

Caring

HEADLINES

January 5, 2006

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards

Inside: Special Issue

Macaluso Award Ceremony	1
Ann Eastman, RN	2
Judy Foster, RN	4
Jackie Mulgrew, PT	6
Virginia Sigel, LICSW ..	8
Macaluso Moments	12
Holiday Happenings ..	14
Educational Offerings	19
About the Award	20

Do you think Stephanie suspected all those years ago that so many gifted clinicians would follow in her footsteps as recipients of the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award? She probably did. And the list grew longer this year with the addition of four

accomplished and highly respected clinicians: Ann Eastman, RN, staff nurse on the Bigelow 14 Vascular Unit; Judy Foster, RN, staff nurse on the Ellison 14 Oncology/Bone Marrow Transplant Unit; Jackie Mulgrew, PT, physical therapy clinical specialist; and

Virginia Sigel, LICSW, clinical social worker.

In her remarks at the award presentation ceremony, December 8, 2005, in O'Keeffe Auditorium, senior vice president for Patient Care, Jeanette Ives Erickson, RN, noted that 62 clinicians have been

continued on page 11



With senior vice president for Patient Care, Jeanette Ives Erickson, RN (right), and associate chief nurse, Jackie Somerville, RN (left) are 2005 Macaluso award recipients (l-r): Ann Eastman, RN; Jackie Mulgrew, PT; Virginia Sigel, LICSW; and Judy Foster, RN

A graduate of Northeastern University, Ann Eastman has worked at MGH for almost 30 years in a variety of roles and settings. For the past four years, she has worked on the Bigelow 14 Vascular Surgical Unit. She is a nurse who loves to be challenged. She isn't afraid to venture outside her comfort zone to learn new techniques or take on new projects. She shares best practices and seeks the opinions of experienced clinicians and novice clinicians alike. She is committed to creating an environment that promotes quality and safety.

Ann is an advanced clinician in the PCS Clinical Recognition Program

Clinical Narrative

My name is Ann Eastman, and I have been a nurse at MGH for almost 30 years. When working with a patient, my goal, like any healthcare provider, is to help that patient achieve optimal wellness within that encounter. It sounds simple, but achieving it can be a complex matter.

I met Mr. Valentine for the first time one morning as I was working with Coco, a new nurse orientee. It was my first time working with Coco since she had become a nurse, but I had known her well when she was a student and patient care associate.

In planning our day, we saw Mr. Valentine briefly to assess him. The night before he had apparently aspirated, adding one more complication to an already complicated course for this gentleman.

Mr. Valentine had been admitted with mental status changes and during his hospitalization had undergone a carotid endarterectomy. His recovery had been very slow with minimal improvement. This particular morning he was

listless, weak, and nearly unresponsive. He had diffuse rhonchii, and some wheezing. His oxygen saturations were poor and his blood pressure was low.

The team had ordered a neurology consult, a chest X-ray, and had already obtained arterial blood gases. After a quick assessment and some changes in Mr. Valentine's oxygen delivery, we moved on to see other patients. One was getting ready to be discharged, the other was scheduled for diagnostic testing that would take most of the morning.

Coco and I worked together to decide on a plan of care. I needed to take the lead because Coco, as a novice, was 'over her head.' But her participation was important. Mr. Valentine needed one nurse, but surely two would be better.

We broke down our assessment into three areas: altered mental status, respiratory compromise, and potential cardiovascular compromise. From there we organized our thoughts and actions.

We checked with the team about their plans.

First and foremost, they wanted a neurology consult. The team reviewed the chest X-ray and arterial blood gases obtained earlier.

The first thing we did was perform a more comprehensive assessment. Our assessment of Mr. Valentine could guide us and give important input to the team. After trying hard to rouse Mr. Valentine by voice and touch, we got him to open his eyes. He was clearly weak. He didn't voluntarily move any of his limbs.

We reassessed his oxygenation. The adjustments we'd made in his oxygen delivery had improved his saturations slightly. Working together, Coco and I concluded that secretions altering gas exchange and poor respiratory effort due to weakness were important factors.

In assessing his cardiovascular status, we looked at his previous vital signs, medications, and recent trends. Though not optimal, they hadn't changed dramatically.

Now we could construct a plan of care. First, we addressed his



Ann Eastman, RN
staff nurse, Vascular Surgical Unit

respiratory status. That was clearly crucial. We performed vigorous chest physical therapy, repositioning, upright posture, nebulization treatments, and after obtaining an order, nasotracheal suctioning. These maneuvers improved Mr. Valentine's oxygen saturations and lung sounds to our satisfaction. They even seemed to result in a slight improvement in alertness. We knew we were on the right track.

In the meantime, the neurologist arrived to perform her assessment. We made sure she had our input on his mental status and assisted with her examination. She determined that Mr. Valentine needed further evaluation, including a head CT. A head CT could have been problematic because it requires a patient to lie flat, and Mr. Valentine needed to be at a 60–90° angle to achieve good aeration. Also, Mr. Valentine was

very ill and would need a nurse to accompany him to any tests, and that conflicted with our other responsibilities on the unit.

We talked with the nursing supervisor who was already aware that Mr. Valentine was very ill. We arranged for a nurse from the Rapid Response Team to help us. Then we had to decide what role each of us would play. When the nurse arrived, we gave her a thorough report, and she felt comfortable traveling with Mr. Valentine. We all agreed that Coco should accompany her because she had worked with Mr. Valentine, and it would be a good learning opportunity for her. I would stay behind with our other patients.

It was difficult turning over my responsibilities to the rapid response nurse. I felt a deep sense

continued on next page

Narrative (Ann Eastman)

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of responsibility to Mr. Valentine and felt we had begun a plan of care that could help him through this event. But members of the Rapid Response Team travel with very ill patients all the time. They're familiar with Radiology and the resources available there.

Coco and the rapid response nurse left, and I was anxious seeing them

go. The risks to Mr. Valentine were significant, but this test was important to rule out a new stroke (not uncommon after endarterectomy).

Throughout the morning, Coco and I touched base, and I prepared to give report to the ICU as the plan was now for Mr. Valentine to be transferred as soon as possible after his head CT.

While in Radiology, the decision was made to do an MRI on Mr. Valentine. An MRI also requires the patient to lie flat, and while undergoing the MRI, Mr. Valentine's condition deteriorated. His respiratory pattern became more labored and his saturations decreased. Coco and the rapid response nurse returned promptly and told me of the events. The decision was made to return Mr. Valentine to the unit immediately.

We asked the team if Mr. Valentine's wife had been informed of his condition. Earlier they had said they were waiting for the results of the test to have something concrete to tell her. I understood their desire to have something concrete to tell her, but I knew Mrs. Valentine was concerned about her husband and his care. We felt she would want to be informed. The point became moot as Mrs. Valentine had just arrived on

the unit and was waiting outside his room. The house officer went out to discuss Mr. Valentine's condition with her. We hoped our earlier conversation had prepared the team to speak with her.

I called ahead to the Burn Unit where a bed was available for Mr. Valentine. Coco and the rapid response nurse went with Mr. Valentine and the house officer to the Burn Unit (one floor below). After notifying

continued on page 10



Staff nurse, Ann Eastman, RN (right) and colleague, Nicole 'Coco' Wilcox, RN, with patient, Walter Allen, on the Vascular Unit

A graduate of the University of Tennessee, Judy Foster received her master's degree in Nursing from Yale University and has worked on the Ellison 14 Oncology/Bone Marrow Transplant Unit since 2002. She came to MGH with more than 20 years of experience in oncology nursing. Judy has an inquisitive mind that quickly grasps complex protocols and their implications for patients and families. A tireless patient advocate, she seeks out opportunities to improve systems that will benefit patients and the institution. Judy enters a patient's world and instantly understands what can often not be explained. She knows when to teach, when to talk, and when to be silent.

Clinical Narrative

Walnuts

a poem by J.D. Rumi (translation)

Philosophers have said that we love music
Because it resembles the sphere sounds
Of union. We've been part of a harmony
Before, so these moments of treble and bass'

Keep our remembering fresh. But how
Does this happen within these dense bodies
Full of forgetfulness and doubt and
Grieving? It's like water passing through us.

It becomes acidic and bitter, but still as
Urine it retains watery qualities.
It will put out a fire! So there is this music
Flowing through our bodies that can dowse

Restlessness. Hearing the sound, we gather
Strength. Love kindles with melody. Music
Feeds a lover composure, and provides form
For the imagination. Music breathes

On personal fire and makes it keener.
The waterhole is deep. A thirsty man climbs
A walnut tree growing next to the pool
And drops walnuts one by one into

The beautiful place. He listens carefully
To the sound as they hit and watches
The bubbles. A more rational man gives
advice,
"You'll regret doing this. You're so far

From the water that by the time you get down
To gather walnuts, the water will have
Carried them away." He replies, "I'm not
Here for the walnuts. I want the music
They make when they hit."

Like the man dropping walnuts in the pond, I am keenly interested in sounds. Rumi says that "within these dense bodies full of forgetfulness and doubt and grieving is a music flowing through that can dowse restlessness." At times, attuning oneself to the music within dense, ill bodies seems foolish and futile. Other times, it seems to be a perfect metaphor for the practice of nursing. This narrative illustrates one attempt to help a woman find her own inner strength and comfort during a prolonged, complicated hospital stay by simply tuning in to her sounds.

KB is a 46-year-old woman with Type 1 DDM. She has had brittle diabetes since she was two but has managed it reasonably well without any organ toxicity. She is married and has a 20-something year old stepson. I've been one of her primary nurses since she was admitted to MGH several months ago. She remains hospitalized at this moment for a number of complex illnesses with conflicting priori-

ties. She has undergone an emergent splenectomy, induction chemotherapy for acute lymphocytic leukemia, biopsy and treatment for fungal pneumonia, allogenic bone-marrow transplantation with twice daily whole-body radiation treatments and more chemotherapy, and is currently undergoing treatment for acute graft-versus-host disease. Summer and autumn have come, but she remains hospitalized with no foreseeable discharge date.

KB can be described as fragile. Currently, she weighs approximately 105 pounds. Having lived with diabetes most of her life, she is familiar with illness, dependency, and physical symptoms. Initially, she spoke with a gentle, sweet, almost childlike voice. Now her voice denotes resignation, frustration, and withdrawal. She moves slowly and mechanically.

She insists that her splenectomy incision (from June) is painful on movement or even light touch. She goes to bed at 7:00pm and gets up at 10:00am.

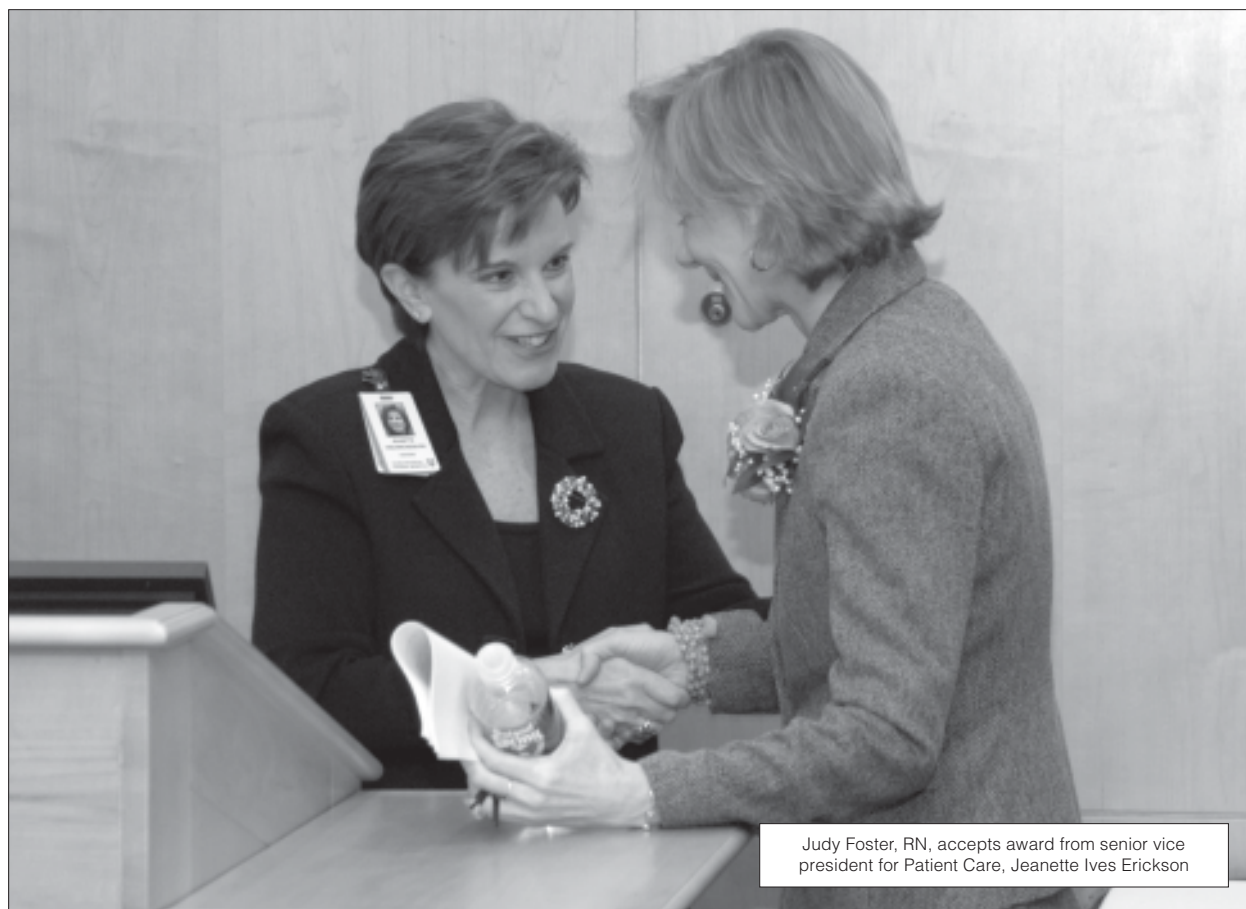
Though she is awakened periodically for medications, vital signs, and alarming IV pumps, it always appears that she is sleeping soundly. Every morning she reports that she didn't sleep at all the night before. Insisting that she is always cold, we are constantly turning the heat up in her room. Caregivers must don an isolation gown before entering the room. Once inside, it feels like you've entered a sauna. She puts cotton balls in her ears to 'keep out the draft.'

KB has endured one complication after another. Graft-versus-host disease (GVHD) is the most recent set-back. This complication of allogenic transplant consists of the donor (graft) white blood cells attack-

continued on page 18



Judy Foster, RN
staff nurse, Oncology/Bone Marrow
Transplant Unit



Judy Foster, RN, accepts award from senior vice president for Patient Care, Jeanette Ives Erickson

Past Macaluso Award Recipients

September 5, 1996
Stephanie Macaluso, RN

July 2, 1998
May Cadigan, RN
Pat English, RRT
Valerie Fullum, LICSW
Sarah Rozehnal Ward, CCC/SLP

December 17, 1998
Maureen Beaulieu, RN
Tessa Goldsmith, CCC/SLP
Diana Grobman, RN
Karen Lechner, LICSW
Donna Slicis, RN

July 1, 1999
Rochelle Butler, LPN
Alice Chaput, RN
Diane Plante, PT
Louise Sethmann, RN

January 5, 2000
Elizabeth Johnson, RN
Sucheta Kamath, CCC/SLP
Sandra McLaughlin, LICSW
Fredda Zuckerman, LICSW

June 15, 2000
Emilyn S. Bellavia, RN
Mary Elizabeth McAuley, RN
Diane McKenna-Yasek, RN
Marica Wasenius Rie, PT

December 7, 2000
Gae Burchill, OTR/L
Pamela DiMack, RN
Claire Farrell, RN
Marie Elena Gioiella, LICSW
Irene Giorgetti, RN
Lisa Sohl, RN
Susan Thel, MSW

June 21, 2001
Neila Altobelli, RRT
Constance Dahlin, RN
Sylvia Gordon, LICSW
Catherine O'Malley, RN

December 13, 2001
Clare Beck, RN
Anita Carew, RN
Robert Goulet, RRT
Kristen Jacobsen, SLP
Thomas Lynch, RN

June 13, 2002
Sharon Brackett, RN
Marguerite Hamel Nardozzi, LICSW
Mary Lou Kelleher, RN
Judith Lynch, RN
Kristin Parلمان, PT
Debra Smith, RN

December 12, 2002
Kathryn Best, RN
Jennifer Kelliher, RN
Michael McElhinny, MDiv
Carol McSheffrey, LICSW
Jean O'Toole, PT

December 11, 2003
Erica Edwards, RN
Kimberly Stewart, CCC-SLP
Cynthia Thibodeau, PT
Mara Wernick Robinson, PT
Brenda Whelan, RN

December 9, 2004
Betty Ann Burns-Britton, RN
Danielle Doucette, RRT
Alison Squadrito, PT
Mary Zwirner, LICSW

Jackie Mulgrew received her diploma in Physical Therapy from Liverpool University in England and has worked at MGH since 2001. Jackie is a board-certified cardiovascular and pulmonary clinical specialist, one of only 84 in the country. She is a teacher and mentor to other therapists on her team. She possesses a sense of scholarly inquiry and scientific curiosity that translates into a tireless pursuit of excellence. Jackie works closely with patients to help them achieve their goals—whether it's negotiating a set of stairs or walking outside in the fresh air.

Clinical Narrative

My name is Jackie Mulgrew. I have practiced physical therapy for 15 years; the last four here at MGH. I love all aspects of my clinical professional responsibilities and over the last eight years, I've had a special interest in cardiovascular and pulmonary physical therapy. In my role as a clinical specialist, I practice on all the cardiac medical and surgical units. It was while working recently in the Critical Care Unit (CCU) that I met my patient, Fred. I chose to present Fred's case in my clinical narrative because it represents the importance of helping patients reach their goals, and it presented a challenge to me that I had never been faced with before.

The CCU is an intensive care unit for patients who have critical illness from heart dysfunctions such as cardiac pump failure, critical arrhythmias, or severe ischemia. The CCU resident had consulted Physical Therapy to 'optimize' Fred's functional status prior to cardiac transplantation.

I reviewed his medical record and learned that Fred had been trans-

ferred to MGH two weeks earlier from an out-of-state hospital with complaints of chest pain. This was not the first admission for Fred nor his first time receiving physical therapy. He had been here nine months earlier, and it had been determined by the transplant team that he would need a heart transplantation. Fred was on 'the list' as a type I-A. This meant that without medical treatment, Fred would have less than seven days to live. His heart was being supported by continuous intravenous infusions of several high-dose inotropes, dobutamine, and milrinone, which help the heart muscle pump.

Fred had been living with ischemic cardiomyopathy for more than ten years. He had suffered a large heart attack in 1992 from coronary artery disease, which had left his heart muscle very weak. Over the next few years, his heart became overstretched and he had a difficult time pumping blood out of his heart. His ejection fraction continued to drop to only 12% (normal is 55–65%). Because his heart was so

weak, Fred was having a difficult time walking; he couldn't climb stairs, and it was a chore for him to get showered and dressed every day.

I spoke to Fred's nurse before entering his room and she informed me that Fred was limited in his mobility because he was on a number of continuous IV medications and was attached to invasive heart-monitoring devices. All he'd been able to do was transfer from the bed to the commode over the last two weeks.

I knocked on his door and after being invited in, I introduced myself to Fred and his wife, Jill. I found Fred sitting up in bed, alert but quiet. As I explained my role and began interviewing Fred, his wife actively participated in answering many of the questions I asked to get a clear picture of who Fred was. He didn't mind his wife speaking for him, and I could feel immediately the wonderful support and love she gave him. I pulled up a chair and engaged both of them in the interview process.

When I asked Fred about his exercise his-

tory, he described himself as someone who always had to be doing something. He had retired from engineering but loved being active and enjoyed puttering around his home doing odd jobs. He also enjoyed taking walks with his wife but over the last 12 months his exercise capacity had significantly decreased. He told me he wanted to be as conditioned as he could as he waited for a heart transplantation.

I asked Fred if he had any hobbies he enjoyed?

Fred's eyes brightened and he smiled. "Koi fish," he said.

"What's that?" I asked.

"I raise Koi fish. I have about fifty in my garden pond. I built the pond myself and I raise them. When I'm not busy taking care of the fish, I sit out on the deck that overlooks the pond with Jill. We like to watch our grand-daughter play around the pond. I laugh when I hear her screech

when the family bullfrog hops too close to her. She loves the Koi."

He looked at his wife and said, "I need to get a heart."

I examined Fred and gathered data to help me determine what impairments he had. He was surprisingly strong for someone who'd had limited mobility for the last two weeks being confined in the hospital. Fred told me he had remembered the exercises he'd been taught by his physical therapist on his last admission and he performed those exercises daily to maintain his strength. Fred reported no pain, his skin was intact, he had no signs of pressure sores, and his range of motion was full. He moved well in and out of bed considering all the lines and wires he was attached to. He only needed supervision to help manage the lines as he moved from the bed to the commode. He was

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Jackie Mulgrew, PT
physical therapy clinical specialist

Narrative (Jackie Mulgrew)

continued from previous page

able to stand without any support, but I noted that his head was flexed forward and his shoulders were rounded. He was able to correct his posture with simple cueing from me. I knew that if Fred got a donor heart, it would mean having a sternotomy, an opening of his chest to perform the surgery. Often, patients develop poor posture after a sternotomy, so I

wanted to address this early on with Fred. As he stepped toward the commode, I noted that his strides were short and his foot clearance was very low.

Based on the data I drew from the echo-cardiogram, the monitoring devices in his room, and the history Fred gave me regarding his low level of function prior to admission, I knew he most

likely had a low exercise tolerance. In order to confirm and quantify this, I wanted to perform a low-level exercise test. Based on the results of the test, I would be able to prescribe a very specific exercise program for Fred that would gradually increase his exercise capacity by training his peripheral muscles to be more efficient, thereby decreasing the demands on his already weakened heart. This approach has been well documented in the literature.

I noted that Fred was attached to a pulmonary artery (PA) line. This line monitored Fred's heart pressures, and I knew based on its location in the heart that I needed to be very careful handling this line. The line sits in the pulmonary artery. It can be advanced further into the pulmonary capillaries to measure the pulmonary capillary wedge pressure. This is performed by a critical care nurse under strict guidelines. I knew I had to monitor the screen to

make sure I'd quickly recognize any changes in the waveforms that would indicate advancement or slippage of the PA line. If for any reason the PA line advanced forward in an uncontrolled situation into the capillary, it could cause a pulmonary infarction or damage the capillary wall.

I'd performed hundreds of sub-maximal exercise tests before but never on a patient who had a PA line. I had work-

continued on page 16



Physical therapy clinical specialist, Jackie Mulgrew, PT, works with patient, Errick Cannon

A graduate of Harvard College and the Boston University School of Social Work, Virginia (Ginny) Sigel started working at MGH in 1991.

Over the course of her long career, Ginny has become an expert in treating survivors of sexual abuse through individual and group sessions. Recognizing the unique needs of this population, she provides educational programs for clinicians who care for sexual-abuse survivors. Among her many accomplishments, she and a colleague started a support group for women of color who have survived sexual abuse. A resource to colleagues and all members of the MGH community,

Ginny brings expertise, wisdom, compassion, and a comforting sense of humor to each encounter with a client.

Ginny is a clinical scholar in the PCS Clinical Recognition Program.

Clinical Narrative

(This is not the clinical narrative that accompanied Virginia Sigel's nomination portfolio; that narrative was not printed to preserve patient confidentiality.)



Virginia Sigel, LICSW
clinical social worker

My name is Virginia Sigel, and I have been a social worker for more than half my life. After working with community agencies for many years, I came to MGH where I've worked with outpatients for the past 14 years. I'm a psychotherapist, and although I work primarily with individuals, I've led groups for sexual abuse survivors and disabled men. I'm currently participating in the advanced couples seminar and am increasingly treating couples.

As a psychotherapist, I believe my work has several components: first, to identify what's causing people subjective distress; second, to create a plan for changing what's changeable; third to work with them as they explore the roots of their unhappiness; and fourth to support them in their practice of cognitive and behavioral shifts. I guess that makes me a private (confidential) investigator/planning consultant/travel guide. But the essential

foundation for treatment is the relationship that develops between therapist and patient. Trust, regard, and mutual respect are required for any work to progress.

Recently, I began working with a new patient. I had to listen carefully to the phone message because the voice was very soft, almost timid. The woman said her primary care physician had referred her to me, but she was on her way out and would call me later. By 4:00pm, I hadn't heard from her, and since I had heard the anxiety in her voice, I decided to return her call. Another woman answered and called for Linda. After what seemed a rather long time, Linda came to the phone.

Her voice was barely audible. When I inquired about the referral, she quietly said that she had an ongoing depression, that she lived in a pressure cooker, and that's why her primary care provider had referred her to me. She sounded so

depressed, I offered to see her in the next few days. She was reluctant to commit to an appointment so soon, so I offered to see her the following week. And she accepted. But because I sensed that she was very unhappy and very passive, I repeated my offer to see her sooner, which she more comfortably declined, saying, "I will come to the appointment next week."

I was reminded of a very competent patient I had seen years ago who was working with Jewish Vocational Rehab to change careers. She had diligently completed many of the tasks and had completed her resume. She began searching for a new job and reported in one therapy session that she'd sent out a number of resumes and cover letters. She came to a subsequent session anxious and distressed. She'd received positive responses from two companies! As we explored the reasons for her upset, she said, "I

was only ready to send out letters."

Linda was apparently only ready to make the initial call and cautiously make an appointment. She wasn't ready to meet the therapist. By next week she would have made herself ready to come to an appointment. I wondered how often we mistakenly interpret caution and fear as resistance, how in our desire to help we miss the patient's initial cues. I believed that Linda would come to the first appointment, and I was relieved that I'd been able to recognize her need to control the time of our first meeting.

Linda arrived on time. Somewhat overweight, she wore no make-up. She was casually dressed, and the total effect was of a formless, beige woman. She looked anxious, depressed, and uncomfortable. I was relieved I'd been punctual because it was likely that Linda's anxiety

would have escalated in the waiting room.

We started with my asking routine intake questions. I find that people are usually more comfortable after a few minutes of simple demographic information. When we got to the point in the interview where I ask about possible presenting problems in alphabetical order, we didn't get past the As. As soon as I said, "abuse," Linda started to tear up. She acknowledged that she had been physically, psychologically, and sexually abused by her father throughout her childhood. All her siblings had been abused as well, but because she was the oldest in the family, more abuse and responsibility fell to her. Linda's mother frequently blamed her for having to marry Linda's father. I remarked how painful her mother's words must have been despite the illogical and inappropriate

continued on next page

Narrative (Virginia Sigel)

continued from page 8

ate accusations.

As we continued with the interview, it became evident that Linda had a history of anxiety, panic attacks, chronic depression, domestic violence in her family of origin, sleep disturbances, isolation in her present family, trauma, and suicidal ideation.

Linda explained that she usually presented well. She had recently called her primary care provider, however, and when the doctor advised her to come in, Linda

broke down in tears. She reported that she has ups and downs due to 'underlying stuff;' she's not a 'happy camper,' but she does okay generally.

Linda expressed concern that she was becoming angrier lately. It didn't take much to get her riled, and she snapped at people. Linda was so honest in her self-reporting—it almost felt like she was at confession, trying to remember all her sins and failings. The guilt and self-re- crimination, the expect-

tation that she would be judged were so obvious. While my instinct was to reassure her and offer support and 'forgiveness,' I refrained, knowing that the most helpful response was simply to listen and not judge. In that first session, it was essential that I achieve some initial understanding of Linda's world. My task was not to evaluate the 'truth' or reality of her perceptions. My goal was to build an alliance, accept her emotional reality and validate her behaviors as adaptive to her very painful past experiences. It was evident that Linda was in

great pain when she disclosed her abusive past. Listening to, and connecting with, her distress and shame was extremely sad for me. We are all reassured by knowing that our experiences make sense to another person. I hope that Linda felt I understood and was genuinely concerned for her. I believe that when we verbalize our darkest fears and experiences, when another person bears witness to our pain or shame, we can walk away a little bit lighter, released from a small amount of the emotional burden.

Linda has continued

in therapy. She said after several sessions that she couldn't remember feeling this well. In one of our early sessions when Linda was very upset and sharing details of her abusive history, I suggested she visualize leaving some of her pain behind in one of my desk drawers. Since then she has said that during the week she thinks about my desk drawer and what she'll try to leave behind in the next session. I know this is a new beginning for this woman who was brave enough to accept a referral and begin therapy.

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Clinical social worker, Virginia Sigel, LICSW (right), talks with patient Karen Igharosa

Narrative (Ann Eastman)

continued from page 3

the OAs on our unit that I would be gone for a little while, I went to the Burn Unit. Coco was with Mr. Valentine. He was about to be intubated. I introduced myself to his nurse, then checked with a staff member regarding the whereabouts of Mrs. Valentine. I was reassured that a staff member from the Burn Unit was with her.

Coco and I stepped back but stayed while Mr. Valentine was intubated. I was able to explain the procedure, the equipment, and the course of care to Coco. We were able to see Mr. Valentine begin to improve. We checked in with his nurse to make sure she had no questions, and then we left.

In the morning, my goal was once again to help Mr. Valentine achieve optimal wellness during our time together. As always, there were complicating factors.

Orienting a new nurse is always an asset and a challenge. There's a delicate balance involved in providing a new nurse the experience she needs while at the same time responding wholeheartedly to the patient's needs. Both of these demands are compelling and common in our current clinical atmosphere. Ongoing assessment of the patient, the orientee, and the developing situation

is required. Because of her skills and knowledge, Coco was able to help assess Mr. Valentine, verbalize her findings, and participate in his care. She was able to absorb some of the 'big picture' behind what was going on. In talking with her afterward, we both felt the experience was valuable for her, gave her some concrete knowledge, some new skills, exposure to managing acute situations, and an understanding of the utilization and value of our resources.

The team had a plan that involved further diagnostics, which were important but also came with risk. Getting Mr. Valentine through these tests required careful work on our part to maximize his condition so he could tolerate the test(s) he needed. We had to make use of resources outside our unit including the nursing supervisor and the rapid response nurse. We needed to call on our own unit staff including: operations associates, our nurse coworkers, our clinical nurse specialist, and our nurse manager. Collaboration is an important part of patient care. Without it, it would be easy to miss our goal of providing optimal patient care.

The team's plan required that we present our assessment to the

neurologist, including our thoughts about his respiratory needs. Our observations, plan of care, actions, and assessments were important. Our input helped the medical team 'connect the dots' in the clinical picture that morning.

Did Coco and I meet our goal of helping Mr. Valentine achieve optimal wellness? It's hard to say. Obviously, a less eventful course would have been more desirable. But as always, we were working within the constraints of the situation. The best care for this patient involved conflicting needs (for example, the risk of respiratory compromise versus the need to learn the cause of his mental status changes). There was also the balance of who would be the best caretaker at any given time. And finally there was the issue of achieving optimal wellness for our other patients. How did they fare?

We were able to meet the needs of our other patients with help from our colleagues. We did our best for Mr. Valentine. His status improved during our care. We were able to maximize his oxygenation well enough for him to undergo diagnostic testing. We got him to the unit in time to be intubated and recover.

And he did recover. He was extubated after this event and lived for several more months. It would be nice to be

able to present a narrative without complications, without conflict, and without an outcome that doesn't meet our highest hopes. But what we do every day doesn't always allow us that privilege. We're at our best in the real world where we make decisions and provide care in a complex environment. Afterward, we can always think of what might have worked better, what might have helped. And that reflection is important. But the only purpose for that is 'for the next time.' And that's what experience is all about.

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

Ann's narrative gives us a glimpse into the myriad complex decisions nurses make every day. While managing a rapidly changing situation, Ann balanced crucial patient-care responsibilities with teaching opportunities for her orientee. She advocated for Mr. and Mrs. Valentine. She worked with the team on her unit and in other areas to ensure Mr. Valentine received the best possible care at every juncture. With each new development Ann re-grouped and re-evaluated to try to reach her goal of helping Mr. Valentine achieve optimal wellness while under her care. This is a very insightful narrative.

Thank-you, Ann.

Narrative (Virginia Sigel)

continued from page 9

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

Ginny's narrative gives us insight into the expert practice of a clinical social worker. Even before she met Linda, during their telephone conversation, Ginny was present and acutely aware of what Linda was saying, and more importantly, what she wasn't saying. When they did meet, Ginny immediately established a safe and nurturing environment where Linda could let her story unfold on her terms.

Ginny's deft handling of the situation and her understanding of the complexities associated with sexual and psychological abuse gave Linda the sense of comfort and confidence she needed to 'unburden herself' in Ginny's presence.

In a moment of reflection, Ginny wondered how often we misread a patient's fear and anxiety as resistance. Interpreting those cues is such an important part of what we do as caregivers.

Linda was fortunate to find Ginny and her trusty desk drawer as repositories for her pain.

Thank-you, Ginny.

Macaluso Award Ceremony

continued from front cover

recognized since the inception of the award in 1998. Ives Erickson thanked the members of the Macaluso Review Board for their work in selecting this year's recipients, and acknowledged all nine clinicians who were nominated.

Associate chief nurse Jackie Somerville, RN, shared some observations on the importance of 'knowing' patients, being true to your own calling and inner voice, and honoring the authenticity and individuality of every patient. She ended her remarks with a quote from poet, Mark Van Doren: "There are two statements about human beings that are true... that all human beings are alike and that all are different. On those two facts, all human wisdom is founded."

As has become tradition, Ives Erickson read from letters of support and recommendation as she introduced each recipient. Quoting Dr. Paul Uhlig, she said of Jackie Mulgrew, "Jackie is an expert clinician and natural leader whose clinical skills are exemplary. She has a quality that can best be described as personal authenticity. Very simply, Jackie lives what she believes. Because of this, her power to teach and inspire others is profound."

Michael Sullivan, PT, director of Physical and Occupational Therapy,

wrote, "Jackie brought to the MGH inpatient service, eleven years of acute care experience, a wide spectrum of physical therapy knowledge and skills, a keen interest in cardiovascular/pulmonary physical therapy, and exceptional communication, customer-service, and conflict-management skills. As a clinician, Jackie's intuitive abilities facilitate adept clinical reasoning and embody patient-centered care."

Introducing Ann Eastman, Ives Erickson read from a letter written by social worker, Mary Zwirner, LICSW (former Macaluso recipient). Wrote Zwirner, "Ann provides compassionate care that clearly demonstrates her understanding of, and appreciation for, the whole patient not just the illness. She is curious and thoughtful about the social, cultural, and economic situation of the patient and family and incorporates that into her practice."

Staff nurse, Jennifer O'Neil, RN, wrote, "Ann is a frequent preceptor and mentor to new graduate nurses and students. Her knowledge and support facilitate the successful transition and growth of new team members. Ann is a role model for all of us."

In her letter nominating Virginia Sigel, social worker, Carol McShef-

frey, LICSW (also a former Macaluso recipient), wrote, "Ginny is an intelligent, compassionate, and extraordinarily accomplished clinician. I often turn to her when I have a challenging client in need of an experienced therapist. In the 90s, Ginny was in the vanguard of treating women with early trauma histories. At a time when diversity

dow to her work. Patients will say, 'I really wanted to drink (or eat, or overspend, or call my ex...) but I could just hear what Ginny would say about that.' They've internalized her while respecting the clear, safe boundaries she sets."

In a letter supporting Judy Foster's nomination, nurse manager, Ellen Fitzgerald, RN, wrote,

We are a world-class institution, relentless in our pursuit of patient- and family-centered care. You are all heroes in my eyes, and I thank you for what you do.

was not part of everyday parlance, Ginny was considering how to respond to the clinical needs of her minority clients. When one of Ginny's African American clients told her she felt like, "a fly speck in a glass of milk," Ginny teamed up with another MGH social worker to develop a group for women of color."

Psychiatrist, BJ Beck, MD, wrote "I've accepted psycho-pharmacology referrals from Ginny for patients I would never agree to manage on my own. But knowing that I'll be working with a seasoned, pragmatic, and positively focused therapist makes those referrals not only possible, but rewarding. Therapy is a singular, private, and unobserved practice. I've never been in the room with Ginny and a patient. However, being in the room with one of our shared patients is a win-

"Judy is always focused on the goals of her patients and their families. She is respectful and supportive of their wishes and is able to incorporate this perspective in her collaboration with the multi-disciplinary team."

Oncology chaplain, Michael McEllhinny, MDiv (former Macaluso recipient), wrote of Foster, "Judy's skills manifest a confidence that builds trust in patients, their families, and her colleagues. Her knowledge of complementary and alternative therapies is also a plus. She remains calm in crisis and able to implement creative approaches to care. When one patient was taxing the staff with long monologues about his religious beliefs, Judy listened long enough to learn of his interest in singing. She helped him

channel his energy into performing Dean Martin songs, which pleased him and was a great relief to his caregivers. From Judy, he learned he could relate to people in ways other than long, biblical discourses."

Typically, one Macaluso recipient is asked to share her narrative at the award ceremony, and this year, that clinician was Judy Foster (see page 4). Following the reading, Foster was joined by nurse manager, Ellen Fitzgerald, for a dialogue about the insights and observations that contributed to her decision-making throughout her care of KB, a long-term diabetic patient with a number of complicating factors. As in past years, the discourse was illuminating.

In closing, Ives Erickson thanked everyone for coming, adding that Stephanie Macaluso would be proud. Said Ives Erickson, "I was struck this year by the interdisciplinary nature of the nominations. Clinicians from several disciplines stepped forward to talk about the impact another discipline had on a particular patient and on their own practice. This makes me very proud. Every discipline brings a domain of practice that is needed by our patients."

"We are a world-class institution, relentless in our pursuit of patient- and family-centered care. You are all heroes in my eyes, and I thank you for what you do."

Macaluso Moments



*Stepahnie
wasn't the only
one smiling*

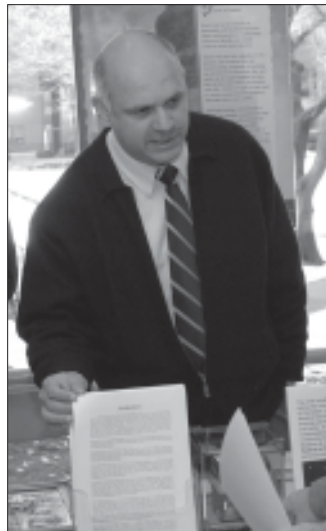


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Holiday Happenings

Peace on earth, good will toward all



Continued on next page



*Happy
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Narrative (Jackie Mulgrew)

continued from page 7

ed with patients with a PA line while they were on bed rest or permitted to get out of bed to transfer to a chair, but not to do a walking or bicycle exercise test. I knew all about the normal and abnormal responses of heart rate and blood pressure to increased workload. But I'd never been taught nor had I read anything about normal or abnormal responses of pulmonary artery pressure (PAP) to increased workload. I told Fred I'd be back in the morning to perform his test, and off I went to the library that evening after work. I found two articles that referred to PAP monitoring in patients with severe heart failure. Although the articles didn't give parameters as to what was suggested as too high, I was able to use my clinical knowledge and expertise to extrapolate the relevant information from the articles. I now had a better understanding of what I would expect with Fred the next day.

The following morning, I telephoned the CCU and spoke with Fred's nurse. I discussed with her my plan for Fred that day and asked when she would be available to coordinate treatment time with Fred. I knew I'd need Fred's nurse in the room to assist with placement and monitoring of the lines, and I'd need her expertise to ensure

Fred's safety during this test that would put greater stress on Fred's already failing heart. As it turned out, Fred's pulmonary artery line had developed a crack and been removed the night before. It was going to be replaced the following day. So it wouldn't hinder our exercise test; in fact, this was going to make it easier to perform!

I wanted to perform a bicycle test with Fred rather than a walking test because it would be more difficult to gather data if Fred was walking with multiple lines and tubes attached to him. I didn't want the lines to slow him down causing me to underestimate Fred's ability. I discussed this with Fred and asked him which mode of exercise he'd prefer. I knew that compliance to exercise programs was greater when patients chose an activity they enjoyed. Fred preferred to do the test on the bicycle.

I recommended that Fred perform the test sitting behind the bike with his feet stretched out comfortably on the pedals similar to the set-up of a recumbent bike. At this point, it was too risky to have Fred sit on the bicycle seat in case

we had to quickly get him back to bed or recline him. I was anticipating that he may have an inappropriate response to exercise based on his pathology, so I wanted to make the environment as safe as possible. With the PA line out, I chose to monitor Fred's heart rate, blood pressure, respiratory rate, oxygen saturation and his subjective rate of perceived exertion. I paid

his respiratory rate (RR) was 14, his oxygen saturation (SpO₂) was 96% on room air, and his rate of perceived exertion (RPE) was 7 on a scale of 6-20. I monitored each vital sign every two minutes to watch for signs of fatigue or worsening heart failure. After six minutes, Fred's HR was 95, BP was 86/58, RR was 18, SpO₂ was 98%, and his RPE was 8. Everything

was going well, and Fred was happy to continue. By the time we reached ten minutes, Fred's HR was 102, BP was 92/58, RR

was 24, SpO₂ was 97%, and his

RPE was 10. I was aware that he was working harder, but his response to exercise was normal. I allowed Fred to continue for another two minutes. At the 12-minute assessment, Fred's HR was 96, and that was enough of an indicator to terminate the test. This early dropping of his HR was a sign of his inability to keep up with the workload. As Fred rested, I continued to monitor his vital signs for another five minutes to make sure he returned to his resting baseline.

Fred was very pleased that he'd been able to cycle for so long. Twelve minutes was the most he'd done in two weeks. I explained how the inotropic medications were helping to support his

heart and without them, he most likely wouldn't be able to exercise at all. I explained how I anticipated that he would see gains in his exercise capacity. We discussed the goal of increasing his duration on the bike.

The following day, we repeated the same procedure. This time, Fred made it to 14 minutes before I terminated the test. The following day, Fred's PA line was replaced, so I didn't get a chance to treat him. On the following day, I was able to use more in-depth monitoring while Fred performed his exercise program. This time, I had access to his PAP response as well as his other vital signs. His PAP was 28/8 at rest.

Normally the PAP is 20-30/10-20, so I knew Fred was stable. And after reading the articles and understanding normal physiological responses to exercise, I knew it was okay for his PAP to rise. I spoke with his resident physician and together we established safe parameters, since neither of us had any evidence to support specific ranges. We agreed that anything higher than double the current systolic PAP would indicate too much work on the right side of the heart. So I used that as a guide as to whether I needed to terminate the exercise. Fred was able to complete 18 minutes of exercise on the bike before I terminated the training. At that point,

continued on next page

As I reflected on Fred's care, I realized that I had confidently overcome a new challenge and realized that this could open the door for other patients with severe heart failure to exercise under the guidance of a physical therapist in the critical-care setting.

particular attention to his facial expressions, signs of fatigue, pallor, and any other symptoms he might report that would indicate he wasn't tolerating the test well.

My goal for Fred was to develop an exercise program that would allow him to increase his duration before increasing intensity. That way, he'd be able to perform low-intensity, functional tasks using pacing techniques. With an ejection fraction of 12%, his heart wouldn't be able to respond to sudden increases in intensity. So I chose to do a bicycle test using duration as the parameter, and I kept the resistance at zero. Before we started, Fred's heart rate (HR) was 76, his blood pressure (BP) was 88/58,

Narrative (Jackie Mulgrew)

continued from previous page

his PAP was only 38/11, but his SBP had started to drop to more than 13 points below the starting point. This indicated an abnormal response to exercise and a criterion for terminating the exercise test.

I continued to work with Fred five times a week, and he got to a point where he was able to exercise for 30 minutes on the bike. Then I introduced a higher intensity (level 2) and repeated the process of building up his duration at that level while I closely monitored his response to exertion.

As I reflected on Fred's care, I realized that I had confidently overcome a new challenge and realized that this could

open the door for other patients with severe heart failure to exercise under the guidance of a physical therapist in the critical-care setting.

I'm happy to tell you that Fred got a heart transplantation seven weeks later and is doing well. He tells me he can't wait to get home and sit on his deck overlooking his Koi pond. Now that he has to protect his donor heart from infection and rejection, he's not allowed to clean his fishpond. He plans to teach his granddaughter how to take care of the Koi.

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

This narrative shows a broad range of Jackie's clinical skills and knowledge. But more than that, it shows that Jackie is not threatened by unfamiliar clinical situations. She sought out information and best practices from a variety of resources. She understood Fred's fragile cardiac status and treated him within the context of who he was as a person. She found out what brought him joy and purpose and geared his treatment around activities that brought him personal satisfaction. It was never stated, but I think Jackie's own passion and enthusiasm spilled over onto Fred and helped him develop the stamina and endurance he needed as he awaited his new heart. What a wonderful narrative.

Thank-you, Jackie.



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Next Publication Date:

January 19, 2006



Narrative (Judy Foster)

continued from page 4

ing the host. In KB's case, the manifestations of GVHD are large volumes of secretory diarrhea. KB may experience eight to ten watery stools a day accompanied by nausea, vomiting, and/or abdominal pain. Her diet has been trimmed down significantly necessitating TPN as her main source of calories. First-line treatment is steroids. Unfortunately, she received little, if any, relief of symptoms with steroids. Currently, she is receiving a second-line treatment in addition to steroids.

In essence, KB is an endocrinologists worst nightmare: a brittle, type I diabetic receiving steroids and TPN. Her blood sugars have dipped as low as the 50s and ranged as high as the 300s. She requires glucose monitoring at least six times a day and a skillful knowledge of when to hold, and when to administer, insulin. Luckily, she has had stellar medical management of her diabetes with close involvement and collaboration with nursing.

With her overwhelming complications and protracted length of stay, it's easy to guess that KB has become clinically depressed. She reluctantly agreed to see a psychiatrist and even more reluctantly agreed to try antidepressants. Her

mood improved briefly after initiating ritalin. Unfortunately, she decided to stop for various personal reasons.

Caring for this fragile, depressed, medically complicated, chronically ill woman has been a challenge. It appears that KB has forgotten the person she was and has resigned herself to her illness. It's difficult to don an isolation gown and enter that sad, overheated room. It's easy to believe that no matter what we do, she's just going to experience one more complication. It's hard to imagine she will ever get better. But these are the arguments of the 'rational man' in Rumi's poem. My goal has been to transcend the rational and find the brief moments of music within her illness.

Beginning with purely physical needs, I've tried to care for KB in a way that comforts her. She has a few hygiene rituals I try to honor. She is particularly meticulous about mouth care. Part of our routine consists of me supplying her with a toothbrush, toothpaste, and mouthwash. We do this faithfully in the morning and again before bed time. She likes to soak her feet in warm water. We have made this part of her bath ritual. She likes the bed covers arranged so that her feet

aren't covered. All these small, seemingly insignificant actions are my attempts to help her feel safe and in control of her environment.

She needs assistance with all her activities of daily living. She needs encouragement to get out of bed, walk outside her room, and take her medications. I try to motivate her to do these things with the caveat that she controls when and for how long.

Medically, KB needs a nurse who is intensely aware of her many issues. Managing her blood sugars, physical symptoms, blood-transfusion needs, anti-rejection and anti-GVHD medications require my constant attention. In terms of her diabetes, I inform KB of all her blood sugars, the dose of insulin ordered, and ask if she agrees with the plan. The endocrinologist has made provisions for us to adjust her regular insulin at breakfast and dinner time. Usually, the amount of regular insulin ultimately given is a joint decision between KB and myself. The IV medications are usually non-negotiable. Her oral medications are negotiable. She knows her pills.

KB will tell me when she's decided to stop taking a medication and nothing will change her mind, so we try to find substitutes or other methods. KB's complex clinical situation also provides rich opportunities

to teach new nurses about diabetes, leukemia, GVHD, and the complexities of balancing conflicting medical priorities.

KB spends a lot of time alone. Her husband works full time and his visits have decreased in frequency. Her parents and siblings live out of state and have been unable to visit with any regularity. She brightens when people visit, so I have enlisted the help of chaplains, the psychiatric clinical nurse specialist, volunteers, nursing students, and unit service associates to provide increased social support. KB enjoys music especially classic rock. She has a radio in her room that I turn on when she's awake. Paul McCartney is the favorite Beatle for both of us. I always try to get her to sing along whenever one of his songs is played. She told me her favorite Rolling Stones song is *White Horses* (the actual name of the song is *Wild Horses*).

KB is an intensely spiritual person. She prays frequently and discusses her faith in God. She has a few inspirational books and at times reads them. It is her connection with people that gives her the most lift.

After 23 years as a nurse, I am constantly amazed by the human spirit. Sickness and disease wreck the physical and emotional body. But there's always something

beyond the physical and the emotional that can be discerned. The great poet, Rumi, calls it music. I hope to continue to hear those sounds.

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

Judy's comparison of Rumi's poem (in which a man hears music in the sound of walnuts falling) to her care of KB is an eloquent way of describing the many layers of her clinical expertise. Illness and hospitalization can cause patients to experience a loss of control as much of the care and treatment they receive is prescribed by others. But in Judy's account of her care for KB, we get a sense that Judy is taking the journey with her, a partner in the experience.

Judy hears the sounds of KB's illness as she negotiates her medication administration, adjusts the temperature in the room, helps KB perform meticulous personal-care rituals, and yes, sings her favorite Rolling Stones song. All these 'sounds' are a barometer of KB's physical and emotional health, and Judy takes them into account as she assesses KB's status.

After reading this narrative, I'm sure a lot of clinicians will be listening with 'new ears' to those sounds that Rumi, the poet, calls music.

Thank-you, Judy.

Educational Offerings

January 5, 2006

When/Where	Description	Contact Hours
January 9, 10, 23, 24, 30, 31 7:30am–4:30pm	Greater Boston ICU Consortium Core Program Faulkner Hospital	44.8 for completing all six days
January 11 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
January 11 11:00am–12:00pm	Nursing Grand Rounds “Documentation: Knowing your Patient.” Haber Conference Room	1.2
January 11 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
January 11 4:00–5:00pm	More than Just a Journal Club Thier Conference Room	1.2
January 11 8:00am–12:30pm	Pediatric Advanced Life Support (PALS) Re-Certification Program Training Department, Charles River Plaza	---
January 17 and 18 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: CCH; Day 2: VBK601	14.4 for completing both days
January 18 1:30–2:30pm	USA Educational Series Haber Conference Room	---
January 19 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
January 19 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
January 19 1:30–2:30pm	Nursing Grand Rounds “Electronic Medication Administration Record.” O’Keeffe Auditorium	1.2
January 20 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
January 23 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
January 24 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
January 25 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
January 25 8:00am–4:00pm	Review Class for Cardiac/Vascular Nursing Certification SRC-3120	---
January 26 8:00am–12:00pm	BLS Certification—Heartsaver VBK 401	---
January 26 1:30–2:30pm	Nursing Grand Rounds “Support for Support Staff in the Oncology Setting.” O’Keeffe Auditorium	1.2
January 26 12:00–3:30pm	Basic Respiratory Nursing Care Sweet Conference Room	---
January 27 8:00am–4:00pm	Creating a Therapeutic and Healing Environment O’Keeffe Auditorium	TBA
January 30 and 31 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: NEMC; Day 2: VBK401	14.4 for completing both days
January 30 8:00am–4:00pm	Advanced Cardiac Life Support—Instructor Training Course Thier Conference Room	---

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

History and background of the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Excellence in Clinical Practice Award (originally called the Expertise in Clinical Practice Award). The purpose of the award is to recognize direct-care providers whose practice exemplifies the expert application of values put forth in our vision: practice that is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

The first recipient of the award, in 1996, was Stephanie M. Macaluso, RN, thoracic clinical nurse specialist. In honor of the high standards she set as an expert caregiver, the award is now known as the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award.

Macaluso embodied the qualities and characteristics of an expert practitioner. She was known for her strong knowledge base and intuitive skills. She knew when a clinical situation was changing even when common indicators remained unchanged. As an expert coach, she was one on whom peers relied and to whom physicians responded immediately because of her solid, proven track record of sound judgement.

Macaluso did not stand outside of a patient's realm of experience in her role as clinical teacher. She stood alongside patients conveying empathy and genuine concern. Macaluso's ability to be with patients in a way that acknowledged their shared humanity is the basis of a caring practice.

Macaluso understood the relationship of health, illness and disease. It was this understanding that led her in her car-

ing work to seek patients' stories. She knew that every illness had a story—relationships were disturbed, plans were thwarted, and symptoms became laden with meaning as to what else was going on in a patient's life.

Macaluso had the uncanny ability to put herself in touch with others and bring the encounter to an intimate level. It's hard to express how she made this contact with patients; maybe it was the way she approached them, the questions she asked, or the language she used. But somehow, they trusted that she knew what she was talking about. This trust and understanding allowed her to connect with patients and promote a sense of caring.

Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate

expert practice throughout Patient Care Services. The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award is now given annually. Registered nurses, occupational therapists, respiratory therapists, physical therapists, speech-language pathologists, social workers and chaplains who provide direct care are eligible for the award and may nominate co-workers whose practice exemplifies the standards described earlier.

Clinicians who are nominated submit a professional portfolio which is reviewed by a selection committee comprised of clinicians, administrators and MGH volunteers. To assist recipients in achieving both personal and professional development, recipients receive tuition and travel expenses to the professional development conference of their choice.

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award allows us to publicly re-commit ourselves to the highest standards of care we hold for our patients, and contribute to the on-going professional development of clinicians within Patient Care Services.

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