February 2, 2006

Caring HEADLINES

Inside:

Visiting Professor shares expertise in wound healing

—by Virginia Capasso, RN, clinical nurse specialist

On December 15, 2005, the Knight Nursing Center for Clinical & Professional Development and the Clinical Nurse Specialist (CNS) Wound Care Task Force hosted the Inaugural Visiting Professor in Wound Healing Lecture, with guest lecturer, Dr. Courtney Lyder, a doctorally-prepared geriatric nurse practitioner and professor of Nursing and Medicine at the University of Virginia. Lyder's extensive research has included ground-breaking studies on characteristics of Stage I pressure ulcers in people of color.

Lyder is a past president of the National Pressure Ulcer Advisory Panel (NPUAP), which developed the current schema for staging 'top-down' pressure ulcers. He is a member of a NPUAP task force, which recently suggested there may also be a 'bottom-up' process or Deep Tissue Injury (DTI) that may result in Stage III or IV pressure ulcers within a few days or weeks after injury. Extensive research is still necessary to define characteristics, describe development over time, and test strategies to prevent DTI. This phenomenon will dramatically change the systems of staging and reimbursement for care of pressure ulcers.

As an expert on pressure ulcers, Lyder is one of many authorities to give testimony to the Center for Medicare and Medicaid Services (CMS) on developing criteria for 'avoidable' and 'unavoidable' pressure ulcers. These criteria have been incorporated into regulation F-314, which

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Dr. Courtney Lyder

Capacity management and the human factor: what we're doing to facilitate timely, high-quality care

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

Whenever human beings are involved in a process, there is always an element of unpredictability. In health care, the potential for unexpected events is even greater because the human factor affects both sides of the equation (those providing care and those receiving care).

In managing the flow of patients throughout the hospital, our goal is to minimize delays that can arise due to unexpected events while maintaining the highest standards of quality, safety, and patient care. This is no small feat when you consider the myriad factors impacting the care of every patient who comes through our doors. Bed availability, patient-specific needs, a high demand for diagnostic testing, rapidly changing clinical situations, state- and JCAHO-mandated regulations, and operational issues are only *some* of the considerations affecting a hospital's ability to admit, care for, and discharge patients in a safe and timely manner.

Everyone at MGH is committed to identifying and overcoming obstacles to the efficient flow of patients through the hospital, but we need the help of every clinician and support staff member in order to be successful. Clinical staff are in a unique position to be able to identify underlying barriers; facilitate timely discharge; and work collaboratively with all disciplines to help minimize or avoid unscheduled delays. Good communication is critical to our ability to manage patient flow. Good communication and a solid infrastructure are the cornerstones of effective capacity management. Yes, more space and more beds would help, but expanding our physical environment is not the whole solution.

Good communication is critical to our ability to manage patient flow. Good communication and a solid infrastructure are the cornerstones of effective capacity management.

Much has already been accomplished in our work around capacity management.

- Working closely with Admitting, we've established a proactive communication system to keep units and key personnel informed about bed availability
- We have expanded the role of clinical nursing supervisors to provide round-the-clock triage for critical-care and general-care patients
- We've implemented the flexible, highly skilled Rapid Response Team that deploys broadly trained nurses as needed throughout the hospital to assist with short-term emergencies, admissions, and general support
- We have modified the roles of patient care associates and operations associates to help facilitate patient flow
- We opened the Trauma Rapid Admission Care Unit (TRACU) on Ellison 7 for short-term, observational care of trauma and emergency surgical patients
- We've implemented a number of solutions involving the creative use of space to alleviate back-ups and delays (such as the Bigelow 12 discharge lounge and pre-admission chemotherapy area; several other pilot programs have been conducted, and others will be launched in the coming weeks)
- In 2004, we added five new beds and nine bassinets
- In 2005, we added four more beds

As you can see, we've devoted significant time, energy, and resources to improving patient flow and satisfaction. And there are more initiatives in various stages of planning and process.

- To increase capacity and efficiency in the Emergency Department and reduce the amount of time spent on divert, an ED Observation Unit is being planned for Bigelow 12
- The Pediatric Intensive Care Unit will be relocating, expanding from eight to 14 beds later this year
- Adopting a 'Just say yes' policy, there is work under way to help us understand what can be done to allow us to accept transfer patients from other hospitals more quickly
- A number of technology-based improvements will soon be implemented, and others are still under consideration
  - An on-line bed-management system that will allow hospital-wide monitoring of bed availability is nearing implementation
  - Cell phones and pagers will be used to improve communication among caregivers and increase response time to patients (already being piloted on some inpatient units)
  - Wireless access to CAS and automated green books are other initiatives being explored

Currently, MGH has 902 adult beds and 44

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Martin Luther King, Jr. celebration 'rocks' East Garden Dining Room

—by Cheryl Coss, program assistant, Training & Development, and treasurer of AMMP

On Friday, January 18, 2006, the MGH community came together in an inspirational and moving tribute to Dr. Martin Luther King, Jr. and to celebrate this year's theme, "In the Spirit of Unity and Service: Remember. Celebrate. Act."

Keynote speaker Milton J. Little, Jr., president and CEO of the United Way of Massachusetts Bay, asked the standing-room-only crowd to focus on the 'act' portion of this year's theme. He reflected on recent national and international tragedies in 'remembrance,' and recalled civil rights milestones in 'celebration.'

"More than anything, Martin Luther King, Jr. was a man of action," said Little as he called upon the crowd to, "Act, just a little bit differently. Talk to someone who doesn't look like you, or who speaks a different language. You never know what you'll find. Beneath our differences are fundamental similarities such as the desire to live well and make a better world for our children."

The second annual Martin Luther King, Jr. breakfast, sponsored by the MGH chapter of The Association of Multicultural Members of Partners (AMMP), began with the debut appearance of the Voices of MGH Choir. The choir, comprised of 19 MGH employees from various departments, 'rocked' the East Garden Dining Room, according to MGH president, Peter Slavin, MD. Dressed in black with colorful scarves and ties, each wearing a white rose for peace, the choir was a visual representation of the unity and diversity of our employee population—a fitting tribute to Dr. King.

Voices of MGH Choir

Jeanette Ives Erickson

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bassinets. We consistently operate at a very high level of occupancy, often 100% occupancy with more patients waiting to get in. You can see how effective communication and coordination of services are imperative if we're to operate at peak efficiency.

We need to be vigilant at every juncture. Unanticipated delays in one area of the hospital can have repercussions throughout the entire system. Despite all the steps we're taking to minimize delays, there's no substitute for good communication. As I said before, clinicians at the bedside and unit-based support staff are uniquely positioned to identify impediments to timely care. We've invested a lot of time and resources in addressing the complex issue of capacity management. And we will continue to do so.

As we move forward with these new initiatives, I'm interested in hearing your thoughts, ideas, concerns, and suggestions. It really does take a village.

Thank-you.

Updates

Marie Leblanc RN, has accepted a position as staff specialist supporting a number of projects within Patient Care Services.

Amanda Stefancyk, RN, has accepted the position of nurse manager for the White 10 General Medicine Unit. Many thanks to Marita Prater, RN, for her management of both White 8 and White 10 for the past two and a half years.

Theresa Cantanno-Evans, RN, has accepted a 20-hour-a-week position as clinical nurse specialist in Ethics in the Knight Nursing Center for Clinical & Professional Development. She will officially begin in the spring, sharing CNS responsibilities with Ellen Robinson, RN, giving the ethics CNS role a full-time presence in PCS.

Bringing specialized wound-care education to all patient care units

—by Virginia Capasso, RN, clinical nurse specialist

For the past 17 months, the Clinical Nurse Specialist (CNS) Wound Care Task Force has worked to educate and empower unit-based clinical nurse specialists and staff nurses to deliver contemporary, evidence-based wound care throughout the hospital 24 hours a day, seven days a week. Some early outcomes of the task force include a section for wound assessment on the new general care patient flowsheet and development of a comprehensive wound care education program.

The field for wound assessment on the general care patient flowsheet consists of 13 parameters to assess a wide variety of wounds. Parameters are derived from the 15-item Pressure Sore Status Tool (PSST), which was developed and tested by Dr. Barbara Bates-Jensen of the University of Southern California, School of Nursing. Parameters include location, shape, size (length, width, depth), type, characteristics of the skin along the margin of the wound, as well as other characteristics. A systematic approach to wound assessment allows detection of dramatic or gradual progress toward healing or deterioration in a wound bed.

Phase I of the Wound Care Education Program will be launched this month and consists of programmed instruction related to wound cleansing, assessment, and documentation. Phase I is earmarked for newly-hired nurses, but will be completed by all current nursing staff.

Phase II of the Wound Care Education Program will be a two-day comprehensive nursing continuing education program. Morning sessions will feature didactic presentations by CNS experts on topics pertinent to general wound care and care of high-risk and high-frequency wounds, such as pressure ulcers, vascular ulcers, atypical wounds, burns, and radiation injuries. Afternoon sessions will focus on description of wounds, selecting appropriate treatments for wounds, and applying specialty dressings, such as multi-layer compression dressings and vacuum-assisted closure (VAC) dressings.

Above: Jill Pedro, RN, clinical nurse specialist, demonstrates application of the VAC dressing. Below left: participant applies 'Unna's boot.' At right: participants practice application of VAC dressing.

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The program was tested by 60 enthusiastic clinical nurse specialists and nurse practitioners in November, 2005. The inaugural program for nursing staff was offered on January 11 and 18, 2006. Response has been overwhelmingly positive. Nurses seek educational offerings that provide an introductory level of specialty knowledge and skills so they can troubleshoot wound and skin-care issues on their units.

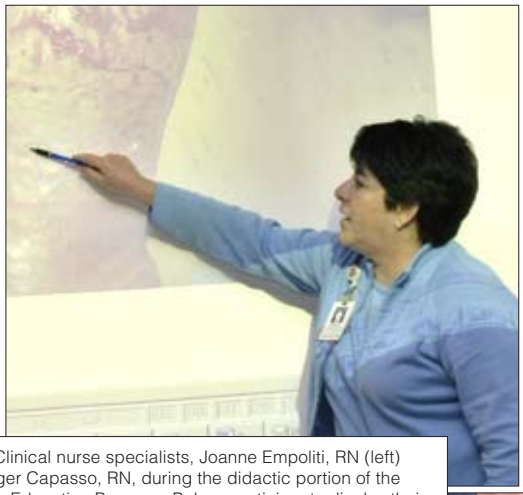
Phase II will be offered four more times in 2006:

- Wednesday, March 1, and Wednesday, March 8
- Wednesday, June 7, and Wednesday, June 14
- Friday, September 8, and Wednesday, September 13
- Wednesday, November 1, and Wednesday, November 8

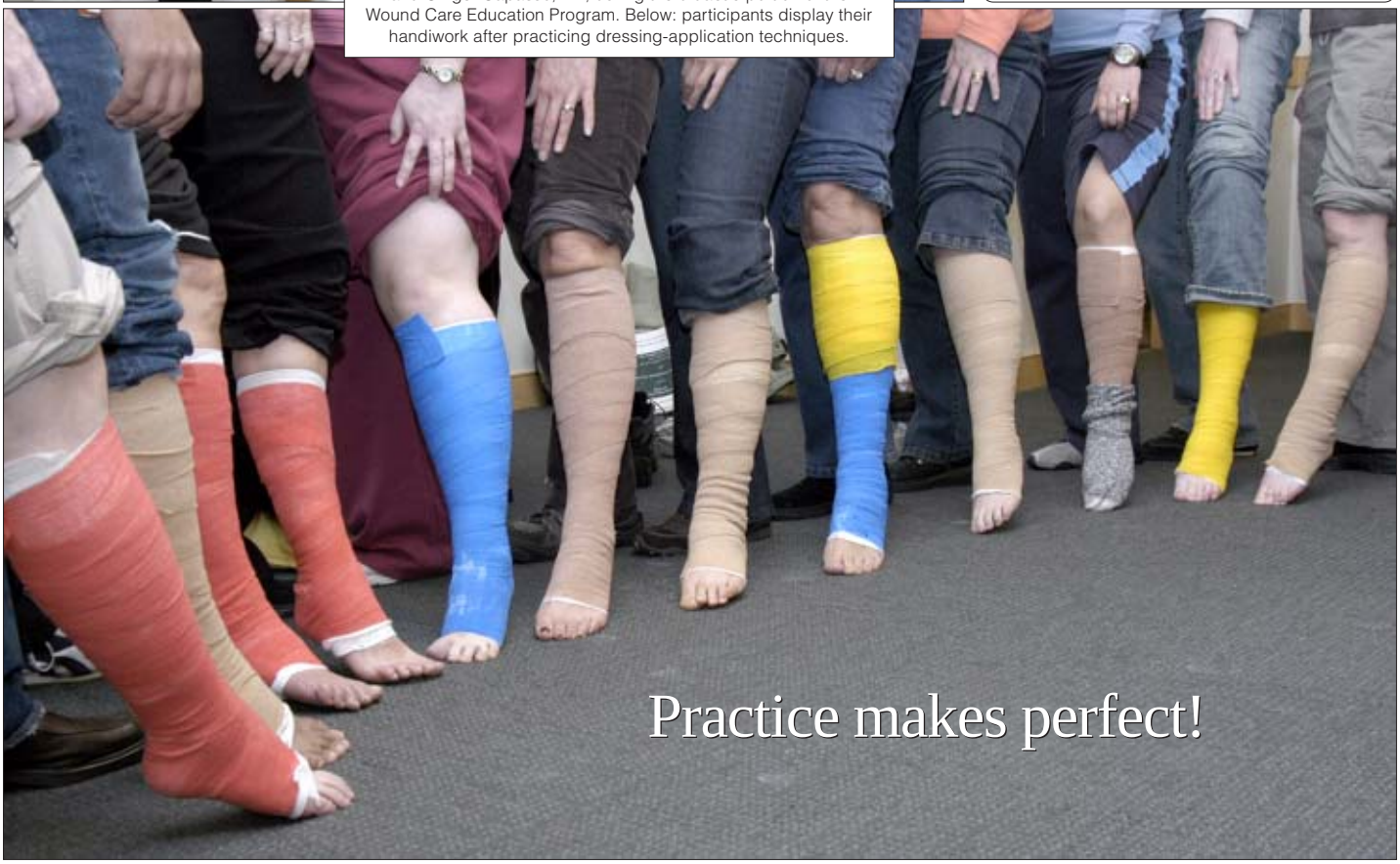
Registration is limited to 60 people per session. To register, call the Knight Center for Clinical & Professional Development (at 6-3111). For more information about the Wound Care Education Program, contact Virginia Capasso, APRN, co-chair of the CNS Wound Care Task Force.

CNS Wound Care Task Force
2004-2005

- Virginia Capasso, APRN, co-chair
- Joanne Empoliti, APRN, co-chair
- Ann Martin, ARRN, co-chair
- Theresa Cantanno-Evans, ARNP
- Jacqueline Collins, RN
- Erin Cox, ARNP
- Vivian Donahue, RN
- Joan Gallagher, ARNP
- Susan Gavaghan, RN
- Catherine Griffith, ARNP
- Sioban Haldeman, RN
- Marian Jeffries, APRN
- Susan Kilroy, RN
- Cynthia Lasala, RN
- Madeline Odonnell, RN
- Jill Pedro, RN
- Marion Phipps, RN
- Susan Stengrevics, RN



Above: Clinical nurse specialists, Joanne Empoliti, RN (left) and Ginger Capasso, RN, during the didactic portion of the Wound Care Education Program. Below: participants display their handiwork after practicing dressing-application techniques.



Practice makes perfect!

Smoking: quitting might be easier than you think

If you smoke, quitting is the best thing you can do for your health. Every year, more than 400,000 people in the United States die from smoking-related diseases. That's more than the total number of people who die annually from homicides, motor vehicle accidents, and fires.

Smoking is linked to cancers of the pancreas, stomach, kidney, bladder, cervix, lung, mouth, esophagus, head, and neck. Smoking is associated with lung diseases such as chronic bronchitis and emphysema and aggravates asthma. It is a risk factor in heart disease, vascular disease, stroke, ulcers, infertility, osteoporosis, and impotence. Women who smoke are more likely to have miscarriages, premature or low-birth-weight babies, or babies with sudden infant death syndrome (SIDS.) While the percentage of people who smoke has dropped from nearly 50% to 21% nationwide (19% in Massachusetts), smoking remains a major concern for healthcare providers everywhere.

MGH has launched an initiative to help identify smokers among our inpatient population and provide them with advice on how to quit smoking as part of our standard of care. The nursing assessment form has been revised to help nurses obtain more detailed information about our patients' smoking practices. These changes meet existing and future requirements of JCAHO regarding the documentation of treatment of hospitalized smokers. JCAHO requires that smoking-cessation information be provided to any patient with certain diagnoses who has smoked in the past year. The MGH Quit Smoking Service (QSS) created the booklet, *A Smoker's Guide to Being in the Hospital*, which explains how the QSS can help with smoking-cessation. If patients don't wish to quit at that time, nicotine-replacement products are available to make them more comfortable during their hospital stay. The booklet has been very successful, and a Partners-wide pamphlet, *A Guide for Hospital Patients who Smoke*, will be available soon.

To better facilitate smoking-cessation efforts among our patients, the QSS developed a protocol to help nurses and other healthcare providers determine what must be provided to patients who smoke or recently quit, and who can provide it.

Question: How many smokers are admitted to the hospital each year?

Jeanette: MGH admits more than 47,000 patients per year. If 19% of the population of Massachusetts smoke, then more than 9,000 smokers are admitted to MGH each year. Assuming that half that amount would be interested in quitting, we could potentially help more than 4,500 people to stop smoking. The benefits to patients, families, the hospital, and society are enormous.

Question: Why is quitting while you're in the hospital a good idea?

Jeanette: Hospitalization is a window of opportunity. Smoke-free hospitals require temporary abstinence from tobacco; illness motivates many people to quit; and formal interventions may help them succeed.

Question: Will patients really consider quitting just because I give them a booklet?

Jeanette: Studies show that any intervention can be effective. Simply telling your patient, "Quitting smoking is the most important thing you can do for your health," can make a difference. Giving her a booklet lets her know that help is available at MGH.

Question: Should I give a booklet to a patient who doesn't want to quit?

Jeanette: Yes. The booklet explains that nicotine-replacement therapy is available for patients to help manage nicotine withdrawal symptoms during their hospitalization (when they can't smoke).

Question: How does the QSS help?

Jeanette: Counselors specially trained in tobacco-cessation come to the bedside and provide a variety of services. QSS counselors take a soft approach. They can help provide relief from symptoms of nicotine withdrawal for hospitalized patients, and/or they can work with patients to create an individualized smoking-cessation plan. They can also provide follow-up through QuitWorks, the state-sponsored telephone quit line.

Question: I'm already so busy. How can I fit this into my schedule?

Jeanette: Initiating the process to help someone quit smoking is an important intervention, and it only takes a few minutes. Nurses are already helping by identifying patients who smoke on the nursing assessment form. Booklets should be stocked and available on each unit. Referrals for QSS counseling are automatically made when the order is entered in the Provider Order Entry (POE) system. We've come a long way toward simplifying the process and making it more efficient for you and your patients.

Question: What if my patient doesn't want to quit? Am I violating his trust by referring him to the QSS?

Jeanette: Helping patients to quit smoking is part of our standard of care. QSS counselors are trained to approach patients in an empathic, non-judgmental manner. Counselors respect patients' rights. Counselors have found that patients who appear to be resistant to counseling often express concerns about smoking and fears about quitting. Even if they're not ready to quit, speaking to a counselor opens a door to thinking about quitting and lets them know there's help available when they're ready. Patients benefit from many different levels of intervention.

Question: How satisfied are patients with the counseling they receive from the QSS?

Jeanette: The Quit Smoking Service conducts follow-up surveys with patients who have been seen by our counselors.

- 88% find speaking with a counselor helpful
- 94% say every smoker should see a counselor at MGH
- 62% say that seeing a counselor increased their interest in quitting
- Of patients surveyed, 45% report not smoking since being discharged from MGH.

For more information about the Quit Smoking Service or to receive a QSS protocol, call 6-7443.

Members of the EICPC present in Washington, DC

—by Gayle M. Peterson, RN, staff nurse

In October, 2005, a multi-disciplinary group from the Patient Care Services Ethics in Clinical Practice Committee (EICPC) headed to Washington, DC, to attend the annual meeting of the American Society for Bioethics and Humanities. The theme of this year's conference was, 'Justice and Suffering.' The week-long conference brought together a national audience to examine and discuss emerging issues in bioethics and the medical humanities. Topics addressed by panels and individual presenters ranged from, "Abu Ghraib and Guantanamo Bay: Medical Professionalism, Dual Loyalties," to, "Issues that Just Won't Die: Conflicts about DNR."

Regina Holdstock, RPh, pharmacist and co-chair of the EICPC, presented her poster, "True Life Stories: the Use of Drama and Mini-Theater as a Method for Educating Healthcare Providers about Advance Health Care Planning." The play spotlighted in her poster was presented months earlier to the MGH community as an educational offering with members of the Ethics in Clinical Practice Committee playing all the parts. The program, "Advance Directives: Humor, How Tos, and Hard Facts," uses drama as an educational tool to engage performers and audience members and emphasize the importance of advance directives in all care situations, but especially end-of-life care.

During the week-long conference, Ellen Robinson, RN, clinical nurse specialist, and Keith Perleberg, RN, nurse manager, presented a case study to the Nursing Affinity Group.

For more information about the work of the Ethics in Clinical Practice Committee or advance directives, contact Ellen Robinson, RN, at 4-1765.

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, visit:
www.mghnursingresearchcommittee.org

Deadline for submission is March 1, 2006

(Photo provided by staff)

Members of the Patient Care Services Ethics in Clinical Practice Commttee attend meeting of the American Society for Bioethics and Humanities in Washington, DC. Pictured from left to right are: Marion Parker, RN, staff nurse; Gayle Peterson, RN, staff nurse; Keith Perleberg, RN, nurse manager; and Ellen Robinson, RN, clinical nurse specialist. Regina Holdstock, RPh, who also attended, is not pictured.

Building trust and bridging gaps: one PT's approach to patient-centered care

Colleen Gillen is a clinician in the PCS Clinical Recognition Program

Colleen Gillen, PT
staff physical therapist

My name is Colleen Gillen, and I have been a staff physical therapist at MGH for almost three years. My first encounter with Mary was an unforgettable one. I was struck by the thought that Mary looked far older than her stated age. Her face was as motionless as a mask. Wide brown eyes, nearly panic-filled, stared up at me as I introduced myself as her physical therapist. The hiss of oxygen through her nasal cannula and the whir of her pressure-relieving mattress filled the room. Mary told me, in her soft, high-pitched voice, "I just feel terrible. Nauseous and dizzy, really dizzy."

Mary was a 67-year-old wife and mother of two grown daughters. Her complicated medical history included recurring aspiration of fluids following placement of a J tube, and most recently, gastric surgery to correct her chronic reflux. Mary had transferred to MGH from an acute-level rehabilitation hospital with a fever of unknown origin and increased non-productive cough. Her most recent hospitalization at MGH had been six weeks in duration, and included massive aspiration treated with antibiotics; recurrent hypotension and a slowed heart rate of unclear etiology; intermittent chest pain despite a normal stress test; and inflammation of the gallbladder. This time, Mary had been admitted to the Medical Service for continued work-up for suspected aspiration pneumonia. She was put on IV antibiotics, supportive nebulizers, and the Pain Service was consulted to assist in managing her newly worsening chronic pain.

Mary had undergone a below-the-knee amputation on her right leg three years ago due to complications from multiple surgeries trying to stabilize a compound right femur fracture. Mary had sustained the fracture during a fall at home and was known to have severe osteoporosis. Six years earlier, Mary had experienced a stroke with residual weakness on her right side. She had restrictive lung disease from scoliosis. Her sensory input was obscured by cataracts and peripheral neuropathy. Two years before, Mary had been diagnosed with reflex-sympathetic dystrophy and struggled with chronic pain. She had an internally implanted spinal-cord stimulator with an opiate pump.

For the first several days, anxiety took hold of Mary and limited the scope of our intervention. Mary was very distractible, requiring frequent cues for redirection to the tasks at hand. For this reason, I tried my best to ensure that her environment was free of excess noise during our treatment times. Mary needed a good deal of extra time to complete simple tasks. 'Setting up' for treatment often took a long time and involved donning her prosthesis, interrupting her tube feedings, coordinating her portable oxygen source, setting up the chair, deflating the bed, etc. As I got to know Mary's husband, Art, I involved him more in preparing Mary for her physical therapy treatments. Art had a very dry wit, and had been a kind and devoted partner to Mary for 42 years. He would often chime in with remarks like, "Oh sure, what would you ladies do without me?" I believe Art was grateful to be able to contribute to his wife's complex medical stay during which, up until now, he'd had little direct involvement. At the conclusion of every meeting, Mary and I agreed on a time for our next appointment. This allowed Art to assist in donning her prosthesis and shoes. It gave Mary a 'mental rehearsal' and an element of control over her care that she needed to succeed.

I quickly learned that in Mary's case, success would not be measured in inches and feet, but in milestones of confidence. Mary was progressing slowly but steadily; demonstrating emerging torso control for improved sitting balance and increasing ability to clear her airway to improve ventilation. However, our greatest difficulty revealed itself when we strayed from the bed to begin working on balance exercises while standing. Due to her chronic neuropathy, Mary had lost joint-positioning sense in her left foot, and was without position sense on the right due to her amputation. For this reason, she was extremely anxious upon standing as she struggled to establish her center of gravity over her base of support.

Mary would shout, "I'm afraid, Colleen. I'm afraid I'm going to fall." Yet, the more physical assistance I gave her, the more anxious she became. Mary lacked the ability to self-correct at her ankle or hip level, and her trunk and arms weren't yet strong enough to compensate. I listened to her explain, "I need to get my balance by myself. When someone tries to help me, I get unsteady."

To overcome the 'mountain' that sitting-to-standing had become, I learned to let Mary count aloud prior to initiating the sit-to-stand motion. I asked her to say aloud the steps she went through to adjust her prosthesis and transition to standing so the aide and I could provide the assistance she needed, *when* she needed it, and not in excess. I often needed to let her 'fail' to help her learn the limits of her balance and center

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

Clinical Narrative

continued from previous page

herself more effectively.

At the end of each session, I'd ask Mary to reflect back on our time together and let me know if there was anything she or I could have done differently. Through this process of self-reflection, she was able to learn from her trials and make small modifications to help next time. Mary was receptive to this informal way of gathering feedback to shape our interventions and focus on the work we needed to do. This helped us build trust in each other as teammates. Because of her struggle with depression and a lack of a noticeable change in her facial expressions with mood changes, it was important to get this information in this explicit way.

Trouble arose when new members were added to Mary's team. Perhaps because Mary required additional time, attention, and specialized set-up, some clinicians meeting Mary for the first time were hesitant to assist in her transfers out of bed.

Later, Mary told me, "I feel like I'm imposing on people, but I'd like to be able to walk to the bathroom." I facilitated improved communication by placing a sign detailing Mary's needs on the wall in her room. With Mary's input, I highlighted the process of donning her prosthesis, described the steps of transfer, drew pictures to display proper positioning, and included a goal for frequency. These steps led to greater ease of transfers and empowered Mary to assume a more active role in directing her care.

Mary's unique communication style often impacted her ability to give and receive accurate information to and from the medical team. One example that led to increased anxiety for Mary was a break-down in communication that prompted her to ask, "What's happening? Am I going to rehab for surgery or am I having surgery here?" Mary was an extremely intelligent, insightful, and compassionate woman, but these traits were not readily apparent at first, second, or even third meeting. It was only after many hours together that I began to pick up on her subtle changes in body language, breathing patterns, and vocal tone that let me know how she was feeling or responding to treatment. For this reason, I did my best to take an active role in relaying information between Mary and members of the team regarding her current symptoms, concerns, or medical plan of care.

Reflecting back on my time spent working with Mary, I am struck by how important it is to really 'know' the patient. As with all patients, communication barriers need to be overcome in order to maximize the quality of multi-disciplinary care. Knowledge of the individual gained through each patient interaction needs to be integrated immediately by caregivers. As we come to a greater understanding of the unique person in our care, we're better able to select individualized interventions, better our practice, and ensure true patient-centered care.

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

This is a wonderful example of the power of knowing your patient. Mary had a complex medical history as well as a unique way of interacting and communicating with people. By getting to know Mary and her husband, Colleen was able to customize creative interventions and adapt her treatment plan to meet Mary's needs.

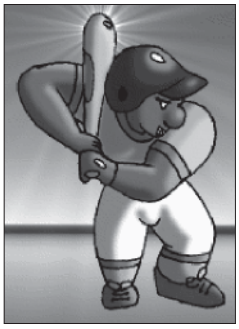
Colleen involved Mary in directing their time together by encouraging her to share her feelings after each treatment session. This was not only a constructive reflection technique, it was a trust-building opportunity that helped bolster Mary's confidence. And by sharing her insights with other members of the team, Colleen enabled others to provide optimal care for Mary, as well.

Thank-you, Colleen.

Quick Hits to improve your writing!

A low-stress, high-yield class aimed at helping you develop your writing style and eliminate some of the angst commonly associated with writing

Offered by Susan Sabia, editor of *Caring Headlines*



Classes now scheduled for:

Tuesday, January 31, 10:00am–1:00pm
Monday, February 27, 10:00am–1:00pm
Wednesday, March 15, 12:00–3:00pm
Monday, April 17, 11:00am–2:00pm
Tuesday, May 30, 11:00am–2:00pm

All classes held in GRB-015 Conference Room A

Classes limited to 12; pre-registration is required
To register, call Theresa Rico at 4-7840

Brian A. McGovern, MD, Clinical Excellence Award

In 2004, the Massachusetts General Physicians Organization (MGPO) established the Brian A. McGovern, MD, Clinical Excellence Award in memory of Dr. Brian McGovern. The award recognizes physicians who demonstrate the qualities that characterized McGovern: clinical excellence, commitment, and compassion. The 2006 McGovern awards will be presented at the Physician Recognition Dinner in the spring. Any employee may submit a nomination. Deadline for submission is February 16, 2006. To nominate on-line, please visit the MGPO website at: http://is.partners.org/mgpoonline/mcgovern.asp. For more information, call Beth LaRossa at 724-4549.

Zollfrank receives Cedarleaf Award

Rev. Angelika Zollfrank received the Len Cedarleaf Award at the national conference of the Association for Clinical Pastoral Education in November, 2005.

Klein presents

Aimee Klein, PT, physical therapist, presented, "Diagnostic Imaging: Applied Information for the Physical Therapist," at Columbia University, October 20–21, 2005.

Brush appointed to Disaster Committee

Kathryn Brush, RN, clinical nurse specialist, Surgical Intensive Care Unit, has been appointed to the Disaster Committee for the Society of Critical Care Medicine.

Brien, Dunbar, and Goodwin present

Barbara Brien, RN; Colleen Dunbar, RN; and Liz Goodwin, RN, Medical Intensive Care Unit, presented, "Nursing Strategies to Change End-of-Life Care in the Intensive Care Unit," at the New England Hospice and Palliative Care Education Conference on November 1, 2005, in Marlboro, Massachusetts.

Capasso presents

Virginia Capasso, APRN, clinical nurse specialist, The Knight Nursing Center for Clinical & Professional Development, presented, "Leg Ulcers," at the Comprehensive Update on Vascular Disease Conference, in Waltham, Massachusetts, November 3, 2005.

Duffy, Perry, and Read publish

Mary Duffy, PhD, nursing faculty, Boston College; Donna Perry, RN, professional development co-ordinator, The Knight Nursing Center for Clinical & Professional Development; and Cathy Read, RN, nursing faculty, Boston College, published, "Design and Psychometric Evaluation of the Psychological Adaptation to Genetic Information Scale," in the third quarter, 2005, issue of the *Journal of Nursing Scholarship*.

Cole certified

Elizabeth Cole, PT, physical therapist, was certified by the Lymphedema Association of North America, in Seattle, October, 2005.

McCormick and Sullivan present

Talli McCormick, GNP, nurse practitioner, and Patricia E. Sullivan, PT, physical therapist, presented their paper, "An Update on Fall Prevention and Exercise," at the Oxford Round Table on Successful Aging in Oxford, England, August 11, 2005.

Brush co-authors chapter

Kathryn Brush, RN, clinical nurse specialist, and Ulrich Schmidt, MD, authored the chapter, "Prophylaxis," in the *Critical Care Handbook of the Massachusetts General Hospital*.

Carroll, Hamilton, and Kenney present

Diane Carroll, RN, clinical nurse specialist; Glenys A. Hamilton, RN; and Barbara K. Kenney, RN, presented, "Changes in Fears and Concerns in Recipients of the Implanted Cardioverter Defibrillator," at the American Heart Association Scientific Sessions in Dallas, November 16, 2005.

Cohen and Nalipinski present

Audrey Cohen, CCC-SLP, and Paige Nalipinski, CCC-SLP, speech-language pathologists, presented: "Speech-Language Pathologists in Acute Care: Maintaining the Breadth of our Practice," at the 2005 American Speech, Language and Hearing Association Convention, November 17–20, in San Diego.

MGH nurses present

Kathleen Grinke, RN, General Clinical Research Center; Catherine Griffith, RN, clinical nurse specialist; Kathleen Walsh, RN, case manager; Mary Larkin, RN, diabetes nurse coordinator; and Virginia Capasso, APRN, clinical nurse specialist, presented "Promoting Research Utilization—The MGH Nursing Committee," at The Journey to Nursing Excellence and Magnet Designation, in Boston, November 17–18, 2005.

Prater on panel

Marita Prater, RN, nurse manager, General Medicine, was part of a panel presentation on, "Transforming the Work Environment—Best Practices," at the Massachusetts Hospital Association meeting, in Waltham, Massachusetts, November 16, 2005.

Brush presents

Kathryn Brush, RN, clinical nurse specialist, presented, "Advanced Bedside Procedures: Impact on Nursing," at the New England Regional Trauma Conference, November 10–11, 2005, in Burlington, Massachusetts.

Brackett co-authors chapter

Sharon Brackett, RN, Surgical Intensive Care Unit; Rae Allain, MD; and William E. Hurford, MD, authored the chapter, "Ethical and End-of-Life Issues," in the *Critical Care Handbook of the Massachusetts General Hospital*.

Connors and Ulles publish

Patricia M. Connors, RNC, Obstetrics, and Monica M. Ulles, RN, Cystic Fibrosis Center, published, "The Physical, Psychological, and Social Implications of Caring for the Pregnant Patient and Newborn with Cystic Fibrosis," in the *Journal of Perinatal and Neonatal Nursing*, October–December, 2005.

Morash presents

Susan Morash, RN, nurse manager, General Medicine, presented, "Bringing it All Back Home: Creating a Conflict-Wise Workplace," at the Association of Conflict Resolution, New England Chapter Annual Meeting in Tyngsboro, Massachusetts, in November, 2005.

Nurses publish

Carolyn Hayes, RN; Patricia Reid Ponte, RN; Amanda Coakley, RN; Escel Stanghellini, RN; Anne Gross, RN; Sharon Perryman, RN; Diane Hanley, RN; Nancy Hickey, RN; and Jacqueline Somerville, RN, published the article, "Retaining Oncology Nurses: Strategies for Today's Nurse Leaders," in the *Oncology Nursing Forum*, November, 2005.

Continued on next page

Gonzalez certified

Colleen Gonzalez, RN, Coronary Care Unit, passed the Medical-Surgical Clinical Nurse Specialist certification examination.

Michel publishes

Theresa Michel, PT, physical therapist, published the chapter, "Physical Therapy," in the *MGH Handbook of Pain Management*.

Pain advocates featured

Mary Lou Kelleher, RN; Katherine DiMare, RN; Tom Quinn, RN; and Elena Cliff, RN, were featured in the October, 2005, *On Call* magazine article, "Going After Pain."

NICU nurses certified

Anita Carew, RNC; Stephanie Trombalee, RNC; Eileen Jones, RNC; Tina Staffier, RNC; and Susan Worden, RNC, of the Neonatal Intensive Care Unit, were certified as neonatal intensive care nurses.

Nunn presents

Danny Nunn, CCC-SLP, speech-language pathologist, presented, "Oral Pharyngeal Laryngeal Motor Exercises for Swallow: Controversial Subject," at the 2005 American Speech, Language and Hearing Association Convention, November 17-20, 2005, in San Diego.

Brush joins Steering Committee

Kathryn Brush, RN, clinical nurse specialist, Surgical Intensive Care Unit, has been named to the University Health Consortium Steering Committee on Central Venous Catheter Line-Related Bacteremias.

Colleagues publish

Elizabeth Hiltunen, RN; Patricia Winder, RN; Michelle Raitt, MA; Elizabeth Buselli, RN; Diane L. Carroll, RN; and Sally Rankin, RN, published, "Implementation of Efficacy Enhancement Nursing Interventions with Cardiac Elders," in *Rehabilitation Nursing*, November/December, 2005.

Peterson named president-elect

Gayle Peterson, RN, staff nurse, General Medicine, has been appointed president-elect of the Massachusetts chapter of the American Society of Pain Management Nurses (ASPMN).

Bonander presents

Evelyn Bonander, MSW, director emerita, MGH Social Services, presented the break-out session, "The Innovation of Social Work: The Best Way to Explain it is to Do it," at Innovation at 100, October 27–28, 2005, in Boston.

Quinn elected to Nominating Committee

Thomas Quinn, RN, project director for MGH Cares About Pain Relief, has been elected to the Nominating Committee of the American Society for Pain Management Nursing.

Capasso presents

Virginia Capasso, APRN, clinical nurse specialist and co-director of the MGH Wound Care Center, presented, "Wound Volume Measurement: The Challenges of a Biometric Pilot," at the Faculty Research Colloquium, MGH Institute of Health Professions, on December 2, 2005, in Charlestown.

NICHE Committee receives grant

The NICHE Committee (Networking to Improve the Care of Healthsystem Elders) has been awarded a $5,000 grant from the Hartford Institute for Geriatric Nursing to be used to promote gerontology certification for nurses. Kate Barba, RN; Sheila Golden-Baker, RN; and Mary Ellen Heike, RN, submitted the proposal on behalf of the NICHE Committee.

Gundersen and Konner present

Natascha Gundersen, LICSW, and Karon Konner, LICSW, Social Services, presented, "Social Work's Role in Disaster Medical Response," at the Massachusetts chapter of The National Association of Social Work's quarterly meeting of the Disaster Response Committee, November 21, 2005, in Waltham.

Brier presents

Marilyn Brier, LICSW, Social Services, presented, "Developing a Prostate Cancer Support Group," at Innovation at 100, October 27–28, 2005, in Boston.

Hazelwood and Joyce present

Michelle Hazelwood, LICSW, and Eileen Joyce, LICSW, Social Services, presented, "It Takes a Village," at Innovation at 100, October 27–28, 2005, in Boston.

Social workers present

Sheryn Dungan, LICSW; Eileen Joyce, LICSW; and Michele Lucas, LICSW, Social Services, presented, "When Does Care End: Providing Bereavement Care in Cancer Centers," at Innovation at 100, October 27–28, 2005, in Boston.

Horne-Mebel and Zuckerman present

Leigh Horne-Mebel, LICSW, and Fredda Zuckerman, LICSW, Social Services, presented, "Every Mother, Every Baby, Every Family... Compassionate Care for All," at Innovation at 100, October 27–28, 2005, in Boston.

Nurses and social workers present

Mary Connolly, RN; Susan Fisher, RN; Joan Monahan, RN; Paula Murphy, LICSW; Barbara Olson, LICSW; and Alice Rotfort, LICSW, Social Services, presented, "Community Care Programs: Social Worker/Nurse Teams Bring Care into the Home," at Innovation at 100, October 27–28, 2005, in Boston.

Dahlin presents

Constance Dahlin, APRN, palliative care nurse practitioner, presented, "The Impact of Clinical Guidelines in Palliative Care for Gerontological Nursing," at the National Association of Gerontological Nursing Conference, on October 22, 2005, in Myrtle Beach, South Carolina. Dahlin presented, "Advanced Practice Nursing: Practical Aspects of Palliative Medicine," on October 21, 2005, in Boston, and she presented, "Oral Complications in End-of-Life Care," at the Hospice and Palliative Care Federation of Massachusetts Conference, on November 2, 2005, in Marlborough.

Continued on next page

Essig presents

Debbie Essig, LICSW, Social Services, presented, "Can This Marriage Work? Weaving a Clinical Perspective into an Oncology Website," at Innovation at 100, October 27–28, 2005, in Boston.

Clair-Hayes and Levin-Russman present

Kathy Clair-Hayes, LICSW, and Elyse Levin-Russman, LICSW, Social Services, presented, "Take Good Care Packs: Promoting Communication and Comfort for Children with Cancer," at Innovation at 100, October 27–28, 2005, in Boston.

Multi-disciplinary team presents

Katie Binda, LICSW, Social Services; Elizabeth Alterman, BS, administrative director, Clinical Programs, Cancer Center; and Barbara Cashavelly, RN, nurse manager, Cancer Center, presented "Meeting the Needs of Support Staff at a Patient- and Family-Centered Oncology Center," at Innovation at 100, October 27–28, 2005, in Boston.

Social workers present

Evelyn Bonander, MSW, director emerita, Social Services; Catherine Carlo, LICSW; Kitty Craig-Comin, LICSW; Susan Fisher, LICSW; Leigh Horne-Mebel, LICSW; Lisa Mortimer, LICSW; and Barbara Olson, LICSW, Social Services, presented, "Pioneering a Profession: a History of Social Work Innovation at the MGH 1905-2005," at Innovation at 100, October 27–28, 2005, in Boston.

Multi-disciplinary team presents

Ellen Abele, LICSW; Barbara Sarnoff Lee, LICSW; Tami May, LICSW; Fredda Zuckerman, LICSW; Social Services, Shannon Bennet; Brett Litz, PhD; and Shira Maguen, PhD, presented, "The Perinatal Loss Project and the Boston Perinatal Loss Initiative: a Multi-Center Study to Understand the Psychological and Social Consequences of Pregnancy Loss," at Innovation at 100, October 27–28, 2005, in Boston.

Lucas presents

Michele Lucas, LICSW, Social Services, presented, "The Unique Needs of the Primary Brain Tumor Patient Population," at Innovation at 100, October 27–28, 2005, in Boston.

Diversity Council presents

Members of the MGH Social Work Diversity Council presented, "The Experience of a Diversity Council," at Innovation at 100, October 27–28, 2005, in Boston.

Coreas, Troncoso, and Vega present

Marisol Coreas, Niza Troncoso, and Carolyn Vega, HAVEN advocates, presented, "De Mujer a Mujer: Woman to Woman," at Innovation at 100, October 27–28, 2005, in Boston.

Murphy and Wise present

Rebecca Murphy, LICSW, and Marilyn Wise, LICSW, Social Services, presented, "Getting to Know Patients who Cannot Speak on Their Own Behalf: Commitment to an Ethic of Care," at Innovation at 100, October 27–28, 2005, in Boston.

Multi-disciplinary team presents

Susan Lipton, LICSW, Social Services; Beth Holleran, LICSW, Social Services; Alice Newton, MD, Pediatrics and Social Services; Andrea Vandeven, MD, Social Services; and Mark Sapp, MD, Pediatrics, presented, "Child Protection Team: Working Toward a Safer Future for Children and their Families," at Innovation at 100, October 27–28, 2005, in Boston.

Multi-disciplinary team presents

Marilyn Brier, LICSW, Social Services; Regina Holdstock, RPh, oncology pharmacy supervisor; Diane Doyle, APRN, Hematology/Oncology; Evelyn Malkin, LICSW, Social Services; Katie Binda, LICSW, Social Services; and Stacey Paiva, MBA, HOPES program manager, presented, "Living with Cancer, Moving Forward After Treatment: a Multidisciplinary Collaboration," at Innovation at 100, October 27–28, 2005, in Boston.

Gioiella, Wise, present

Marie Elena Gioiella, LICSW, and Marilyn Wise, LICSW, Social Services, presented, "Narratives in Social Work: Illustrating Our Clinical Practice," at Innovation at 100, October 27–28, 2005, in Boston.

Wolf Dresp presents

Christine Wolf Dresp, LICSW, Social Services, presented, "Dreamwork in Clinical Practice," at Innovation at 100, October 27–28, 2005, in Boston.

Zwirner presents

Mary Zwirner, LICSW, Social Services, presented, "A Case Study: Interdisciplinary Care of the Patient with Brain Injury of Unknown Etiology Experiencing Sympathetic Storming," at Innovation at 100, October 27–28, 2005, in Boston.

Dahlin and Goldsmith publish

Constance Dahlin, APRN, palliative care nurse practitioner, and Tessa Goldsmith, clinical specialist, Speech, Language & Swallowing Disorders, authored the chapter, "Dysphagia, Dry Mouth, and Hiccups," *in Oxford Textbook of Palliative Nursing*, second edition, Oxford University Press, New York, 2005.

Dahlin, Giansiracusa, publish

Constance Dahlin, APRN, and David Giansiracusa, MD, Pain and Palliative Care Center, wrote the chapter, "Communication," *in Oxford Textbook of Palliative Nursing*, second edition, Oxford University Press, New York, 2005.

Jagodynski Samatis, Pittman, publish

Kristen Jagodynski Samatis, BS, health educator, and Taryn J. Pittman, RN, patient education specialist and manager, Blum Patient & Family Learning Center, published the article, "Consumer Health Within an Academic Medical Center: State-of-the Art Services and Technology," in the *Journal of Hospital Librarianship*, 2005.

Continued on next page

Dacunha certified

Shannon Dacunha, RN, staff nurse, General Medicine, became certified as a medical-surgical nurse, in December 2005.

Otis certified

Leann Otis, RN, staff nurse, on the Cardiac Access Unit, was certified as a cardiac-vascular nurse.

Edwards certified

Erica Edwards, RN, Cardiac Critical Care Unit, passed the cardiac nursing certification exam given by the American Association of Critical-Care Nurses.

Peterson certified

Gayle Peterson, RN, staff nurse, General Medicine, was certified in pain management nursing by the American Nurses Credentialing Center.

Feldman presents

Ellen Feldman, LICSW, Social Services, presented the break-out session, "Working with Couples Undergoing Assisted Reproductive Technologies," at Innovation at 100, October 27–28, 2005, in Boston.

McSheffrey presents

Carol McSheffrey, LICSW, Social Services, presented the break-out session, "Getting Up to Speed: A Review of Clinical Interventions in Couples Therapy," at Innovation at 100, October 27–28, 2005, in Boston.

Madigan, Moore, publish

Janet Madigan, RN, PCS Information Systems, and Karen Moore, RN, published the article, "MARN Supports the Patients First Initiative," in *Massachusetts Report on Nursing*, Volume 3, Number 4, December, 2005.

Binda, Clair-Hayes present

Katie Binda, LICSW, and Kathy Clair-Hayes, LICSW, Social Services, presented the break-out session, "Creating Innovative Support, Education and Wellness Programming for Patients, Families and Staff," at Innovation at 100, October 27–28, 2005, in Boston.

Forman presents

Ellen Forman, LICSW, Social Services, presented the break-out session, "Helping Patients Navigate the Crazy Quilt System," at Innovation at 100, October 27–28, 2005, in Boston.

McCorkle, McLaughlin present

Chuck McCorkle, LICSW, and Sandy McLaughlin, LICSW, Social Services, presented the break-out session, "HIV/AIDS: Changing Needs Means Changing Practice. What Do We Know 20+ Years In?" at Innovation at 100, October 27–28, 2005, in Boston.

Social workers present

Natascha Gundersen, LICSW; Karon Konner, LICSW; and Kristen Prendiville, LICSW, Social Services, presented the break-out session, "Supporting Lives and Spirits: Tsunami Relief in Indonesia," at Innovation at 100, October 27–28, 2005, in Boston.

Social Services team presents

Bonnie Zimmer, LICSW; Patti Rosell, LCSW; Sandra Elien; and Erin Gibson, LCSW, Social Services, presented the break-out session, "Domestic Violence Advocates and Social Workers: Teaming Toward Safety," at Innovation at 100, October 27–28, 2005, in Boston.

Social workers present

Kathy Clair-Hayes, LICSW; Carla Cucinatti, LICSW; Nancy Leventhal, LICSW; Rebecca Murphy, LICSW; and Marguerite Hamel-Nardozzi, LICSW, Social Services, presented the break-out session, "I Don't Know What to Say to My Child—How Therapeutic Backpacks Can Help Start the Conversation Between Parents and Kids," at Innovation at 100, October 27–28, 2005, in Boston.

Levin-Russman presents

Elyse Levin-Russman, LICSW, Social Services, and Parent Members of the Pediatric-Oncology Family Advisory Committee, presented the break-out session, "Partnering with Families to Enhance Clinical Services: The Development of a Family Advisory Committee," at Innovation at 100, October 27–28, 2005, in Boston.

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February 16, 2006

Visiting Professor in Wound Healing

continued from front cover

governs reimbursement to long-term care (LTC) facilities. Reimbursement may be reduced if a patient develops a new pressure ulcer or if an existing pressure ulcer worsens while in the care of the LTC facility or nursing home. Lyder reports that a similar regulation may be enacted related to reimbursement for acute care hospitals in the near future. Other consequences may include reluctance of LTC facilities and nursing homes to accept patients from acute care facilities if they have new or worsened pressure ulcers. There has been an increase in litigation against hospitals and nurses by family members in cases where pressure ulcers develop, especially following the death of a loved one due to complications of pressure ulcers, which were perceived as avoidable. Lyder recommends:

- documenting the presence and status of all pressure ulcers at time of admission, periodically throughout the hospital stay, and upon discharge
- documenting, when appropriate, that a new or worsening pressure ulcer was unavoidable and why (for example, prolonged immobility associated with sepsis and hemodynamic instability)
- documenting how the plan of care changed in order to prevent additional pressure ulcers or worsening of existing pressure ulcers.
- using a wedge at the foot of the bed to prevent shear forces and pressure ulcers in patients who are mechanically ventilated and require the head of the bed to be elevated
- considering micro-shifting in patients whose conditions prevent turning

Lyder's visit consisted of four sessions. The first was a standing-room-only dialogue with critical care nurses on avoidable and unavoidable pressure ulcers. A luncheon session with the CNS Wound Care Task Force focused on strategies to help educate staff about pressure ulcers. Nursing Grand Rounds focused on the implications of DTI and F-314 for acute care. The closing session, which featured a mock deposition in a lawsuit against a hospital where a patient had developed pressure ulcers, illustrated the importance of complete nursing documentation in defending nursing practice. The Visiting Professor Program revealed opportunities for advancement in our skin and wound care program.

Magnet calendars available

(featuring MGH nurse, Katie Fallon)

The inaugural issue of the Magnet Recognition Program's annual calendar is now available.

The 2006 calendar highlights excellence in nursing service at Magnet hospitals with photos depicting the 14 forces of magnetism. The calendar is not available for purchase, but may be viewed and printed from the Magnet website at: http://www.nursecredentialing.org/magnet/forms/Calendar2006.pdf

For more information, contact Georgia Peirce at 4-9865.

When should hand hygiene be performed?

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

- Hand hygiene should be performed *before* any contact with patients or patients' environments.

  (Before handshakes, pulse checks, physical examinations, giving a boost up in bed, touching the bedside table, transporting equipment, laundry, etc.)

- Hand hygiene should be performed *between* tasks if a clean site is to be touched after a contaminated site.

  (Between redressing a wound and checking an IV site; between handling a bedpan and refilling the water pitcher; between collecting used lunch trays and preparing a snack in the kitchen)

- Hand hygiene should be performed *after* patient care, before touching anything in the non-patient environment.

  (After administering an injection, before charting it in the patient's record)

- Hand hygiene should be performed *before* donning gloves and *after* glove removal (both sterile and non-sterile gloves).

Call for Nominations

Cancer Nursing Career Development Award

The Cancer Nursing Career Development Award recognizes an MGH staff nurse who consistently demonstrates excellence in delivering care to patients with cancer, who is a role model to others, and who demonstrates a commitment to professional development.

Staff nurses whose primary responsibility is direct care of cancer patients and their families (inpatient or outpatient) are eligible for nomination. Recipient will receive $1,000 to advance his/her professional development.

Colleagues, patients, and family members can nominate a staff nurse.

Nominations are due by February 24, 2006

For more information, please contact Lin-Ti Chang, RN, at: 617-643-2995

When/Where	Description	Contact Hours
February 10 and 27 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
February 16 and 23 8:00am–4:00pm	**Oncology Nursing Society Chemotherapy-Biotherapy Course** Yawkey 2220	16.8 for completing both days
February 16 1:30–2:30pm	**Nursing Grand Rounds** "Anti-Coagulation." O'Keeffe Auditorium	1.2
February 22 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
February 23 1:00–2:30pm	**Natural Medicines: Helpful or Harmful?** FND626	1.8
February 24 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
March 1 and 8 8:00am–4:30pm	**Phase II: Wound Care Education** Training Department, Charles River Plaza	TBA
March 1 8:00am–4:00pm	**Assessment and Management of Patients at Risk for Injury** Haber Conference Room	TBA
March 2 8:00–4:00pm	**Oncology Nursing Concepts: Advancing Clinical Practice** Yawkey 10-640	TBA
March 7 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
March 8 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
March 8 11:00am–12:00pm	**Nursing Grand Rounds** "Lymphedema." Haber Conference Room	1.2
March 8 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
March 9, 10, 16, 17, 27, 30 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** NEBH	44.8 for completing all six days
March 10 and 27 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
March 15 9:00am–3:30pm	**A Safer Start: Empowering Pregnant Women Living with Domestic Violence** Training Department, Charles River Plaza	- - -
March 15 4:00–5:00pm	**More than Just a Journal Club** Thier Conference Room	1.2
March 16 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** Training Department, Charles River Plaza	TBA
March 16 1:30–2:30pm	**Nursing Grand Rounds** "Provoking Ischemia, Risking Infarction: Stress Testing." O'Keeffe Auditorium	1.2
March 20 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
March 20 and 22 7:30am–4:30pm	**Pain Relief Champion Day** Thier Conference Room	1.2

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

Patient Care Services remembers cherished friends

The MGH community was saddened to learn of the passing of two long-time Patient Care Services employees last month when Paul Lindquist and Robin Holloway passed away within days of each other.

Lindquist, a member of the MGH family for more than 32 years, died on January 15, 2006, after an extended illness. During his tenure at MGH Lindquist worked as a unit coordinator and administrative coordinator for Clinical Administration and Nursing Support Services.

In 1990, he joined Patient Care Services Management Systems as a financial analyst, the position he held until his death.

Colleagues remember Lindquist as, 'a quiet friend and caring mentor.' He had a great sense of humor and knew the organization inside and out. You could go to him with questions and he'd always know where to go to get answers. He was always willing to help.

Lindquist had a natural appreciation for customer service. He was the 'go-to' person in his areas of expertise; highly regarded for his knowledge and insight. He approached issues with an open mind and a 'can-do' attitude; he was respectful of others and always willing to provide assistance and support.

Says Christina Graf, RN, director of PCS Management Systems, "Family was very important to Paul. He was a proud husband, father, and grandfather. He loved the ocean and being near the water. He loved spending time on his boat on Lake Winnipesaukee. He was a very important part of *our* family, and he will be missed."

Holloway worked at MGH since 1978, first as a Northeastern University co-op student, then after receiving her BSN, as a nurse on the Medical Service. Most of Holloway's career was spent working in the Medical Intensive Care Unit.

Holloway's advance directive captures the way she wanted to be remembered:

"If anyone asks, please tell them:

l love life
I love adventure
I love exploring.

I love giving of myself
in my job
and in my life.

I love making a difference
however large
or small it may be."

According to friends and colleagues, Holloway did make a difference, and she will be missed by many.

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