October 5, 2006

Caring HEADLINES

Peace, Shalom, Salaam

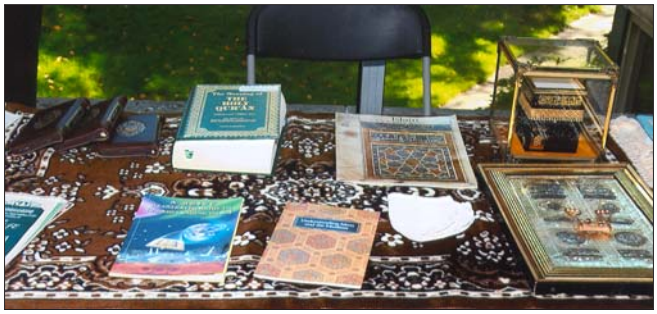
sharing a celebration of the Hebrew and Islamic holy months

—prepared by the Patient Care Services Diversity Committee

Inside:

Due to an unusual aligning of the Hebrew and Islamic calendars, the holy months of Tishrei (Hebrew) and Ramadan (Islam) occurred on the same day this year, September 22, 2006 (on the solar, or Gregorian, calendar). Jewish and Muslim months always begin on the first day of a new moon. But since the Jewish calendar adds an extra month periodically to keep their holidays occurring in the biblically ascribed seasons, Tishrei and Ramadan only coincide once every dozen years or so.

Taking advantage of the auspicious occasion, the Patient Care Services Diversity Committee held an educational booth in the Main Lobby to provide information about the two religions and to celebrate one of the many common aspects these two ancient traditions share.



(Photos by Abram Bekker)

Below: members of the PCS Diversity Committee (l-r) Khalil El-Rayah, Rabbi Ben Lanckton, and Firdosh Pathan, RPh, staff informational table in the Main Lobby

Above: American Sign Language interpreter, Susan Muller-Hershon, displays the sign-language symbol for "interpret," reinforcing the importance of communication between people and cultures

MGH Patient Care Services

Working together to shape the future

The Yvonne L. Munn Center for Nursing Research

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

Research is a critical component of the MGH mission and a central part of Patient Care Services' Professional Practice Model. The Yvonne L. Munn Center for Nursing Research is one of the pillars of the new Institute for Patient Care along with The Knight Nursing Center for Clinical & Professional Development; The Maxwell & Eleanor Blum Patient and Family Learning Center; and The Center for Innovations in Care Delivery.

Thanks to Yvonne Munn's generous gift in support of nursing research, we are able to advance our research agenda. In developing programs for the Munn Center, one of our guiding principles was to provide opportunities for nurses to participate in research at all levels of practice. Building on our values and guiding principles, we are committed to:

- creating a practice environment that fosters a spirit of inquiry
- developing new knowledge and testing that knowledge within the clinical practice environment
- translating knowledge into practice to impact patient-care outcomes and the overall patient-care environment
- generating and using evidence to inform practice and improve outcomes

Toward that end, we have developed a formal program of nursing research that offers opportunities to nurses prepared at all educational levels (non-master's and non-doctorally prepared nurses; master's prepared nurses; doctoral students; and doctorally prepared nurses). *Some* of the opportunities available for non-doctorally prepared nurses include:

- participating in the Nursing Research Committee
- participating in the Nursing Research Journal Club
- identifying and developing ideas for research studies
- securing research funding through the Munn Nursing Research Awards
- attending and/or presenting at grand rounds

This month, we formalized a Nurse Scientist Advancement Model for doctorally prepared nurses that delineates three levels of nursing research: associate nurse scientist; nurse scientist; and senior nurse scientist (see abridged overview below). Our goal is to give all nurses the opportunity to contribute to the development of nursing knowledge. This is a highly adaptable program that can be tailored to meet the needs of each clinician or researcher.

We'll be funding new nurse researcher positions for seasoned researchers who have an established record of funded research in an area of nursing inquiry.

This is a revolutionary program in the healthcare arena and a milestone in the evolution of the Yvonne L. Munn Center for Nursing Research.

In auspicious coincidence with this milestone, I'm thrilled to inform you that nurse practitioner, Barbara Roberge, RN,

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Overview of the Nurse Scientist Advancement Model for doctorally prepared nurses

Associate nurse scientist

- This title is given to all nurses upon completion of a doctoral degree
- Associate nurse scientists have a strong clinical background and an emerging area of inquiry that can be further studied and expanded
- Associate nurse scientists are expected to build a program of research, seek funding, contribute to nursing knowledge, and disseminate research at local and national meetings

Nurse scientist

- This title is given to a nurse researcher who has successfully initiated a career in research and who has completed a portfolio describing that research according to established criteria
- Nurse scientists are expected to grow a program of research, seek external funding, contribute to nursing knowledge, and disseminate information at local and national meetings

Senior nurse scientist

- This title is given to a seasoned nurse researcher with expertise in developing, testing, evaluating, and utilizing research
- A senior nurse scientist has served as PI on an externally funded study and continues to seek external funding, contribute to nursing knowledge, disseminate information at local and national meetings, and is a leader in the field

For a more complete version of this model, contact Marianne Ditomassi, RN, at 4-2164

New inpatient care building to go up on main campus

Question: Is MGH going to be constructing a new building in the near future?

Jeanette: Yes. MGH is in the process of planning and securing approval for a new inpatient care building on the main campus. The 'Building for the Third Century of MGH,' or B3C (until a more permanent name can be assigned), will have ten above-ground and four below-ground levels. The new building is slated to open in 2011, coinciding with the bi-centennial anniversary of MGH.

Question: Why do we need a new building?

Jeanette: The construction of B3C and other renovations (WACC 3 and Ellison 3) are intended to help alleviate some of the capacity issues on campus. The new building will add 150 private rooms (for adults), operating and procedure rooms, more post-anesthesia care space, and a renovated intake area for the Same Day Surgical Unit. It will house a new Radiation Oncology area, a completely re-designed Sterile Processing area, expansion of the Emergency Department, and a covered area for ambulance drop-offs. The new building will enhance access to MGH; be equipped with state-of-the-art technology; and through strategic design, make optimal use of clinical services.

Question: Who's involved in the planning?

Jeanette: Hospital leadership and front-line staff from throughout the hospital have been closely involved in the design and development of the new building. The goal was to create the best possible environment for patients and the delivery of high-quality care.

Question: Where will the new building be?

Jeanette: B3C will be built on the site currently occupied by the Clinics, Vincent-Burnham, and Tilton buildings.

Question: When will all this happen?

Jeanette: We've already begun to renovate space and re-locate people in preparation for construction. We expect demolition of existing buildings to begin in May of 2007. Construction of the new building will begin nine months later and take approximately three years to complete.

Question: How will the Emergency Department function during construction?

Jeanette: We're all keenly aware of the need to maintain access to the hospital and minimize the effects of construction on patients and staff. A multi-disciplinary team is developing a plan that will be shared with the entire MGH community when it's complete.

Throughout demolition and construction, detailed information will be communicated via *Caring Headlines*, *MGH Hotline*, staff meetings, and other vehicles.

Question: Can you tell us anything about the design of the new building?

Jeanette: Our goal is to create a patient- and family-focused environment that supports the most advanced clinical interventions, treatment, and care available. Multi-disciplinary and multi-departmental planning teams have worked together to design an environment that supports the highest quality care and the needs of those providing it.

The Planning Team has visited hospitals in Arizona, Chicago, St. Louis, and other cities to benchmark cutting-edge designs and workflow processes. We hope to incorporate input from groups such as the Patient Family Advisory Council and 65Plus, a multi-disciplinary group that focuses on the needs of older patients.

All 150 new patient rooms will be private affording us the opportunity to create family space in patient rooms and elsewhere on the units. Particular attention is also being given to the design of caregiver workspace in patient rooms and in public areas.

For more information about the construction of the Building for the Third Century of MGH, call Dawn Tenney, RN, at 4-8460.

Jeanette Ives Erickson

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has been awarded a two-year, $300,000 grant from the Robert Wood Johnson Foundation to fund her research project, "The Nursing Ambulatory to Hospital Transition Program." Barbara will be the primary investigator for the research team of: Ellen Mahoney, RN; Kenneth Minaker, MD; Barbara Moscowitz, LICSW; and Sung Chuang, MD. The study seeks to determine whether communicating a preventative nursing care plan between ambulatory and hospital nurses will improve nursing care and reduce hospital complications. What a wonderful contribution to nursing knowledge.

As I said, The Institute for Patient Care and The Yvonne L. Munn Center for Nursing Research are still in their infancy. We continue to shape their scope and vision. As we move forward, we will actively seek to align our work in research, education, and patient care to ensure an ongoing legacy of excellence and innovation.

We will continue to look for opportunities to engage in scientific inquiry. We will continue to advance our research agenda to improve patient care. And we will continue to ask 'why' and persevere in our search for answers. The possibilities are endless. We're limited only by the ideas we have and the questions we ask.

Updates

I'm pleased to announce that Pamela Wrigley, RN, has accepted the position of pediatric perioperative clinical nurse specialist for the Main Operating Room, Same Day Surgical Unit, and related surgical services.

Beth Ellbeg, RN, has accepted the position of nurse manager for the Pre-Admission Testing Area. Many thanks to Angelleen Peters-Lewis, RN, for her interim leadership of the unit when Bessie Manley, RN, assumed nurse manager responsibilities for Phillips House 22.

The TRACU: making a difference one year later

—by Marian Wilson, RN, and Donna McKay, RN

In April of 2005, MGH opened a four-bed Trauma Rapid Assessment Care Unit (TRACU) on Ellison 7. The TRACU is managed by Theresa Capodilupo, RN, nurse manager for the surgical units on Ellison 7 and White 7, and staffed by nurses from both units.

Patients are referred to the TRACU from the Emergency Department (ED), from other units throughout the hospital, from community hospitals, and from other states and countries. Most admissions to the TRACU are planned, but trauma is not a predictable event so accommodating an influx of trauma patients can be challenging. Trauma patients require frequent monitoring and assessment. Once they're stabilized in the ED, they have to be moved to another venue to make room for other critically ill patients. That's where the TRACU comes in.

The concept of a trauma rapid assessment care unit is relatively new. Associate chief nurse, Jackie Somerville, RN, had heard about units in other hospitals created specifically to help decompress the ED and provide intensive, specialized care to trauma patients. Somerville and chief of Surgery, Andrew Warshaw, MD, enlisted the aid of George Velmahos, MD, a physician experienced in developing such units and met with him to strategize about how to create a TRACU at MGH. Space was allotted on Ellison 7; a budget was provided; new equipment was purchased; criteria and protocols were set; and training was initiated. Velmahos is the attending physician for the unit, which is now staffed 24 hours a day, seven days a week.

Staffing in the TRACU is determined by a number of factors, including patients' acuity levels, the experience of the nurses at the bedside, and the staffing needs on White 7 and Ellison 7.

Training for nurses includes one year of nursing experience; training on a specialized computer program with follow-up testing; a four-hour mentoring session in the Surgical Intensive Care Unit (that includes care, monitoring, and setting up arterial lines) and a mentored orientation program in the TRACU. Mentoring can last from one to three days depending on the needs of the nurse.

Training includes orientation to the new telemetry system; travel monitors; vital-sign protocols; neurological and CSM checks; and phlebotomy, admission, and traveling procedures. Traveling with patients is a frequent occurrence. Patients may need diagnostics, surgical intervention, or to be transferred to an ICU. Traveling protocols require patients to be moved with a nurse, telemetry, oxygen, Ambu bags, AED, and when necessary, a doctor.

Following is an example of a patient we might see in the TRACU. A 19 year-old young man with multiple gun-shot wounds is transferred from the ED. He has been shot 11 times and still has seven bullets in his body. One entry wound is in his face, four bullets are lodged in his thigh, one in his lower back, one in his groin, and one in his left buttock. He has numerous bullet fragments throughout his body. Remarkably, he sustained no major injury to his vital organs.

He arrives awake, alert, and able to move all extremities. He is breathing on his own and able to maintain good oxygen saturation. His vital signs are stable and after numerous CT scans, it's determined that he doesn't meet the criteria to be placed in an ICU, but he isn't stable enough for a patient care unit. This patient needs to be monitored closely for 24 hours for changes that could be life-threatening. Hemodynamic monitoring, including full-body and respiratory assessment, needs to be done

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TRACU nurse manager, Theresa Capodilupo, RN (right), and clinical nurse specialist, Ann Martin, RN (third from left), with some members of the TRACU staff

Nursing Research Journal Club breaking new ground

—submitted by the Nursing Research Committee

On September 13, 2006, the PCS Nursing Research Committee broke new ground, teleconferencing a meeting of the Journal Club from the Satter Conference Room in the Yawkey Building to the General Clinical Research Center on White 13. Jacques Mohr professor of Geriatric Nursing Research, Diane Feeney Mahoney, RN, presented her research on, "African American, Chinese, Latino Family Caregivers' Impressions of the Onset and Diagnosis of Dementia: Cross-Cultural Similarities and Differences," to interactive audiences at both sites. Feeney Mahoney's study explored cross-cultural similarities and differences in minority family caregivers' perceptions of the onset and diagnosis of Alzheimer's disease in their relatives, with specific attention to clinical encounters. The study revealed that though ethnic and cultural differences exist, there are similarities that offer clinicians an opportunity to unify quality improvements in caring for Alzheimer's patients. Services such as outreach, education, credible Internet websites, and awareness among community physicians will help normalize families and decrease the stigma associated with Alzheimer's disease.

The Journal Club, now in its third year, has hosted prominent nurse investigators from MGH and local universities, including Northeastern University, Boston College, the University of Massachusetts, and Salem State. MGH presenters include:

- Susan Gavaghan, RN
- Virginia Capasso, RN
- Mary Ellen McNamara, RN
- Donna Jenkins, RN
- Colleen Gonzalez, RN
- Sara Dolan, RN
- Diane Carroll, RN
- Susan Stengrevics, RN
- Ellen Fitzgerald, RN
- Mary Jane Costa, RN

The Journal Club meets bi-monthly, spotlighting original, published, nursing research presented by the author(s). The sample, methods, findings, and implications for practice are discussed using a summary tool as a guide. Discussion includes the author's experience with the research process and personal journey as a researcher. Attendees hear up-to-date research on various topics and learn more bout how to conduct research in a clinical setting.

The Journal Club is an innovative vehicle for research dissemination and discussion. Attendance varies, and methods to broaden access, such as webcasts and video links, are currently being explored.

Clinical inquiry is often born at the bedside. Improvements in patient care frequently result from research ignited by those questions. The Journal Club offers a unique forum for authors to present their work. Not only do attendees have an opportunity to network and engage in collegial discussion, they can share research findings that contribute to the growing body of nursing knowledge. Closing the gap between new knowledge and translating it into practice remains a challenge.

The Journal Club is an effective way to disseminate research findings. The Journal Club will continue to teleconference its sessions and hopefully broaden its audience to include other hospitals and universities in the Boston area.

If you'd like to attend a Journal Club meeting or present your original, published research, go to: www. mghnursingresearchcommittee.org, or e-mail Chelby Cierpial, RN, or Catherine Griffith, RN. A complete list of presenters is available on the website.

Members of the Journal Club listen as Jacques Mohr professor of Geriatric Nursing Research, Diane Feeney Mahoney, RN (right), presents her original, published research

‘Thank-you’ means a lot coming from critically ill pediatric patient

Christine Perino is an advanced clinician

Christine Perino, RRT
respiratory therapist

My name is Christine Perino. I’ve been a registered respiratory therapist at MGH for six years. I’ve worked in the neonatal and pediatric intensive care units (NICU and PICU) for five of those years. I’ve met many patients and families, some who stayed for a short time, others who were with us for months. In every situation, whether it’s caring for a newborn or an elderly person, care is provided to the family as well as the patient. In the pediatric world however, you often find yourself caring for families as much, if not more, than the patient. You learn about patients from their families. They share stories and pictures that bring the child ‘to life’ for you.

One of my most memorable patients was ‘Abbie,’ a two-and-a-half-year-old little girl who came to MGH via Med Flight from an outlying hospital. She had been with her family at an amusement park when her mother noticed she was experiencing a dry cough. They brought her to the local hospital thinking she had a simple viral illness. The physician at the hospital realized the severity of her condition and sent her to us.

I was the respiratory therapist working in the PICU that evening. I remember Abbie coming to our unit and thinking how much she looked like a ‘Precious Moments’ doll. She had two brown pigtails and the brightest eyes I’d ever seen. She didn’t look like someone who was going to require maximum life-support, but within a very short time, that’s what she and her family would face.

Upon arrival, Abbie seemed to be breathing comfortably, requiring only a minimal amount of oxygen and IV fluids for hydration. The medical team ordered a chest X-ray when she came in and noticed she had a large right-sided pleural effusion (accumulation of fluid around the lung). It was decided that as long as she remained stable throughout the night, a chest tube would be placed the following day to drain the fluid. The following day a chest tube was placed, and a large amount of fluid was drained from her pleural space. Often, when patients have pleural effusions drained, their clinical status improves dramatically. Abbie, however, did what she would do many times in the course of her stay with us... which was the opposite of normal. Almost immediately her respiratory status declined rapidly, and she could no longer breathe on her own. She required intubation and mechanical ventilation. And that was the last time we would see her awake for weeks.

It turned out that Abbie had severe pneumonia. Within a week, her condition worsened, and we were losing the ability to support her with conventional life-support. Extracorporeal membrane oxygenation (ECMO) was considered, and we discussed the risks and benefits. ECMO is a form of treatment that uses an artificial lung and pump to support patients in acute respiratory failure. The criteria for using ECMO is well established for newborns but it’s less clear for the pediatric population. ECMO has been used for children in Abbie’s condition, but the survival rate is only 50-60%. After much discussion between the family and the various clinical services, it was decided that Abbie’s best chance for survival was ECMO. On hospital day five, she was placed on ECMO.

When a patient begins ECMO, an ECMO specialist and a nurse remain at the bedside 24 hours a day. Our ECMO program is overseen by pediatric surgeons, while minute to minute ECMO support is managed by a team of specialists. On ECMO, survival depends on the system being properly maintained and adjusted according to the patient’s needs. A disruption in the support or an unrecognized complication can be devastating. Although being responsible for ECMO can be stressful, I’m confident in my ability to manage patients as a result of successfully completing an ECMO training course and having many hours of precepted pump time. To become an ECMO specialist, respiratory therapists must complete rigorous training and successfully complete a certification exam. In a department of more than 80 respiratory therapists, only 18 are ECMO specialists. I’m proud to say I’m a member of that team.

Abbie required ECMO support for three weeks. I had the pleasure of taking care of her throughout her rocky course. Abbie and her family (and her caregivers) endured many touch-and-go days, evenings, and nights. She would slowly improve, then experience horrific setbacks. During one particularly difficult time, Abbie was actually given last rites, or the Sacrament of the Sick.

One particular shift stands out in my mind. I came in at 7:00pm to find that Abbie had had a difficult day. She had developed a pneumothorax (air in the pleural cavity), and become more unstable cardiovascularly. She needed to have a chest tube placed to relieve the pressure. Placing a chest tube in a patient on ECMO is more complex because patients on ECMO need to be systemically anticoagulated. The addition of a chest tube poses a higher risk for bleeding.

By the time I came in, Abbie’s chest tube had already been placed, and while the pneumothorax had improved, she was experiencing significant bleeding from the chest

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

Clinical Narrative

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tube She had already received several blood transfusions and the bleeding was getting worse.

Amicar is a hemostatic agent that works to form clots. I'd learned about it during ECMO training. I thought amicar might be able to control, or at least decrease, the bleeding. Concerned about the amount of blood Abbie was losing and the number of transfusions she'd had, I paged the pediatric surgeon on call. We discussed auto-transfusing, which involves collecting the patient's lost blood and re-infusing it back to the patient through sterile technique. Setting up an auto-transfusion takes time, so I suggested amicar. We discussed the risks and benefits. The physician agreed it could help the situation and we should try it in conjunction with auto-transfusing.

Keeping in mind the risks associated with amicar, we started the infusion at 9:00. By the end of my shift, Abbie's bleeding was under control, and by the end of the next shift it has stopped completely.

With Abbie's bleeding under control, we could focus on maintaining her ECMO support while her lungs hopefully healed. With the help of the clinical team—many doctors, ECMO specialists, and nurses—Abbie slowly improved and was soon able to come off ECMO. She remained on conventional ventilator support for several more days until her lungs were healthy enough to support her respiratory needs. Eventually, she was taken off the ventilator and gradually improved in her own time.

Though I took care of Abbie for more than a month, my only memory of her awake was when she first arrived. I learned about her through the countless hours I spent at her bedside with her and her parents. I grew to adore Abbie, often looking at her picture and wondering when this precious little girl would finally speak again. Sometimes, I wondered *if* she would ever speak again. There were days when I would hug her parents, leave for the day, and pray and cry for her and her family.

My favorite memory of Abbie came about a week after the ventilator was removed. I would visit her every day when I worked, but she hadn't spoken in over a month, and now that she could, she was afraid to. Still, I visited her, played games with her, or just tried to make her laugh. But still, no words. Until one night, I poked my head into her room, and her mother said, "Abbie, what do you have to say to Christine?"

She looked at me with those pigtails and big, beautiful eyes, and said, "Thank-you."

Those were the most beautiful words I had ever heard.

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

Christine's considerable knowledge and skill are as evident in this narrative as her compassion for Abbie and her family. Abbie's respiratory status changed rapidly soon after her arrival and continued to change throughout her hospitalization. Christine's knowledge of complex respiratory management and her intuitive grasp of Abbie's changing status played a pivotal part in Abbie's care. Once Abbie was put on ECMO and had a chest tube placed, Christine provided vital input on how best to manage her bleeding issues. And amid all these critical decisions and interventions, Christine managed to provide support and reassurance to Abbie's family.

Thank-you, Christine.

The TRACU

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hourly for signs of bleeding, infection, airway distress, or cardiovascular shock. He is placed on spinal cord precautions with a C-collar and requires hourly neurological assessment to rule out spinal cord changes due to a displaced C1 fracture. The potential for compartment syndrome in his thigh is extremely high and requires hourly vascular checks including PVRs. The patient and his family have emotional and safety concerns so many disciplines are involved in his care including Police, Security & Outside Services, Case Management, Physical Therapy, and Social Services.

By admitting this patient to the TRACU, his need for continuous observation and monitoring is met. Any subsequent need for immediate medical or surgical intervention can be implemented quickly. After 24 hours in the TRACU, he is transferred to a unit. His entire hospital stay is four days before being discharged home.

In this case, not only were the patient's needs for intense monitoring and stabilization met by being admitted to the TRACU, his length of stay (in the ED and the hospital) were reduced enabling the ED and the ICU to accommodate other patients.

The goal when we opened the TRACU in 2005 was to decrease the length of stay in the ED, decrease the length of stay in the hospital, provide quality care in the most appropriate setting, and save healthcare dollars. Based on TRACU statistics for the last year, we are meeting our quality-care goals and improving cost effectiveness.

Says Capodilupo, "The volume of patients in the TRACU has not changed dramatically over the past year, but the acuity level has—it's much higher. That's because clinicians are using our services appropriately and sending us only their most acutely ill patients."

Currently, the four-bed TRACU admits trauma patients who are cared for by a team of trauma residents, specialized trauma nurse practitioners, and specially trained nurses.

Capodilupo's vision for the TRACU is to acquire more specialized equipment; train more ACLS-certified nurses, and offer training in adjunctive therapy, such as endotracheal ventilation, inotropic and sedative drug therapy. The goals remain the same: make beds available to help decompress the ED; centralize expert trauma nursing care; and provide high-quality care with limited healthcare dollars. A year after its inception, the Trauma Rapid Assessment Care Unit is making a difference in the lives of our patients and in the quality of care provided at MGH.

Farren certified

Scott Farren, RN, clinical service coordinator, Main Operating Room, became certified as a perioperative nurse in August, 2006.

Finn certified

Susan Finn, RN, became certified as an advanced oncology clinical nurse specialist in August, 2006.

Dahlin receives award

Constance Dahlin, RN, Palliative Care Services, received the Leading the Way Award from the Hospice and Palliative Nurses Association.

Holland receives award

Karen Holland, RN, Operating Room Nursing Service, received the Champions in Health Care Award from the *Boston Business Journal*, in July, 2006.

Arnstein receives award

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, received the Pain and Society Fellowship Award, from the Mayday Foundation, in July, 2006. He was the only nurse selected for this award in 2006.

Doherty presents

Regina Doherty, OTR/L, occupational therapist, presented, "Steering Through the Maze of Ethical Conflicts," at the New England Occupational Therapy Educational Council Annual Conference for Fieldwork Educators, MGH Institute for Health Professions, in June, 2006.

Moscowitz produces

Barbara Moscowitz, LICSW, Geriatric Medicine, served as featured expert and executive producer of the 28-minute film, *Family Matters: Coming Together for Alzheimer's*, which won a Gold Remi at the 39th Annual WorldFest Houston International Film Festival, and has been nominated for a FREDDIE (the International Health and Medical Media Awards). The film and the accompanying resource journal introduce newly-diagnosed families to the world of Alzheimer's disease.

Law presents

Suy-Sinh Law, PT, physical therapist, presented, "Maintaining Healthy Bone," at the George Schlichte Learning Center in Boston, August, 2006.

Baker certified

Medical nurse, Colleen Baker, RN, became certified in Cardiovascular Nursing by the American Nurses Credentialing Center in August, 2006.

Millar, guest panelist

Sally Millar, RN, director, Office of Patient Advocacy, was a guest panelist on the topic of "Physician Misconduct" at Harvard Medical School in July, 2006.

Atkins publishes

Patricia Atkins, RN, operating room nurse, published, "Can Your Staff Re-Start Your Anesthesia Machines?" in *Outpatient Surgery Magazine*, July, 2006.

Petruska publishes

Alex Petruska, PT, physical therapist, published, "In Vivo Kinematics of the Knee After Anterior Cruciate Ligament Reconstruction," in the *American Journal of Sports Medicine*, August, 2006.

Nurses present poster

Mary McAdams, RN; Laura Sumner, RN; Debra Burke, RN; Mary Sullivan, RN; Marion Growney, RN; Jerene Bitondo, RN; and, Mary Ellen Heike, RN, presented their poster, "Designing and Implementing an Advanced Practice Clinician Learning Needs Assessment," at the National Nursing Staff Development Organization in Orlando, Florida, in July, 2006.

French receives award

Brian French, RN, professional development and education manager, The Knight Nursing Center for Clinical & Professional Development, received the 2006 Excellence in the Role of Professional Development Facilitator, Change Agent and Consultant Award, from the National Nursing Staff Development Organization at their convention in Lake Buena Vista, Florida, July, 2006.

Flory certified

Nicole Flory, RN, became certified in Oncology Nursing by the Oncology Nursing Society in August, 2006.

Hartman certified

Teresa Hartman, RN, became certified in Oncology Nursing by the Oncology Nursing Society in August, 2006.

Klein appointed

Aimee Klein, PT, physical therapist, was appointed, legislative committee member for the American Physical Therapy Association, Massachusetts Chapter.

LaSala appointed

Cynthia LaSala, RN, clinical nurse specialist, was appointed to the American Nurses Association's Center for Ethics and Human Rights Advisory Board for a two-year term beginning July, 2006.

Seitz appointed

Amee Seitz, PT, physical therapist, was appointed committee member of the Shoulder Special Interest Group, by the Sports Physical Therapy Section of the American Physical Therapy Association, in Alexandria, Virginia, in August, 2006.

Nelson and Madigan present

Karen Nelson, RN, and Janet Madigan, RN, presented, "Patients First Initiative," at the Tennessee Hospital Association and Tennessee Organization of Nurse Executives' CNO Summit in Nashville, July 28, 2006.

Connors presents

Patricia Connors, RN, clinical nurse specialist, Perinatal Unit, presented, "The Massachusetts General Hospital CNSRFT's Implementation of Evidence-Based Practice Programs in Response to the Identification of Common Patient Problems, Level of Preparation, and Adequacy of Resources," at Sigma Theta Tau's 17th International Nursing Research Congress on Evidence-Based Practice, in Montreal, in July, 2006.

Continued on next page

Professional Achievements

continued from previous page

Myers certified

Michele Myers, RN, became certified in Oncology Nursing, by the Oncology Nursing Society in August, 2006.

Nazzaro certified

Lorraine Nazzaro, RN, became certified in Oncology Nursing by the Oncology Nursing Society in August, 2006.

Kovalski certified

Deanna Kovalski, RN, became certified in Cardiovascular Nursing by the American Nurses Credentialing Center in August, 2006.

Kindman certified

Mary Kindman, RN, became certified in Cardiovascular Nursing by the American Nurses Credentialing Center in July, 2006.

Opolski certified

John Opolski, RN, became certified in Oncology Nursing by the Oncology Nursing Society, in August, 2006.

Staff Perceptions of the Professional Practice Environment

Your Opinion Counts!

Clinicians will receive both a paper version and an on-line version of The Staff Perceptions of the Professional Practice Environment Survey, and may complete either

Clinicians who complete the survey (paper or on-line) will be eligible to receive one of 40 gift certificates to The MGH General Store & Flower Shop worth $25

For more information contact Eric Campbell at 726-5213

Fitzmaurice appointed treasurer

Joan Fitzmaurice, RN, director, Office of Quality and Safety, was appointed to a second two-year term, as treasurer of the Massachusetts Coalition for Prevention of Medical Errors, in July, 2006.

Perry receives PhD

Donna Perry, RN, professional development coordinator, The Knight Nursing Center for Clinical & Professional Development, received her PhD from Boston College in June, 2006.

Call for Nominations

Norman Knight Preceptor of Distinction Award

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

Nurses may nominate nurse colleagues whom they know to be strong educators, preceptors, mentors, and coaches. Nomination forms will be available on all inpatient units, in The Knight Nursing Center for Clinical & Professional Development (located on Founders 3 effective October 1st), or upon request by e-mail

Nominations must be received by November 10, 2006

The Norman Knight Preceptor of Distinction Award ceremony will be held March 8, 2007. Recipient will receive a certificate and professional-development award in the form of tuition for a nursing course or a program of study with a clinical nurse specialist

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

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Submission of Articles

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

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

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October 19, 2006

Endoscopy nurse finds closure after ten years

—by Kathy DeGenova, RN, Endoscopy Unit

In order to experience nursing, you have to have a nursing experience. That may not sound profound, but it's ever so true. One of the things we're taught in nursing school is not to get too attached to patients. We need to be empathetic and at the same time distance ourselves. Sometimes, that's easier said than done. Some patients stay with us forever.

I'd like to share a nursing experience that began ten years ago in the Medical Intensive Care Unit (MICU). I cared for 'Danny,' a 22-year-old senior at Northeastern University. He was a gravely ill young man who'd been admitted with meningococcal septicemia. His parents were in their early 40s with three sons. Joe, the father, was a local police officer. They were young and scared; their son, Danny, was not expected to survive. His kidneys were failing and he was feverish all the time. His body was shutting down and septic emboli were attacking his feet and fingers. The handsome child was intubated with IVs everywhere, and we were going to do CVVH, a new form of round-the-clock dialysis at the bedside.

We were all concerned. I vividly remember the room, the IVs, the nurse who gave me report, what Danny looked like beneath the cooling blanket, the smell of lanolin, and so many other details. As nurses, we try to support the patient and family—in this case, parents whose son was probably not going to leave the hospital. We also try to support each other in these emotionally trying situations.

Much to the surprise of his caregivers, Danny left the ICU many months later, alive and in improving health. After he left the hospital, I never knew what happened to him. The family lived in the next town over from me, and I thought I might run into Joe some time, but I never did. But even as the years passed, I never forgot them.

I'm now a nurse on the Endoscopy Unit on Blake 4. Recently, I saw Joe's name on one of our cases. The age and local telephone number told me it was Danny's father. I was so happy. I asked some of my co-workers who'd been in the MICU when I cared for Danny if they remembered him. No one did, which made me a little sad. I couldn't believe no one remembered.

When Joe came in, I went to him immediately. I introduced myself and reminded him that I had cared for Danny ten years before. I told him I often thought about them and wondered how Danny was. He barely remembered me, but vaguely recalled that I had lived in the next town over. We talked about Danny, and I learned that he had been diagnosed with diabetes, his kidneys had totally failed requiring a kidney transplant (his mom had donated one of her kidneys a few years ago). Danny was permanently disabled, but had a part-time job at the State House. I was so relieved to know he had survived.

Kathy DeGenova, RN
staff nurse, Endoscopy Unit

I was looking forward to seeing Danny's mom, who was picking Joe up after his procedure. At around 4:30, I was informed that Joe's escort was in the waiting area. I went downstairs, but didn't see her. I asked if there was an escort for Mr. B, and a young man raised his hand. I assumed it was another of Joe's sons. I introduced myself and mentioned that I was one of the nurses who had cared for his brother when he was sick.

The young man said, "Which brother?"

"Danny," I said.

He looked at me and said, "I'm Danny."

I almost lost it. Sitting before me was a handsome, 32-year-old man, husky, healthy-looking, wearing a baseball cap. We had a great conversation. Thankfully, he didn't remember me or the experience that knocked on heaven's door. We hugged. I finally felt like I had closure to questions that had never left my mind.

It really reinforced the belief that as nurses, we do good work. It was so great to be able to see the end result. I held it together until I got home and then cried my eyes out. Not tears of sadness, but incredible joy that only I understood. I had been at the right place at the right time, and now I could rest easy, knowing that Danny was okay.

October is Domestic Violence Awareness Month

"Teens and relationships: what every parent needs to know"
Thursday, October 5th—12:00–1:00pm
Thier Conference Room

"Something my father would do: overcoming the legacy of family violence"
Wednesday, October 11th—11:45am–1:00pm
Burr Conference Rooms (lunch provided)

"MGH Men Against Abuse"
October 11th and 20th—7:00– 9:00am
Central Lobby

"Triumph: to achieve victory, to survive"
October 20th—11:45am–100pm
Burr Conference Rooms (lunch provided)

For more information, contact
Bonnie Zimmer at 4-0054

Educational Offerings

When	Description	Contact Hours
October 12 and 19 8:00am–4:00pm	**Oncology Nursing Society Chemotherapy-Biotherapy Course** Yawkey 2220	16.8 for completing both days
October 12 and 13 Day 1: 7:30am–4:00pm Day 2: 8:00am–1:00pm	**Pediatric Advanced Life Support (PALS) Certification Program** Training Department, Charles River Plaza	- - -
October 12 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
October 13 and 30 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
October 17 11:00am–12:30pm	**Chaplaincy Grand Rounds** "Guided Imagery." Sweet Conference Room	- - -
October 18 11:00am–12:00pm	**Nursing Grand Rounds** "Zambia Nursing Project." Haber Conference Room	1.2
October 23 and 24 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: SRC-3110; Day 2: VBK401	14.4 for completing both days
October 25 8:00am–2:00pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
October 26 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
October 26 8:00am–4:30pm	**Psychological Type & Personal Style: Maximizing Your Effectiveness** Training Department, Charles River Plaza	8.1
October 26 1:30–2:30pm	**Nursing Grand Rounds** "Pulmonary Hypertension." O'Keeffe Auditorium	1.2
October 31 8:00am–12:00pm	**BLS Certification–Heartsaver** VBK601	- - -
November 1 8:00am–4:00pm	**Assessment and Management of Patients at Risk for Injury** Haber Conference Room	TBA
November 1 and 8 8:00am–4:30pm	**Phase II: Wound Care Education** Training Department, Charles River Plaza	TBA
November 2 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
November 2 8:00–4:00pm	**Oncology Nursing Concepts: Advancing Clinical Practice** Yawkey 2210	TBA
November 3, 7, 10, 14, 17, 21 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** Mount Auburn Hospital	44.8 for completing all six days
November 3 8:00am–4:00pm	**Creating a Therapeutic and Healing Environment Part II** O'Keeffe Auditorium	- - -
November 8 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
November 8 4:00–5:00pm	**More than Just a Journal Club** Yawkey 2210	1.2
November 8 11:00am–12:00pm	**Nursing Grand Rounds** "Zambia Nursing Project." Haber Conference Room	1.2
November 8 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -

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.

Looking back on 40 years at MGH

On Tuesday, September 12, 2006, friends and colleagues of Darryl Firenze, RN, came together to celebrate her 40 years of service to MGH. Firenze started as a full-time staff nurse in 1966 and has seen many changes in the course of her career. From four generations of OR leadership to radical advances in surgical technology, Firenze has helped usher in new nurses and surgical technologists for four decades.

Says associate chief nurse, Dawn Tenney, RN, "Darryl has always approached her work with a smile, a sense of humor, and a commitment to putting the patient first. She was one of my preceptors when I started at MGH as a student surgical technologist in 1974. It has been a privilege to know and work with her."

Said Firenze, "Thank-you for this wonderful celebration. It's awe-inspiring to see four cakes and know they each represent ten years of my life! Thank-you again for this incredible recognition."

(Photos by Paul Batista)

On the occasion of her 40th anniversary of service to MGH, operating room staff nurse, Darryl Firenze, RN (front row, third from right) celebrates with friends and colleagues, including associate chief nurse, Dawn Tenney, RN (left). Four cakes were prepared for the occasion, one for each decade of service to MGH

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