September 22, 2005

Caring HEADLINES

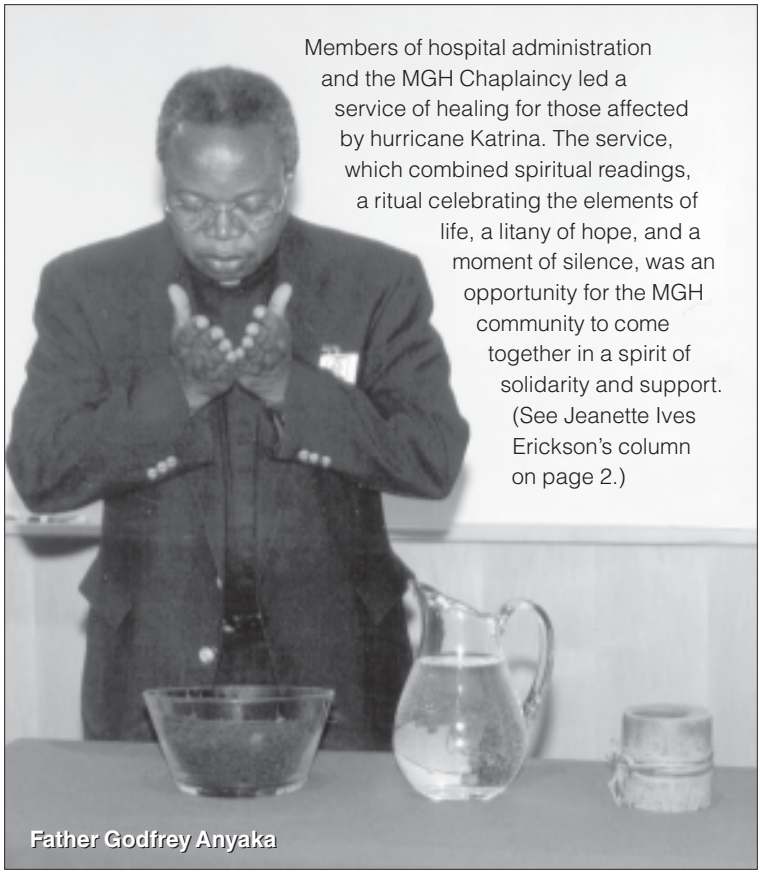
A service of healing for those affected by hurricane Katrina

Inside:


Ives Erickson

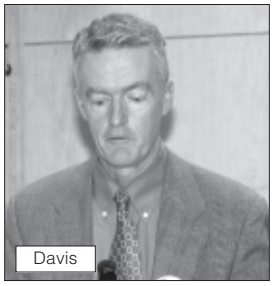

McElhinny


Haywood


Father Godfrey Anyaka

Members of hospital administration and the MGH Chaplaincy led a service of healing for those affected by hurricane Katrina. The service, which combined spiritual readings, a ritual celebrating the elements of life, a litany of hope, and a moment of silence, was an opportunity for the MGH community to come together in a spirit of solidarity and support. (See Jeanette Ives Erickson's column on page 2.)


Slavin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(Photos by Michelle Rose)

Hurricane Katrina, MGH, and relief efforts on the Gulf Coast

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

Once again, in the aftermath of a catastrophic natural disaster, MGH was among the first to volunteer to help. Hurricane Katrina, which many are calling the worst natural disaster ever to strike the United States, killed (at press time) more than 650 people, destroyed dozens of communities along the Gulf Shore, and left more than one million people homeless and/or displaced.

Our response has taken many forms. First to be deployed were five MGH clinicians (two nurses, two social workers, and a pharmacist) and one Police, Security & Outside Services staff member. These individuals, along with other members of our local DMAT team, were dispatched to the coast of Mississippi where they worked closely with FEMA (the Federal Emergency Management Agency) to provide medical assistance to those in greatest need.

Shortly thereafter, 21 MGH clinicians headed to Baton Rouge, Louisiana, with the International Medical Surgical Response Team (IMSuRT East) headed by Susan Briggs, MD. This team has taken on the dual responsibility of providing care to survivors and helping in the management and identification of the bodies of those who perished during and after the hurricane.

Still other MGH clinicians have volunteered to work with Project HOPE to staff the US Navy hospital ship, the Comfort, which is stationed in waterways in Mississippi. The first team of Project HOPE volunteers (22 nurses, two social workers, six physicians, and a pharmacist) has been deployed for a two-week tour and is scheduled to return September 28th. Depending on circumstances, a second team of MGH Project HOPE volunteers is prepared to be deployed.

Karen Holland, RN, a staff nurse in our Emergency Department, has been asked to serve as chief nursing officer aboard the Comfort. She was recruited by Project HOPE as a result of her service on the USNS Mercy in southeast Asia after the tsunami disaster. Karen is overseeing all Project HOPE nursing volunteers aboard the Comfort.

I'd like to take this opportunity to thank the members of the Ladies' Visiting Committee (LVC) for their generous donation in support of our team serving on the Comfort.

Whenever there is a crisis of this magnitude, it affects our heart and psyche. On Wednesday, September 7, 2005, hospital administration and the MGH Chaplaincy held a special service of healing for those affected by the hurricane. MGH president, Peter Slavin, MD; senior vice president for Human Resources, Jeff Davis; chairman and CEO of the MGPO, David Torchiana, MD; members of the Chaplaincy; and I led a service of remembrance, hope, and a celebration of life.

Friday, September 16, 2005, was designated a national day of prayer and remembrance for those affected by Hurricane Katrina. On that day, all scheduled services in the MGH Chapel (the Jewish Shabbat service; the ecumenical service; the Muslim prayer service; and the Roman Catholic mass) incorporated special thoughts and acknowledgments for those affected by the hurricane.

MGH has a long tradition of selfless giving and compassionate care in the face of adversity. And this tragedy has been no different. There has been an unprecedented outpouring of support, concern, and offers of personal generosity. One thing people can do in the coming weeks and months is to consider giving blood in the MGH Blood Donor Center. Blood products are being sent to affected areas from all over the country leaving local blood banks in short supply. Giving blood is an easy and meaningful way to contribute to relief efforts. For information, or to make an appointment to give blood, call the MGH Blood Donor Center at 6-8177.

MGH will continue to offer support to the people of the Gulf Coast, both formally and informally, for as long as our services are needed. And I know that when our colleagues return from their humanitarian mission, they will need our support, too. I don't have to tell you how proud I am of everyone in this hospital for your incredible response to this national disaster. In the best of times... and in the worst of times... it is a privilege to work with you.

Update

I am pleased to announce that Chelby Cierpial, RN, has accepted the position of clinical nurse specialist for the Ellison 11 Cardiac Access Unit. Chelby will share CNS responsibilities with Sioban Haldeman, RN.

Faith, spirituality, and patient-centered care

Question: For many patients and families, spirituality is an important dimension of their lives. How would you define 'spirituality?'

Jeanette: In a clinical setting, spirituality is best defined as the universally human aspect of existence that is expressed through a variety of values, beliefs, rituals and practices. Spirituality is that which is of ultimate concern to a person.

Question: How does a healthcare professional know when a patient is struggling with spiritual issues?

Jeanette: Caregivers need to learn how to read the signals. Patients might use 'god-language' such as:

- "Is God teaching me a lesson?"
- "Why am I sick? I always say my prayers."
- "God doesn't seem to listen to me."

Others might express distress in more secular or existential ways. They might say:

- "What is my legacy?"
- "How do I want to be remembered?"
- "I never realized how precious each day is."

Question: How do healthcare professionals incorporate spiritual care into clinical practice?

Jeanette: Research suggests that patents' spiritual well-being can have a positive effect on recovery after surgery, hypertension, coping abilities, and a person's will to live. The key to integrating spiritual care into clinical practice is training. Healthcare professionals need to be comfortable raising spiritual issues, and it takes training to know how to initiate, deepen, and terminate relationships with meaningful closure. It takes training to be able to maintain your own belief system while supporting the different beliefs of your patients.

Spiritual caregiving includes individualized spiritual assessments and spiritual care plans, cultivating awareness of spirituality, and having knowledge of other spiritual and religious traditions. It's important to understand how ethical issues can affect patients' belief systems. When spiritual issues arise, be comfortable referring patients to the MGH Chaplaincy (by calling 6-2220).

Question: How can clincians learn to integrate spirituality into their practice?

Jeanette: The Chaplaincy offers a training program specifically geared toward healthcare professionals. This unique program offers fellowships in Spiritual Care sponsored by the department of Nursing and the Kenneth B. Schwartz Center. The next training session will run from January 9–May 22, 2006.

Question: Who is eligible to participate in the fellowship?

Jeanette: Any healthcare professional who has direct patient contact is eligible to apply. Nurses, physicians, psychologists, social workers, and administrators have participated in the program.

Applications are available in the Chaplaincy office on Clinics 3. For more information, contact Reverend Angelika Zollfrank, at 4-3227.

Call for Nominations

The Norman Knight Preceptor of Distinction Award

Nominations are now being accepted for the Norman Knight Preceptor of Distinction Award, which recognizes staff nurses who consistently demonstrate excellence in educating, precepting, mentoring, and coaching fellow nurses. Nominees should demonstrate commitment to the preceptor role, seek opportunities as life-long learners to enhance their own knowledge and skills, and work to create a responsive and respectful practice environment.

Nurses can nominate colleagues whom they know to be strong educators, preceptors, mentors, and coaches. Nomination forms are available on all inpatient units and in The Knight Nursing Center for Clinical & Professional Development on Founders 6.

Nominations are due by October 21, 2005

The Norman Knight Preceptor of Distinction Award will be presented, February 23, 2006. Recipient will receive tuition for a program of study with a clinical nurse specialist.

For more information, call Rosalie Tyrrell, RN at 724-3019

October is Domestic Violence Awareness Month

Helping patients and employees who are experiencing abuse can be a real challenge, but it is a challenge worth meeting. October is Domestic Violence Awareness Month.

MGH Men Against Abuse and the MGH Domestic Violence Working Group are sponsoring a one-man, educational comedy entitled, "Voices of Men," performed by Ben Atherton-Zeman

Friday, October 7, 2005
11:45am–1:00pm
Walcott Conference Room

Panel discussion of domestic violence in the workplace, with Emily Rothman, ScD; David Adams, EdD; Donna Kausek, LMHC; and Matthew Thomas, of the MGH Special Investigations Unit

Thursday, October 20, 2005
11:45am–1:00pm
Thier Conference Room

The annual MGH Domestic Violence Vigil, will be held in the MGH Chapel in December (date and time to be announced)

For more information, call 726-8182; 726-8963; or 724-3838

Nutrition & Food Services completes Phase I of service-improvement initiative

—by Susan Doyle, RD, senior manager, Patient Food Services

Approximately one year ago, the department of Nutrition & Food Services embarked on a service-improvement initiative to improve patient-satisfaction while minimizing the intervention of nurses during meal service. Our goal was to improve service to our two primary consumers: patients and nurses. Phase I of our initiative has been completed and we'd like to give you a brief update.

We began by creating several inter-disciplinary task forces to look at different components of the existing system. This gave us a good, collaborative overview and a blueprint for analyzing every process. With input from Nursing, Administration, and Quality Improvement, in conjunction with the data we collected, we developed a plan for our service-improvement initiative.

A pilot study was conducted on six patient care units. The key objective was to ensure that patients got what they wanted, when they wanted it, how they wanted it, with minimal intervention from Nursing. Increasing 'face time' between patients and representatives from Nutrition & Food Services was a big part of the process.

As a result of the pilot study, several important changes have been implemented:

- Patient menus have been revised to ensure greater satisfaction. Patients now return their completed tray tickets with their meals, and meal-selection time has been moved closer to meal service
- A ten-week leadership class was successfully completed by all Nutrition & Food Services supervisors
- A six-session customer-service class focusing on 'the excellent encounter' was completed by nutrition service coordinators
- Nutrition service coordinator responsibilities were evaluated and revised to facilitate more personal interaction with patients and greater availability to nursing
- The 4-Food Program was revamped with an emphasis on efficiency and customer service
- Regularly scheduled meal rounds are conducted with nursing staff, operations associates, and operations coordinators on patient care units to facilitate effective communication. Unit-specific needs are addressed in a timely fashion as identified on each unit
- We have worked to more closely integrate clinical dietetics and patient food services

We learned a lot from the pilot study. The need for a consistent, reliable work force on each unit was clearly identified, and we're working to implement a scheduling pattern to facilitate that.

Phase I of our service-improvement initiative has been very gratifying. We have seen significant improvement in patient-satisfaction and improved communication and collaboration with Nursing. The goal is to roll out the new nutrition service coordinator responsibilities on more patient care units.

This is an exciting time for Nutrition & Food Services. Key to our success will be ongoing monitoring, evaluation, and communication with patients and nurses. Says Susan Barraclough, RD, director of Nutrition & Food Services, "This is a process, not a destination. The train has left the station. Now we need to continually test and adjust, test and adjust."

Nutrition & Food Services will be expanding the Open Galley Project, which was implemented last winter. Information on the expansion will be included in a future issue of *Caring Headlines*.

For more information about any of Nutrition & Food Services' service-improvement initiatives, contact Susan Doyle, RD, senior manager of Patient Food Services, at 6-2579.

Spanish for healthcare workers

MGH Human Resources Training & Workforce Development offers a number of Spanish classes to help employees enhance the hospital experience for Spanish-speaking patients and their families.

Courses meet one evening per week for 14 weeks
165 Cambridge Street, second floor
5:30–7:30pm

Beginners I & II: (Tuesdays) September 20–December 20, 2005
Intermediate I, II & Advanced: (Thursdays) September 22–January 5, 2006

Registration at the East Garden Café staircase, September 9th and 13th from 11:30am to 2:00pm. The cost per course is $75 (which includes textbook and materials). The deadline to register is September 15, 2005.

For more information go to:
http://is.partners.org/hr/New_Web/mgh/mgh_training.htm>
or call 617-726-5741

Medical Terminology I

Open to all MGH employees. Fee: $70 includes textbook
Meets Mondays 4:45–6:45pm, September 26–December 12, 2005

Medical Terminology II

Open to MGH employees who have completed Medical Terminology I. Fee: $50 if you have recent textbook, otherwise $70.00 (continuation of Medical Terminology I textbook)
Meets Wednesdays, 4:45–6:45pm, September 28–December 14, 2005
(Attendance at all classes is mandatory) Classes held at 165 Cambridge St.

For more information, call 617-726-5741

Ben Corrao Clanon Memorial Scholarship

—by Mary Ellin Smith, RN, professional development coordinator

On Thursday August 25, 2005, members of the Corrao Clanon family returned to the Newborn Intensive Care Unit (NICU) where they presented Shanna Heffernan, RN, with the 2005 Ben Corrao Clanon Memorial Scholarship. The scholarship was established in 1987 by Regina Corrao and Jeff Clanon in memory of their son, Ben, to recognize NICU nurses who demonstrate exemplary practice, a commitment to primary nursing, and ongoing support and advocacy for patients and their families.

In her introductory remarks, Peggy Settle, RN, NICU nurse manager, reminded those in attendance that Ben would have turned 19 years old this year. Settle spoke about this year's nominees as nurses 'still new in their care of NICU patients.' She commented on how that reflected on the more experienced NICU nurses and their ability to instill the importance of primary nursing in their newer colleagues.

Regina Correo shared that despite the passage of time, she still draws comfort from the memory of how NICU nurses supported her and Jeff during Ben's hospitalization. Jeff Clanon remarked that although much has changed in the 19 years since Ben died, what makes the MGH NICU so special is how their commitment to primary nursing has not changed. He thanked everyone for keeping those values alive.

Heffernan, RN, spoke of her love of nursing, her appreciation to the Corrao Clanons, and of her respect for her colleagues for demonstrating every day what it means to be a primary nurse.

Corrao Clanon award recipient, Shanna Heffernan, RN, (wearing corsage) with colleagues (above) and members of the Corrao Clanon family (below).

Nutrition Grand Rounds

Tuesday, September 27, 2005
2:30pm
O'Keeffe Auditorium

"The basic care and feeding
of homo sapiens: are we truly clueless?"
presented by
David L. Katz, MD, MPH, FACPM
associate clinical professor of Epidemiology
& Public Health and director of Medical
Studies in Public Health at Yale University

Reception immediately following
For more information, call 6-2587

Systematic approach to identifying and treating BPPV brings patient great relief

Emily Smith, PT
senior physical therapist, advanced clinician

My name is Emily Smith, and I have been a physical therapist in the outpatient Physical Therapy Department for the past 12 years. My primary area of focus is Neurology, but I treat patients with a wide variety of diagnoses.

Mrs. C was a 59-year-old woman who was referred for physical therapy with a diagnosis of dizziness. As I took her history, she revealed that she had been in her usual state of good health until last July when she was in an accident at work. She had been preparing the bus she drove every day, when the next thing she knew, she was surrounded by paramedics, and her bus had been crumpled. She was told that a cement truck had hit her bus, and she'd been knocked unconscious.

She was brought to a local emergency room and cleared for discharge despite the fact that she felt dizzy and had pain in her neck. She was told the dizziness was related to a concussion and would resolve over the next few days. Mrs. C had been undergoing chiropractic care since the accident, and her neck pain was resolving, but the dizziness persisted—not all the time, but when she laid down to sleep at night and when she woke up in the morning. Sometimes the dizziness was so bad, she could hardly get out of bed. The dizziness really scared Mrs. C, to the extent that she didn't go out much because she was afraid she'd get dizzy while out in public.

During the interview, Mrs. C frequently became tearful and questioned why this had happened to her. Her hands shook as she covered her face. She said she'd had a lot of anxiety in general since the accident, she was taking Valium regularly, and working with a social worker. She hadn't taken Valium before coming in for her evaluation. She felt extremely limited by her symptoms and wondered why she was still feeling dizzy three months after the accident. She didn't feel the doctors at her local hospital were taking her seriously, and she had no idea why she'd been referred for physical therapy.

As I listened to Mrs. C tell her story, my mind went through a checklist of possible causes for her symptoms. Given her history and symptoms, I thought the dizziness could be related to one of three things: her concussion, anxiety, or BPPV (benign paroxysmal positional vertigo). BPPV is a condition where the small calcium crystals, or otoliths, normally embedded in a gel matrix in the inner ear, break off and float into the ear canals creating a sense of movement when the head is actually still. Any one of these issues could be causing Mrs. C's dizziness, or it could be a combination of all three. I asked a few more questions to sort out the particulars of her condition. Her responses continued to support my hypotheses, but pointed more toward BPPV.

To rule these three possibilities in or out, I would have to perform a Hallpike-Dix test for BPPV, among other things. The Hallpike-Dix test involves having the patient sit on a plinth (flat surface). While holding the patient's head, the examiner quickly lowers the patient into a lying position so that her head hangs over the end of the plinth (angled to the left or the right). The examiner then looks for nystagmus (a distinctive movement of the eyes) while the patient describes any symptoms she may be experiencing.

After approximately 30 seconds, the examiner quickly sits the patient back up and looks for nystagmus again. The goal is to re-create the patient's symptoms in order to determine how long it takes for symptoms to come on and how long it takes for them to resolve.

If the test is positive for BPPV, the examiner typically performs a particle-repositioning technique which begins with a Hallpike-Dix and proceeds through a series of motions designed to move the otoliths out of the ear canals. The technique takes about five minutes, during which time the examiner holds the patient's head (the patient may experience symptoms repeatedly during this time).

In the best of situations, this test and corrective technique can be very difficult for patients who are trying to do everything in their power to *avoid* symptoms (which often include nausea and vomiting). As I contemplated performing this test on Mrs. C, I knew it was going to be a challenge to get her to agree to the test, let alone the re-positioning technique.

I took some time to explain to Mrs. C what I was thinking about her symptoms and the role a physical therapist could play in treating her dizziness. I explained the workings of the inner ear and discussed some of the symptoms people can experience when it's not functioning correctly. I described BPPV to her in terms of the anatomy, pathology, and symptoms. I explained that there were other possible causes, which we would screen for first, but if the screening tests were negative, I would have to perform the Hallpike-Dix test. I described the Hallpike-Dix test and repositioning technique, and assured her I wouldn't do it if she didn't want me to. I told her if we

continued on next page

Clinical Narrative

continued from previous page

started the test, and it became uncomfortable for her, we could stop at any time. I answered her questions as calmly and reassuringly as I could. After listening to my explanation, she agreed to the screening tests and said she'd let me know about the Hallpike-Dix.

She passed the neurological screening test without any problems, which was an even stronger indication that her symptoms were the result of BPPV.

I told Mrs. C my thoughts. I explained that if we did the Hallpike-Dix test and it was positive, and if we did the re-positioning technique, there was every chance that her symptoms could be completely (or almost completely) gone by the end of the day. She was intrigued by this, but still hesitant, so I offered to do a modified test, in which she would lie down on two pillows and I would gradually remove them until she was lying flat. I knew she wouldn't be likely to have symptoms when she laid down on two pillows, but as I removed them, she might experience some dizziness (not as severe as with her head hanging over the end of the bed). This method would also let her feel like she had more control, since I wouldn't be holding her head and controlling her movements. Though I didn't really need to do this to get the information I needed, I thought it might minimize her anxiety and help me gain her trust. With apprehension, she agreed to try it, and we proceeded.

As I suspected, when she laid down, she didn't experience any symptoms. I let her lie quietly for a few minutes until she was ready. I explained what would happen next and what she might expect to feel. I encouraged her to breathe normally and offered to hold her hand if she wanted.

When she was ready, I removed one pillow, explaining that if she felt dizzy, it would only last for a few seconds. She felt all right and after a few more minutes of quiet encouragement, she let me remove the second pillow.

At that point, she said, "Oh no," closed her eyes, and said she was having symptoms. Normally during a Hallpike-Dix test, the examiner needs to see the patient's eyes to determine if there is nystagmus and to see which direction the eyes are moving. I asked Mrs. C to try to open her eyes and reminded her that the symptoms would go away soon. She opened her eyes and squeezed my hand and we breathed together. I saw a brief flicker of nystagmus and continued to talk to her and remind her that the symptoms would go away. Soon, she said they were getting better and breathed a sigh of relief. I let her know that the symptoms could return when she sat up, but I assured her I'd hold onto her and they would pass soon. When she got up, she felt dizzy for a few seconds, but she didn't seem as nervous. When she was back to normal, we breathed a sigh of relief together. I rubbed her back and told her what a great job she was doing.

At this point, I was pretty certain that Mrs. C had BPPV and if she was willing, I could perform the particle re-positioning technique and most likely resolve her symptoms that day. But she had been through a lot. I told her everything looked right for a successful treatment, and we could do one of two things—we could go ahead and do the full Hallpike-Dix test today along with the particle re-positioning technique; or we could do it on another day. She thought for a moment or two and opted to do it another day. She felt she'd been through enough for one morning, and I agreed.

We discussed the fact that she might want to schedule her next appointment around her medication schedule, so she'd be a little less anxious. She thanked me for my patience and gave me a big hug on her way out.

When she returned for her next appointment, she was able to undergo both the testing and the particle re-positioning with good success. She thanked me again for my patience and for being so kind. She said she felt like someone had finally taken the time to figure out what was wrong with her and help do something about it.

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

This narrative is a good reminder of how the smallest, seemingly inconsequential abnormality can result in serious, sometimes dibilitating symptoms. Emily is a skilled and confident clinician. During her initial meeting with Mrs. C, she used a systematic approach to assess, evaluate, and identify the root of Mrs. C's symptoms. Frustration, anxiety, and the physical limitiations of her condition made it challenging for Mrs. C to undergo the tests necessary to identify and treat her disorder. Emily understood Mrs. C's trepidation and adapted her plan of care accordingly.

As it turned out, Emily's instincts were correct—Mrs. C did have BPPV. With Emily's help, patience, insight, and skill, Mrs. C was able to have the tests and corrective treatment necessary to resolve her symptoms.

What a wonderful story. Thank-you, Emily.

Domestic violence education and support group

The Employee Assistance Program is offering a confidential, ten-week education and support group for female employees who have been affected by domestic violence. Weekly discussions help members understand the impact of domestic violence on their lives and the lives of their children while promoting individual strength and healing. The group is free and confidential, and open to all female employees within Partners HealthCare

First meeting:
Thursday, October 6, 2005
4:30–6:00pm

For more information and location, call 617-726-6976, or 866-724-4EAP

The Cardiac CNS Group: impacting care across services

—submitted by the Cardiac CNS Group

The role of clinical nurse specialist (CNS) is widely recognized as having a positive impact on the care of patients by disseminating knowledge, teaching new skills, providing expert consultation, and implementing improvements in the care-delivery system. Recently, clinical nurse specialists from Cardiac Medicine and Cardiac Surgery joined forces to impact the care of patients across services with the creation of the Cardiac CNS Group, which spurred the creation of the Cardiac Nursing Practice Committee.

In October of 2004, a group of clinical nurse specialists representing intermediate-level care units met to discuss common issues related to orienting new nurses. These initial meetings laid the groundwork for discussions about improving communication among the cardiac units. Cardiac CNSs recognized an opportunity to help develop clinical practice, and the Cardiac CNS Group was born.

Along with the creation of a mission and vision statement, the group identified core values and goals that reflect an emphasis on patient-centered care (see opposite page). We shared these materials with the cardiac nurse managers, and the Cardiac Nursing Practice Committee (CNPC) was created. Meeting twice a month since January, 2005, membership has grown to include staff nurses from each of the inpatient cardiac areas and laboratories, representatives from the cardiac operating rooms, and a nurse research librarian.

The CNPC has identified several projects for 2005 to address ways to build a healthy work environment and advance clinical practice. Projects include education around: 'knowing patients;' communication across units; a generic pacing policy with step-by-step procedures, ECG monitoring lead placement; standardized cardiac patient-education; the development of a patient-family advisory committee to the MGH Heart Center; the need for consistent activity after sheath removal; and an intra-aortic balloon pump update.

Projects are divided among sub-groups led by staff nurses and/or CNSs. At appropriate intervals, sub-groups return to the group at large for feedback and clarification. This process has proven effective when implementing new initiatives and in promoting consistent, evidence-based cardiac practice across settings. It has the added advantage of helping to develop relationships among staff nurses and the cardiac nursing leadership team.

The Cardiac CNS Group and Vascular Surgery CNSs, have combined efforts to offer a review course to support nurses who sit for the cardiac vascular certification exam. Supporting specialty certification in this way represents a commitment to maintaining the highest standards of patient care. The anticipated outcome of this review course is that by spring of 2006, approximately 10% of the staff nurses in the inpatient Cardiac and Vascular units and laboratories at MGH will be credentialed cardiac/vascular nurses.

The Cardiac CNS Group strives to help nurses provide high quality, evidenced-based, patient- and family-centered care in an environment that supports compassionate, knowledgeable, and skilled nurses. We are beginning to unify our practice across all cardiac specialties and solidify collaborative practice among cardiac clinical nurse specialists.

For more information about the Cardiac CNS Group, call Diane Carroll, RN, at 4-4934, or any of the cardiac clinical nurse specialists.

Clinical nurse specialists: (back row, l-r): Mimi O'Donnell, RN; Diane Carroll, RN; Cathy Griffith, RN; and Vivian Donahue, RN (seated): Sioban Haldeman, RN; and Susan Stengrevics, RN

Cardiovascular Nursing

Vision:

Our primary focus is the delivery of nursing care to patients with cardiovascular disease and their families with an embedded commitment to reducing the incidence of cardiovascular disease and associated disabilities. Our nursing care is guided by knowledge, perfected by skill, and motivated by compassion.

Goals:

- The nurse-patient relationship is the cornerstone of our multi-modal approach to fostering the cardiovascular health of our patients and their families. We use a holistic model of patient-assessment, which includes: assessment of the needs and expectations of our patients and their families; individualized measures of cardiovascular health; integration of patient-specific nursing interventions to reduce cardiovascular risk; and evaluation of nursing care as it relates to patients' cardiovascular health.
- We encourage patients and their families to participate in decision-making regarding aspects of lifestyle that impact their cardiovascular health. Through the nurse-patient relationship, we partner with patients and their families to assess readiness-to-change risk factors, identify resources needed to support lifestyle change, and identify and use community resources.
- We strive to maintain the highest standards of patient care through the synergy created by collaboration with colleagues and the development of an interdisciplinary team. Each team member values the expertise of other members and considers the patient and family to be an integral part of the team. The strengths of the family are recognized and used to help improve patients' cardiovascular health.
- Our expert nursing care spans the health continuum, from wellness through acute illness. Nurses specializing in the care of patients with cardiovascular disease are responsive to medically complex, unstable patients who require comprehensive therapies to optimize their cardiovascular health. Cardiovascular nursing is advanced from novice to expert through comprehensive orientation to the inpatient setting of acutely ill patients; educational programs focused on evidence-based cardiovascular nursing practice; national credentialing; and life-long learning opportunities with an emphasis on recognizing the wide variation in the presentation of cardiovascular disease.
- We actively seek opportunities to improve cardiovascular nursing practice within MGH and in the community. We embrace a spirit of inquiry by developing programs of cardiovascular nursing research with research questions generated from our clinical practice. We design cardiovascular nursing interventions to improve patient care based on research findings and by translating research findings into clinical practice.
- We seek to optimize cardiovascular patient outcomes beyond the care delivered by nurses at MGH. We share our knowledge with colleagues, including: advanced practice nurses, clinical nurses, and experts in other disciplines related to the care of cardiovascular patients. We create educational programs designed to share the knowledge derived from research into nursing clinical practice and patient needs. We offer consultative services that foster optimal care of cardiovascular patients and access to new programs under development in other healthcare organizations.

POPPS Fair 2005

Police, Security & Outside Services invites you to their annual Crime Prevention and Safety Fair

Thursday, September 29, 2005
11:00am–3:00pm
under the Bulfinch tent

The focus of this year's fair is, "Protecting You In this Changing World"

Training for Managers and Supervisors

Learn how EAPcan help with behavioral health, mental health, and substance-abuse. Topics include: time-management, stress-reduction, and staying focused on work.

Thursday, November 3, 2005
1:00–3:00pm, Haber Conference Room

To register, call 726-6976.

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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 by e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

Next Publication Date:
October 6, 2005

The inaugural Knight Visiting Professor Program

—by Ann Martin, RN, and Laura Mylott, RN

The MGH department of Nursing is committed to achieving clinical excellence and providing an environment with opportunity for professional growth. This month we celebrate another generous gift from Mr. Norman Knight with the inaugural Knight Visiting Professor Program. The Knight Visiting Professor Program was created to support professional development, creativity, and innovation in practice by bringing nationally recognized nurse scientists/scholars to discuss their programs of research with the MGH community. Through a variety of clinical forums, including grand rounds, unit-based conferences, small-group dialogues, and individual consultations, Knight visiting professors will have an opportunity to interact with members of the clinical community and share their knowledge and expertise. The Knight Visiting Professor Program is housed within The Knight Nursing Center for Clinical & Professional Development (a new name for The Center for Clinical & Professional Development).

Betty Ferrell, RN, PhD, FAAN, research scientist at the City of Hope National Medical Center in California, will be the first Knight visiting professor to speak at MGH. Ferrell has been involved with oncology nursing for 28 years and has focused her research on pain-management, quality of life, and palliative care. She is a fellow with the American Academy of Nursing and has published more than 220 articles and chapters in peer-reviewed journals and texts. She has authored four textbooks that deal with suffering, pain associated with cancer (specifically in the elderly), and palliative care.

Ferrell's two-day visit is planned for Wednesday, September 28, and Thursday, September 29, 2005 (see schedule on this page). If you have a research question related to pain-management, quality of life, or palliative care, come meet Dr. Ferrell.

MGH is committed to improving hand hygiene

Fingernails and jewelry

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

- Artificial nails and nail jewelry are *prohibited* for all caregivers
- Jewelry harbors germs and has been linked to outbreaks of serious infections at other hospitals
- Wearing rings is allowed, but wearing numerous rings or excessive hand jewelry is discouraged
- Studies have shown that skin beneath rings has higher bacterial counts than skin on fingers without rings
- Studies have shown that bacterial counts are similar between people who do wear rings and those who dont. Further studies are indicated

Knight Visiting Professor itinerary

Betty R. Ferrell, RN, PhD, FAAN
research scientist
Knight visiting professor
Schedule of events

Wednesday, September 28, 2005

"Decisions and outcomes of palliative care in surgery"
8:00–9:00am, Ether Dome, Bulfinch 4
Contact hours will be awarded, all are welcome

"Dying well in the hospital: a dialogue with clinical scholars and advanced clinicians"
9:45–11:15am, O'Keeffe Auditorium
Contact hours will be awarded, all are welcome

Research consultation with Oncology Service
12:00–1:15pm

The First Knight Visiting Professor Lecture
"Clinical excellence in palliative care: nursing leadership to transform care
2:00–3:30pm, O'Keeffe Auditorium
Contact hours will be awarded, all are welcome

Reception
3:30–5:00pm, Trustees Room

Thursday, September 29, 2005

"Mentoring palliative care champions: the MICU experience
7:15–7:45am

"Implementing a pediatric palliative care training program: meeting the special needs of children and families"
8:00–9:30am, Thier Conference Room
Contact hours will be awarded, all are welcome

"When the goals of care change: first experiences in caring for dying patients—a dialogue with clinical nurses"
10:00–11:30am, Walcott Conference Room
Contact hours will be awarded, all are welcome

Unit-based practice consultation
11:45am–1:00pm

Nursing Grand Rounds
"Eliminating barriers to the clinical management of pain and fatigue"
1:30–2:30pm, O'Keeffe Auditorium
Contact hours will be awarded, all are welcome

For more information, call 6-3111

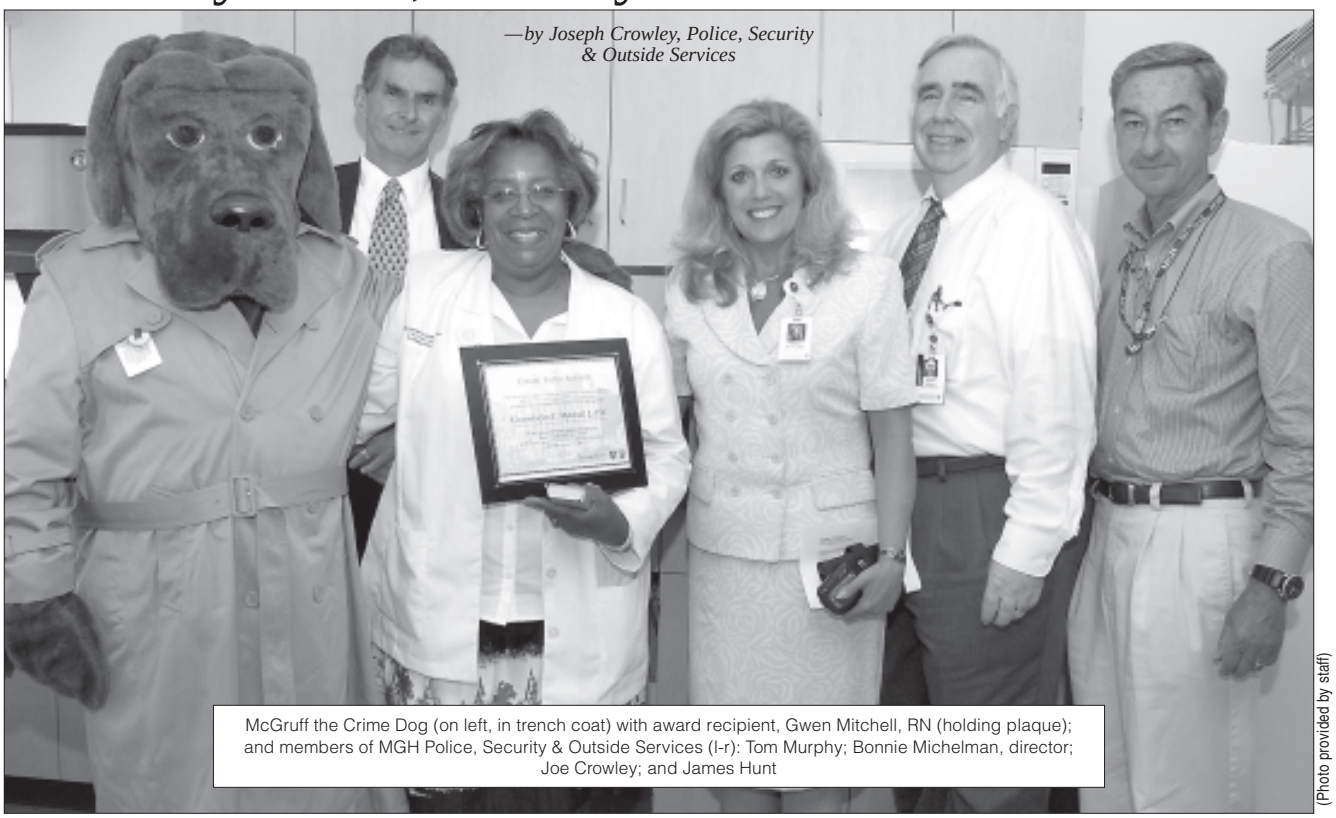
Educational Offerings

When/Where	Description	Contact Hours
September 28 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
September 29 8:00am–4:30pm	**CCRN Review Day II** Haber Conference Room	TBA
September 29 1:30–2:30pm	**Nursing Grand Rounds** Knight Visiting Professor Lecture with nurse researcher, Betty Ferrell, RN. O'Keeffe Auditorium	1.2
September 30 12:00–3:30pm	**Basic Respiratory Nursing Care** Ellison 19 Conference Room (1919)	- - -
October 3 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
October 5 8:00am–4:00pm	**CCRN Review Day II** Haber Conference Room	TBA
October 5 and 6 8:00am–5:00pm	**End-of-Life Education Program** Training Department, Charles River Plaza	TBA
October 6 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
October 6 1:30–2:30pm	**Nursing Grand Rounds** "Infection Control." O'Keeffe Auditorium	1.2
October 7 8:00am–4:30pm	**A Diabetic Odyssey** O'Keeffe Auditorium	TBA
October 12 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
October 12 8:00–11:30am	**Intermediate Arrhythmias** Haber Conference Room	3.9
October 12 12:30–4:30pm	**Pacing Concepts** Haber Conference Room	4.5
October 12 1:30–2:30pm	**OA/PCA/USA Connections** "Diabetes Update." Bigelow 4 Amphitheater	- - -
October 12 11:00am–12:00pm	**Nursing Grand Rounds** "Care of the Behaviorally Challenging Patient." Sweet Conference Room GRB 432	1.2
October 14 and 24 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	16.8 for completing both days
October 14 8:00–11:00am	**On-Line Clinical Resources for Nurses** FND626	3.3
October 19 8:00am–4:30pm	**Preceptor Development** Training Department, Charles River Plaza	- - -
October 20 1:30–2:30pm	**Nursing Grand Rounds** "Kidney Care." O'Keeffe Auditorium	1.2
October 20 and 21 8:00am–4:00pm	**Oncology Nursing Society Chemotherapy-Biotherapy Course** Yawkey 220	16.8 for completing both days
October 21 and 28 7:30am–4:00pm	**Pediatric Advanced Life Support (PALS) Certification Program** Thier Conference Room	- - -

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

Mitchell honored by Police, Security & Outside Services

—by Joseph Crowley, Police, Security & Outside Services



McGruff the Crime Dog (on left, in trench coat) with award recipient, Gwen Mitchell, RN (holding plaque); and members of MGH Police, Security & Outside Services (l-r): Tom Murphy; Bonnie Michelman, director; Joe Crowley; and James Hunt

(Photo provided by staff)

Gwendolyn Mitchell, LPN, staff nurse in the Gillette Center for Women's Cancers, recently received Police, Security & Outside Services' Crime Biter Award for actions above and beyond the call of duty. Mitchell witnessed a potential incident in one of the MGH parking lots and intervened to protect parking-lot attendant, Hagos Berhane. Berhane was being accosted by a number of angry drivers. When it started to look like the situation might escalate, Mitchell blocked the entrance to the lot with her own car to keep vehicles from entering. She called Police, Security & Outside Services and remained with Berhane until an officer arrived on the scene.

Mitchell's concern for Berhane's safety and willingness to get involved really did 'take a bite out of crime.'

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