties. You don't have to do the same thing your entire career; you can keep changing and growing."

Students heard lectures, shadowed nurses in real-life situations, and had an opportunity to observe a number of medical and surgical procedures. There's a lot to be said for 'on the job training.'

Said Flores, "With the shortage of nurses, there's going to be great job security. It's interesting work that always keeps you engaged. More people should choose nursing—it's a great career."

Perhaps Biancardi said it best when she observed, "You never hear about the teamwork, and decision-making, and how much patients rely on nurses. Nursing in the real world is nothing like what you see on television!"

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