December 1, 2005

Caring HEADLINES

Social Services celebrates 'Innovation at 100'

—by Ellen Forman, LICSW

October, 2005, marks the 100th anniversary of the founding of the first hospital-based Social Service department in the country, which occurred here at MGH. Healthcare social workers across the country consider the 1905 founding of the MGH department of Social Services by Dr. Richard Cabot and Ida Cannon the beginning of the social work specialty. A hundred years after its inception, the department now boasts a staff of social workers, nurses, domestic violence advocates, lodging coordinators, support staff, resource specialists, and physicians. The department serves patients and families throughout the hospital and the community.

The auspicious occasion was marked by a two-day symposium entitled, 'Innovation at 100,' and a gala dinner at the Hynes Convention Center, October 27–28. The event showcased the innovative programs and services offered by the department.

Festivities began with the keynote address by Partners HealthCare chief operating officer, Tom Glynn, PhD, entitled, "The Future of the Healthcare Environment and Challenges for Social Work." With anecdotes spanning a long and varied career, Glynn reminded us that our training and experience provide us with unique skills that are useful in any setting, whether working with patients in the hospital or responding to a crisis at the MBTA, as he did in an 'earlier life.'

"It's all about the people," Said Glynn. He encouraged social workers to educate themselves and stay involved in public-policy issues that affect health care and impact patients' lives.

Gary Bailey, MSW, chairperson of the National Social Work Public Education Campaign, gave the second keynote address, "The Power of Social Work: 100 Years

continued on page 4


Ellen Feldman


Tom Glynn


Kathy Clair-Hayes


Kathryn Binda

Inside:

MGH Patient Care Services

Working together to shape the future

Patient Care Services Strategic Planning Retreat

(Part II)

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

In my last column, I began telling you about the work of the Patient Care Services leadership team during our most recent retreat in October. I spoke about the extensive pre-retreat preparation we did, including book reports, assessing our current reality, identifying 'worthy aims,' and hearing from members of our team on key topics to further inform our work.

When the retreat began in earnest, we spent considerable time talking candidly as a group about what was important to us; what issues demand our ongoing attention; what projects or initiatives, if any, we could let go of; and what our patients and staff need from us. In an informal way, we took inventory of our current priorities and deliberated about whether they should remain priorities for the future.

Some of the themes that emerged during this discussion were:

- working toward operational excellence
- creating a culture of quality and safety
- reporting and leveraging clinician-sensitive safety indicators
- improving clinician-physician relationships
- expanding our involvement with global health care
- developing leaders for tomorrow
- improving patient-satisfaction
- improving staff-satisfaction

And those are just some of the topics we discussed.

In break-out sessions, we focused on specific topics, brainstorming about ways to change, augment, improve, or enhance existing systems. In morning sessions we focused on communication, quality and safety, and patient-satisfaction. We talked about the role of the Patient Care Services Executive Committee and whether we're puting our time, energy, and resources to the best use.

We talked about the challenges we face in ensuring the safety of our patients and staff. Are we getting the most from our safety and surveillance rounds? Are all role groups and disciplines who should be participating, participating? What changes can we make to the process, membership, and evaluation of these all-important safety and surveillance rounds?

We talked about patient-satisfaction. Do we really know what's important to our patients; are we listening to them; are we meeting their expectations? Numerous recommendations and suggestions emerged from this session, many related to the idea that every MGH employee should feel empowered to ask patients, "What is the most important thing I can do for you today?" Other suggestions revolved around enhanced communication; creating more family advisory councils; improving our identification of caregivers by role group; and implementing more options for alternative therapies, to name only a few.

Enhancing communication was perhaps the most pervasive topic of the entire retreat, surfacing in almost every break-out session and in some way affecting every issue we discussed. One challenge we identified was our ability to communicate with employees in a timely fashion about operational issues that affect everyone at MGH. How do we accomplish this without adding to the already over-burdened e-mail system? One idea was to create a one-page, informational 'flier' to be distributed 'as-needed' or on a regular basis to keep MGH employees informed of operational issues as they arise. Details are still being worked out, but we will be piloting a new communication tool to try to meet this need. More to come on this...

Other break-out sessions focused on the Clinical Recognition Program, collaborative governance, staff satisfaction, diversity (which I spoke about in detail in the November 3, 2005, issue of *Caring Headlines*), the environment of care, and many other broad and specific issues affecting patients and staff.

Our October retreat was indeed a springboard for new ideas, new programs, and new ways of thinking about our work. We identified a number of actions, which we hope to be able to implement immediately, and others we're developing and refining for future implementation. We knew going in to the retreat it

continued on next page

PCS Clinical Recognition Program

Clinicians recognized
August 1–November 1, 2005

Advanced clinician:

- Linda Shuman, RN, Post Anesthesia Care Unit
- Heather Kuberski, RN, Infusion Unit
- Melissa Roddie, RN, Medical Unit
- Christine Mattera, RN, Cardiac Access Unit
- Deborah Nelson, RN, Same Day Surgical Unit
- Kathleen Ryan, RN, Medical Intensive Care Unit

Clinical scholar:

- Debra Guthrie, RN, IV Therapy Team
- Virginia Sigel, LICSW
- Dana Allison, RN, Labor & Delivery/Newborn Care Unit
- Darleen Crisileo, RN, Cardiac Intensive Care Unit

Tuition Reimbursement

Question: If I want to go back to school, what does MGH offer in the way of tuition reimbursement?

Jeanette: The MGH Tuition Reimbursement Program assists benefits-eligible employees in pursuing basic education, degrees, and certificate programs. The complete list of reimbursable programs can be found in any Human Resources office or at the Training and Workforce Development Office (at 165 Charles River Plaza).

Question: Is there a minimum employment requirement to be eligible for the program?

Jeanette: Yes. You must complete six months of continuous service to MGH in order to apply for the Tuition Reimbursement Program.

Question: Are there restrictions as far as what school I can attend?

Jeanette: Courses must be part of a degree or certificate program offered by an accredited institution.

Question: Am I required to take a minimum number of courses per semester?

Jeanette: No. There is no minimum requirement to receive tuition reimbursement.

Question: I already have a master's degree. If I wanted to get a second master's degree, could I be reimbursed by MGH?

Jeanette: If you already have a degree (associate's, bachelor's, or master's) the Tuition Reimbursement Program will not reimburse for a second degree at the same level. (Human Resources will consider exceptions based on demand for difficult-to-fill positions.)

Question: When should I apply for tuition reimbursement?

Jeanette: Prior to the first day of class, you must submit an official letter of acceptance to the program, a tuition reimbursement application with your supervisor's signature, a course description, and documentation of the cost from the current school or college catalogue.

Question: When will I receive my reimbursement?

Jeanette: Within 60 days of completing the course, you will need to submit a completed Request for Reimbursement form, a copy of your grade report, and a receipt for the tuition paid.

Reimbursements are issued on the second and fourth week of the month by Payroll using direct deposit.

Question: What happens if I change my hours after I submit my application for Tuition Reimbursement?

Jeanette: Your hours at the completion of the course will dictate the amount of reimbursement.

Question: What is the maximum amount available to an individual employee?

Jeanette: Employees who regularly work between 20 and 35 hours per week can receive a maximum of $1,200; employees who regularly work between 36 and 40 hours per week can receive a maximum of $2,000. These are the maximum amounts allowed per fiscal year (September–October).

Question: Besides tuition reimbursement, are there other ways to obtain financial assistance to advance my education?

Jeanette: There are a number of scholarship and award programs:

- The Support Service Employee Grant Program provides up to $1,500 for (hourly) employees toward education that helps advance their careers. Grants are intended for employees with at least two years of service who do not already have a bachelor's degree. Grants are competitive. Candidates must submit an application. Applications for the next round of grants will be accepted in the spring of 2006. For more information about this program, contact Luisa Carvajal at 4-3368.
- Every year, AMMP members are eligible to apply for AMMP scholarships to assist in the pursuit of a degree or other relevant training at a college or university. Current employees are eligible to compete for scholarships of up to $1,000. For more information about this program visit: www. massgeneral.org/ammp and click on 'AMMP Scholarship.'

For more information about the Tuition Reimbursement Program, visit any of the Human Resources Offices (White 14; 75 Blossom Court; CNY, 149 7th floor) or the Training and Workforce Development Office (at 165 Charles River Plaza).

Tuition reimbursement applications are available on-line at: http://is.partners.org/hr/New_Web/mgh/mgh_training.htm, or call Kevin Cotter at 6-2230.

Jeanette Ives Erickson

continued from previous page

was going to be the beginning of a process—a process of sorting out priorities and establishing a long-range plan for the future. We didn't expect to emerge with a list of concrete goals; we wanted a forum in which to exchange ideas, inform our decision-making, and set a strategic direction for the future.

The work we began in our two-day retreat continues in bi-monthly PCS Executive Committee meetings and smaller work groups. While specific goals are still unfolding, I can tell you that our work is focusing on:

- enhancing quality and safety
- improving communication
- increasing participation in the PCS Clinical Recognition Program
- expanding our involvement with international health care
- promoting our research agenda
- increasing capacity and enhancing systems for effective capacity-management
- expanding and enhancing our Diversity Program
- creating new recruitment and retention strategies
- managing costs

I will keep you informed as we move forward with this important work. I look forward to your participation and support as we craft and implement a strategic plan for the future.

Celebrating 100 Years of Social Work

continued from front cover

and Going Strong." He gave a detailed history of Dr. Cabot's interest in the impact of psychosocial issues and how it led to the development of Social Work in health care. Bailey gave an overview of current issues facing the profession, focusing on ways to educate the public about the depth and breadth of what we do.

Participants had an opportunity to attend various break-out sessions and peruse a number of posters during the two-day symposium, some of which are summarized in this issue of *Caring Headlines*.

On the evening of Thursday, October 27th, members of the Social Services Department and others in the MGH community enjoyed a gala dinner complete with pre-meal reception, sit-down dinner, music, and a slide-show recap of the night's festivities. Special guests included Marian Cannon Schlesinger, Ida Cannon's niece; Grace Nichols, MSW, former associate director and acting director of MGH Social Services; and current director emerita, Evelyn Bonander, MSW. MGH president, Peter Slavin, MD, served as master of ceremonies.

Jeanette Ives Erickson, RN, senior vice president for Patient Care, congratulated all MGH social workers and thanked them for the exquisite care they provide to patients and families. Said Ives Erickson, "You make the extraordinary look easy. You are the heart and soul of social work. We celebrate your caring touch and the things you do to promote healing every day."

Ann Daniels, PhD, current executive director of MGH Social Services, provided a brief history of social work at MGH, starting with Dr. Cabot introducing the first social workers into the outpatient setting in 1905. She spoke about Ida Cannon joining the department after graduating from the newly formed School of Social Work in Boston (now Simmons College) and officially becoming director in 1908, a position she held until her retirement in 1945. Cabot and Cannon slowly integrated social work into the inpatient setting.

Cannon's work was based on three fundamental principles: providing patient-centered care; identifying and interpreting the psychosocial aspects of illness and placing the patient within the context of his family and life; and teamwork, all disciplines working together to maximize good patient care.

Said Daniels, "The concepts developed by Dr. Cabot and Ida Cannon remain the guiding principles of social work practice at MGH, and we look forward to meeting the challenges of the next hundred years."

Photos clockwise from top left: visitors peruse poster display; Ann Daniels with guest speaker, Gary Bailey; Ellen White helps Paula Gautier with corsage; Evelyn Bonander asks question of keynote speaker

(Photos by Paul Batista

Reflections of a clinical social worker

—by Marie Elena Gioiella, LICSW, addressing the assembly at large at the 'Innovation at 100' symposium

What would remarks from a social worker be if they didn't include feelings? So I will begin by saying, I feel honored to speak on behalf of my esteemed social work colleagues. I feel humbled by the challenge of trying to briefly highlight some of our many contributions.

How can I describe the variety of services we provide for, and with, patients and families, whether during a one-time crisis intervention, through a therapeutic relationship that develops over years, or some level of intervention in between?

- We offer guidance to parents on how to talk with their children about illness
- We help patients identify strengths and coping strategies that have served them well in the past and can be used to deal with their current situation
- We provide relief to victims of natural and man-made disasters
- We help protect children at risk and treat children who witness violence
- We facilitate family meetings where we promote communication between patients and loved ones trying to protect one another from painful emotions
- We make resources such as affordable lodging and educational materials available for patients and families
- We listen, often with heavy hearts, to the stories of our immigrant patients
- We support the hope of those awaiting organ transplant
- We sustain a nurturing environment for disabled adults and frail elders, enabling them to live with independence in the community
- We lead HAVEN support groups for women in abusive relationships, HOPES workshops for people adjusting to a new cancer diagnosis; seminars for the elderly in neighboring communities
- We strive to respect the diversity of our patients by increasing our ability to provide culturally competent care
- We accompany patients on many journeys, some toward a new or restored sense of self, some through grief, and some toward the end-of-life
- We serve as agents of healing and transformation

We are privileged that patients allow us into their lives, particularly at times of crisis and intensified vulnerability. We are awed by our patients' generosity of spirit in entrusting us with their fears, hope, sorrow, and joy. Though it can be heart-rending to witness physical and psychic suffering and ultimately lose people for whom we have come to care deeply (and in some cases, love), there is great delight in witnessing a patient's growth and ability to triumph over adversity. With our patients and their families as our best teachers, we gain perspective on what's most important in life.

We are able to do what we do because of the collaboration we share with our colleagues—nurses, physicians, interpreters, case managers, chaplains, physical and occupational therapists, respiratory therapists, speech-language pathologists; the invaluable assistance of our support staff; and the generosity of our benefactors, among them The Ladies Visiting Committee, The Friends of the MGH Cancer Center, and The Vincent Club and Board of Managers. It is only as a team that we can address the complex needs of our patients and families.

We are fortunate to practice as clinical social workers at MGH, where learning opportunities abound; where patient- and family-focused care is a lived priority; where we have the autonomy to use our skills and best clinical judgment; where expertise and compassionate care are recognized and rewarded; and where we have social work colleagues with whom we laugh, commiserate, and celebrate.

Ida Cannon said one of the first requests physicians made of social workers at the turn of the century, was to provide patients, 'freedom from worry,' and 'give them courage.' What makes our work so immensely rewarding is that as we help patients manage their anxiety or fear of the unknown, they teach us what is possible... they are the ones who give *us* courage.

May the exceptional, innovative work we have done over the past century and still do today, continue to grow in creativity, increase in its power to transform, and thrive in the healthcare environment of the future.

Social worker, Marie Elena Gioiella (right) with colleagues (l-r): Karen Tanklow, Mary Zwirner, and Marilyn Wise

(Photo by Paul Batista)

Dealing with the devastation of a lost pregnancy

— by Fredda Zuckerman, LICSW
coordinator of the Comfort and Support After Loss Team

In the past 20 years much has been written about pregnancy loss, the emotional impact on bereaved parents, and interventions that can assist them in managing their grief. Traditionally minimized and misunderstood, the loss of a pregnancy wasn't recognized as significant despite its impact. Often, it wasn't even spoken about by family members. Couples' lives were shattered as they struggled to cope with profound feelings of sadness and grief. Emotional support was either non-existent or woefully inadequate.

This lack of acknowledgment deprived parents of the opportunity to process the loss. As grief and bereavement have become more understood and societal attitudes towards pregnancy loss have changed, standards of care have begun to include opportunities for parents to talk about their loss, to see, hold, name, and make funeral arrangements for their lost child. Feedback from parents and cargivers suggests that the open acknowledgment and grieving for a child lost in utero is beneficial to parents' emotional health and well-being.

Obstetrical social workers from MGH, Beth Israel, and Mount Auburn hospitals have been meeting on a monthly basis for many years. In 2002, a study was published in *Lancet* suggesting that the practice of seeing and holding a deceased fetus might actually be harmful to the long-term mental health of parents, particularly mothers. The study found that women who saw and held their deceased babies reported significantly higher depression scores during and after their next pregnancy as compared to those who didn't see and hold their infants.

As social workers who had cared for bereaved families, we were puzzled by these findings. Fortunately we were able to work collaboratively with the National Center for Post Traumatic Stress Disorder to do our own research. Our primary goal was to see how hospital care was associated with psychological adaptation to the loss of a pregnancy. We also wanted to learn about the mental-health risk factors and predictors of coping associated with pregnancy loss and bereavement. Ninety-one women who experienced pregnancy loss at 20 weeks or greater participated in the study. They all delivered at MGH, Beth Israel, Mount Auburn, or Brigham and Women's Hospital.

Preliminary results show that 84% of women who saw their baby found it extremely helpful, and 78% thought holding their baby was extremely helpful. 78% had pictures taken, and of those 75% thought it was extremely helpful. 75% thought memory boxes were extremely helpful. 66% were very satisfied with the way hospital staff met their emotional needs and 75% thought hospital staff were extremely sensitive.

We're still looking at coping styles, acute response, social support, subsequent pregnancies, and how they affect the grief process and adaptation. Our next goal is to look at providing a cognitive behavioral-therapy intervention to improve adaptation.

As a social worker, it has been exciting to learn about research and how it impacts clinical care. It has been a wonderful opportunity to work collaboratively with other hospitals and other disciplines.

For more information about pregnancy loss or the research mentioned in this article, contact Fredda Zuckerman at 4-3177.

Comfort and Support After Loss

As the holidays approach, The Comfort and Support After Loss Team is offering a drop-in session for staff and families who have experienced the loss of a child, including the loss of a pregnancy or loss during childbearing.

Tuesday, December 6, 2005
7:00–8:30am
Schiff Conference Room 4810
Yawkey Building

For more information call
Fredda Zuckerman, LICSW, coordinator
of The Comfort and Support After Loss Team
at 617-724-3177

Call For Abstracts

Nursing Research Day
May 10, 2006

Submit your abstract to display a poster on Nursing Research Day 2006

Categories:

- Encore Posters (posters presented at conferences since May, 2005)
- Original Research
- Research Utilization
- Performance Improvement*

* Two new conditions for acceptance of Performance Improvement abstracts:

- Key personnel have been certified in the Protection of Human Subjects. (http://www.citiprogram.org/default.asp)
- Project has been reviewed and approved or excluded by the Partners Human Research Committee (HRC). For more information about the HRC review, contact your clinical nurse specialist; Catherine Griffith, RN, co-chair of the Nursing Research Committee; Virginia Capasso, RN, coach; or Kathleen Walsh, RN, (pager: 3-1792)

For more information, or to submit an abstract, visit the Nursing Research Committee website at:
www.mghnursingresearchcommittee.org

Abstract deadline is March 1, 2006

Partnering with families: the development of the Family Advisory Committee

—by Elyse Levin-Russman, LICSW
clinical social worker, Pediatric Hematology-Oncology Unit

A family-centered approach to health care has become more prevalent in hospitals over the last decade. Family-centered care promotes collaboration between families and healthcare practitioners. Providers, patients, and families form mutually beneficial partnerships, where the expertise of patients and families is honored and respected.

Some of the principles of family-centered care include: dignity and respect; fostering communication with healthcare providers that is complete and unbiased; honoring the racial, socioeconomic, and cultural differences of patients and families; valuing families' strengths; and empowering families to make informed healthcare decisions. Family-centered care has found much support throughout the United States in pediatric settings where families are often more visible. In the pediatric services at MGH, family-centered care is a priority.

There is considerable research that highlights the benefits of family involvement in health care for the child, the family, and the healthcare system. Studies show that in centers where family-centered care is fully implemented, family satisfaction is significantly improved, length of stay is shortened, and the use of the Emergency Department is decreased. Children experience less anxiety during healthcare procedures when parents are present and involved in their care.

There are significant challenges for families when a child is diagnosed with cancer. Life as they knew it is changed in an instant. Children often spend a lot of time at the hospital (as inpatients and outpatients), receiving intensive treatment to combat their disease. Families form strong relationships with caregivers, whom they trust and rely on for care, guidance, and support.

The strong involvement of families in the Pediatric Hematology-Oncology Unit created a setting where partnership was a natural next step. In 2003, many family programs were already in place to provide education and support to families. Many of these programs were created by clinical social workers with input from our colleagues. In August 2003, following an assessment of families concerning psychosocial care and programming, it became clear that parents were eager for an opportunity to contribute and have a voice in the services being offered.

In November of that year, the Pediatric Oncology Family Advisory Committee met for the first time with eight parents and a clinical social worker who served as facilitator. An oncology nurse and a physician also participated, emphasizing the commitment of the multi-disciplinary care team to this important initiative. The group defined a mission statement and goals and met monthly. The mission is "to form a partnership between parents and providers dedicated to improving the quality of care to children and their families during and after cancer treatment. Parents participating in the Family Advisory Committee are a resource for families and consultants to the Pediatric Oncology Practice concerning operations and program-development."

For the past two years, the Family Advisory Committee has been instrumental in guiding the development of programs in the Pediatric Oncology Unit. The group has suggested topics for inclusion in the educational series for parents. They initiated the summer Fun in the Sun Program that brought families of children in treatment together for an afternoon of food, fun, games, and community connection. Members of the Family Advisory Committee put hard-hats on and toured the Yawkey Building when it was being built to provide input about clinic design and organizational structure. They have worked with staff to create a healing environment for children, choosing age-appropriate art work and murals to be displayed in treatment areas. They've been ambassadors at events such as the annual holiday party and this year's Fall for the Arts Program, welcoming other parents and their children.

When asked to reflect on the experience of being part of the Family Advisory Committee, one parent said, "It has been a blessing to be involved, focused, and sometimes even distracted. My hope in participating initially was to gain strength, friendship, and support. I indeed accomplished that. And I've been energized and empowered to be involved in a variety of quality care initiatives as well."

The Family Advisory Committee allows us to put family-centered care principles into practice. Families are often our best teachers. Partnering with them gives us the opportunity to reach our common goal of providing excellent care to each child and compassionate care to the entire family.

For more information about the Pediatric Oncology Family Advisory Committee, please contact Elyse Levin-Russman at 4-0757.

December Vacation Club

MGH Back-Up Childcare Center
December 27–30, 2005

Camp Hours: 7:30am-5:45pm
Cost: $225 for 4-day week;
individual days $60 per child

The program is planned for children 6–12 years old

Activities may include:

Science Magic (traveling show from the Museum of Science); trip to Basketball City; puppet-making workshop; and making gingerbread houses

Closed Monday, Christmas day

The Backup Center will provide care for younger children (15 months–5 years old)

For information, call 617-724-7100

Physical therapist builds rapport to overcome patient's prior experiences

Matthew Travers is a clinician in the PCS Clinical Recognition Program

Matthew Travers, PT
physical therapist

My name is Matthew Travers, and I've worked in outpatient orthopedic physical therapy for more than five years, the last eight months here at MGH. I've found that the best patient-therapist relationships start with establishing a good rapport during the initial evaluation.

I met Tom when he came for his initial evaluation in the outpatient Physical Therapy Department. Tom was a 45-year-old man who'd been referred by his primary care physician for treatment of lower back pain. Tom was pleasant as I shook his hand and introduced myself in the waiting room. As we walked to the private treatment room, I learned a bit more about his case. Tom's response to my usual question, "Have you been to physical therapy before?" yielded an unusual answer. It was from his answer I realized I was in for a challenge.

Tom said he'd been in and out of physical therapy for about six years and didn't think very highly of the physical therapy profession. Not only did Tom have a long history of back pain, he'd 'been made worse by three physical therapists' prior to finding one he felt had helped him. When we got to the treatment room, he handed me a letter from his last physical therapist detailing his prior treatment. I realized I needed to establish a rapport that would make Tom and me a team with a clear understanding of our common goals. He obviously knew what he wanted, and it would be very easy to lose control of the situation if I didn't make it a positive experience for him.

I agreed with Tom that, like any profession, there was variability in the practice of physical therapy. I spoke about the many areas of specialization and continuing education in the profession. We talked about his concerns and the approach I'd be taking during evaluation and treatment. I tried to assure him that he was an active participant and should continue to express any questions or concerns he may have.

I thought I should wait to read the letter so as not to bias my evaluation. He thought this was a good idea. At no time was Tom rude or disrespectful, but it was clear that he would be evaluating me as much as I was going to be evaluating him. I thought, Okay, this has happened before; I'm up to the challenge.

I proceeded to take his history by reviewing the health status questionnaire. Soon, I encountered another minor set-back in building a rapport. Tom reported that he'd had an 'IDET' procedure in the past. I wasn't sure what that was, or even what part of the body it was performed on. I could either ask him about it and risk him thinking less of me as a therapist, or not ask and try to maintain his confidence in me. I was already off to a shaky start, but I decided to ask. It was better to be honest and gain as much information as I could.

I sensed the uneasiness in his reply. "It was for my back," he said.

That didn't really help me, and I'm sure he read that in the expression on my face. Fortunately, Tom was knowledgeable about the procedure and happy to describe it. The IDET did sound vaguely familiar but I knew I'd need more information. Tom felt better when I assured him I'd learn more about the procedure. At that point, I was just happy he didn't get up and leave. We ended the subjective history with a discussion of his functional problem and goals.

Functionally, Tom was only able to remain in a position comfortably for about ten minutes. On a scale of one to ten, his pain was 2-3 at best, and 6-8 at worst when sitting, staying in a prolonged position, driving, or twisting. The pain was limiting his ability to work at a desk, travel, or participate in recreational activities. His goals were to do no further damage to his back with physical therapy; avoid another surgery; and ultimately feel better. He didn't expect to be pain-free, but his timeline for improvement was relatively short. As we began the physical exam, I hoped I'd find something we could treat.

Tom was impressed during the segmental-mobility and lower-extremity flexibility exams. I gained a little credibility in his eyes. He said it was nice that some of the testing I was doing he'd never seen before. As I examined him, I asked about his past treatments. I learned he hadn't done a lower-extremity flexibility program. Most of his home program had been trying to 'crack' his back. I observed that Tom stood with his pelvis rotated forward with increased backward rotation in his lower lumbar spine. He transferred using a valsalva maneuver, bending and twisting to get on and off the bed.

After the exam, I understood why manual therapy had helped him in the past. He had significant, increased motion in segments of his spine which were rotated backward, while segments above were tight and rotated forward. Tom's sacrum was rotated forward, and he had tight hip muscles, hip joints, and hamstrings.

There were many things Tom could do as an adjunct to manual therapy in a home program that would address tissue hypomobility and core stability. I was concerned about the lack of body awareness and posture he exhibited.

Now it was time to explain my assessment and plan of care. My opinion was that Tom's

continued on next page

Some portions of this text have been altered to make the story more accessible to non-clinicians and lay-people.

Clinical Narrative

continued from previous page

posture was causing static loading and increased compressive forces on his spine. His irritability could have been caused by both facet and disc components. Clinically, it seemed that facet compression was more of a problem. Tom experienced the most pain with backward bending. Using a model of a skeleton along with drawings, I helped Tom visualize the forces on his facet joints and disc. I explained that by altering prolonged postures and positions, he could significantly decrease those loads. It could be as powerful as anything we could do in the clinic in two thirty-minute sessions a week.

Tom was engaged and seemed to understand the mechanics. He said my explanation made a lot of sense to him, and he was willing to give it a try.

We ended the exam with instruction in standing and sitting posture and suggestions for workstation ergonomics. I think the evaluation ended on a positive note.

This was a case of a patient arriving with a clear opinion of what he wanted and needed. However the exam exposed other significant components that needed to be addressed for long-term management and rehabilitation. Both our opinions needed to unite in a common plan. I think the encounter was a success because I respected his opinion and didn't respond negatively when challenged.

This was a complicated case, so I consulted with a clinical specialist who reinforced my thoughts and added to my understanding of Tom's condition.

I had a small window of opportunity to try to relieve Tom's pain. I underestimated the amount of time he was willing to give our plan. During our second meeting, I had stressed the importance of good posture while sitting, standing, bending, and lifting. When he arrived for his third session (with his wife), he was upset. He asked what my intention was for his treatment. Was I going to use any of the techniques his past therapist had used. I felt a bit under attack.

I took time to review the letter from Tom's past physical therapist in depth with Tom and his wife. I reinforced my feelings about the need for postural modification for long-term success and management. I outlined my plan to his wife. They agreed, but Tom needed some relief from his symptoms. Clinically, it was time to incorporate manual skills into his treatment. I could have incorporated manual techniques earlier, but I felt that postural awareness was of primary importance prior to manual techniques.

I have treated Tom four times since his initial evaluation. He is encouraged by his decreased pain. He reports that the stretching program for hip flexors has given him relief and he wishes he'd been doing them long before he met me. Tom still needs occasional cueing for transferring and posture. I'm not sure what the ultimate outcome will be. Usually patients experience some relief around six to eight weeks when motor control improves and tissue hypomobility decreases.

I'm optimistic because Tom is already able to modify his pain by adjusting his posture. Regardless of the outcome, I feel confident about the plan we put forth. Tom has been empowered to participate in his own care. And it all began by overcoming those initial hurdles and establishing a good rapport.

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

With changes in health care and increased access to information, patients today are more informed and knowledgeable about their care and treatment. Tom was well informed about his condition and had clear expectations of his physical therapist. Matt was sensitive to Tom's concerns from the start. Instead of becoming defensive, Matt redoubled his efforts to earn Tom's confidence. He was ultimately able to earn Tom's respect with his knowledge and skill as a physical therapist.

This story speaks to a situation many clinicians encounter—having to shoulder the 'baggage' that patients bring from previous caregivers. Matt handled the situation beautifully, with skill and grace.

Thank-you, Matt.

Call for Proposals

The Yvonne L. Munn, RN, Nursing Research Awards

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 7–12, 2006.

Proposals are due January 15, 2006. Guidelines for developing proposals are available at: www.mghnursingresearchcommittee.org under "Funding Sources"

For more information, contact Virginia Capasso, PhD, at 617-726-3836, or by e-mail at vcapasso@partners.org

The Knight Nursing Center presents

Inaugural Visiting Professor in Wound Healing

Courtney H. Lyder, ND, GNP, FAAN, professor of Nursing, professor of Internal Medicine and Geriatrics, University of Virginia

Thursday, December 15, 2005

"Pressure Ulcers: Avoidable or Unavoidable?"
11:00am–12:00pm, Blake 8 Conference Room
All are welcome, CEUs will be awarded

"Building an Infra-Structure for Wound Care in Acute Care"
12:00–1:15pm, Blake 8 Conference Room
Open to CNS Wound Care Task Force

"Shifting the Paradigm: Implications of Deep Tissue Injury and F-Tag 314 on Care of Pressure Ulcers"
1:30–2:30pm, O'Keeffe Auditorium
All are welcome, CEUs will be awarded

"Pitfalls of Pressure Ulcers: Avoiding a Malpractice Suit"
2:30–3:30pm, Blake 8 Conference Room
All are welcome, CEUs will be awarded

Take Good Care Packs: an innovative way to support parents and children at MGH

—by Kathy Clair-Hayes, LICSW, Take Good Care Packs Program

As social workers, many of us have sat with parents to talk about how they can talk with their children when a parent or a sibling is ill. It was from that clinical experience that we created the Take Good Care Packs Program. Through this program, we give parents developmentally appropriate information about how to talk to their children about what's happening in their family. Therapeutic backpacks give parents and children tools to talk about what's happening and how they can cope with the crisis together.

Currently the Take Good Care Packs Program focuses on four areas:

- adult oncology, when a parent has cancer
- pediatric oncology, when a child has cancer
- trauma or sudden illness, when a parent is involved in a trauma or life-altering illness
- grief, when a parent dies at MGH

Packs for all these programs have been tailor-made by clinicians to meet the needs of the family members they support.

The goals of the Take Good Care Packs Program are to:

- support parents at a time of crisis
- provide outreach to an unseen population (a patient's children or siblings of a child with cancer)
- promote family communication
- encourage expression of feelings
- provide developmentally appropriate resources that families can take home to their children

We do this by offering a therapeutic backpack to each family member when the appropriate situation arises. Five types of packs are available: parent, teen, school-aged (ages 7-11), preschool/kindergarten (ages 3-6) and toddler (under 3). Each pack contains comfort, expressive, stress-reducing, and educational items, all the things that help families cope when there's a serious illness.

Each pack contains a brochure written in plain language by MGH social workers. For parents, the brochure addresses how to talk with children about what's happening. For children, the brochure speaks to the many questions they have when a parent or sibling is ill.

Adult oncology packs were first created in the fall of 2001. To date, we've given more than 4,000 packs to cancer patients and their children. Each pack has an evaluation postcard, and we hear from parents and their children that the packs have been very helpful. The packs make children feel included.

As social workers we know that illness impacts the whole family. One way we can intervene is to make sure that children are told what's happening and support parents in talking with their children.

Marilyn Brier, LICSW, oncology social worker, says, "When I give a pack to a parent, it says to that patient, 'I'm thinking of you as a whole person, not just a sick patient, but a mother or father.' It says I'm thinking of how the illness affects the whole family. Parents are so grateful to have something to give their children at a time when they feel vulnerable and worried about how their illness will impact their children's lives."

The pediatric oncology packs were created in the winter of 2003 to help parents talk with a child who has cancer and his/her siblings. They help parents initiate a conversation about how

continued on next page

(Photo provided by staff)

Social Services helps couples cope with infertility

—by Ellen Feldman, LICSW

The MGH Fertility Center is a specialized unit offering medical and emotional care for couples and individuals trying to have a family with the help of assisted reproductive technology. At the recent 'Innovation at 100' symposium, Ellen Feldman, LICSW, led a break-out session exploring the role of the social worker in helping couples cope with infertility.

Infertility is a major life crisis that affects one in six couples of childbearing age in the United States (or more than ten million people). Often it's the first crisis a couple experiences, and it can be debilitating for both partners. Infertility can have medical, social, and psychological ramifications. The duration of the crisis is unpredictable and different for everyone, and resolution may require resources beyond familiar problem-solving methods.

Feelings of helplessness and loss of control over life events can negatively affect sexuality and self-esteem. Stress, depression, anxiety, and despair can replace confidence and well-being. Infertility affects both partners simultaneously, often creating competing needs and marital conflict.

The role of a social worker trained in the medical and psychosocial aspects of infertility and assisted reproductive technology can be an integral part of helping a couple confront and manage the crisis. Whether contact is an initial educational consultation prior to medical treatment or ongoing support, studies have shown that counseling is a beneficial coping strategy.

During the break-out session, Feldman informed participants about an ongoing, free research opportunity at MGH for first-time parents undergoing in vitro fertilization. This study, headed by Anne Fishel, PhD, offers couples multidisciplinary group interventions during and after pregnancy. Interventions provide couples with coping strategies for managing first-time births, a life-altering event that's often overshadowed by infertility.

For more information about the MGH Fertility Center, call Ellen Feldman at 4-0053.

Take Good Care Packs

continued from previous page

they can cope with the illness as a family.

According to Elyse Levin-Russman, LICSW, pediatric hematology-oncology social worker, "The siblings of pediatric cancer patients are especially appreciative to be remembered and included at a time when an ill brother or sister is the focus of their parent's lives." Sibling packs were designed to provide children with activities they can do alone or with others, recognizing there are times when parents can't be available. One sibling told Levin-Russman she appreciated the informational materials about having a brother or sister with cancer and she felt 'special' for being included in the program.

In the fall of 2003, a group of clinical social workers from throughout MGH started a committee called, Kids Express. Says Carla Cucinatti, LICSW, "We see the many ways in which children are impacted by the life-altering illness or injury of a parent or loved one. In many instances, we see a child's needs being inadvertently overlooked by family members and staff, as a medical crisis draws attention away from children and their emotional needs."

Kids Express joined forces with Kathy Clair-Hayes, LICSW, to create the Trauma/Sudden Illness Take Good Care Pack. Working collaboratively, the clinicians formulated best-practice ideas for supporting parents with children. The group wrote brochures for parents on talking about trauma and illness and preparing children for hospital visits.

Cardiac Unit social worker, Marguerite Hamel-Nardozzi, LICSW, says the packs help her "quickly make a meaningful connection with children and their well parent." She finds that packs "remind kids that they're cared about, too."

Neurology social worker, Berney Graham, LICSW, describes how she used the packs with one family. "I was able to talk with mom and help her make a plan for how to tell her children that dad was in the ICU and unable to communicate. The next day, she came to me absolutely relieved. She had given the children the packs and they sat and played with the stress balls and puzzles while mom talked with them. Throughout the week, the children would find their packs and sit with mom to find out how dad was doing. In this case, the packs became a centering point for the children and a vehicle to talk about their father's illness."

Grief packs are the newest addition to the program. Grief packs are given to a surviving parent or caregiver when a parent dies at MGH. Often these families aren't connected with hospice and rarely return to the hospital. As clinicians we felt we needed to create a holding environment for these families. Grief packs can be given to families to take home. They contain information on how to talk to children about the death of a parent, common reactions children may have, and how to prepare children for a memorial service or funeral. Expressive journals, a memory book, and a teddy bear are included. This is one way we can support families just begining their grief journey.

Rebecca Murphy, LICSW, social worker in the Surgical Intensive Care Unit, tells of an experience helping prepare a patient's children for the death of their father. "The packs were a way for me to help this patient's wife start talking about the impending loss of her husband. She was really asking for help to support the kids. The packs were an incredible help to this family at a very difficult moment in their lives."

Take Good Care Packs are a family-friendly model that allow clinical social workers to extend the boundaries of psychosocial care from the bedside to the home. In doing so, we're acting in a preventative way, to shore up families' coping abilities and remind parents that they're the best supporters and teachers of their children.

Social work at the ethics table

—by Marilyn Wise, LICSW

Understanding the role of ethics has an increasingly important place in social work today. One session at the 'Innovation at 100' symposium was dedicated to a review of ethics education and collaboration in the Social Services Department at MGH. Panelists included Karon Konner, LICSW; Shoshana Savitz, LICSW; Angelica Tsoumas, LCSW; and Marilyn Wise, LICSW.

To establish common ground, the presentation began with a working definition of ethics as the study of what 'ought' to be, how one 'ought' to act. The panel discussed the many opportunities clinical social workers have to incorporate ethics theory into social work practice within the department, the hospital, and the healthcare community at large.

MGH social workers are involved with a number of ethics programs including the Optimum Care Committee, Ethics Rounds on patient care units, and the recently established, monthly Social Work Ethics Forum. The panel detailed the importance of incorporating ethics into the social worker's role and examined why it's so vital to our patients, colleagues, and profession.

During the second half of the session, attendees were encouraged to join a discussion related to an actual case where end-of-life decision-making and advance-care planning were central to the outcome. The case was analyzed within the context of an ethics framework. Participants were given an outline on how to work up an ethics issue, hand-outs explaining ethics terminology, the NASW Code of Ethics, and a bibliography of additional resources.

The presentation concluded with a discussion of the benefits of blending ethics and social work. Ethics is a natural complement to traditional social work, so there is great benefit to our patients when ethics has a transparent role in practice. Continuing to educate ourselves in this area will promote greater consistency in the profession and enable social workers to more fully articulate their role and expertise. Combining formal ethics into social work practice promotes a common ground between all disciplines and enhances patient care.

The more we learn about ethics, the more we develop a common language and valuable tools with which to discuss important, sensitive issues.

Ethics is the common ground upon which all disciplines intersect. We must:

- continue to educate ourselves and others
- articulate more fully our role and expertise in the area of ethics
- promote greater consistency within the social work profession
- expand our role beyond patient care to increase visibility in our various organizations and communities

For more information about ethics and social work, contact Marilyn Wise at 6-2617.

MGH Ethics Task Force Ethics Forum

"Triage Decisions and Scarce Resources in the Tsunami Relief Effort in Indonesia"
presented by
Connie Wilson, RNC, OB staff nurse

Friday, December 9, 2005
12:00–1:00pm
Sweet Conference Room, GRB432

no pre-registration required
bring a lunch. Snacks and drinks provided
for more information, e-mail
erobinson1@partners.org

Social Services Diversity Council

—submitted by members of the Social Services Diversity Council

Since early 2002, the Social Services Department has been developing and implementing a comprehensive diversity plan. The Cultural Competence Committee laid the groundwork for open communication and trust, two elements essential to any diversity effort. In conjunction with department leadership, the committee hired a consultant to formally look at where we were and assess our needs. Findings from the survey suggested the need for further training and a more representative committee to carry the work forward.

The Social Services Diversity Council convened in 2004. An essential step in developing trust and communication was a two-day, off-site, diversity training retreat, facilitated by a diversity specialist. The focus of the retreat was self-awareness through experiential exercises. Through sharing personal 'stories,' developing group unity, and establishing an environment where each person's ideas and experiences were valued, we created a vision for a fully diverse and inclusive department. The Diversity Council used this visioning process as the foundation for a strategic plan.

New initiatives implemented since the retreat include:

- establishing a Diversity Resource Library
- holding monthly, open, unstructured diversity dialogues
- holding a monthly Diversity Media Hour with discussions about readings or films
- distributing a monthly diversity events calendar.

The Diversity Council continues to consider new ways to bring diversity awareness to the department. It is currently developing a plan to enable all members of the department to attend intensive diversity training. Hard work and commitment are required to truly incorporate diversity into all aspects of practice. Creating a welcoming environment, one that fosters trust and caring and genuinely values diversity, is an ongoing process, one to which the Social Services Department is strongly committed.

For more information about the Social Services Diversity Council, call Maria LoDuca at 4-9498.

Two of many posters on display at the Social Services' 'Innovation at 100' symposium

For more information about Social Services'Family Care Program, contact Eileen White at 724-0759. For more information about the Coordinated Care Program contact Paula Murphy at 724-0056.

MGH is committed to improving hand hygiene; we encourage all staff to use Cal Stat:

Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131
726-2036

- Start with dry hands that aren't visibly soiled (wash hands first if they're soiled and then dry thoroughly)
- Apply Cal Stat to one hand from the wall or pump dispenser
- Spread Cal Stat over all surfaces of both hands, rub hands and fingers together until dry

NOTE: If sufficient amount of Cal Stat is used, it will take at least 15 seconds for hands to dry

Holiday Resource Table

The Employee Assistance Program (EAP) will offer a holiday resource table with information on how to handle stress, how to set realistic goals, how to take better care of yourself at this time of year, and how to enjoy the holidays

Wednesday, December 14, 2005
2:00–3:30pm
WACC Lobby

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

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

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

Managing Editor
Susan Sabia

Editorial Advisory Board
Chaplaincy (interim)
Marianne Ditomassi, RN, MSN, MBA

Development & Public Affairs Liaison
Victoria Brady

Editorial Support
Marianne Ditomassi, RN, MSN, MBA
Mary Ellin Smith, RN, MS

Materials Management
Edward Raeke

Nutrition & Food Services
Martha Lynch, MS, RD, CNSD
Susan Doyle, MS, RD, LDN

Office of Patient Advocacy
Sally Millar, RN, MBA

Orthotics & Prosthetics
Mark Tlumacki

Patient Care Services, Diversity
Deborah Washington, RN, MSN

Physical Therapy
Occupational Therapy
Michael G. Sullivan, PT, MBA

Police & Security
Joe Crowley

Reading Language Disorders
Carolyn Horn, MEd

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech-Language Pathology
Carmen Vega-Barachowitz, MS, SLP

Volunteer, Medical Interpreter, Ambassador and LVC Retail Services
Pat Rowell

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

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

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

Next Publication Date:
December 15, 2005

Please recycle

CareNotes: improving patient education and documentation

—by Judy Gullage, RN; Donna Lawson, RN; and Jill Taylor Pedro, RN
Patient Education Committee

CareNotes from Micromedex is a customizable documentation system that's available on-line as a resource to clinicians for patient education. Information on more than 3,500 topics is available and includes:

- Pre-care information: preparation and pre-procedure or pre-surgical information
- General information: health condition summaries
- Inpatient information: diagnostic and treatment processes during hospitalization
- Discharge instructions: instructions for a variety of health conditions
- Aftercare information: discharge documents for Emergency Department patients

The goal of CareNotes is to:

- standardize practice for patient education
- individualize teaching for each patient
- improve documentation of patient teaching

CareNotes are written at an eighth-grade level to make it easy for patients to understand. CareNotes are available in English and Spanish and can be customized to meet specific patient needs.

Also available within the CareNotes system are DrugNotes. DrugNotes are a great resource for patients going home with new medications. You can browse drug names alphabetically and obtain the desired information.

For example, if you had a patient admitted with atrial fibrillation, you could give her the CareNotes general information on atrial fibrillation to provide an overview of her condition. You could give her pre-care information on cardioversion or ablation (or any other procedure she may require). When she's ready for discharge you can customize her discharge information to meet her specific needs, and give her the DrugNotes for the medication she'll need at home.

CareNotes is simple to use. From the Start button on your computer, click on Partners Application, then Clinical References, then CareNotes. Once in the CareNotes system you can search for your patient's specific health condition, diagnostic test, procedure, medications, and more.

Clinicians have just begun using CareNotes in the past few months. General consensus is that it makes patient education easier. Having CareNotes available on-line eliminates the need to store teaching materials in a file cabinet, and the system is continuously updated to ensure that information is current and accurate.

Says one nurse, "It's so easy to access. I was able to give a newly diagnosed diabetic patient information in Spanish about her disease, about insulin, and how to give injections."

Another nurse notes, "CareNotes has allowed me to tailor, in a time-efficient manner, the educational materials I use on a daily basis. Patients who are new on the unit with either a new or re-occurring diagnosis are provided with literature to help explain and prepare for their hospitalization. CareNotes gives patients an opportunity to ask questions and get clarification about their diagnosis and related treatments. Patients have a much better experience in the hospital and after discharge when they're prepared to actively participate in their own care."

CareNotes helps in the delivery of patient education. As clinicians we teach patients every day. Remember to document your patient teaching.

For more information about accessing or using CareNotes, contact Judy Gullage at 6-1409, or patient education specialist, Taryn Pittman at 4-3822.

CareNotes Patient Education System

(A quick reference for discharge instructions)

To access:
- Start/Partners Applications/Clinical References/CareNotes -DrugNotes

To search: (2 options)
- To search by 'keyword,' type in subject
- To search by 'Care and Condition,' select medical topic
- Select appropriate document (Discharge)
- Click on 'English' or 'Spanish' to customize

To customize: discharge document
- Click 'Start to Fill in Blanks' button

Medications
- Nurse does not have to type name of medication in box (it's optional)
- Make sure patient has information about new medications from either DrugNotes or LexiPals; review with patient; answer all questions
- Use Medication Schedule if needed
- Tell patient to keep updated medication list

Follow-up appointment
- Make sure information is in CareNotes or Post Hospital Patient Care Plan

Call or seek care immediately If
- Type in name and phone number of follow-up provider

Other
- Customize additional information as needed (temperature, weight, etc.)

To print
- Press 'Print Now' to add further special instructions, adjust font size, add patient or provider name, and then print
- Press 'Print Later' to put document in the printer list (queue)
- Press 'Print List' when you're ready to print all documents selected
- Press 'Print Preview' to preview materials before printing

To document:
- From admission through discharge, use Interdisciplinary Teaching Form
- For discharge: use Post Hospital Patient Care Plan

Educational Offerings

When/Where	Description	Contact Hours
December 7 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
December 7 8:00–11:45am	**Intermediate Arrhythmias** Haber Conference Room	3.9
December 7 12:15–4:30pm	**Pacing Concepts** Haber Conference Room	4.5
December 7 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
December 12 8:00am–4:30pm	**Intermediate Respiratory Care** Thier Conference Room	TBA
December 14 11:00am–12:00pm	**Nursing Grand Rounds** "Pilmonary Hypertension." Sweet Conference Room GRB 432	1.2
December 15 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** Training Department, Charles River Plaza	TBA
December 15 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
December 15 1:30–2:30pm	**Nursing Grand Rounds** "Deep Tissue Injury." O'Keeffe Auditorium	1.2
December 16 12:00–1:00pm	**Schwartz Center Rounds** Walcott Conference Room	- - -
December 16 8:00–11:00am	**On-Line Clinical Resources for Nurses** FND626	3.3
December 19 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK401 (No BLS card given)	- - -
December 20 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
December 21 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
December 22 1:30–2:30pm	**Nursing Grand Rounds** "Care of the Stroke Patient." O'Keeffe Auditorium	1.2
January 5 8:00–4:30pm	**Cancer Nursing Concepts: Advancing Clinical Practice** Yawkey Conference Room (TBA)	TBA
January 9, 10, 23, 24, 30, 31 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** Faulkner Hospital	44.8 for completing all six days
January 11 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
January 11 11:00am–12:00pm	**Nursing Grand Rounds** Sweet Conference Room GRB 432	1.2
January 11 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
January 11 4:00–5:00pm	**More than Just a Journal Club** Thier Conference Room	1.2
January 11 8:00am–12:30pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Training Department, Charles River Plaza	- - -

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.

Comfort and Support After Loss memorial service

—by Kathryn Beauchamp, RN

The Comfort and Support After Loss Team held its 14th annual Pediatric, Neonatal, and Obstetric bereavement ceremony on November 6, 2005. The service is held for those who have experienced the death of an infant, child, or adolescent, or have had a miscarriage, stillbirth, or neonatal loss.

The ceremony was moderated by Fredda Zuckerman, LICSW, clinical social worker, and began with a welcoming address by Howard Weinstein, MD, chief of Pediatric Oncology and Kathryn Beauchamp, RN, clinical nurse specialist, in Pediatric Critical Care. Several family members shared stories and poems, describing their journeys through grief and bereavement.

(Photos by Michelle Rose)

Under the direction of musical director, Paul Vitale, the St. Thomas Villanova Church and St. Florence Parish choirs provided music and songs throughout the service. Parents, families, and friends participated in the naming ceremony. They were given tulip bulbs and a pewter heart in memory of their child (or children). Photos spanning 14 years were shown in a special slide show.

Following the service a reception was held in the Thier Conference Room. Memorial quilts were available for viewing outside the MGH General Store, and memorial scrapbooks were available at the reception.

Comfort and Support After Loss Team members:

- Fredda Zuckerman, LICSW
- Kathryn Beauchamp, RN
- Ann Haywood-Baxter, MDiv
- Leigh Horne-Mebel, LICSW
- Heidi Jupp, RN
- Elyse Levin-Russman, LICSW
- Joyce McIntyre, RN
- Brenda Miller, RN
- Heather Peach, CCLS
- Jeanine Perez, LICSW
- Beth Place, RN

Caring HEADLINES

Send returns only to Bigelow 10
Nursing Office, MGH
55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston MA