

# Caring

January 19, 2006

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## Kirvilaitis Awards recognize partners in caring

—by Thomas Drake, senior training and development specialist

**A**n atmosphere of celebration, remembrance, and pride filled O’Keeffe Auditorium on December 14, 2005, for the fourth annual Anthony Kirvilaitis, Jr. Partnership in Caring Awards. This year’s recipients were Michael DiLuigi, senior registration coordinator in the Emergency Department, and Eulawn Heron,

operations associate on the Bigelow 14 Vascular Surgical Unit.

Tony Kirvilaitis served the MGH community as a mentor and educator for 16 years, and his legacy was the foundation for this award. The Kirvilaitis Awards are given annually to recognize two support staff members (operations associates, unit service associates,

operating room assistants, unit assistants, patient service coordinators, ED admitting assistants, patient care information associates, and information desk associates) who demonstrate reliability, responsiveness, assurance, collaboration, flexibility, creativity, and support to enhance the

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Kirvilaitis award recipients, Michael DiLuigi, senior registration coordinator in the Emergency Department, and Eulawn Heron, operations associate on the Bigelow 14 Vascular Surgical Unit

## Taking good care of others means taking good care of ourselves

Working in health care is not like working in any other field. When nurses and other healthcare providers come to work, people's lives hang in the balance. That's a formidable responsibility, and one we don't take lightly.

Providing high-quality patient care involves more than education, experience, skill, and commitment. No amount of training or professionalism can compensate for a caregiver who is tired, overworked, out of shape, or in poor health. That's why, as important as it is to take excellent care of our patients, it's equally

important to take excellent care of ourselves.

I'm sure many of you are familiar with the 2004 Institute of Medicine (IOM) report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, in which staffing levels, overtime, and number of hours worked per shift and per week were discussed in relation to patient safety. Citing a connection between prolonged work hours and diminished performance due to fatigue, the report recommended limiting the number of 12-hour shifts and/or 60-hour weeks worked by nurses. Research is ongoing to

learn more about work hours and work patterns and their relationship to patient safety and adverse events. But much of the debate around work hours and patient safety revolves around common sense and good judgement. As healthcare professionals, we need to know our strengths and limitations. We have a responsibility to keep ourselves in peak form to ensure that our patients receive the best we have to give. We need to apply the same critical thinking and informed decision-making we use at the bedside to ensure our own good health and well-being. If we're not taking good care of ourselves, we're not taking good care of our patients.

Self-reflection has become a big part of our clinical culture. We need to take that self-reflection beyond the clinical realm and apply it to the personal choices we make every day about diet, exercise, rest, stress-management, our lifestyle outside of work, and time spent with family.

Health care changes every day. Technology changes every day. The needs and expectations of our patients change every day. We need to be mentally and physically prepared to meet those challenges.



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

In the two years since the IOM report was released, Patient Care Services conducted an analysis, under the direction of Christina Graf, RN, director of PCS Management Systems; and Peggy Shaw, RN, project manager for PCS Information Systems, of the hours worked by MGH nurses. The study was conducted in the 12-week period between April and June in 2004 and again in 2005. Among other things, the study looked at the extent to which nurses worked more than 12-hour shifts and more than 60 hours per week. The study showed a significant decrease in the number of greater-than-12-hour shifts worked from 2004 to 2005, and a smaller decrease in the number of greater-than-60-hour weeks worked. It appears that increased awareness about the concerns associated with prolonged work hours and diminished performance are driving staff to make good decisions.

The study will be conducted again in 2006.

The IOM report and other studies such as the Rogers study, *The Working Hours of Hospital Staff Nurses and Safety*, are helpful in calling our attention to important issues affecting patient safety. But the most important factor influencing patient safety is personal accountability. We're each responsible for the care we provide and the skills we bring to the bedside. We're responsible for the choices we make, at work and at home. I know you share my belief that taking care of others means taking care of ourselves. So please continue to use common sense and good judgement in the choices you make.

Thank-you.

### Update

Colleen Gonzalez, APRN, will become a part-time clinical nurse specialist for Phillips House 20 and 21 beginning January 22, 2006.

## Eldercare Discussion Group

The Employee Assistance Program will hold its monthly Eldercare Discussion Group

**Tuesday, January 24, 2006  
12:00-1:00pm**

**Eric Doerr Conference Room (#10650)  
10th floor of the Yawkey Building**

Facilitator: Janet T. Loughlin, LICSW, Partners Employee Assistance Program  
Speaker: Barbara Moscovitz, LICSW, geriatric social worker

Please join us to discuss: normal aging, how to identify problems, and the basic steps to begin planning for care

Additional sessions will be held, February 28, March 28, and April 25.

Feel free to bring a lunch

For more information, contact the EAP at 6-6976, or visit: [www.eap.partners.org](http://www.eap.partners.org)

## Guidelines for communicating via e-mail at MGH

*Question:* We use e-mail very frequently at MGH these days. Who has access to e-mail?

*Jeanette:* E-mail has been rolled out to all clinical and secretarial staff within Patient Care Services and many staff members in other departments, including physicians and other providers. Staff who've been given access to e-mail can log on from any Partners workstation using their user name and password. Staff can also access e-mail on the Internet at [www.partners.org/email](http://www.partners.org/email).

*Question:* Are there guidelines for using e-mail for

general hospital communication?

*Jeanette:* E-mail should be used for non-urgent, hospital-related business. When sending e-mail, use the subject line to state the purpose of the correspondence. Keep sentences brief and clear and avoid using clinical shorthand or Internet abbreviations that can be confusing. Use upper and lower case letters the same as you would when composing a letter or report. Words written in all upper case may come across AS IF YOU ARE SHOUTING. Spell-check your e-mail before sending. If you're replying, include the original mes-

sage as a reminder to people of the topic. Avoid sending large attachments with pictures or graphics as they can overload mailboxes and slow communication. If you have to send an e-mail with a large attachment, alert the recipients so they can save it to their H (home) drives and delete the message from their mailboxes.

*Question:* Can e-mail be used by providers to communicate patient-care information?

*Jeanette:* E-mail is a valuable communication tool for transmitting patient-care information, particularly in the ambu-

latory setting, but confidentiality is crucial. Remember that e-mail messages sent within the Partners network are secure, but those sent outside the Partners firewall (via the Internet) are not. That's like sending a postcard through the mail. If you send an e-mail about a patient, make sure you have the correct recipient (many employees have the same or similar names, and you want to be sure that confidential patient information doesn't go to the wrong person).

Identify the message as 'confidential' by clicking on Options and selecting confidential in the field labeled, Sensitivity. Alternatively, include the following statement of confidentiality: "The

information contained in this electronic message and any attachments to this message are intended for the exclusive use of the addressee(s) and may contain confidential or privileged information. If you are not the intended recipient, please notify me immediately and destroy all copies of this message and any attachments."

You can avoid having to re-type this each time by setting it up as a standard signature. You can do that by clicking on Tools in the e-mail Toolbar. Click Options. Click Mail Format. Click Signature, and create a signature message that will appear on all your e-mails.

*Question:* My healthcare provider is here at MGH. Is e-mail communication an option for patients as well?

*Jeanette:* Yes, but before e-mailing your healthcare provider for the first time, make sure he or she is agreeable to receiving e-mail communications from patients. Use it only for non-urgent matters that can't wait until your next scheduled appointment. Be aware that your provider's secretary or another provider may open the e-mail. Also, your message may be added to your medical record or forwarded to other providers if necessary for your care.

## An update on nursing educational opportunities

—by Julie Goldman, RN, and Miriam Greenspan, RN

In November, 2004, in collaboration with academic institutions, the department of Nursing launched the MGH on-site/on-line RN to BSN program. To date, more than 20 MGH nurses have enrolled in classes to further their education.

Based on the success of the RN to BSN program, the department of Nursing decided to broaden the scope of educational offerings. Initial surveys of staff revealed

an interest in graduate-level education. And a need for nurses prepared in the CNS role was identified based on current research, increased patient acuity, and a focus on providing high-quality care. Working with local academic institutions provided a means to respond to both areas of interest. The result of this collaboration is the availability of on-site CNS/master's programs offered by both The MGH Institute of Health Pro-

fessions (IHP) and Northeastern University (NEU). To date approximately 15 MGH nurses have enrolled in graduate courses.

The effort to publicize these programs began in June, 2005, with informational sessions, posters, and on-line advertisements. In addition to holding classes on campus, schools have offered other incentives to staff. Nursing leaders at MGH participated in developing course content. Managers have supported

staff with guidance and flexible schedules to enable staff to participate in these programs.

Resources and support are available for MGH nurses seeking to advance to BSN or graduate-level preparation. For information, visit: [www.massgeneral.org/pcs/abt\\_health\\_career.asp](http://www.massgeneral.org/pcs/abt_health_career.asp). This site provides information about MGH tuition reimbursement, scholarships, and financial-aid opportunities.

For more information about MGH on-site/on-line RN to BSN and graduate-level programs, contact Miriam Greenspan at 4-3506.

## Kirvilaitis Award Ceremony

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patient and family experience.

In her opening remarks, Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse, welcomed attendees and reflected on the Kirvilaitis legacy. "When I think about the important work we do every day caring for patients and their families, I can't help but think of the contributions Tony made during his tenure at MGH. Tony was the benchmark for excellence for thousands of support staff. He walked the talk. He showed students why

their work was important. He made them see the pivotal role they played in ensuring a safe and caring hospital experience for patients and their families."

Ives Erickson thanked Selection Committee co-chairs, Thomas Drake, senior training and development specialist, and Carolyn Washington, operations coordinator, and the entire Selection Committee for their hard work and commitment in selecting this year's recipients.

Before introducing the recipients, Ives Erickson invited Marianne Ditomassi, RN, executive director

of Patient Care Services operations, to speak. Ditomassi, a long-time friend and colleague of Kirvilaitis, recalled a time when she talked with Tony about some of his favorite books. "It was during that conversation," she said, "that he shared with me his interest in the writings of Frederick Buechner. Buechner suggests that a spider's web is an apt metaphor for the inter-relatedness of people. Observes Buechner, 'If you touch a spider's web anywhere, you set the whole thing trembling. As we move through and around this world, and as we act with kindness, or indifference, or even hostility toward the people we meet, we, too, are setting the great spider web a-tremble. The life I touch will touch another life, and that, in turn, another, until who knows

where the trembling stops or in what far place and time my touch will be felt.'

"You couldn't find a better way to quantify or qualify Tony's legacy," said Ditomassi. "Just think of the web that Tony has set a-tremble. Through the continued commitment to the values celebrated by this award, we will continue to feel Tony's gentle touch."

Ives Erickson introduced recipient, Michael DiLuigi, senior registration coordinator in the Emergency Department. Reading from a letter of support written by Keith Kwiatkowski, a supervisor in the ED, Ives Erickson said, "Michael is an empathetic, compassionate, young man who does whatever he can to improve the lives of those around him. He brings a warm smile, a gentle

sense of humor, and an air of concern that comforts people. Michael is the first to say, 'Can I help you?' and he really means it."

Nurse manager, Sharon Bouvier, RN, wrote of Eulawn Heron, operations associate on the Vascular Surgical Unit, "Eulawn demonstrates sensitivity towards patients with special needs. In the case of one hearing-impaired patient who was unable to use our call system, she frequently checked on the patient herself until a more formal solution could be found."

Ives Erickson thanked attendees for celebrating Tony's spirit as it's carried forward in the work of this year's recipients.

For more information about the Anthony Kirvilaitis, Jr. Partnership in Caring Award, contact Tom Drake at 6-9148.



Above: Marianne Ditomassi, RN, executive director of Patient Care Services operations, speaks at Kirvilaitis award ceremony in O'Keeffe Auditorium.

At right: Some of Tony's friends and colleagues attend award ceremony.



## An interview with Michael McElhinny, the new director of MGH Chaplaincy

*On January 3, 2006, Michael McElhinny, MDiv, assumed the role of director of the MGH Chaplaincy. An oncology chaplain at MGH since 1998, and a former Stephanie Macaluso Excellence in Clinical Practice Award recipient, McElhinny is an authority on spirituality and patient care. Shortly after accepting his new role, McElhinny sat down to talk with Caring Headlines.*

**Caring Headlines:** How does it feel to be the new director of the MGH Chaplaincy?

**Mike:** It's a real mix of feelings. I've been overwhelmed by the kind wishes and generous support of my department and many of my colleagues in the MGH community. I'm humbled by the trust people have placed in me. I'm going to miss working with the patients, families, and caregivers in our Cancer Center, but I rejoice at the prospect of helping members of the MGH Chaplaincy as they provide spiritual support to patients, families, and staff.

**Caring Headlines:** Can you tell us a little about your background?

**Mike:** I was born in a small town in Maine where the simple blessings of each day are valued; where people are pretty level-headed; where you work hard while realizing your limits; and where sometimes you have to smile at life's little mysteries.

**Caring Headlines:** Are there events in your life that helped shape the direction of your career?

**Mike:** When my dad was dying of a brain tumor nearly twenty-nine years ago, the local hospital chaplain was a quiet presence of support for me and my family, far more than we realized at the time. My desire to give something back for spiritual care led me to become a chaplain. It's a calling from God for which I'll be forever grateful.

**Caring Headlines:** You've been a chaplain at MGH for more than

seven years. How would you describe your team?

**Mike:** MGH chaplains are a generous fellowship of people who like to laugh and eat. They have true compassion for all people. Every member of the team brings a unique strength and perspective that when taken all together positions the department to provide exquisite spiritual care.

**Caring Headlines:** How would you describe your leadership style?

**Mike:** I value collegiality. I like to listen and build consensus whenever possible. I seek to earn people's respect, for I know I'll need to draw on it in making the difficult decisions I am responsible for.

**Caring Headlines:** As the director of the Chaplaincy, what is your first priority?

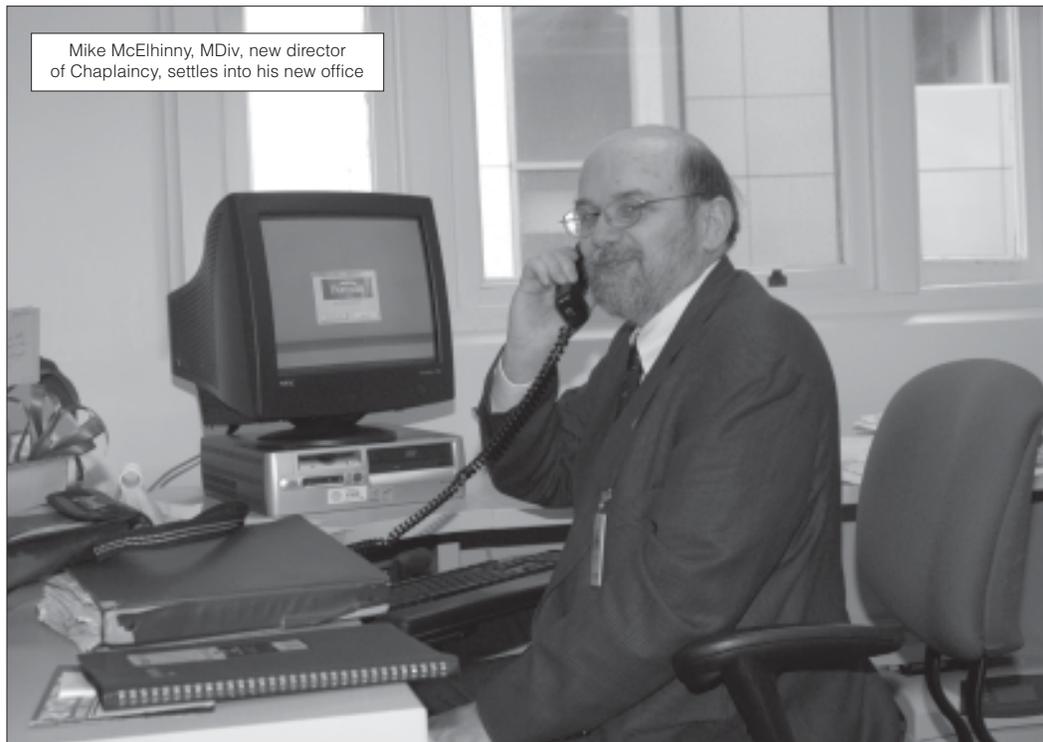
**Mike:** I feel privileged to have been appointed to lead the Chaplaincy team. I look forward to listening to what's important to my team, to patients and families, and to the MGH community. My priority is to work together to create a shared vision for our future.

**Caring Headlines:** As you look ahead, what are your expectations for the department?

**Mike:** I plan to work for greater unity in our department, increased integration of chaplaincy at all levels of care, education, research, and community support. I want to work closely with my team of professionally trained chaplains to make the services they provide more visible, both internally and externally.

**Caring Headlines:** Is there anything else you'd like people to know?

**Mike:** I can tell you that my wife and I love to travel and enjoy watching the 'dancing' fountains at the Bellagio Hotel in Las Vegas. My four-and-a-half-year-old granddaughter thinks I'm cool. And I'm a great fan of Tolkien's *The Lord of the Rings*.



## A riddle from Food & Nutrition Services

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

What is 70 feet long, has ten heads, 20 hands, and requires a *lot* of food? If you guessed the patient food service tray line, you're right!

For those of you not familiar with this aspect of patient food delivery, the tray line is the conveyor belt where patients' meal trays are assembled. Two of these 'moving counters' are located in the Ellison basement adjacent to Eat Street Café.

Patients' menu selection sheets are delivered to the tray line after being carefully counted and calculated in the Data Center. Each tray line employee has a 'station' on the tray line and is responsible for placing selected items on each tray.

It may sound simple, but every day, the tray line assembles approximately 2,100 trays. Typically, the speed of the tray line is set to assem-

ble four trays per minute. Tray line servers visually scan 93 menu items to identify which items have been selected. All items are strategically placed on the tray. Hand-eye coordination is a must! The accuracy of tray assembly is a key factor in customer satisfaction.

In the 'old days,' the tray line ran three times a day (at breakfast, lunch, and dinner) because that was when most patients

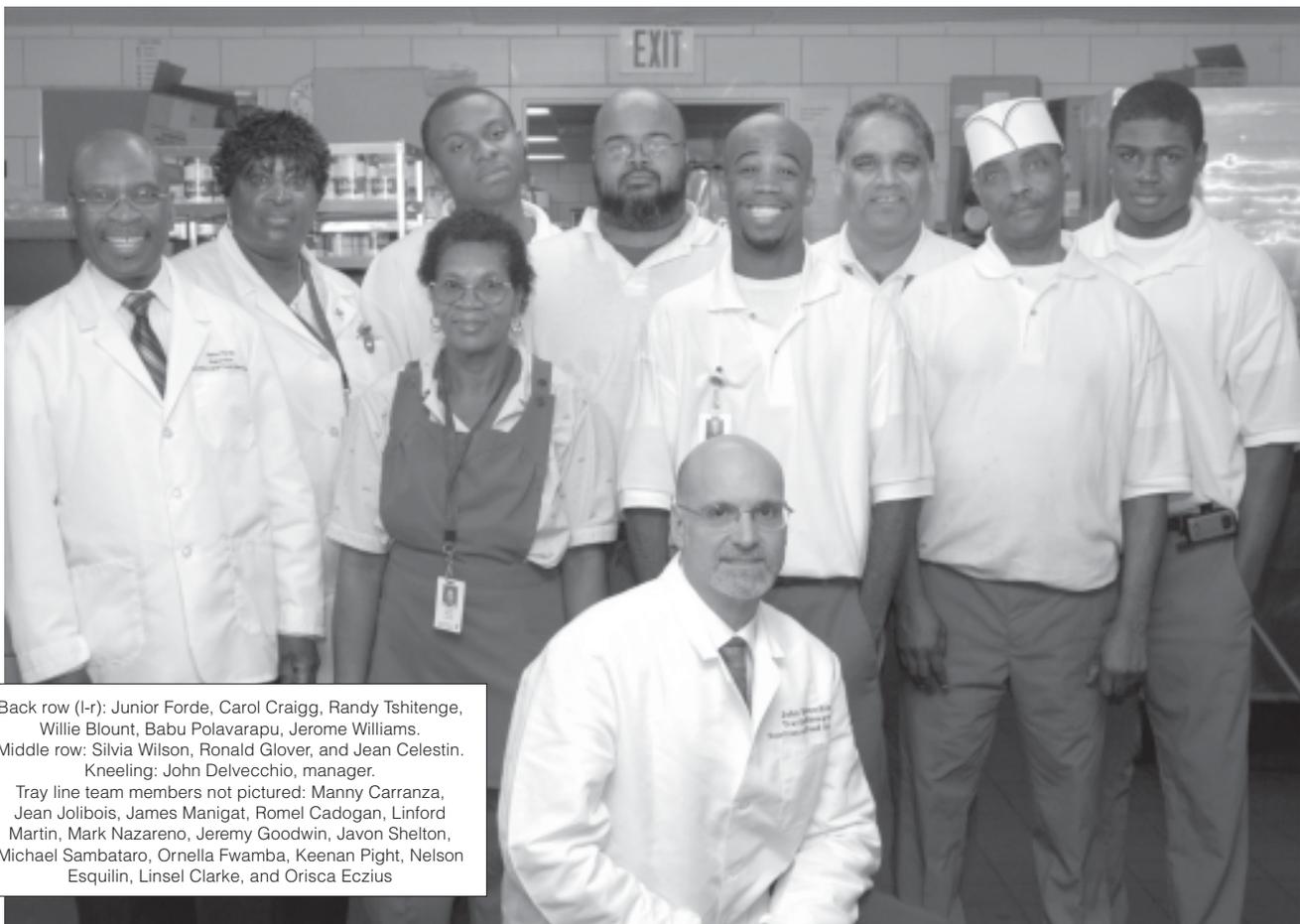
received their meals. The line was fairly quiet in between meal times. Today, trays assembled at meal time account for only part of our patients' food delivery service. There is a flurry of activity on the tray line even between meal times. With diet advances and round-the-clock new admissions, three meals-a-day is a thing of the past.

In an attempt to familiarize myself with the challenges and intricacies of working the tray line, I staffed a station on the tray line shortly after becoming senior manager of Patient Food Ser-

vices. Those of you who have seen the *I Love Lucy* episode where Lucy and Ethel take a job on the candy-wrapping-tray line will appreciate what a humbling experience that was! Needless to say, I have not been invited back.

It's a privilege to introduce the talented members of our tray line team to the readers of *Caring Headlines* (see photo below).

For more information, or if you have questions or comments about patient food tray assembly, please call Susan Doyle at 6-2579 or e-mail [sjdoyle@partners.org](mailto:sjdoyle@partners.org).



Back row (l-r): Junior Forde, Carol Craig, Randy Tshitenge, Willie Blount, Babu Polavarapu, Jerome Williams.  
Middle row: Silvia Wilson, Ronald Glover, and Jean Celestin.  
Kneeling: John Delvecchio, manager.

Tray line team members not pictured: Manny Carranza, Jean Jolibois, James Manigat, Romel Cadogan, Linford Martin, Mark Nazareno, Jeremy Goodwin, Javon Shelton, Michael Sambataro, Ornella Fwamba, Keenan Pight, Nelson Esquilin, Linsel Clarke, and Orisca Eczius

## Perioperative Nursing Education Program

—by Sandra Silvestri, RN, clinical nurse specialist

**A**s the shortage of nurses in specialty practice areas looms before us, the demand for qualified

perioperative nurses is growing. One factor affecting the shortage in operating rooms is the lack of perioperative

education and clinical experience available in undergraduate nursing programs. Most programs provide one or two days

of observation as their only exposure to operating room nursing.

In order to meet the demand for perioperative nurses, MGH has launched its own perioperative education program. Perioperative nursing is a specialized area of nursing practice. Periopera-

tive nurses are integral members of the surgical team. They work in collaboration with other disciplines to provide care to patients undergoing surgery. Ever-changing technology used in the OR setting requires high-level critical think-

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Above left: Susan Haneffant, RN, demonstrates new monitoring technology to Shanna Christina, RN, and Amal Nassar, RN

Above right: Nassar (standing second from left) demonstrates electronic bed remote control to (l-r): Kathy Rogers, RN; Cathy Holley, RN; Christina; and Debra Greenberg, RN (on bed)

At right: Barbara Drowne, RN, explains the finer points of the 'endoscopy tower' to Holley; Rogers; Greenberg; Nassar; Christina; and Haneffant



## Compassion and advocacy, a powerful combination in the SDSU

*Kristin Appel is an advanced clinician in the PCS Clinical Recognition Program*

**M**y name is Kristin Appel, and I am a registered nurse in the Same Day Surgical Unit (SDSU). My primary role is circulating nurse on the orthopedic team. Circulating nurses advocate for patients in an unfamiliar environment when they're unable to do so for themselves. My goal each day is to ensure a safe and stress-free environment for patients. Working in collaboration with surgical teams, anesthesia teams, and surgical technicians, we strive to maintain a smooth and efficient flow in the operating room (OR).

The following story is a normal occurrence in the extraordinary day of a circulating nurse.

Mrs. H is a 65-year-old, healthy woman, who was scheduled to undergo a carpal-tunnel release of her left hand under local anesthesia with Dr. P. This condition occurs when the median nerve, which runs from the forearm to the hand, becomes compressed. This results in pain, weakness, or numbness in the hand and wrist. Many patients complain of a burning or tingling sensation that leaves their fingers feeling useless, as was the case with Mrs. H. Her

condition was drastically affecting the normal activities of her daily life. Not only was she having difficulty performing everyday tasks, but she was the primary caregiver for her ill husband at home.

I wasn't scheduled to be in the OR with Mrs. H, but I was assisting the circulating nurse by conducting the pre-op interview with Mrs. H. Since the operation was with local anesthesia, which would be administered by the surgeon, there was no need for an anesthesiologist. So nurses would be monitoring her intra-operatively. Mrs. H had come to the hospital alone, arriving early due to the availability of a ride. She didn't drive, and her family was unable to wait with her.

In the course of the interview when I asked Mrs. H if she understood the procedure and post-operative care, she said it had been so long since she'd spoken with the surgeon she wasn't really sure what to expect when she arrived in the SDSU. But the process seemed more involved than she remembered. She was sur-

prised she had to change out of her own clothing and answer so many questions. Many patients express these feelings so I wasn't surprised Mrs. H felt that way.

I tried to alleviate her fear of the unknown before bringing her into the OR by joking with her. I told her that patients undergoing carpal tunnel release have to change clothes so they don't look better than their nurses. Mrs. H had a great sense of humor and laughing seemed to help her relax. I've found that in some cases, humor is the best way to break the ice with patients who are tense when they enter the pre-op assessment area. I explained to Mrs. H that the real reason she had to change clothes was because she was going into a sterile environment and she couldn't wear her street clothes because we had to keep the area as clean as possible to decrease the chance of infection. I empathized with her about the need for so much paperwork



Kristin Appel, RN  
Same Day Surgical Unit

and showed her some of the paperwork I would be filling out for the same procedure. I think she actually felt worse for me and commented that I would be having carpal-tunnel surgery next! I told her the reason she had to fill out the entire assessment form was so we could be confident she was being thoroughly assessed and cared for pre-operatively. These explanations seemed to relieve some of her concerns, but she was also concerned about what was going to happen in the operating room.

Since I work in the OR with Dr. P on a regular basis, I was able to explain the protocol to Mrs. H. I know the operating room can be a fright-

ening environment for people, so I explained that she was going to be the focus of attention and

the most important person in the room. There's usually a flurry of activity in the beginning, which may have seemed chaotic to Mrs. H, but in reality it's a synchronized stream of activity to ensure that every instrument and piece of equipment is in place so we can provide the best possible care during surgery.

The circulating nurse, whom she would meet shortly, would ask Mrs. H many of the same questions I was asking, then escort Mrs. H into the OR. We would double- and triple-check the procedure to be performed and the procedure site. Many patients become nervous when we continue to ask the same questions over and over. I assured Mrs. H that this was a safety measure to ensure that everyone, the patient, scrub tech, nurse, and surgeon was alert to the correct procedure and correct site.

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### C O R R E C T I O N

In the December 15, 2005, issue of *Caring Headlines*, Meredith Pitzl, RN, was incorrectly identified as a clinician in the PCS Clinical Recognition Program. Pitzl was recognized as an advanced clinician in July, 2005. We apologize for the error.

## Clinical Narrative

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The circulating nurse would assist Mrs. H to a comfortable position on the operating room table and proceed to apply a blood-pressure cuff and pulse oximeter while the surgical resident assisting Dr. P would apply another blood-pressure cuff, or tourniquet, to the operative arm. The scrub tech, also wearing a sterile gown and gloves, would set up the table to be ready to assist the surgeons. If Mrs. H had any questions she could feel free to ask them at any time. We are never too busy to answer questions or alleviate a patient's concerns. The surgical experience is a collaborative effort between the whole team and the patient to ensure the best possible outcomes.

After the surgeons scrubbed and gowned, they would inject local anesthesia into Mrs. H's hand. I shared with Mrs. H that I had to have a local injection myself for foot surgery and that the injection definitely stings, but it goes away quickly. Some patients try to bear the pain in silence. I assured Mrs. H that she could yell if she wanted, and it had made me feel a lot better when I did during my procedure. I told her if she felt any discomfort at all once the procedure began, she

should let the circulating nurse and surgeon know and more local anesthetic would be given.

Further along in the interview while talking with Mrs. H about her medical and surgical history, she said she'd never had surgery before but had been in the hospital many times with her ill husband. She hadn't asked her children to wait with her because she didn't want to be a burden on them and was worried about keeping her daughter waiting. Her surgery was scheduled for 11:00am and it was already 11:45. The surgeon was running late due to a complicated case and would possibly be delayed another hour. Mrs. H was starting to become anxious that she wouldn't be ready when her daughter came to pick her up, and she was contemplating canceling the surgery. She explained that she had to make several special arrangements to obtain care for her ill husband and she felt uncomfortable being away from him for so long. She asked if I could find out how much longer it might be and if she should re-schedule.

I felt that with Mrs. H's increased anxiety and the fact that her hand

was truly affecting her ability to perform activities of daily living and care for her ill husband, she should have the surgery today. I asked her to wait a few moments while I assessed the situation. It would be a shame for her to re-schedule after hav-

told her her mom's surgery would be performed in the next half hour and she would be ready for discharge soon after. While on the phone, I answered many of the questions and concerns she had regarding her mother's procedure. I

day knowing her mom was in 'good hands.'

Mrs. H was much more relaxed knowing her daughter wasn't being inconvenienced, and I was more comfortable going into the operating room knowing that Mrs. H's fears had been allayed. I also felt more at ease about Mrs. H going home post-operatively with the love and assistance of her family. I was grateful for the chance to speak with her daughter as most of the time, we don't have an opportunity to discuss our concerns about home care with family members. This surgery would not only be affecting Mrs. H and her husband, but her children as well, and I felt I did my best to achieve the best possible holistic outcome for Mrs. H and her family.

I escorted Mrs. H into the OR and prepared her for surgery. She said that due to my review of what to expect in the OR, there were no surprises. After hooking her up to the monitor and tourniquet, I was able to sit with her and hold her hand during the injection of local anesthesia. She indeed gave a little, "Ouch!" but other than that, Mrs. H handled the shot very well. I knew what music she liked, so I played it in the background to relax her even more. I did my

**There's usually a flurry of activity in the beginning, which may have seemed chaotic to Mrs. H, but in reality it's a synchronized stream of activity to ensure that every instrument and piece of equipment is in place so we can provide the best possible care during surgery.**

ing made all these special arrangements.

I went into the OR and explained the situation to Dr. P. He agreed she shouldn't re-schedule and said he'd be happy to step out and complete her procedure, leaving his fellow in charge of the current case.

After checking the schedule and conferring with the resource nurse and my team leader, we were able to obtain an operating room. A scrub tech was available to assist with the procedure, and I volunteered to circulate the case. Dr. P and Mrs. H were informed that we would be able to accommodate Mrs. H right away. We set up the room and brought Mrs. H to the OR within a half hour.

I spoke with Mrs. H's daughter (Ms. M) to explain about the delay and

reviewed the post-op instructions with Ms. M and expressed my concern about home care for both her mother and father. I asked Ms. M if she'd like me to contact a social worker to set up home care until Mrs. H had full use of her hand again. Ms. M told me she would be taking time off from work and staying with her parents for a while and then family members would work out a schedule to assist their parents as long as Mrs. H needed help. She felt her parents' care could be managed within the family, but they were open to discussing future medical needs. She thanked me for my concern and thorough care of her mother and said she was glad I'd be with her mother during the procedure. She could continue with her

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## National Youth Leadership Forum at MGH

—by Lauren Holm, RN, staff specialist

The National Youth Leadership Forum (NYLF) on Nursing is a program designed to help young people make well-informed career choices by exposing them to professional work experiences during their high school years. The nation-wide program drew 540 young people to the Boston area to

attend educational sessions offered in October, 2005.

MGH hosted 160 NYLF students over a four-day period providing an intensive job-shadowing experience showcasing the many career opportunities available in nursing. The visit paired students with staff nurses and nurse practitioners from 47 clinical settings,

both inpatient and outpatient, for unit-based learning experiences.

Many students reported that their visit to MGH solidified their decision to pursue a career in nursing. In addition to unit-based job shadowing, the visit included a panel discussion moderated by professional development coordinator, Mary Ellen Smith, RN. Panelists,

nurses from a variety of settings, spoke about why they decided to become nurses, what they looked for in a nursing program, what was important to them as they transitioned to their first nursing position, and what strategies helped them fulfill their desire to become a nurse. Human Resources representatives provided written information on nursing practice at MGH and gave each student a small token commemorating their visit to MGH.

This was the third

year that the National Youth Leadership Forum has offered these programs to high-achieving high-school students. Through the combined efforts of hospitals and nursing schools throughout Massachusetts, a total of 1,250 students have explored nursing as a career. Many students reported that the program was a life-changing experience. In addition to impacting students, the program affected nurses who participated, finding it, 'very energizing to

*continued on next page*



## National Youth Leadership Forum

*continued from previous page*

share nursing practice with such an impressive group of young people.'

The MGH Planning Team that coordinated the NYLF visit included: Candace Burns; Marianne Ditomassi, RN; Susan Gavaghan, RN; Trish

Gibbons, RN; Julie Goldman, RN; Maureen Greenberg; Lauren Holm, RN; Susan Kilroy, RN; Karen Lipshires, RN; Ann Martin, RN; Judy Newell, RN; Carlyene Prince-Erickson; Steve Taranto; Sarah Welch; and Galia Wise.



**Opposite page:** Staff nurse, Laurie Falaro Shoemaker, RN, works with student in the ED.

**Top right:** Staff nurse, Jayne Hill, RN, with student in Radiation Oncology.

**Above:** Staff nurse, Kathy DeGenova, RN, with student in the GI Endoscopy Unit.

**Above right:** Falaro Shoemaker helps student don gown and gloves.

**At right:** White 6 staff nurse, Jinneane Sperrazza, RN, with patient, Mr. McManus, and NYLF student.



## Clinical Narrative

*continued from page 9*

best to take care of Mrs. H's concerns pre-operatively and everything went very smoothly in the operating room. The procedure took about 15 minutes during which I was able to sit with Mrs. H and talk about her grandchildren, which distracted her from the procedure and helped pass the time for her.

When the procedure was over, she said that after all her worrying she had felt very comfortable in the OR; that the time had passed quickly as she talked about her favorite thing—her grandchildren. I learned a lot about Mrs. H in those 15 minutes, and at the same time provided her with the necessary distraction to get through surgery. Mrs. H is a strong person

who is used to being the primary caregiver and in control of most situations. It was hard for her to be at the mercy of others in a foreign environment. Armed with a little information about what to expect during and after surgery, it turned out to be a pleasant experience for Mrs. H. She even said she'd consider having her other hand operated on!

After the procedure I escorted Mrs. H to the post-recovery lounge for some juice and cookies and to go over her post-op instructions again. I've found that many patients are so anxious about upcoming procedures they frequently don't retain information given to them beforehand. Post-operatively, they're able to

concentrate and retain instructions more clearly. We do send written instructions and doctors' phone numbers home with patients to review with their families. I encouraged Mrs. H to call her doctor with any questions or concerns, as she wouldn't be seeing her doctor until her follow-up appointment in ten days.

I believe all patients undergoing procedures where they go home the same day benefit from a post-op phone call, especially patients like Mrs. H, who experience a high level of anxiety. I spoke with Dr. P later in the day to find out his practice regarding follow-up care with patients discharged the same day. He asks patients to follow up ten days post-operatively, unless they're having difficulty with pain, swelling, fever, or infection (in which case they should call sooner). There was no follow-up in the initial post-op phase unless the patient or family initiated it. Dr. P said his office didn't have the resources to call every patient who underwent a same-day surgical procedure.

Currently, I'm involved in a study with patients undergoing arthroscopic day-surgery procedures to determine if those patients would benefit from post-operative phone calls from a nurse. It's my hope that based on the initial re-

sults of this research, we can develop a program in the Same Day Surgical Unit to allocate nursing resources to perform follow-up phone calls for patients undergoing same-day surgical procedures.

I've known since I was 12 years old that nursing would be my chosen profession, and working with Mrs. H reconfirmed my belief that nursing was the right choice for me. I've seen many changes throughout my nursing career and moving into the high-tech, fast-paced SDSU was the biggest challenge of my career. The majority of my time with patients is spent while they're under anesthesia, so when I have time to really connect, get to know my patients and their families, and make a difference in their hospital experience, it makes me feel good about myself and nursing in general.

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

The surgical setting is one that causes many patients a high level of anxiety. It's not an exaggeration to say that Kristin's knowledge, compassion, and advocacy were responsible for Mrs. H having surgery on the day it was scheduled. Every intervention was designed to put Mrs. H at ease, educate her about the procedure, and ensure a positive outcome for her and her family. And Kristin's advocacy didn't end when Mrs. H was discharged. She explored follow-up care and made sure Mrs. H was fully informed about what to do and how to reach her doctor.

This narrative gives us a wonderful glimpse into the operating room setting and the practice of a very caring nurse.

Thank-you, Kristin.

## February Vacation Club

at the MGH Backup Childcare Center

**Hours: 7:30am–5:45pm  
February 21–24, 2006**

Cost: \$225 for four days  
(or \$60 per child per day)

Program is available for 6–12-year-olds

Activities will include:  
Origami workshop; skating on the Frog Pond; a visit to the Harvard Natural Science Museum; a movie at the Boston Common Cinema (closed Monday for the holiday)

The Backup Childcare Center will provide care for younger children, aged 15 months to 5 years old

Call: 617-724-7100, or stop by the center to reserve space

## 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/mcgvorn.asp>. For more information, call Beth LaRossa at 724-4549.

## Good news on hand hygiene

—by Judy Tarselli, RN, Infection Control Unit

As you know, MGH has been working hard to raise awareness about the importance of hand hygiene in controlling and preventing the spread of pathogens (germs) that can cause disease. A number of coordinated programs and initiatives have been implemented to help staff achieve our goals for hand-hygiene compliance. Some of those initiatives include: unit-based hand-hygiene champions, a hand-hygiene rewards program, educational booths, a poster campaign, special events, and customized presentations to various role groups. I'm happy to report that our hard work is paying off in the form of higher hand-hygiene compliance scores and a safer environment for our patients.

Hospital-wide hand-hygiene compliance rates continued to improve in the third quarter of

2005, reaching a high of 61% before contact and 78% after contact. While both rates fall short of the goals set for the third quarter, they show continued improvement and represent the highest overall rates achieved to date.

Eight units did achieve third quarter goals. Their before-and-after scores were:

- Ellison 6 (Orthopaedics) 82/84
- White 11 (Medical) 77/92
- Ellison 3 (Neonatal Intensive Care Unit and Pediatric Intensive Care Unit) 73/91
- Ellison 7 (Surgical) 71/81
- Ellison 14 (Oncology-Bone Marrow Transplant) 79/84
- Phillips 22 (Surgical) 78/80
- Bigelow 11 (Medical) 72/89

The highest before contact rate was 82% achieved by Ellison 6 (Orthopaedics). The highest after contact rate was 97%

achieved by Blake 6 (Transplant). Congratulations to all.

Nosocomial infection rates for MRSA and VRE have continued to decline as hand-hygiene compliance rates have improved, a trend that started in early 2004 with hospital-wide rollout of the Hand Hygiene Program. While other factors may have had an impact, the correlation between the decline in infection rates and the improvement in hand-hygiene compliance is significant.

Special thanks to all employees who contributed to the success of this program by practicing good hand hygiene before and after contact with patients and patients' environment.

The next hand-hygiene compliance goal, set by the STOP Task Force is 80/80. Units will be notified of their results as soon as scores are available. Compliance rates of 90/90 are expected for 2006 (in compliance with JCAHO standards), and it's anticipated that some units will achieve 100%. The only questions is, who will be first?

## Perioperative Nursing Education Program

*continued from page 7*

ing and the ability to coordinate and facilitate care while ensuring patient safety.

The first in-house educational program for perioperative nurses was held in June of 2005. Nine nurses (from other hospitals and MGH nurses transferring to the OR) completed the didactic portion of the program and are currently finishing the practical orientation.

In October, another nine nurses completed the didactic portion of the program and are currently being precepted. They start their practical orientation to

surgical specialties this month. The goal of the Perioperative Nursing Education Program is to attract and educate 20 nurses per year. The program will be offered twice a year, in March and October, with approximately ten nurses per class.

The Perioperative Nursing Education Program consists of four weeks of didactic study, hands-on lab work, and observation. Nurses learn to apply the principles of nursing practice in planning nursing interventions for individuals requiring intra-operative care.

The principles of perioperative nursing practice are based on standards of practice related to the pre-operative, intra-operative and post-operative needs of patients and their families. Nurses learn how the role of perioperative nurse encompasses patient advocacy, coordinating services, and being a leader in planning comprehensive care for patients undergoing specific surgical procedures.

For more information about the Perioperative Nursing Education Program, call Sandra Silvestri at 4-0150.

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For more information, call: 617-724-1746.

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## Observations of a Northeastern University co-op student

As a young person, deciding which career path to take can be incredibly difficult, and that was especially true for me as I entered Northeastern University nearly three years ago. I started as a Speech Language Pathology major but decided to switch to the Psychology program last year to explore my interest in the intricate design of the human mind. I'm extremely glad I did, because through Northeastern University's Cooperative Education Program, where students alternate between classes and practical work experience, I had the opportunity to work in the General Clinical Research Center on White 13 under the direction of nurse manager, Bonnie Glass, RN.

Mass General opened my eyes to a whole array of career possibilities I had never really considered—from nurses and doctors to researchers and a range of administrative-support positions. Working in a research environment has exposed me to many aspects of research, including the consent process, the significant amount of preparation required for every visit, and the essential role of study coordinators. Not only have I been exposed to these areas, but I've observed the flow of communication required to generate a lucrative and successful

protocol. Nurses, operations associates, bionutritionists, lab technicians, and study coordinators form the foundation of a tight-knit community, constantly maintaining the high degree of interaction necessary to run an efficient unit.

As my first co-op experience, my responsibilities were to set up the charts of subjects and prepare tubes, trays, and labels for the blood work of incoming patients. I was able to participate in the processing of specimens and special projects, such as doing the groundwork for a handbook on the phases of a patient visit. Not only did I work on the main campus, but I was able to be a part of the team at the GCRC Biomedical Imaging Center at the Charlestown Navy Yard, under co-director, Randy Golub. Though my duties were similar, the people I met and the experiences I

gained in both environments are unforgettable. I remember seeing the face of one patient light up as she walked through the door, delighted to see her nurses. They never hesitate to go that extra mile with their subjects. It might simply be sitting down and having a conversation with them. The pace and the relationships between the research staff and patients just astound me. Never have I seen such enthusiasm.

Going into this co-op situation, I didn't expect nearly as much hands-on experience and exposure as I enjoyed during this six-month journey. Every person I've encountered in these past few months has taught me something, academically and personally. As I continue to tread down the unknown road that is my future, I'll look back and be thankful to all who have contributed to this wonderful, unforgettable experience.



Sandy Wong  
Northeastern University co-op student

### 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

### EAP manager and supervisor training session

The Employee Assistance Program (EAP) is offering a training course for managers and supervisors on how the EAP can be a resource to assist with behavioral, mental-health, and substance-abuse concerns

**January 31, 2006  
9:00–11:00am**

**Haber Conference Room**

Other sessions schedule for: March 28,  
May 9, September 13, and November 2

For more information, visit  
[www.massgeneral.org/leadershipacademy](http://www.massgeneral.org/leadershipacademy).

# Educational Offerings

January 19, 2006

When/Where	Description	Contact Hours
January 26 8:00am–12:00pm	<b>BLS Certification–Heartsaver</b> VBK 401	---
January 26 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Support for Support Staff in the Oncology Setting.” O’Keeffe Auditorium	1.2
January 26 12:00–3:30pm	<b>Basic Respiratory Nursing Care</b> Sweet Conference Room	---
January 27 8:00am–4:00pm	<b>Creating a Therapeutic and Healing Environment</b> O’Keeffe Auditorium	TBA
January 30 and 31 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: NEMC; Day 2: VBK401	14.4 for completing both days
January 30 8:00am–4:00pm	<b>Advanced Cardiac Life Support—Instructor Training Course</b> Thier Conference Room	---
January 30 and 31 8:00am–4:30pm	<b>BLS Instructor Program</b> VBK601	---
February 1 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
February 1 11:00am–12:00pm	<b>Ovid/Medline: Searching for Journal Articles</b> FND626	---
February 2 8:00am–12:00pm	<b>CVVH Core Program</b> Training Department, Charles River Plaza	6.3
February 2 8:00–11:30am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
February 2 12:15–4:30pm	<b>Pacing Concepts</b> Haber Conference Room	4.5
February 4 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK401 (No BLS card given)	---
February 6 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
February 8 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
February 8 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
February 8 11:00am–12:00pm	<b>Nursing Grand Rounds</b> Haber Conference Room	1.2
February 8 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
February 9 8:00am–4:00pm	<b>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</b> Training Department, Charles River Plaza	8.1
February 10 and 27 8:00am–5:00pm	<b>Advanced Cardiac Life Support (ACLS)—Provider Course</b> Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	---
February 16 and 23 8:00am–4:00pm	<b>Oncology Nursing Society Chemotherapy-Biotherapy Course</b> Yawkey 2220	16.8 for completing both days
February 22 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)

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>.

## Mihrab comes to the Masjid

—submitted by the MGH Chaplaincy

**O**n November 18, 2005, members of the Muslim community came together in the Thier Conference Room with representatives from the Chaplaincy, administration, and others in the MGH community to celebrate the addition of a Mihrab to the Masjid (the Muslim prayer room).

A Mihrab is a colorful work of art and architecture formed by carefully arranging tiles in symbolic and artistic patterns. In a mosque, the Imam faces the Mihrab to lead prayers and align worshipers in the direction of Mecca. This symbolizes unity as a community.

Now in the MGH Mas-

jid, Muslim patients, families, and staff have a Mihrab to help guide them toward Mecca during prayers.

The Mihrab is the result of the work of Dr. Wasmaa Chorbachi; the leadership of Dr. Imam Talal Eid, Muslim chaplain; and the generous support of the MGH Muslim community and others who contributed to its creation and installation. The Mihrab is a work of art and a spiritual symbol that will be cherished by all who worship in the Masjid.

For more information about the Mihrab, the MGH Masjid, or the Muslim community at MGH, contact the MGH Chaplaincy at 6-2220.



MGH employee, Youssef Naciri, stands beside Mihrab in the Masjid, located on Founders 1

# Caring

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