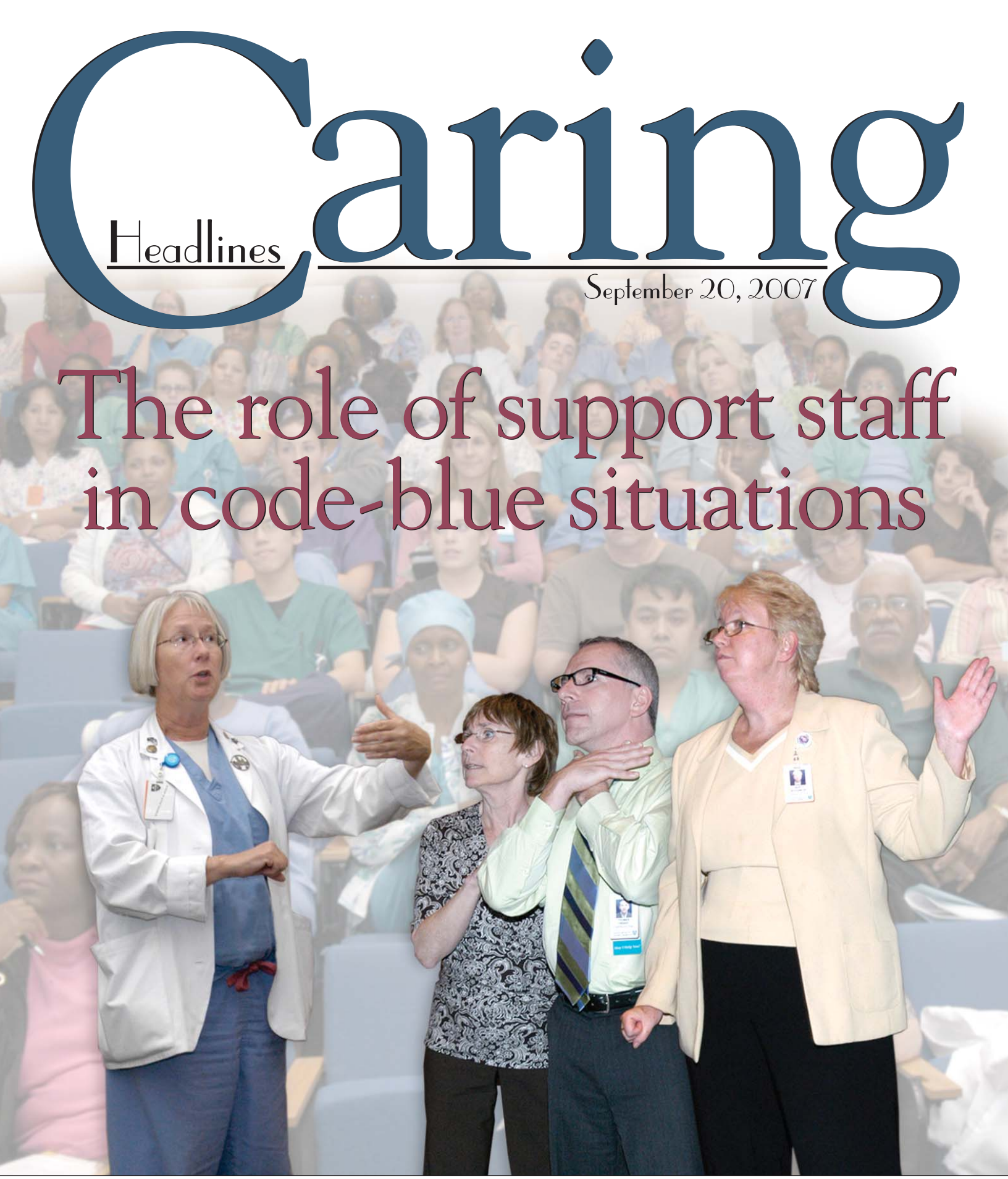
Caring Headlines
September 20, 2007

The role of support staff in code-blue situations



In the September 12, 2007, OA/PCA/USA Connections session entitled, "The Role of Support Staff in Code Blue Situations," (l-r): Mary O'Brien, RN; Roberta Raskin Feldman, RN; Tom Drake; and Mary McAdams, RN, of the Norman Knight Nursing Center for Clinical & Professional Development, talk about support-staff response in situations such as: respiratory arrest, stroke, obstructed airways, and cardiac arrest.

The newsletter for Patient Care Services
Massachusetts General Hospital

Return to school brings new initiatives, new leadership, new partnerships

As summer draws to a close, students across the country are returning to school and academic pursuits. As a teaching hospital, this is a time of renewal and new beginnings for MGH, as well. I'm happy to report that Janis Bellack, RN, has been named president of the MGH Institute of Health Professions (IHP), the independent graduate school and academic affiliate of MGH that offers post-baccalaureate-degree and certificate programs in Nursing, Physical Therapy, Speech-Language Pathology, Clinical Investigation, and Medical Imaging. Janis comes to us from the Massachusetts College of Pharmacy and Health Sciences where she served as president of Academic Affairs and provost and professor of Nursing and Health Sciences.

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

> I had the pleasure of addressing new and returning students at IHP's orientation ceremony. I assured them that during their clinical rotations they could expect strong, patient-centered leadership; opportunities to participate in cutting-edge care; an integrated, multi-disciplinary team approach; and opportunities to realize their personal and professional goals.

On September 4, 2007, I had the pleasure of addressing new and returning students at IHP's orientation ceremony. I assured them that MGH, a world-class Magnet hospital, was here to support them during this important leg of their educational journey. I assured them that during their clinical rotations they could count on us for strong, patient-centered leadership; opportunities to participate in cutting-edge care; an integrated, multi-disciplinary team approach; mutual respect and support; and opportunities to realize their personal and professional goals.

I'm happy to report that a new clinical rotation tracking system is being explored to track students doing clinical rotations throughout the Partners HealthCare System. This broad-based, unified, automated tracking system would provide enhanced

continued on next page

Our efforts to nurture the next generation of clinicians are crucial to ensuring a constant, competent, and caring workforce in the future. As we move forward with this work, we will continue to forge partnerships and put mechanisms in place to share our knowledge and expertise with the newest members of our professions.

communication with students during their clinical rotations, help establish strong relationships between students and their host hospitals, and give us a way to reach out to students who are approaching graduation. This would provide an effective means to strengthen our clinical workforce pipeline. We're still in the early stages of this work; I'll keep you informed as we move forward with this initiative.

And speaking of pipelines, we've entered into an exciting new relationship with the University of Massachusetts College of Nursing and Health Sciences. In an effort to increase the number of racially and ethnically diverse nurses in our workforce, we have created the UMass/Partners Clinical Leadership Collaboration for Diversity in Nursing. Under this new program, racially and ethnically diverse students enrolled in the UMass Nursing Program who meet the criteria (grade point average of 3.0 or higher; demonstrate leadership in the academic setting; demonstrate excellence in clinical practice; and participate in community activities) will be invited to apply for this educational opportunity. The program offers on-site clinical experiences; tuition-reimbursement and reimbursement for other fees and expenses as applicable; regular mentoring sessions with experienced nurses of diverse backgrounds; and opportunities to meet and network with colleagues.

If an applicant meets the criteria and submits an application, he or she will be interviewed by a review board as the final step in the acceptance process. To support the workforce pipeline, students accepted into the program will be asked to work at their host hospitals following graduation for the same amount of time they participated in the program.

Applications are already being received, and we expect the first class of students in the UMass/Partners Clinical Leadership Collaboration for Diversity in Nursing to start this month. We hope to enroll as many as 30 students through this new initiative.

These initiatives represent only a few of the partnerships we share with local schools and universities. Last year, through affiliations with 28 nursing schools, we offered on-site clinical education to more than 1,200 nursing students (997 in group-instruction situations; 234 individually precepted).

Our efforts to nurture the next generation of clinicians are crucial to ensuring a constant, competent, and caring workforce in the future. As we move forward with this work, we will continue to forge partnerships and put mechanisms in place to share our knowledge and expertise with the newest members of our professions.

Updates

I'm pleased to announce that Nancy Kelly, RN, nurse practitioner, has joined the staff of Medical Teams 4 and 5.

Sharon Zisk, RN, has accepted the position of clinical nurse specialist on the White 9 Medical Unit effective immediately.

In this Issue

ProTech graduation: heralding the next generation of healthcare workers

— by Galia Wise, MGH/EBHS partnership manager

Every year, MGH celebrates the accomplishments of East Boston High School and Health Careers Academy students who successfully complete the ProTech Program, a structured, two-year program combining classroom instruction with work-based learning experiences to introduce students to the world of health care. ProTech internships encompass a variety of positions throughout the hospital and expose students to different levels of job responsibility. The program demands a great deal of students, including the ability to balance work, academic, social and family obligations.

On August 23, 2007, staff, family members, and guests came together in the Thier Conference Room to honor the nine East Boston High School students who successfully completed the rigorous program this year.

(Photo by Abram Bekker)

Graduates of the 2007 ProTech Program below with MGH/EBHS partnership manager, Galia Wise (front right); senior vice president for Human Resources, Jeff Davis (back left); Michael Rubin, headmaster, EBHS (back); keynote Sspeaker, Dr. Jessie Kimbrough-Sugick (back row, third from right); and Joan Quinlan, director, MGH Community Benefit Program (back row, second from right).

The graduation ceremony included remarks by Galia Wise, MGH/EBHS partnership manager, Jeff Davis, senior vice president for Human Resources, Michael Rubin, headmaster of East Boston High School, and keynote speaker, Jessie K. Kimbrough-Sugick, MD, Aetna/DSC healthcare disparities fellow at the MGH Disparities Solutions Center. Speakers congratulated graduates on their achievements, offered words of wisdom, and thanked students and ProTech supervisors for their hard work and dedication.

Llanira Ruiz, a 2007 ProTech graduate who interned in the Center for Comparative Medicine (CCM), spoke on behalf of the graduating class. Said Ruiz, "The skills, training, and experience I gained through ProTech sets me apart from other high school graduates. My internship helped me develop skills I'll be able to use in my future career. Coming to MGH every day after school helped me learn discipline and balance. I had to find time for school, work, and family responsibilities." Ruiz' speech, in which she talked about being the first person in her family to go to college, received a standing ovation. Ruiz will continue to work at CCM part-time while attending Wheelock College where she plans to study Social Work, a long-time dream of hers.

This year's graduating class included a high school salutatorian, two POSSE scholars, and two graduates enrolled in nursing programs. All nine graduates have been accepted into post-secondary institutions with the majority pursuing careers in health services. Four graduates will continue their employment at MGH on a part-time basis while attending college.

The ProTech Program is a School Partnership initiative of the MGH Community Benefit Program and is funded by Partners Human Resources. For more information about ProTech, please call Galia Wise at 4-8326.

New Graduate in Critical Care Nursing Program

— by Gail Alexander, RN, clinical educator

On August 30, 2007, seven nurses from MGH and the North Shore Medical Center were recognized for successfully completing the New Graduate in Critical Care Nursing Program. The 2007 graduating class brings the total number of graduates of this program to 108.

Certificates of completion went to MGH nurses:

- Alicia D'Agostino, RN, Cardiac ICU
- Bernadette Lord, RN, Cardiac Surgical ICU
- Michael Kelly, RN, Medical ICU
- Meghan McCourt, RN, Pediatric ICU
- Ashley Lamontagne, RN, Pediatric ICU

Edwin Aroke, RN, and Marco Loi, RN, of the North Shore Medical Center ICU also received certificates of completion.

At the 12th graduation celebration, speaker, Brenda Miller, RN, nursing director for the Pediatric Intensive Care Unit, noted that 25% of staff in the PICU are graduates of this six-month, intensive orientation program. Said Miller, "Over time as these nurses have developed their own practice, many have influenced care in the unit and become preceptors to others participating in the program."

(Photo by Abram Bekker)

Program coordinator, Gail Alexander, RN (back left) with 2007 New Graduate in Critical Care Nursing Program graduates (standing, l-r): Edwin Aroke, Michael Kelly, Meghan McCourt, Marco Loi, (and seated): Ashley Lamontagne, Alicia D'Agostino, and Bernadette Lord.

New graduate, Ashley Lamontagne, RN, shared a narrative of her experience in the program, describing a situation that required collaboration between many disciplines to manage the post-operative pain of a six-year-old boy. Lamontagne and her preceptor were assigned to care for the boy who had been re-admitted for pulmonary toilet following a liver transplant. Says Lamontagne, "I look back and see myself standing in the background, listening, watching, and I realize how far I've come in six months. I don't stand and watch anymore; now my preceptor stands and watches me."

Heidi Simpson, RN, a 2001 graduate of the program and Lamontagne's preceptor, asked Lamontagne to describe her transition from student to professional nurse. Lamontagne said the support she received from the PICU staff, particularly her preceptors, made all the difference in the world.

Gail Alexander, RN, program coordinator, thanked the many contributors who made the program so successful, including senior vice president for Patient Care, Jeanette Ives Erickson, RN, for her vision and continued support; nursing directors and clinical nurse specialists for creating an environment in which learning can take place while maintaining quality patient care; clinicians who shared their expertise as faculty; and the preceptors without whose commitment and guidance the program would not be possible.

For more information about the New Graduate in Critical Care Nursing Program, visit the Norman Knight Nursing Center for Clinical & Professional Development website at: www.mghnursing.org or contact Gail Alexander at 617-726-0359. For application information, call David Pattison in Human Resources at 617-726-5593.

‘A little humanity’ goes a long way on Bigelow 11 General Medical Unit

My name is Emily Stieglitz-Shell (Emi), and I have worked on the Bigelow 11 General Medical Unit for one year, my first year as a nurse. I cared for ‘Mike’ earlier this year, every day for the better part of two months. But he had an impact on me disproportionate to the amount of time we spent together. Mike was the first patient I was really able to give myself to. Before caring for Mike, my focus was mainly on providing safe care through a series of tasks. I would generally only go to my patients’ rooms with a specific duty or list of duties in mind. I was kind and friendly and made appropriate small talk and provided emotional support as I was able, but I never found it possible to really be myself with them. Mostly I was so focused on keeping my day ‘under control’ that I’d end up cutting conversations short, often I’m sure, coming off as flustered and unable to handle the emotional reality of my patients’ conditions.

I was so focused on keeping my day ‘under control’ that I’d end up cutting conversations short, often I’m sure, coming off as flustered and unable to handle the emotional reality of my patients’ conditions.

Mike, a single man in his 50s, was admitted to our unit last winter after being found in a grocery store overcome with hepatic encephalopathy (a kind of toxic liver failure). I was told he’d been admitted to our unit many times in the past, but this was my first time meeting him. His condition, brought on by hepatitis C acquired from IV drug abuse, had advanced to where he was taking large doses of lactulose daily to maintain a clear mental status. Mike had been admitted to stabilize his mental status. Our job as nurses was to keep Mike safe, convince him to take his medications, and support him through this time of change and loss. Upon meeting him, it was immediately apparent that this was going to be a challenge.

Emily Stieglitz-Shell, RN
Bigelow 11 General Medical Unit

Mike had been functioning in society, albeit poorly. He’d been living in a room at a semi-shelter with assistance from a visiting nurse and a caseworker from Social Services. He’d been admitted on many occasions after not taking his medication, and this time he would be deemed mentally incompetent to leave or refuse treatment and would require placement at a care facility for safe discharge.

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My sister always says that everyone is born with a gift inside that's meant to be given to the world. This gift is like a piece of fruit; if we don't give it away, it will rot inside and shrivel our souls. Through caring for Mike, my first year as a nurse, I learned how to give my gift to the world.

Initially, I approached Mike's care the same way I had every other patient, focusing on things I needed to get done, medication-administration, assessment, etc. But Mike made it clear on our first day together that he wouldn't tolerate my 'distance.' I was friendly but reserved. The more I tried to be efficient and business-like, the slower he'd go, the more he'd protest his care, the more he'd resist my requests. On that first day, after a morning dose of lactulose, he was alert enough to want to get out of bed, so I assisted him with transfer to his chair, which he was able to do on very unsteady legs. I asked him to call me if he wanted to get up; I thought this was a reasonable request. I see now that to Mike, I was imposing on his freedom, so he became determined to get around my 'rules.' After many attempts to cajole him to take his medication and stay in the chair when I wasn't present, I became very frustrated. All I could think of was the time ticking away, all the tasks I had to finish before the end of my shift, and what the night nurses would think if I didn't get everything done. Mike was taking up my time with something so (seemingly) silly!

Not knowing what else to do, I sat on his bed and said, "Mike, what's going on here?"

I would come to know that feeling of exasperation well in the weeks to come. That feeling has taught me more than any feeling of accomplishment ever could. That first morning, as I sat in his room, Mike told me he was done with doctors and nurses, done with hospitals and social workers and people who thought they knew what was best for him. But mostly, he was done with the humiliating bowel incontinence he suffered (from the lactulose) that made doing simple things impossible. All he wanted was to be able to go to his favorite coffee shop and chat with friends again. He told me he was ready to stop treatment and die. I sat and listened. I didn't tell him he was wrong to have these feelings of frustration and grief. It was at that point I think that we both began seeing each other differently.

As the days passed, he continued to tell me about himself, his work, his relationships, his interests. I saw that taking the time to talk with Mike was necessary in order to provide the treatments his body needed. One day as I sat in the chair beside his bed, I brought up the subject of his discharge, and he began to cry. Tears rolled down his cheeks as he revealed his profound disappointment and grief at how is life had turned out — how he'd contracted Hepatitis C and the guilt he felt about doing this to himself. I felt lost again, but this time not in frustration, in helplessness. I couldn't tell him to hang in there and things would get better, or that everything would be alright. I couldn't offer him hope, or medication, or pillows, or even more time to talk. All I could give him was my humanity. I let him know his mistake was just a human error; it didn't make him a bad person. I told him his humiliation at being incontinent was understandable but that I saw him as a man, and I respected him. I allowed myself to be open to his reality so I could respect his pain, and he responded by unburdening himself of his guilt.

With Mike, I allowed myself to become entangled in emotional weeds. And through that entanglement I became able to give what I became a nurse in the first place to give — myself.

My sister always says that everyone is born with a gift inside that's meant to be given to the world. This gift is like a piece of fruit; if we don't give it away, it will rot inside and shrivel our souls. Through caring for Mike, in my first year as a nurse, I learned how to give my gift to the world.

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

What a powerful narrative. Emi's story captures a pivotal moment in her professional growth and development. Initially, she saw Mike as a patient with a set of needs that had to be met. When he resisted her attempts to accomplish her 'tasks,' Emi confronted him and ultimately discovered her own 'humanity.' By allowing herself to interact with Mike in a genuine, human way, she enabled them both to have breakthrough experiences. I think every veteran clinician can relate to this story.

Thank-you, Emi.

The CNS Wound Care Task Force: promoting evidence-based nursing practice

— submitted by Virginia Capasso, RN; Jacqueline Collins, RN; Catherine Griffith, RN; Susan Kilroy, RN; Cynthia LaSala, RN; Ann Martin, RN; Jill Pedro, RN; and Susan Wood, RN on behalf of the CNS Wound Care Task Force

Almost three years ago, clinical nurse specialists recognized a need for consistent, evidenced-based, around-the-clock wound care for patients throughout MGH. The CNS Wound Care Task Force was convened in August, 2004, compris of clinical nurse specialists who were experts in, or had a high level of interest in, the management of cutaneous wounds.

Mission Statement:

The CNS Wound Care Task Force creates an integrated wound-care program that builds on the existing infrastructure and promotes care of patients with wounds that is seamless, comprehensive, collaborative, evidenced-based, effective, caring, cost-effective, and innovative.

During the following year, the task force drafted a mission statement (see pull-quote above), a philosophy statement (see pull-quote on opposite page), and an infrastructure to support evidenced-based wound care.

The infrastructure is two-pronged encompassing an array of wound-care specialists and focused educational programming. Specialists fall into four categories, two of which have been the focus of development over the past three years. Through the efforts of the CNS Wound Care Task Force, unit-based clinical nurse specialists are now designated as first-line consultants for wound care on units. In order to streamline consults, this information has been added to house officer handbooks. Unit-based operations coordinators and operations associates have been educated about how to triage wound-care consults to their clinical nurse specialists. And through intensive education and ongoing consultation, a number of staff nurses have been prepared to act as wound-care champions, making contemporary, evidence-based knowledge of wound care available throughout the week, including off-shift and weekends.

Initially, the educational component consisted of a two-day continuing education program. The program includes lectures and skills labs and features educational presentations on the physiology of wound healing and patho-physiology of chronic wounds, general principles of wound healing, wound-care products and treatments, and management of various types of wounds (vascular ulcers, pressure ulcers, burns, radiation injuries, and atypical wounds). Cognitive skills stations focus on wound assessment, serial treatment decisions, and documentation. Psycho-motor skills stations concentrate on application of the Vacuum-Assisted Closure (VAC)™ dressing, application of the Unna's multi-layer compression dressing, and measurement of the ankle-brachial index (ABI). Pre- and post-session tests are administered to participants to evaluate their knowledge of the information presented.

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Philosophy: Wound care is a complex, interdisciplinary process that requires initial and periodic evaluation in order to craft or revise the plan of care. The goal of wound care is to accelerate healing by removing barriers to healing while using the most efficacious and cost-effective methods of wound management.

The two-day Wound Care Education Program was offered seven times between November, 2005, and January, 2007. A total of 410 staff nurses and advanced practice nurses have completed the program. The program has been very well received with participants reporting great interest in the clinical decision-making segment.

In a follow-up survey of the unit-based clinical nurse specialist role, three themes emerged:

- Units with the highest attendance at the Wound Care Education Program (15-25 attendees) reported the most positive outcomes, that is, a change in staff skill, growth in wound-care expertise, increased staff autonomy with wound-care decision-making, and a change in the reliance on the clinical nurse specialist to make wound-care decisions. Units with lower participation in the Wound Care Education Program generally seemed to have a lower prevalence of patients with wounds and had difficulty justifying staff attending a two-day course away from the unit
- Clinical nurse specialists reported increased staff autonomy with wound care and appropriate risk-taking. They noted a decrease in the number of wound-care consults and a sense of increased staff-nurse ownership and empowerment regarding wound care on the unit. Clinical nurse specialists observed staff nurses making independent, accurate assessments and appropriate decisions regarding products, creating an appropriate plan of action with re-assessment and earlier re-formulation of the initial plan as needed
- The role of clinical nurse specialists related to wound care has changed since the Wound Care Education Program was implemented and a number of specially trained staff nurses are available on patient care units. Staff are managing wounds that in the past would have needed a formal consult with a clinical nurse specialist. In many cases, the nature of clinical nurse specialists' involvement in wound care consultation has shifted from prescription to validation of a plan of care

Clinical nurse specialists unanimously agree that the two-day program has been a great success and should continue. A one-day wound care class has been added to ensure consistent knowledge of wound care among new graduates and all new nurses hired at MGH.

Evidenced-based wound care is thriving at MGH. Unit-based clinical nurse specialists and staff-nurse wound-care champions are the cornerstones of the program. Multi-level educational programming is advancing practice and enhancing nursing knowledge.

For more information about the Wound Care Education Program, call the Norman Knight Nursing Center for Clinical & Professional Development at 6-3111.

Members of the CNS Wound Care Task Force (l-r): Cynthia LaSala, RN; Virginia Capasso, RN; Jill Pedro, RN; Jacqueline Collins, RN; Susan Kilroy, RN; and Catherine Griffith, RN (Not pictured: Ann Martin, RN, and Susan Wood, RN)

Magnet re-designation the forces of magnetism

— by Suzanne Cassidy, senior project specialist

On October 31, 2007, MGH will submit written evidence to the American Nurses Credentialing Center (ANCC) to complete Phase I of becoming re-designated as a Magnet hospital. (Phase II is a site visit). The ANCC has established 14 Forces of Magnetism, or characteristics of exemplary nursing practice that define what it means to be a Magnet hospital. In a series of articles that began in June, *Caring Headlines* is highlighting each of the forces of magnetism.

Force 7: Quality improvement

Quality-improvement activities are viewed as educational. Nurses at all levels of the organization, together with other members of the healthcare team participate in the quality-improvement process and perceive the process as one that improves the quality of care delivered within the organization.

The infrastructure within Patient Care Services provides the resources, education, and support needed to empower nurses and their colleagues to contribute to and lead organizational and unit-based quality-improvement initiatives. For example, The Institute for Patient Care provides the structure to meet patients' needs; advance care-delivery systems; and foster, study, and promote innovations in care. Within the Institute, the educational programs of The Norman Knight Center for Clinical & Professional Development provide staff and leadership with the educational support needed to engage in quality-improvement activities within the organization.

The newest component of the Institute, The Center for Innovations in Care Delivery, offers resources and support to bring nurses and interdisciplinary teams together to identify opportunities to improve care, evaluate the impact of care, and implement changes to enhance care.

Staff nurses participate in the quality-improvement process through their involvement in collaborative governance. Over the past ten years, collaborative governance has evolved into an effective infrastructure of resources, education, and support to facilitate staff involvement in quality-improvement activities, both departmentally and at the unit level. Collaborative governance committee members receive formal orientation and training and ongoing mentoring and support from coaches. They are supported by many activities and an annual event to celebrate the success of their work.

Force 8: Consultation and resources

Adequate consultation and other human resources are available. Knowledgeable experts, particularly advanced practice nurses, are available and play an integral role in care delivery.

More than 360 nurses at MGH function in advanced practice roles as defined by the ANCC. These nurses provide a wealth of clinical knowledge and expertise to support the delivery of high-quality care throughout the institution.

More than 60 clinical nurse specialists practice in unit-based and departmental roles; more than 290 nurse practitioners practice in primary care, outpatient specialty practices, and other roles outside the practice setting; 15 nurse midwives are responsible for approximately 900 inpatient deliveries per year or 30% of all deliveries at MGH; and 22 nurse anesthetists provide anesthesia services to patients in all areas of the hospital.

These clinicians manage and support numerous clinical programs throughout the hospital including the Wound Care Education Program, the Tracheostomy Quality Team, the Pain Relief Program, the Palliative Care Program, and the Pediatric Orthopedic Team.

A strong infrastructure that supports and promotes quality improvement and a wealth of resources to support clinicians in their practice are two more characteristics that make MGH a Magnet hospital.

For more information, contact Suzanne Cassidy, senior project specialist, at 6-0368.

The 14 Forces of Magnetism

1) Quality of nursing leadership
2) Organizational structure
3) Management style
4) Personnel policies and programs
5) Professional models of care
6) Quality of care
7) Quality improvement
8) Consultation and resources
9) Autonomy
10) Community and the healthcare organization
11) Nurses as teachers
12) The image of nursing
13) Interdisciplinary relationships
14) Professional development

Educational Offerings – 2007

September 28

Basic Respiratory Nursing Care

Bigelow Amphitheater
12:00 – 4:00pm
No contact hours

October 1

CPR Re-Certification

Founders 325
7:30 –10:30am and 12:00–3:00pm
No contact hours

October 1

Obstetrical Excellence: Focus on Patient Safety, Teamwork and Collaboration

O'Keeffe Auditorium
8:00am – 4:30pm
Contact hours: TBA

October 2&3

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2220
8:00am – 4:00pm
Contact hours: TBA

October 2

BLS Certification for Healthcare Providers

Founders 325
8:00am – 12:30pm
No contact hours

October 3

Cardiac/Vascular Nursing Certification Preparation Course

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: TBA

October 9

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

October 10

New Graduate RN Development Seminar I

Training Department
8:00am – 12:00pm
Contact hours: 3.6
(for mentors only)

October 10

Nursing Grand Rounds
"Quality Improvement and TPS"

Haber Conference Room
11:00 – 12:00pm
Contact hours: 1

October 10

OA/PCA/USA Connections
"Disaster Preparedness"

Bigelow 4 Amphitheater
1:30 – 2:30pm
No contact hours

October 12&29

ACLS Provider Course

Day 1: 8:00am – 3:00pm
O'Keeffe Auditorium

Day 2: 8:00am – 3:00pm
Thier Conference Room
No contact hours

October 15

Special Procedures/Diagnostic Tests: What You Need to Know

O'Keeffe Auditorium
8:00am – 4:00pm
Contact hours: TBA

October 15&22

Care of Patients with Vascular Disease

Simches Conference Room
8:00am – 4:00pm
Contact hours: TBA

October 17

Workforce Dynamics: Skills for Success

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: 6.5

October 17

Intermediate Arrhythmia

Yawkey 10-660
8:00 – 11:30am
Contact hours: 3.5

For more information about educational offerings, go to: http//mghnursing.org, or call 6-3111

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Next Publication
October 4, 2007

Clinical Recognition Program retreat

The retreat spotlighted our focus on professional reflection, which speaks to our evolution as an organization. As a hospital, we've come to appreciate the importance of reflecting on practice, a perspective not widely held prior to implementation of the Clinical Recognition Program.

Question: I heard there was a retreat recently related to the Clinical Recognition Program. Is that true?

Jeanette: Yes. A full-day retreat was held on June 12, 2007, in which Patient Care Services and Clinical Recognition Program leaders came together to discuss issues specifically related to the Clinical Recognition Program.

Question: What did discussion center around?

Jeanette: We've heard from staff that the Clinical Recognition Program provides important recognition of their work and contributions. The retreat was an opportunity for us to take stock of what we've accomplished and where we need to go with this program. The focus was twofold: we talked about reflective practice as a key element of professional development and a linchpin of the Clinical Recognition Program. And we talked about the Review Board's process for reviewing and evaluating portfolios. The Review Board presented a mock portfolio and took attendees through the whole process including portfolio review and interview. Discussion was lively and encompassed the wide range of perspectives that exist within and among the disciplines of Patient Care Services.

Question: What were the major outcomes?

Jeanette: We accomplished several things. First, the retreat was a great opportunity to introduce new leaders within Patient Care Services to the Clinical Recognition Program. Since developing the program, many new leaders have joined our ranks, and this was a valuable learning experience for them.

Second, the retreat spotlighted our focus on professional reflection, which speaks to our evolution as an organization. As a hospital, we've come to appreciate the importance of reflecting on practice, a perspective not widely held prior to implementation of the Clinical Recognition Program.

And last but not least, the vital role of coaching was modeled for attendees.

Question: What's next for the Clinical Recognition Program?

Jeanette: The ongoing success of this program depends on the engagement of front-line managers with their staff. The retreat did much to create a common perspective and dispel myths about the program. We need that message to be heard and embraced by clinicians throughout Patient Care Services.

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September 20, 2007

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