

PP NURSES	N	HRS	FTE	#	RATE
1/4	430	108	100	10	0.3
SD	"	29	11	9.0	16
AC	2	8	1.1	132	0
TH	1/4	29	11	63	15
TOTAL	1249	45990	1149.76	11966	965

Caring

Headlines

July 3, 2008



Graf retires: MGH
pays tribute with tears
and testimonials

(See page 6)

Former, long-time director of PCS Financial Management Systems, Chris Graf, RN (foreground) with friends and colleagues at her farewell party, June 24, 2008.

Nurse staffing ratios back in the news

Among other things, this bill seeks to impose across-the-board, around-the-clock, nurse-patient ratios, essentially eliminating the flexibility and individualized care required to meet the needs of every patient.

As many of you are aware, the issue of government-mandated nurse staffing levels is back in the news with the recent vote of approval in the Massachusetts House of Representatives on bill H-4783 (formerly H-4714), the Patient Safety Act. In the Commonwealth of Massachusetts, approval by both the House of Representatives and the Senate as well as the signature of the governor are required for a bill to become law. Bill H-4783 is slated to reach the Senate some time before the legislative session ends on July 31, 2008.

Among other things, this bill seeks to impose across-the-board, around-the-clock, nurse-patient ratios, essentially eliminating the flexibility and individualized care required to meet the needs of every patient.

My thoughts on the wisdom of this bill have not changed since it was first introduced in 2006. At a time when patient-care needs are more complex and demanding than ever before, 'one-size-fits-all' staffing is not the answer.

I am reminded of a clinical narrative that appeared in *Caring* recently recounting the care provided to a severely ill woman who weighed more than 400 pounds. At times during her hospitalization, her care required the participation of every nurse on the unit. In a situation like this, can we really provide high-quality care to all patients without taking into account the skill, experience, knowledge, and leadership capabilities of all nurses involved with providing that care?

One of our colleagues, Maureen Hemingway, RN, clinical service coordinator for General and Vascular



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

Surgical Services in the Main Operating Room, in a research paper for her Health Policy and Politics class wrote, "It cannot be disputed that quality nursing care translates into quality patient outcomes... Logical, science-driven, reasonable solutions need to be crafted... A practice environment that empowers caregivers will lead to quality care... Patients' outcomes depend not only on the type and severity of the illness, but on the skill and mix of the nurses and physicians providing care... Relying on nurses' professional judgement is the best manner of determining staffing levels."

I couldn't agree more.

Alternative legislation has been introduced and is still pending. Senator Richard Moore's bill (S-1244), An Act to Promote the Nursing Profession and Promote Safe Patient Care, calls for scholarship funding for nurses; more faculty in state-run nursing schools; public posting of nurse staffing plans; and decisions related to patient care being made by nurses and nurse managers, not state legislators.

continued on next page

Legislators make laws. Well-informed legislators make well-thought-out laws. Who knows better than we do the intricacies and complexities of providing optimal patient care? Who knows better than we do the consequences of inadequate, 'cookie-cutter' nurse staffing?

What Senator Moore's bill does *not* include are pre-mandated ratios, and this passage from his website tells us why: "While there is considerable research that supports the importance of adequate nursing, no evidence-based research has been able to clearly identify what specific ratios are appropriate. The reason for this is that the condition of patients can change for better or worse within a (single) shift; the physical ability, education, and experience of nurses on duty vary; technology, hospital settings, and the availability of support staff vary widely from hospital to hospital."

We know from our own experience and from the experience of healthcare organizations across the country that:

- with staffing ratios, we run the risk of replacing critical nursing judgement and assessment with fixed numbers.
- all patients are not the same. Needs vary from patient to patient, and for the same patient over time. Nurses must have the flexibility to staff accordingly.
- all nurses are not the same. At times when less experienced nurses are working, more staff may be needed. At times when more experienced nurses are working, fewer staff may be needed.
- because of shortened lengths of stays and the need to admit patients for short-term observation, census and acuity can change from shift-to-shift, from hour-to-hour. Flexibility is required to staff according to patient need, not number.

- once established, mandated minimum staffing ratios often morph into maximum staffing limits.
- other mandated practices have failed because they neglected to take into account the individual needs of each patient (mandated 24-hour OB deliveries, mastectomies, etc.)

The ethical debate over whether there should or should not be government-mandated nurse staffing levels doesn't even take into account the financial impact of such legislation. Some researchers estimate a state-wide increase in healthcare costs of up to \$500 million annually if staffing ratios are enacted.

I don't dispute that there's a problem. But rushing to a simple, short-sighted solution when a careful, comprehensive plan is required can cause more harm than good in the long run.

Legislators make laws. Well-informed legislators make well-thought-out laws. Who knows better than we do the intricacies and complexities of providing optimal patient care? Who knows better than we do the consequences of inadequate, 'cookie-cutter' nurse staffing practices?

Some time between now and July 31st, our state senators are going to vote on a bill that will profoundly affect our patients, our practice, and our future. I urge you to share your thoughts, concerns, and most importantly, your expertise with the men and women who represent us on Beacon Hill.

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The Jean M. Nardini, RN, Nurse of Distinction Award

—by Julile Goldman, RN, professional development coordinator

On June 19, 2008, on the occasion of the fourth presentation of the Jean M. Nardini, RN, Nurse of Distinction Award, Jeanette Ives Erickson, RN, senior vice president for Patient Care, observed, “How fitting it is that today’s parade to honor the world champion, Boston Celtics, coincides with the celebration of our own champion, Jean Nardini. I know if Jean were here, she’d think the parade was for her!” Before presenting the award to this year’s recipient, Cheryl Gomes, RN, staff nurse in the Same Day Surgical Unit, Ives Erickson provided some background about the award.

Established in 2005, the Jean M. Nardini, RN, Nurse of Distinction Award recognizes a clinical staff nurse who consistently demonstrates leadership, excellence in clinical practice, and a strong dedication to the profession of nursing. Nardini was an exemplary leader, a committed patient advocate, and a caring nurse, teacher, and role model. She left an indelible mark on the MGH community.

Scott Ciesielski, RN, nursing director for the Same Day Surgical Unit, introduced Gomes, saying, “When I first

assumed responsibility for the pediatric recovery room, I immediately recognized Cheryl as an excellent clinician and role model. One year later, my initial impressions have been validated with dozens of examples of her impact on patients, families, and staff. I knew my assessment was accurate when, over the past year, I listened as Cheryl’s peers spoke of her as a role model during *their* performance evaluations. Cheryl’s impact on patients, families, and staff is inspiring. Every decision she makes is based on what’s best for her patients.”

Pamela Wrigley, RN, operating room and pediatric clinical nurse specialist, who nominated Gomes, wrote, “Cheryl excels as a preceptor and as a mentor to new staff. She promotes excellence through her years of experience as a clinical nurse and her desire to continually develop her nursing skills.”

Gomes accepted the award, thanking her colleagues, family, and unit leadership, and expressing her appreciation to the Nardini family for the privilege of being recognized in Jean’s memory.

Nardini’s husband, Al, spoke on behalf of the family, congratulating Gomes and thanking the MGH community for continuing to acknowledge Jean’s contributions to patient care.

For more information about the Nardini award, contact Julie Goldman, RN, at 4-2295.



Nardini award recipient, Cheryl Gomes, RN (center front) with members of the Nardini family, sons Trevor (left), Brett (center) and husband, Al; senior vice president for Patient Care, Jeanette Ives Erickson, RN (front left); and long-time friend and colleague, Nina Rubin, MD.

Nobel Peace Prize Laureate speaks at MGH

—by Roy Ahn, SD, senior administrative manager

2006 Nobel Peace Prize Laureate, Muhammad Yunus, PhD, a pioneer in the field of ‘micro-credit,’ a financial system that provides loans to the poor, spoke to a packed O’Keeffe Auditorium, on Saturday morning, June 7, 2008. The seminar, entitled, “Strategies for Health Care Financing in Under-Resourced Environments,” was co-sponsored by the MGH Center for Global Health and the MGH Cancer Center.

Yunus began his lecture with a historical overview of the Grameen Bank, which he founded in the mid-1970s as a vehicle for helping the poor in his native Bangladesh. Speaking about the original impetus for Grameen Bank, Yunus described his outrage at local ‘loan sharks’ preying on the disadvantaged, and these lenders holding poor people’s lives in their sway: “For so little, people have to suffer so much.” Yunus described his first loans—a total of \$27 to 42 people—and how much that small sum of money affected the borrowers’ lives.

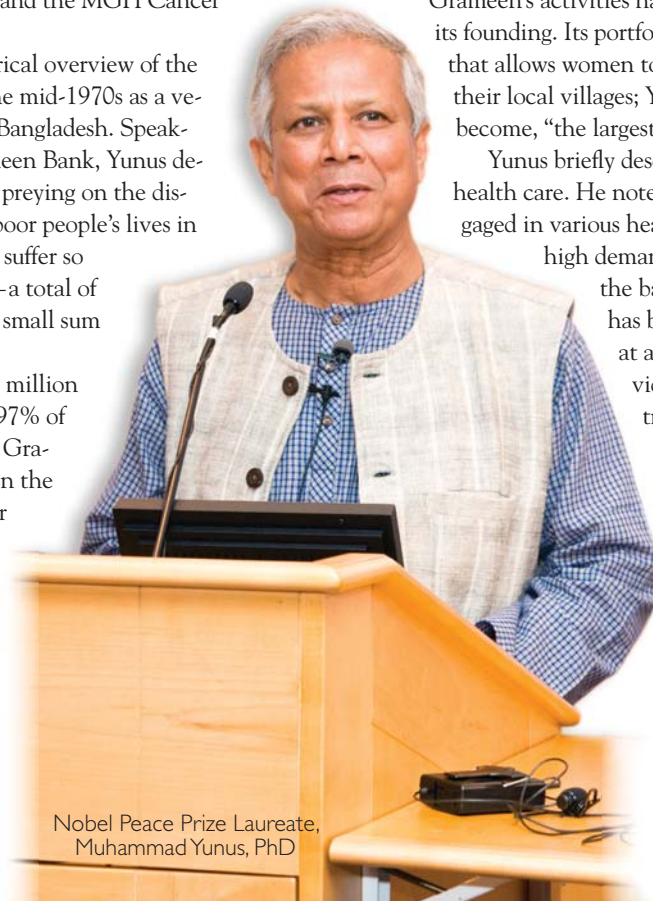
Yunus noted that of the more than 7 million borrowers of the Grameen Bank today, 97% of the borrowers are women. He described Grameen’s business model, which is based on the idea that ‘social business’ can operate for the benefit of the poor: “It’s a bank owned by poor women that works for poor women. When the bank makes money, it goes back to these women, who are the shareholders of the bank, as dividends. It’s a complete circle.” Yunus insisted that Grameen was built on the premise that the poor could and would pay for services, noting, “In Grameen Bank, we give nothing free.” In its announce-

ment of the 2006 Nobel Peace Prize, the Norwegian Nobel Committee wrote: “...Yunus has, first and foremost through Grameen Bank, developed micro-credit into an ever more important instrument in the struggle against poverty. Grameen Bank has been a source of ideas and models for the many institutions in the field of micro-credit that have sprung up around the world.”

Grameen’s activities have expanded in scale and scope since its founding. Its portfolio now includes a cell-phone business that allows women to provide cell-phone service to people in their local villages; Yunus estimates that this endeavor has become, “the largest cell-phone company in the country.”

Yunus briefly described Grameen’s next major foray: health care. He noted that Grameen, over the years, has engaged in various health-related activities, because of the high demand for such products and services from the bank’s borrowers. For instance, Grameen has been a purveyor of vegetable seeds (sold at affordable prices to the poor); has provided loans for the construction of latrines; and has set up health clinics in rural Bangladesh. In the future, Yunus envisions a hospital, medical school, nursing school, and other facets of a comprehensive healthcare system in his country.

Yunus’s lecture culminated a year of global-health seminars sponsored by the MGH Center for Global Health. The lecture will be broadcast in July on the MGH Center for Global Health’s website (www.massgeneral.org/globalhealth). For more information, call Roy Ahn, SD, at 3-0067.



Nobel Peace Prize Laureate, Muhammad Yunus, PhD

(Photo by Abram Bekker)

Graf retires after 23 years of service to MGH

There was laughter. There were tears. Funny stories were told, memories shared, good times recalled. It was the bitter-sweet happiness that accompanies all farewells. And this one was no exception. On June 24, 2008, the MGH community said good-bye to Chris Graf, RN, former director of Patient Care Services' Financial Management Systems.

As friends and colleagues crowded into the Trustees Room, executive director for The Institute for Patient Care, Gaurdia Banister, RN, opened the ceremony. One of the newer members of the PCS leadership team, Banister observed, "I may not have known Chris as long as others here today, but I certainly benefitted from her wisdom and generosity. When I first arrived at

MGH, one of my colleagues said of Chris, 'Never ever think that she's only a numbers person. She uses numbers to raise awareness and give voice to what the numbers mean.' And she was so right."

Director of PCS Information Services, Sally Millar, RN, called Graf, "one of the great blessings in my life." She vividly recalled Graf's arrival on October 7, 1985, because it corresponded with implementation of the Medicus system. Said Millar, "My office has been right beside Chris' for as long as I can remember. What stands out in my mind more than anything when I think about Chris is how fair and equitable she is, and what a good friend she has been. I will miss her terribly."

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, brought some levity to the proceedings with a 'numbers' game created especially for Graf. She called out numbers, asking attendees to guess the relevance they held for Graf's career. For instance, Three: the number of states in which Graf worked as a nurse; 4,805: the number of pages in the volumes of evidence compiled for Magnet re-designation; or 23: the number of budget cycles through which Graf shepherded Patient Care Services.

Ives Erickson reminded attendees that when Graf began at MGH in 1985, the hospital had 1,081 licensed beds, 21,145 admissions (compared to 47,447 today), the average length of stay was 10 days, and the maximum pay rate for staff nurses was \$16.12 an hour.

Closing with a quote from Kenneth Blanchard, author and management specialist, Ives Erickson said, "The key to successful leadership is influence, not authority.' Thank-you for your twenty-three years of influence, and for something whose monetary value is priceless—your friendship."

Bidding farewell to long-time friend and colleague, Chris Graf, RN, are (l-r): Sally Millar, RN; Jeanette Ives Erickson, RN, and Gaurdia Banister, RN.



Reiki, Beethoven, work wonders in SDSU

—by Carolyn Bartlett RN, Same Day Surgical Unit

Recently, nurses in the Same Day Surgical Unit (SDSU) were presented with an interesting challenge. Mr. P arrived in the SDSU for an inguinal hernia repair. During pre-op assessment, Cecile Hannon, RN, noted that his blood pressure was 180/103. She ascertained that he had taken certain medications that morning then chatted with him about his interests, in particular, his love of Beethoven. A re-check of his blood pressure showed it had increased to 224/107. Hannon called the operating room (OR) and notified the surgeon who was going to cancel the procedure until Carol Card, RN, a nurse in the OR, suggested Reiki to try to reduce Mr. P's pressure. The surgeon agreed, adding that Mr. P's pressure would have to be below 175/80 in order to operate.

Reiki is a Japanese word for Universal Life Force. It's an ancient healing art that channels energy through the hands of the practitioner to the recipient.

The major effects are promoting a state of relaxation and relieving pain and stress.

Carolyn Bartlett, RN, resident Reiki master and music resource for the SDSU, went to the holding area, introduced herself to Mr. P, and explained that she was there to help him relax.

Bartlett asked Mr. P what typically makes him feel relaxed. When he mentioned Beethoven, a CD player was obtained. Bartlett placed her hands on Mr. P's shoulders, asked him to close his eyes, and began playing Beethoven softly on the CD player. After a few minutes, Paul Craigie, RN, the nurse who would be administering sedation, checked Mr. P's blood pressure. It had decreased to 185/90, so he began IV sedation.

After about 30 minutes, Mr. P's pressure was 157/73. Bartlett notified the operating room. It's not unusual for blood pressure to decrease 10-20 points with Reiki, but 50 was remarkable. Even the surgeon was impressed. Mr. P's pressure remained stable, so with Craigie providing sedation, Card as the scrub nurse, and Bartlett as circulating nurse, Mr. P was taken to surgery.

Reiki and music can be used in any setting to foster relaxation. The positive effect of music on patients has been studied on several units. MGH Channel 45 plays continuous relaxing music and is available to all patients. Music affects heart rate, breathing, blood pressure, and brain waves by way of 'entrainment.' Entrainment is when the body adjusts itself to the pulse of the music. Slow music decreases pulse rate, blood pressure, and breathing, while fast music does the opposite.

A person's choice of music is personal and subjective. We were fortunate that Mr. P enjoyed classical music, because it had a profoundly positive effect on his outcome.

Canceling surgery is disruptive for anyone, but especially for someone 82 years old. Staff were pleased they were able to provide complementary therapies that allowed Mr. P to have his surgery as anticipated.

For more information about Reiki and music therapy, call Carolyn Bartlett at 6-2851.

SDSU staff nurses, Carolyn Bartlett, RN, and Paul Craigie, RN, demonstrate the Reiki relaxation technique used to comfort Mr. P before surgery.



New therapist gains confidence and experience caring for GBS patient

When I first started reading through Mr. F's chart, I felt his symptoms were consistent with Guillain Barre Syndrome

My name is Jennifer Miraglia, and I have been an inpatient physical therapist at MGH for almost three years. Mr. F was a patient I cared for while on my Neuroscience rotation. When I first walked into Mr. F's room, I was greeted by a tearful, 43-year-old man lying in bed with his wife at his side. I immediately started to consider the best way to approach him so I could address his concerns and still identify his physical-therapy needs. After initiating a conversation, it was clear that Mr. F's emotions were the result of his uncertainty at the changes taking place in his body. In addition to being nervous about not understanding what was happening, he felt as if no one was hearing him or had a true understanding of what was going on.

When I first started reading through Mr. F's chart, I felt his symptoms were consistent with Guillain Barre Syndrome (GBS). GBS is an auto-immune disorder of the peripheral nervous system that can cause progressive weakness and significant loss of functional mobility. With this information, I went into the room to examine Mr. F. He presented with proximal weakness primarily limited to his shoulders and hips. He reported sensory changes in his hands and toes, yet, on exam-



Jennifer Miraglia, PT, inpatient physical therapist

ination, his sensation was intact. His motor control, coordination, core strength, and balance while sitting and lying down were normal. What was interesting about Mr. F is that when he stood up and started to walk, his gait was significantly more impaired than I had anticipated. He was ataxic (had irregular muscle coordination) with an increased lateral weight shift that appeared as if his upper body were uncontrollably swaying from side to side as he walked. Occasionally, his knees would give out and he'd stoop to a very low squat, but he'd independently recover and immediately return to standing. While his gait deviations reflected the strength impairments I had observed in his hips, I wouldn't have anticipated that his weakness would have affected his gait to the degree that I was seeing.

Aside from his gait pattern, my findings were not consistent with his subjective report or the informa-

continued on next page

tion I had read in his chart. I discussed my findings and concerns with the neurology team. As they continued to work with Mr. F, their findings were also inconsistent with a diagnosis of GBS, and the results of the nerve conduction velocity test (a test used in diagnosing GBS) was normal. Based on Mr. F's initial subjective reports of sensory changes, weakness, and difficulty ambulating, GBS had seemed like a possible diagnosis, but the information was not adding up, so the work-up continued in an attempt to determine the etiology of Mr. F's symptoms.

With no conclusive finding or diagnosis, Mr. F's anxiety continued to grow. He expressed feelings of frustration at not being heard and became increasingly worried that he'd be 'stuck' like this indefinitely. While I agreed that the findings from his examination didn't fit a clear diagnostic pattern, he still had impairments that needed to be addressed. With acute Guillain Barre Syndrome still remaining as a differential diagnosis, I made the decision not to intervene with a strengthening program, as this could exacerbate his symptoms if he were in the acute stage of demyelination.

Instead, assisted by evidence in the literature, I decided to focus on keeping him as functional as possible while teaching him how to maximize his independence and mobility. I instructed him in the use of crutches, which provided extra support during ambulation and compensated for his ataxia and impaired trunk control. During this time, I carefully monitored for changes in his strength to assess for progression of the disorder and ensure he was tolerating the treatment.

As a physical therapist, it's my role to perform a comprehensive examination to identify impairments specific to the individual. Impairments are defined as an anatomical, physiological, mental, or emotional abnormality. This is important because it's the patient's impairments and history, not the diagnosis, that guide the treatment or plan of care. Without examining and treating patients at the impairment level, it's difficult to objectively determine what, if any, changes occur and what may have caused them. This information seemed particularly relevant in this case and played an important role in my decision-making. While I was first concerned about not having a clear medical or physical-therapy diagnosis for Mr. F, his case reminded me of the importance of treating patients at the impairment level based on my examination and what I'm observing.

Working with Mr. F reminded me how important it is to truly listen to our patients in order to better understand their fears, concerns, and goals. Sometimes the best information we can gather about patients comes not from the chart, but directly from our patients. Looking back, I think I could have made the decision to delay treating Mr. F until a diagnosis had been determined, but it was clear, that wasn't what he needed.

While Mr. F did not present with typical symptoms and findings, after further work-up, Mr. F was, in fact, diagnosed with Guillain Barre Syndrome. He was treated with high-dose, intravenous immunoglobulin and started to show signs of improvement before he left the hospital. While he began to make some progress, he was still below his baseline level of functioning and unable to return fully to his roles as husband, father, and regional manager of his company. When it was time for Mr. F to be discharged from the hospital, I referred him to outpatient physical therapy to continue to work toward his previous level of functioning and his new goals.

Reflecting back on how Mr. F's medical course played out, I'm grateful I made the decisions that I did. I used my clinical decision-making skills and evidence-based practice to guide my plan of care. Had I chosen to wait to treat him, I think I would have missed the window of opportunity to maximize his functioning, and I don't think he would have responded to me as positively as he did. I think the open communication we maintained throughout his hospital stay was one of the major factors driving his participation and progress throughout the course of his physical-therapy care.

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

Despite the fact that Jennifer walked into Mr. F's room with a diagnosis in mind, she was able to trust her instincts and see the evidence before her. She listened to what Mr. F was saying. This enabled her to treat Mr. F effectively, 'at the impairment level,' and not plan her interventions according to a pre-described diagnosis. Jennifer shared her concerns with the team, and together they were able to give Mr. F the complete and comprehensive work-up he required.

Thank-you, Jennifer.

Working with Mr. F reminded me how important it is to truly listen to our patients in order to better understand their fears, concerns, and goals. Sometimes the best information we can gather about patients comes not from the chart, but directly from our patients.

Living and working with ovarian cancer

—by Wanda Ponte, RN, Same Day Surgical Unit

This year, an estimated 22,000 women in the United States will be diagnosed with ovarian cancer. It will claim the lives of approximately 2/3 of those diagnosed. Early detection of ovarian cancer has never been more important. When diagnosed in stage 1, ovarian cancer is 90% curable.

The most common symptoms of ovarian cancer include: bloating, pelvic or abdominal pain, trouble eating or feeling full quickly, and urinary symptoms. Women who experience persistent or worsening

Staff nurse, Wanda Ponte, RN, staffs ovarian cancer education booth in the Main Corridor



symptoms for two to three weeks should see their doctor, and a family history of ovarian or breast cancer increases the risk.

I've been a nurse at MGH for 23 years. I started as a new graduate nurse, never expecting to stay as long as I have, but I'm very happy I did. In November, 2002, with no history of cancer in my family, I was diagnosed with stage 3C ovarian cancer. Five and a half years later, I'm still here. The love and support I receive from my colleagues lifts me when my will to fight is low. I've worked in the Same Day Surgical Unit for nine years. My faith, prayers, and the continued love and support of my family, friends, and my extended family at MGH is why I'm still here.

I love being a nurse. I often see patients with cancer diagnoses. Sometimes I share my story with them as a kind of encouragement. I see the fear in their eyes. When they see that I'm surviving, they feel hope. They think: If she can do it, so can I. I feel honored and blessed to be able to comfort them in this way.

Forty years ago ovarian cancer was considered a 'women's disease.' But it's not a women's disease when men are losing their wives, mothers, sisters, and daughters at an alarming rate. Ovarian cancer doesn't just affect women.

Knowledge is power. I recently held an ovarian cancer education booth in the Main Corridor, and I plan to return every year to help raise awareness about the symptoms, treatment, and early detection of ovarian cancer.

I'd like to thank all those who love and support me. I'm truly grateful and blessed to have you in my life.

For more information, call Wanda Ponte, RN, at 6-2851.

ESOL program contributes to success at work and at home

—by Stephanie Cooper, training and development specialist

Friday, June 6, 2008, marked the 13th annual celebration of achievement for the English for Speakers of Other Languages (ESOL) program. The program, now in its 16th year, is a collaborative effort between MGH and Jewish Vocational Services (JVS), and was one of the first of its kind to be offered in the Boston area. The themes of commitment and teamwork so essential to the program's success were woven throughout the ceremony.

Carlyene Prince-Erickson, director of Employee Education and Leadership Development, credited the success of the program to, "the dedication of the students and the collective partnerships of many people in many areas throughout the hospital." She noted that the program is strengthened year after year by the con-

Massachusetts State Representative, Linda Dorcena Forry (right) congratulates employees on their success in the ESOL program.

nection between workplace and classroom learning, the support of families and managers, and the commitment of senior leadership, JVS, and MGH volunteers.

President of JVS, Jerry Rubin, observed "I can't think of another event in the city where so many people come together to celebrate ESOL classes." Calling the teachers, "some of the best"; the students, "an inspiration to their colleagues"; and the program, "an example modeled by other hospitals," he praised the accomplishments of all who participate.

Lead teacher, Beth Butterfoss, recognized students who had excellent attendance and those who've received US citizenship as she distributed certificates to the 103 employees who participated in the program this year. She thanked volunteers, Elaine Kwiecien, for her help in the computer lab, and Deborah Russell for her, "gentle patience in the classroom." Butterfoss congratulated students on their success, recognizing that, "many have two jobs and families and still make time to learn English, a difficult language."

Representing the high intermediate class, student speaker, Marina Guerrero, who works in the Operating Room, shared that the ESOL program has improved her life in many ways. "When I started," said Guerrero, "I did not speak a lot of English and I did not know how to read and write. Now I can see how this English class helps me in my daily life, in my job, and with my children. MGH gave me the opportunity to make my life better. I would like to say thank you to MGH."

Special guest, Massachusetts State Representative, Linda Dorcena Forry, spoke to students at the reception following the ceremony. She commended students for making the time and commitment to learn English and thanked MGH for creating a program that allows students to take time away from work to better their lives.

The next session of English for Speakers of Other Languages will begin in the fall. For information, contact Beth Butterfoss at 617-726-2388.



(Photo by Joanne Choi)

Professional Achievements

Ashland appointed

Jean Ashland, CCC-SLP, speech pathologist, was appointed to the position of adjunct clinical faculty at the IHP: Department of Communication Disorders, in May, 2008.

D'Avolio appointed

Deborah D'Avolio, RN, geriatric specialist, was appointed as a board member of the National Gerontological Nursing Association, Clinical Practice Committee, on May 5, 2008.

Pollard honored

Michelle Pollard, CCC-SLP, speech pathologist, received the ASHA award for Continuing Education ACE, from the American Speech, Hearing & Language Association, on April 14, 2008.

Levin recognized

Barbara Levin, RN, Orthopaedic and Neuroscience Service, received the 2008 AALNC Member of the Year for Leadership, Innovation, Commitment and Professionalism award, at the American Association of Legal Nurse Consultants Conference, in April, 2008.

Roberge honored

Barbara Roberge, RN, nurse practitioner, MGH Senior Health Practice, Geriatric Unit, and nurse scientist, received, "The Exceptional Advanced Practice Clinician and Mentor Award," from the MGH Institute of Health Professions, on May 2, 2008.

Banister, Distinguished Alumna

Gaurdia Banister, RN, executive director, The Institute for Patient Care, was selected as the Distinguished Alumna for 2008, by the University of Wyoming Fay W. Whitney School of Nursing, for contributions to the nursing profession in the areas of administration and nursing practice, in May, 2008.

Cobb certified

Sara Cobb, RN, received oncology nurse certification, from the Oncology Nursing Certification Corporation, in May, 2008

Banister publishes

Gaurdia Banister, RN, executive director, The Institute for Patient Care, wrote the chapter, "Process," in *Nurse Executive: the Four Principles of Management*, published in March, 2008.

Levin appointed

Barbara Levin, RN, Orthopaedic and Neuroscience Service, was appointed, as a member of the American Association of Legal Nurse Consultants Nurse Research Committee, in Tampa, Florida, in May, 2008.

Peterson appointed

June Peterson, RN, clinical educator, PALS coordinator, and lead instructor, was appointed president-elect of the Northeast Organization of Nurse Educators, a chapter of the National Nurse Staff Development Organization, on June 3, 2008.

Ashland publishes

Jean Ashland, CCC-SLP, speech pathologist, wrote the article, "Dysphagia in the NICU Setting: a Multidisciplinary Approach to Management," in *Early Childhood Services: an Interdisciplinary Journal of Effectiveness*, in March, 2008.

Pain team publishes

Paul Arnstein, RN, clinical nurse specialist for Pain Relief; Will Rowe, CEO, American Pain Foundation; Russell Portenoy, MD; Aaron Gilson, MSSW; Mieke Brown, RN; Howard Heit, MD; Perry Fine, MD; Todd Sitzman, MD; and Scott Fishman, MD, wrote the report, "Provider Prescribing Patterns and Perceptions: Identifying Solutions to Build Consensus on Opioid Use in Pain Management," published by the American Pain Foundation, in April, 2008.

Leblanc certified

Danielle Leblanc, RN, received oncology nurse certification from the Oncology Nursing Certification Corporation, in May, 2008.

Yanarella certified

Lisa Yanarella, RN, received oncology nurse certification, from the Oncology Nursing Certification Corporation, in May, 2008.

Carroll and Hamilton publish

Diane Carroll, RN, nurse researcher, and Glenys Hamilton, RN, wrote the article, "Long-Term Effects of Implanted Cardioverter Defibrillators in Health Status, Quality of Life and Psychological State," in the May, 2008, *American Journal of Critical Care*,

Cardiac team publishes

Ann Hurley, RN; Jeffrey Rothschild, MD; Mary Lou Moore, RN; Colleen Snyderman, RN; Patricia Dykes, RN; and, Sofronia Fotakis, MSW, wrote the article, "A Model of Recovering Medical Errors in the Coronary Care Unit," in May-June, 2008 *Heart and Lung*.

Ashland and Hersh present

Jean Ashland, CCC-SLP, and Cheryl Hersh, CCC-SLP, speech pathologists, presented, "Evaluation of Pediatric Dysphagia: the Role of Speech Pathology," at the Update on Pediatric Airway, Voice, and Swallowing Disorders conference, in Boston, April 12-13, 2008.

Carroll presents

Diane Carroll, RN, nurse researcher, presented, "Acute Coronary Syndrome 2007 Updates," at the National Teaching Institute, American Association of Critical Care Nurses, in Chicago on May 5, 2008.

Carroll presents

Diane Carroll, RN, nurse researcher, presented, "Demystifying Nursing Research," at the University of Massachusetts, Lowell, on May 8, 2008.

Chang presents

Lin-Ti Chang, RN, staff specialist, presented, "Disaster Nursing: Changing Priorities and Challenges," and "Innovated Nursing Orientation & Professional Development for Nurses," at the 3rd Shanghai China-US Nursing Conference, in Shanghai, China, May 24 and 25, 2008.

Cole presents

Elizabeth Cole, PT, physical therapist, presented, "PT Treatment of Urinary Incontinence," at Partners Home Health in Waltham, May 21, 2008.

PCS Clinical Recognition Program

The following clinicians were recognized March 1- June 1, 2008

Advanced Clinicians:

- Stephen Joyce, RN, Surgery
- Carolyn Bleiler, RN, Pediatrics
- Linda Kimball, RN, Pediatrics
- Heather Carlson, RN, Medicine
- Julia Brickley, RN, Peri-operative
- James Barone, RN, Peri-operative
- Kathleen Killough, RN, Surgery
- Carolyn Pelley, RRT, Respiratory Therapy
- Patricia Mottla, RN, Peri-operative
- Julie Berrett, LICSW, Social Work
- Kristin Beuparlant, RN, Women's Health
- Melissa DeLisle, RN, Women's Health
- Emily Horrigan, RN, Surgery
- Katherine Swigar, RN, Cardiology
- Denise Mondazzi, RN, Medicine

Clinical Scholars:

- Todd Rinehart, LICSW, Social Work
- Donna Sweeney, RN, Cardiology
- Catherine Mackinaw, RN, Neurology
- Susan Cahill, RN, Obstetrics
- Sharon Sullivan, RN, Cardiology
- Sara Beth Asekoff, RN, Cardiology
- Jane Harker, RN, Endoscopy

Enhancing medication safety

Question: Can you tell us what's going on with the Electronic Medication Administration Process (EMAP)?

Jeanette: Thanks to Jennifer Albert, RN, a staff nurse on the clinical project team, the project has been re-named the Electronic Medication Administration Process for Patient Safety (EMAPPS) to better reflect the patient-safety aspect of the work. As you know the Institute of Medicine (IOM) has mandated hospitals to address the issue of medical errors with its recommendations to implement computerized Provider Order Entry (POE) and bar-coded medication administration (BCMA) systems. POE is already in place at MGH, and we are working to implement BCMA. Using a bar-code scanner, nurses and respiratory therapists will be able to scan medications and the patient's wristband at the bedside to confirm the five rights, then scan their own ID badge to document the time of administration.

Question: What application will nurses and respiratory therapists use to administer medications?

Jeanette: Partners Information Systems is developing an application called the Electronic Medication Administration Record (EMAR) to be used on patient care units. The application is still in development.

Question: Who has been involved in developing (EMAR)?

Jeanette: The initiative involves staff from Information Systems, Nursing, Pharmacy, Respiratory Care, and Medicine. A clinical project team with representatives from patient care units meets twice a month to provide input on the design of the application. A separate team is dedicated to designing a chemotherapy component of EMAR.

Question: When will EMAR be implemented?

Jeanette: Implementation on inpatient units is expected to begin in March of 2009 and will expand throughout the hospital over a ten-month period.

Question: How will EMAR change the way we work?

Jeanette: As you know, MGH has had POE and COE in place for several years, but there has been no electronic connection to Pharmacy. POE/COE orders were entered manually into the pharmacy system and checked by a pharmacist. Soon, POE and COE will be electronically linked to the Pharmacy, eliminating the need to manually enter orders. Pharmacists will review and approve orders on-line. An interface from Pharmacy to automated dispensing machines (Omniceil) is planned for September. When that happens, medications approved by the Pharmacy will appear on the patient's profile so clinicians won't have to scroll through a whole list of medications, rather, only a list of medications that have been prescribed for that patient.

Question: How will this improve workflow?

Jeanette: Nurses and respiratory therapists will administer and document medications in the on-line system. All other disciplines will be able to view EMAR on any Partners computer. Since EMAR will be available on-line, any number of clinicians will be able to view a patient's medication administration record at the same time, decreasing the demand for green books. Transcription is eliminated as orders flow electronically. Nurses and respiratory therapists will use bar-code scanners to scan medications and patient's wristbands to confirm medications electronically. If the bar codes don't match, clinicians will be prompted to review the order again. Finally, clinicians will scan their own ID badge (or input their Partners' password) to document the administration.

For more information about EMAPPS and EMARS, contact Rosemary O'Malley, RN, at 617-726-9633.

Announcements

American Sign Language and Deaf Culture Class

The MGH Council on Disability Awareness will offer a beginning American Sign Language and Deaf Culture class starting in September. The class is open to MGH employees, and space is limited. To register, or for more information, send e-mail to ssabia@partners.org. Participation is first-come, first-served.

Beginning September 11, 2008
Thursday evenings
5:00–6:30pm
for 10 weeks
Location TBA

Power Lunch volunteers needed

Beginning in September, volunteers are needed to participate in the Power Lunch program—a lunchtime literacy and mentoring program for elementary-school children—through MGH Chelsea. MGH volunteers are paired with students at the Edgar A. Hooks School in Chelsea.

For more information or to volunteer, call Luz Betancourt at 617-887-3789

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services.

Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Access to MGH on July 3rd and 4th,

Please be advised that access to MGH buildings (including the Yawkey Building and all garages) on the evening of July 3, through July 4, 2008, will be for staff reporting to work or patient care issues only.

Police, Security & Outside Services will be assigning extra staff to screen vehicles and individuals entering the garages and the Yawkey Building to ensure parking availability for on-duty employees, patients, and hospital visitors.

The general public and off-duty employees attempting to park in MGH garages will be turned away. Due to parking space availability and/or to alleviate traffic congestion, employees may be directed to park in the Yawkey Garage. Numerous road closures may provide challenges for those reporting to work over the 4th of July holiday, so please plan accordingly.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,
7:30am – 5:30pm

Friday, 8:30am – 4:30pm
(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,
Thursday,
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

Invitation for persons with disabilities and veterans to voluntarily self-identify

Every year, the federal government requires hospitals to invite employees who qualify to voluntarily identify themselves as persons with a disability and/or a veteran. If you have responded to this request in the past, there is no need to respond again unless there has been a change in the information you reported.

If this applies to you, please identify yourself by sending an e-mail to mailto:ibridge@partners.org, or by contacting your Human Resources generalist.

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Submissions

All stories should be submitted to: ssabia@partners.org
For more information, call:
617-724-1746

Next Publication

July 17, 2008

Educational Offerings – 2008

July
8

New Graduate RN
Development Program
Founders 311
8:00am–4:30pm
Contact hours:TBA

July
8

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

July
8

Ovid/Medline: Searching for
Journal Articles
Founders 334
9:00–11:00am
Contact hours: 2

July
9

Nursing Research Committee's
Journal Club
Yawkey 2-210
4:00–5:00pm
Contact hours: 1

July
**10, 11, 14,
16, 31, and
August 1**

Greater Boston ICU Consortium
Core Program
Call for locations (6-3111)
7:30am–4:30pm
Contact hours:TBA

July
14

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

July
16

Nursing Grand Rounds
Haber Conference Room
11:00am–12:00pm
Contact hours: 1

July
17

Oncology Nursing Concepts
Yawkey 2-220
8:00am–4:00pm
Contact hours:TBA

July
17

Management of Patients with
Complex Renal Dysfunction
Yawkey 4-810
8:00am–4:30pm
Contact hours:TBA

July
22

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

July
24

Nursing Grand Rounds
O'Keeffe Auditorium
1:30–2:30pm
Contact hours: 1

July
29

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

July
30

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse
POB 448
7:00–11:00am
Contact hours:TBA

July
30

Pediatric Simulation Program
Founders 335
12:30–2:30pm
Contact hours:TBA

July
30

On-Line Electronic Resources for
Patient Education
Founders 334
9:00am–12:00pm
Contact hours: 2.7

July
31

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

July
31

APHON
Yawkey 2-220
8:00am–4:00pm
No contact hours

August
1

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

August
4

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

August
5

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse
POB 448
7:00–11:00am
Contact hours:TBA

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

MGH Idol is a little bit country!

On Wednesday, June 25, 2008, under the Bulfinch tent, hundreds of MGH employees turned out to enjoy Dr. Slavin's annual summer picnic, which included lunch, games, and for the first time ever, a crowd-pleasing version of the hit television show, *American Idol*—our own, *MGH Idol*. Seven finalists returned having been selected after auditioning earlier in the month and sang their hearts out to a packed and very appreciative MGH audience. Judging the contestants were Olako Agburo, admin-

istrative fellow; Bill Banchiere, Environmental Services; Maryanne Spicer, Administrative Fellowship Program; and special guest judge, Patriots wide receiver; Wes Welker. And when all the votes were counted, Scott Hooper of Information Services was the new MGH Idol for his song, *Friends in Low Places*. And if hootin' and hollerin' is any indication, it's fair to say a good time was had by all!



Above: MGH Idol winner; Scott Hooper of Information Services (center), with other finalists (l-r): Isa Katimy from Police and Security; Brandon Clarke, from Nutrition & Food Services; David Maldonado from MGH Downtown; June Cottrell from MGH Beacon Hill; Michelle Dorn, from Immunopathology; and Christine Joyce from the Cardiac Catheterization Lab.

At right: MGH Idol judges (l-r): Wes Welker, Patriots wide receiver; Olako Agburo, administrative fellow; Bill Banchiere, director of Environmental Services; and Maryanne Spicer, co-director of the Administrative Fellowship Program.

At far right: MGH employees enjoy the show.



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