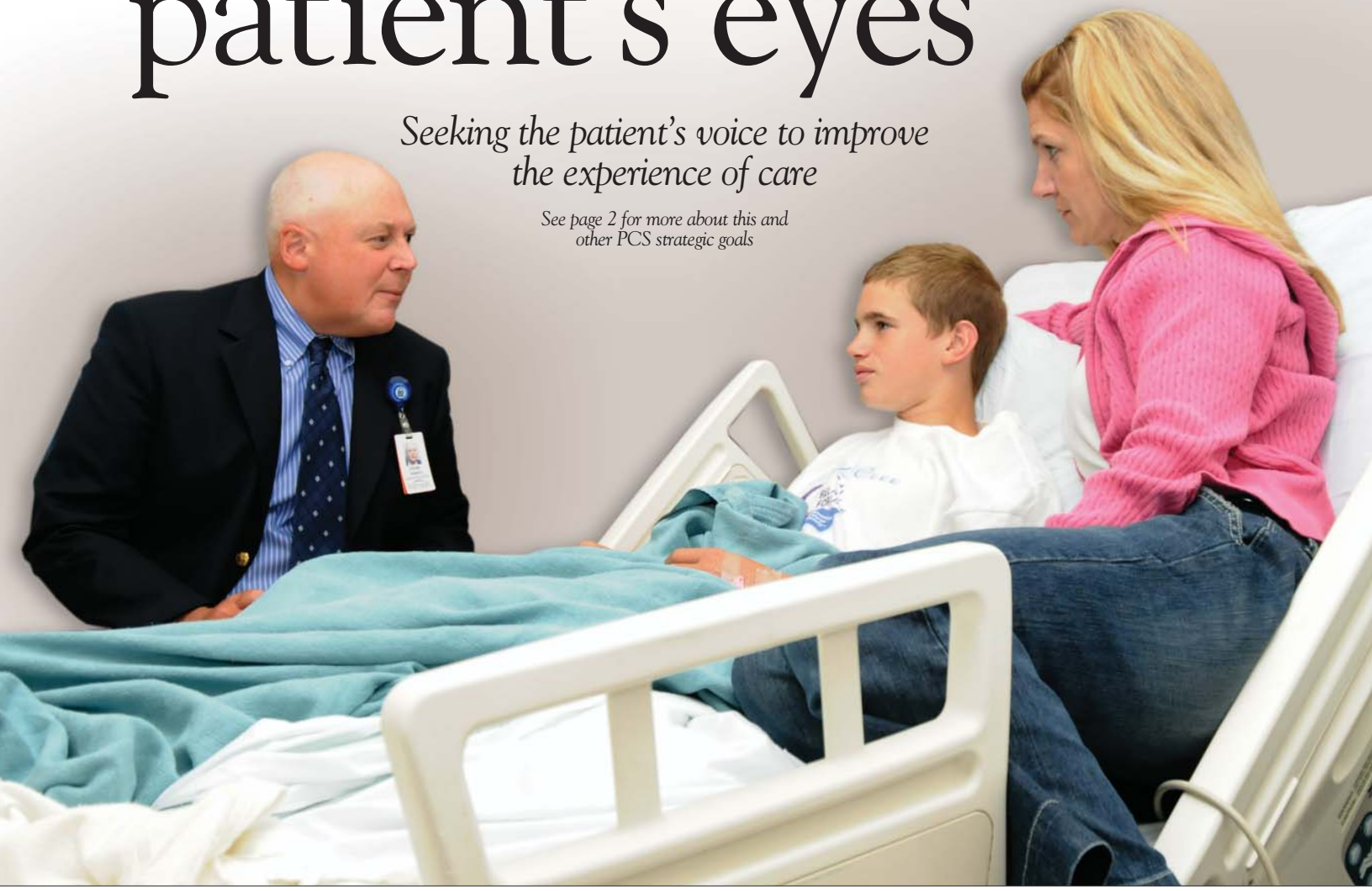
Caring Headlines
September 4, 2008

Through the patient's eyes

Seeking the patient's voice to improve the experience of care

See page 2 for more about this and other PCS strategic goals



Director of Human Resources and member of the PCS executive team, Steve Taranto, talks with 14-year-old patient, Christopher Burr, and his mom, Jeanne Winslow, about what's working at MGH and what's not.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

An update on our 2008 strategic goals

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

As we near the end of fiscal year, 2008, I want to bring you up to date on the progress we're making on our strategic goals. You may recall that following our Patient Care Services Executive Committee retreat last September (Pursuing Perfection: Making IOM Aims a Reality), we identified five goals we felt deserved our effort and attention as we continually try to improve care-delivery and the care experience for our patients. Our 2008 strategic goals were:

- Strategic Goal #1: *Through the patient's eyes*
  Seek the patient's voice to improve the experience of care
- Strategic Goal #2: *Follow the evidence*
  Achieve and sustain evidence-based quality indicators
- Strategic Goal #3: *Handle with care*
  Decrease patient and staff injuries through the use of safe patient-handling practices
- Strategic Goal #4: *Lean & Clean*
  Provide a clean and clutter-free environment for patients and staff
- Strategic Goal #5: *Team PCS*
  Enhance teamwork to achieve excellence in care delivery

We spent considerable time in the weeks and months following the retreat talking about the tactics we would employ to achieve these goals, and I'm happy to report we've made significant progress in all areas.

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Working toward Goal #1 to seek the patient's voice, we employed a number of tactics, including developing a greeter program to help patients arriving at the hospital feel more comfortable and supported. This takes the form of something as simple as giving directions or escorting a patient to his/her destination. It can involve providing a little extra support when a patient may need assistance, such as waiting in line at the Pharmacy or helping navigate the cafeteria. Patients and visitors have been very appreciative of this service that offers a personal touch to their hospital experience.

Members of the PCS executive team conducted one-on-one interviews with patients and family members to hear directly from them what's working and what's not. Random interviews were conducted on all inpatient units throughout the summer generating lots of great feedback. We'll review the themes that emerge from these interviews along with data from other key sources to identify opportunities for improvement.

We heard from patients that noise is an issue on inpatient units, so we've conducted an assessment of the care environment to identify sources of noise and strategies to minimize or eliminate unnecessary noise when

continued on next page

I want to thank everyone in Patient Care Services for your participation and enthusiasm in advancing our strategic plan. Our patients depend on us to bring our best efforts, ideas, and advocacy to the table. I know you share my commitment to honor that trust.

possible. We're piloting a number of noise-reduction products including earplugs and television headphones, and we're developing systems to evaluate the effectiveness of this work.

Goal #2 speaks to our commitment to meet and exceed evidence-based standards for quality and safety. Our tactics for achieving this goal include creating a template for sharing nursing-sensitive indicators at the unit level; raising awareness about 'never events' (serious, preventable, patient-care incidents) through presentations and meetings; and increasing our use of electronic tools to maintain accuracy and transparency in our reporting (electronic ordering, LMR training, acute-care documentation, etc.)

Goal #3 is intended to reduce patient and staff injuries with increased awareness of safe patient-handling practices and access to assistive equipment. We are well into our roll-out of ceiling lifts and bed trapezes, and Gaurdia Banister, RN, executive director of The Institute for Patient Care, is assembling an inter-disciplinary team to design training sessions to support staff in making safe, informed, patient-handling decisions.

Goal #4 employs a number of tactics to ensure a clean and clutter-free environment for patients and staff. We've initiated an advisory group among unit service associates to inform our work, and this group is a rich source of ideas and suggestions. We've installed additional glove and Cal Stat dispensers in common areas throughout the hospital, and we're working with Environmental Services to place Cal Stat dispensers near the most traveled elevators on the first floor. We actively support the MGH recycling initiative, and we are conducting a comprehensive overview of proposed and existing initiatives that support a clean and clutter-free environment.

Goal #5 explores opportunities to enhance teamwork and promote inter-disciplinary collaboration to foster excellence in care-delivery. Some tactics we're employing to achieve this goal include open-forum meetings with various role groups; Personalysis training to enhance communication skills; team-building exercises to promote camaraderie, and unit-based and departmental Cultural Rounds, led by Deb Washington, RN, director, PCS Diversity Program. We are exploring the feasibility of an inter-disciplinary practice committee to further support collaboration and teamwork.

These are only a few of the outcomes we've achieved, and they speak to the importance and appropriateness of the goals we selected. Later this month, the PCS executive team will once again come together for our annual strategic planning retreat. We will revisit these goals, assess our current reality, and chart our direction for 2009. I want to thank everyone in Patient Care Services for your participation and enthusiasm in advancing our strategic plan. Our patients depend on us to bring our best efforts, ideas, and advocacy to the table. I know you share my commitment to honor that trust.

Update

In the coming weeks, the Staff Perceptions of the Professional Practice Environment Survey will be distributed to clinicians throughout Patient Care Services. This is your opportunity to offer your opinions, suggestions, or concerns about your practice environment. The survey is an invaluable systems-improvement tool. I hope you'll make it a priority to respond.

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The awakening

A pediatric nurse recalls the powerful act of caring for a child at the end of life

— by Kathie Pazola, RN, pediatric staff nurse

When David arrived with his young African 'nurse,' it was evident his disease had grown and metastasized. He was dying. He couldn't see, speak, swallow, or stand. And he was in pain. The plan for treatment had changed. David now needed compassionate, end-of-life care.

He was with us for only five days. Five memorable days. Days I call, 'the awakening.' 'David' was three years old, weighed just 15 pounds, and had bilateral retinoblastoma, a malignant tumor of the eye. A charitable organization run by an American woman, Brook, found him in a clinic in Africa and sponsored his trip to the United States with the hope of curing him. But it was not to be.

When David arrived at the Eye and Ear Infirmary with his young African 'nurse,' Claudine, it was evident his disease had grown and metastasized. He was dying. He couldn't see, speak, swallow, or stand. And he was in pain. The plan for treatment had changed. David now needed compassionate, end-of-life care.

The next day, a team meeting was held with Brook, his sponsor. After much discussion, a Do Not Resuscitate order was put in place. It was agreed by all that the goal was to keep David comfortable until his death. Brook was devastated. She and members of her church had been prepared to support David through whatever treatments were necessary with the goal of returning a healthier boy to his parents in Africa. Now, she had the sad job of calling his parents in their village to tell them David would not be returning home.

Kathie Pazola, RN, pediatric staff nurse

I began to care for David after that meeting. The shift from cure to end-of-life care was difficult for Brook. In a short period of time, she had to adjust to the reality that she was now his family, and she would have to see him die. Much of my care was supportive of her, so she could be strong for David. To ensure continuity of care, a core group of nurses cared for David. We all made sure Brook ate, rested, got relief, and had an opportunity to share her feelings. Brook felt responsible for Claudine, who was in a strange country and would also have to deal with the loss of David.

A palliative care physician provided support to them, and offered suggestions on how to personalize David's care. We played African music for him. Brook wrapped him in a beautiful afghan that a church member had made and rocked him for many hours. In the evening, a child life specialist made plaster hand- and footprints of David as a keepsake for his parents.

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I spent time preparing Brook for the physical changes that would occur as David grew closer to death. Though difficult to hear, I've found that preparing families lessens their panic and makes the experience of being with a loved one at the end of life less anxious. As I rubbed David's little feet, I talked to Brook.

I was in charge of the unit that evening and had two other patients to care for. The unit was full to capacity and very busy. It was taxing to try to tend to everything going on and then go quietly into David's room to be truly 'present' for him. Our clinical nurse specialist offered to help in any way she could, and I appreciated her support.

In our five days with David, we truly worked together to help him have a 'good death.' Caring for this little boy who didn't speak and didn't know us awakened feelings in me that are usually hidden away for self-protection. We took turns bearing witness. We felt a sense of connectedness to him, to each other, and all humanity. It was powerful. It was memorable. And it changed us.

The senior resident covering that evening approached me to ask how David was doing. He told me he'd only seen two other children die during his residency, and he asked for guidance. I felt this was a good opportunity to role-model. We sat together and discussed the changes that could occur as David got closer to death and what we would do in each instance. We shared our sense of helplessness and sadness about David. I told him I admired him for being open to asking for help. I suggested he spend time with David and Brook to be present with them. I told him that just being there was an important intervention.

At midnight, Brook called David's father in Africa and put the phone to David's ear. He could only grunt and raise his eyebrows in response to his dad's words. It was clear he knew who was on the other end of the receiver. Brook continued to link David and his family with phone calls. It was touching to witness.

When I reported off that evening, I finally had an opportunity to process what I'd been feeling, and my peers supported me. Everyone who had cared for David had done the same thing—held it together to do what needed to be done, then let it out with tears at the end of the shift. It was a profound, daunting, and tender experience to care for David as we walked with him toward death. His room had become a sacred space.

For the next couple of days, we continued to keep David comfortable with morphine, positioning, foot rubs, and mouth care. Geraldine, one of the core nurses wanted to write a letter to David's parents and asked me what I thought. I felt it was a good idea. It would help link them to their son's final days. She found a beautiful brocade journal, and all his caregivers and visitors wrote messages to his family. I wrote that I tried to keep David comfortable, and that I was honored to care for their boy. David was peaceful and surrounded by caregivers when he died on that fifth day. Two nurses attended his memorial service at a funeral home that was familiar with African customs. They bore witness publicly to David's life. Brook and Claudine were strong and thanked us for our support throughout David's hospitalization.

In our five days with David, we truly worked together to help him have a 'good death.' Caring for this little boy who didn't speak and didn't know us awakened feelings in me that are usually hidden away for self-protection. We took turns bearing witness. We felt a sense of connectedness to him, to each other, and all humanity. It was powerful. It was memorable. And it changed us.

For physical therapist, individualized care means looking beyond traditional testing methods

My name is Laura Tikonoff, and I have been a staff physical therapist at MGH since 2006. Currently, I work on the inpatient Neuroscience Service. This narrative describes my experience with 'Kelly,' a 46-year-old woman who was mentally challenged, and who challenged me to look beyond traditional testing and communication methods to improve her care.

Laura Tikonoff, PT, physical therapist

Physical therapists use a number of standardized tests during evaluation to identify impairments that can inhibit a patient's physical function.

A local hospital had transferred Kelly to MGH with suspected seizures and pneumonia. Kelly began her MGH hospitalization in the Neuroscience Intensive Care Unit; she was transferred to my unit after her condition stabilized. Kelly's physicians consulted physical therapy early to evaluate and treat her. They recognized that patients with Kelly's diagnoses can develop weakness, tight muscles, and reduced tolerance to activity during hospitalization. This de-conditioning can impede a patient's balance and ability to walk safely.

Physical therapists use a number of standardized tests during evaluation to identify impairments that can inhibit a patient's physical function. Therapists use these tests to establish a patient's plan of care. The goal is to maximize the patient's physical function and make recommendations regarding discharge needs.

One of my colleagues evaluated Kelly in the Neuroscience ICU. Her write-up noted that Kelly lives in a group home and ambulates using a gait belt and a rolling walker with the help of two people. Her evaluation revealed a significant impairment in Kelly's cognition and communication: "Kelly is non-verbal, does not follow commands and is stimulus-bound." Kelly's condition prevented my colleague from using the typical tests to identify impairments in Kelly's strength, balance, range of motion, and activity tolerance.

When Kelly was transferred from the ICU to my care, her strength, balance, activity tolerance, and overall mobility remained unclear. My task was to identify any additional impairments, relate them to Kelly's ability to function, and refine her plan of care. When I entered her room for the first time, Kelly was lying in bed with four bed rails up. She was restless and, although her head was turned toward the door, her gaze was fixed somewhere above the door frame.

"Hi, Kelly," I said. She didn't respond. I stepped into the room. "Hi, Kelly." Again, no acknowledgement. I went to the bedside.

Looking for a way to connect with her, I noticed a small, stuffed pig on her bedside table. I picked it up, thinking a familiar object might comfort her. She turned toward the toy and smiled, particularly when I squeezed the toy and it began "oinking." Success. Seizing the opportunity, I tried to assess the strength and range of motion in Kelly's arm. However, just as

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I completed a discharge summary so Kelly's next therapist could benefit from what I'd learned about Kelly's behavior. While Kelly's new therapist would not have to decipher her behavior as I had, I valued my experience with Kelly because it forced me to recognize that treating patients often requires looking beyond traditional testing methods.

quickly as it appeared, her smile faded, and her gaze again fell somewhere across the room. When I lifted her left arm, her right hand began slapping my left forearm. I reached for the stuffed pig again in an attempt to elicit another smile, but this time, it was unsuccessful.

Further attempts at standardized tests and measures failed. I decided to see if Kelly could roll onto her side, thinking it would be a familiar position due to her moderate mobility at home. As I attempted to roll Kelly onto her left side, I was met by more slapping and physical resistance. Disappointed, I returned Kelly to her original position and left.

Reflecting on my experience with Kelly, I realized I would not only need to find a motivating task to engage Kelly, but also find a way to evaluate her outside of traditional standardized tests and measures. Searching for more information, I asked Kelly's nurse how she behaved with other staff. Kelly's nurse reported similar behavior with others.

I decided to call Kelly's father, thinking he would be able to provide more insight into Kelly's interests, motivations, and behavior. I reached him at a bowling alley; his voice and the sound of falling pins echoed as we talked. I explained to Kelly's father that I was struggling to engage Kelly and that, during our first session, she had slapped me. "Oh, that's not slapping," he said, "It's her way of communicating. It means she likes you." A reasonable explanation, I thought. I asked him about Kelly's interests. He said she enjoyed sitting with her friend at the group home and "passing cards." It doesn't matter what kind of cards, he informed me, she just enjoys the passing aspect. "She can do it for hours," he said. I thanked him for his time and told him I'd update him later on Kelly's progress.

With this information, I decided to use the passing activity to learn more about the strength and range of motion in Kelly's upper extremities, her motor control, postural stability in sitting, and the effectiveness of her balance reactions.

The next day, I arrived in Kelly's room with playing cards. I found her in a similar state—slightly restless with her gaze fixed above the doorway.

"Hi, Kelly." No response. I took the playing cards out of my pocket. "Kelly, look what I have." Almost immediately, she smiled broadly, laughed, and began tapping my arm affectionately. I held out a card and she reached for it. I could see that her motor planning and timing were intact in this arm. She looked for the next card. Careful not to interrupt her attention to the game, I assisted Kelly to the edge of her bed. She didn't resist as she continued to focus on the cards. We engaged in the passing game for about thirty minutes, during which time I observed Kelly reach outside of her base of support in all directions. I was able to examine her shoulder range of motion, muscle strength, activity tolerance, and balance reactions. Using this game that Kelly enjoyed, I was able to observe her movement and refine a treatment plan for future therapy sessions.

During my next session, I hoped to observe Kelly's gait mechanics and ability to transfer from the bed to a chair. Success in these tasks would make her discharge more likely. I brought a rolling walker, a gait belt, and another person to assist me, trying to simulate the same conditions under which Kelly stands and walks at home. As soon as the walker came into view, Kelly reached out for the grips and stood up. Once again, she was smiling and laughing. During our session, I learned more about her activity tolerance, standing posture, balance, and gait mechanics.

I concluded that due to the de-conditioning experienced during her hospitalization, Kelly was weak and experiencing reduced activity tolerance. As my colleague and I had suspected, these impairments affected Kelly's balance and gait. For this reason, Kelly was discharged to an inpatient rehabilitation facility where therapists could continue to focus on improving her overall mobility so she could return home and resume her daily activities. I completed a discharge summary so Kelly's next therapist could benefit from what I'd learned about Kelly's behavior. While Kelly's new therapist would not have to decipher her behavior as I had, I valued my experience with Kelly because it forced me to recognize that treating patients often requires looking beyond traditional testing methods.

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

This narrative beautifully demonstrates individualized care and the importance of getting to know the patient. Laura's perseverance and clinical curiosity unlocked the mystery of how to connect with Kelly. Her interventions and interactions allowed her to complete the necessary assessment of Kelly's abilities in order to frame a plan of care. And sharing this information with the rehab team will help speed her recovery. This narrative reminds us to ask the important questions and not assume anything.

Thank-you, Laura.

Early detection makes for very happy ending

—by Edie Sinagra Constantine

The MGH Vascular Center and the department of Nursing will sponsor another Information and Screening Day, Tuesday, September 16, 2008, from 10:00am–12:00pm in the main corridor.

My name is Edie Sinagra Constantine. Earlier this year, I was transitioning from one position to another while at the same time planning my wedding to a wonderful man who also works at MGH. A physician I work with invited me and two of my coworkers to lunch one day to celebrate these upcoming events. On the way back, we passed some members of the MGH Vascular Center staffing an information table in the main corridor. They were offering free carotid-artery screenings. The screening is a quick and easy method of evaluating a person's risk for a stroke. They urged me to be screened, but I felt I was in great health, I exercised, my cholesterol was low, and I didn't smoke. Plus, I was very busy.

But back at my desk, I couldn't concentrate. I kept thinking about my mother who had died 15 years earlier from a stroke caused by blocked carotid arteries.

I had watched my mother suffer for a year after her stoke. This vital woman was left with paralysis, short-term memory-loss and a complete loss of independence. For several months, she was on a ventilator unable to communicate. She went into a nursing home and died a year later.

I remember thinking, why didn't we have her checked? She had been a chronic smoker. Maybe if she'd had the screening, she'd still be here. I turned to my colleague and said, "I'm going to get screened."

I anticipated a quick procedure and I'd be back at my desk. But when the test was over, Irina Staroselskaya, the vascular technologist, put both her hands on mine and looked me in the eye. "Call your primary care physician immediately," she said.

After a brief bout with denial, I called my physician. She told me to go to Warren 9 for a second test. As I waited, more doctors were paged. Fear started to set in. I called my future husband and asked him to come to Warren 9 for support.

I was told I had a 90-99% blockage of my right carotid artery and I needed surgery. I explained I was getting married in two days. He said it would be okay to wait until after the wedding, but I should be aware of the symptoms of a stroke: changes in vision, speech, or strength. If I experienced any of these symptoms, I was to come to the Emergency Department right away.

The next day, Valentine's Day, I married the man I loved surrounded by my family and friends. Our honeymoon was postponed as I prepared to have surgery a few days later. But two days before the scheduled surgery, I was driving on the highway when my vision became blurry. Was I having a stroke? When I got home, I told my daughter, and she drove me immediately to the Emergency Department. A few hours later, I was in surgery. And fortunately for me, 24 hours after that, I was on my way home.

I think back to that day walking through the main corridor, and I'm so grateful I took the extra five minutes to get the screening. If I hadn't, I most likely wouldn't have been around to appreciate my husband, my family, my grandchildren, and my newest grandson born just last week.

The MGH Vascular Center and the department of Nursing will sponsor another Information and Screening Day, Tuesday, September 16, 2008, from 10:00am–12:00pm in the main corridor. If you're in the area, I hope you'll take advantage of this opportunity. It could save your life. I know it saved mine.

Make sure you have time to stop and smell the roses.

What is The Institute for Patient Care?

The Institute for Patient Care is comprised of four centers: The Norman Knight Nursing Center for Clinical & Professional Development, The Blum Patient & Family Learning Center, The Yvonne L. Munn Center for Nursing Research, and The Center for Innovations in Care Delivery. The Institute was designed to support the work of each center promoting a synergy to advance multi-disciplinary clinical work within Patient Care Services.

Question: What is the focus of each center within the Institute?

Jeanette: The Norman Knight Nursing Center for Clinical & Professional Development advances professional development with resources that assist clinicians and other members of the healthcare team to provide high-quality, safe, cost-effective care.

The Center for Innovations in Care Delivery brings inter-disciplinary teams together to identify opportunities for change; evaluate the impact of proposed changes; and construct and implement innovations to improve the delivery of care at MGH and beyond.

The Maxwell & Eleanor Blum Patient and Family Learning Center provides the highest-quality patient-education and health information to the diverse community of MGH patients, families, and staff.

The Yvonne L. Munn Center for Nursing Research focuses on developing, testing, utilizing, and disseminating knowledge obtained through research to improve patient care and optimize professional practice.

Question: Does the Institute house any other programs?

Jeanette: Other programs under the umbrella of The Institute for Patient Care include Collaborative Governance, the Clinical Recognition Program, Ethics and Clinical Decision-Making, Simulation, the International Visitors Program, Credentialing, Workforce Development, Organizational Evaluation and Clinical Affiliations.

Question: Where is the Institute located?

Jeanette: The Institute for Patient Care is located on the third floor of the Founders Building (Founders 316).

Question: What is the purpose of the Institute?

Jeanette: The first-of-its-kind Institute for Patient Care was created to develop innovative answers to the challenges we face. It fosters a multi-disciplinary environment for the advancement of professional development, education, research, and innovation grounded in the values and vision of Patient Care Services. The delivery of safe, timely, efficient, evidence-based, culturally competent care to our patients and families is our primary focus.

Question: What projects is the Institute currently working on?

Jeanette: The Institute is focusing on a number of activities, including:

- partnering with educational institutions to create new models for student education and increase diversity in the nursing workforce
- participating in strategic planning to better meet the learning needs of patients and families
- creating and implementing an RN residency program to build geropalliative nursing-care capacity and improve the quality of nursing care to elders and their families
- planning and implementing of The Staff Perceptions of the Professional Practice Environment Survey

Question: Who leads the Institute?

Jeanette: Gaurdia Banister, RN, is the executive director of The Institute for Patient Care. Gaurdia meets regularly with nursing directors and PCS leadership and interacts with staff in Collaborative Governance, the Clinical Recognition Program and other forums to keep current with day-to-day operations on patient care units and identify ways in which the Institute can support the needs of staff. For more information about The Institute for Patient Care, call Gaurdia at 4-1266.

Announcements

Staff Perceptions of the Professional Practice Environment Survey

In the coming weeks, the Staff Perceptions of the Professional Practice Environment Survey will be distributed to clinicians within Patient Care Services.

The survey gives clinicians a chance to voice their support and/or concerns about aspects of the professional practice environment.
Every voice is important.
All information is reported.

Please make it a priority to respond.

Help enhance the professional practice environment for clinicians throughout Patient Care Services so they can do what they do best—care for patients and families.
For more information, call Susan Lee, RN, at 4-3534.

Call for Abstracts

Nursing Research Expo 2009

Submit your abstract to display a poster during the Nursing Research Expo 2009

Categories:

- Original research
- Research utilization
- Performance improvement

For more information, contact Laura Naismith, RN; Teresa Vanderboom, RN; or your clinical nurse specialist.

To submit an abstract, visit the Nursing Research Committee website at: www.mghnursingresearchcommittee.org

The deadline for abstracts is January 15, 2009.

2008 Robert W. Carey, MD, Lectureship

Sponsored by the nursing staff of the Yawkey 8 Infusion Unit

Speaker: Debra Jarvis, MDiv, oncology chaplain, Seattle Cancer Care Alliance

Topic: "Caring for Our Own in Times of Serious Illness and Stress"

Thursday, September 25, 2008
5:00–7:30pm
O'Keeffe Auditorium

All are welcome
No charge for MGH employees
Other fees may apply

For more information or to register, e-mail: cghiloni@partners.org, or call 617-724-5420.

MGH Photography is moving

Effective Wednesday, September 3, 2008, the Photography Department has moved its customer service center (drop-offs and pick-ups) from Bulfinch 045 to WACC 232 (Police, Security & Outside Services).
This temporary move is to allow renovation of the space in the Bulfinch basement. The service center will return to its original location when renovations are completed.

How does this affect you?

All drop-offs and pick-ups will be handled in our temporary office on WACC 232.

Our telephone number (6-2237), e-mail address (mghphoto@partners.org) and pager numbers remain the same.

All services will continue to be provided.

Thank-you for your patience and understanding during this facility improvement.

Elder care discussion group

Elder care monthly discussion groups are sponsored by the Employee Assistance Program.

Next session:

September 9, 2008
12:00–1:00pm
Maynard Conference Room
Yawkey 7-980

Facilitator:
Janet Loughlin, LICSW
Speaker:
Barbara Moscowitz, LICSW, geriatric social worker

Join us to discuss subjects relevant to elder caregiving.

All are welcome. Feel free to bring a lunch.
For more information, call 6-6976 or visit www.eap.partners.org

Save the dates:

Symposium on geriatric care

65*plus* and The Norman Knight Nursing Center for Clinical & Professional Development present:
the second annual
Best Practices in Acute Care for Older Adults

This two-day program brings together experts to discuss patient-centered and evidence-based care of older adults. Participants will develop a better understanding of best practices in geriatric care in order to promote safety, prevent harm, and recognize common geriatric syndromes. All clinicians are welcome; recommended for those interested in geriatric certification.

Friday October 31, 2008, and
Monday November 17, 2008
8:00am–4:00pm
O'Keeffe Auditorium

For more information, call 643-4873.

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Publisher
Jeanette Ives Erickson, RN
senior vice president for Patient Care

Managing Editor
Susan Sabia

Editorial Advisory Board
Chaplaincy
Michael McElhinny, MDiv

Editorial Support
Marianne Ditomassi, RN
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Training and Support Staff
Stephanie Cooper
Tom Drake

The Institute for Patient Care
Gaurdia Banister, RN

Volunteer Services, Medical Interpreters, Ambassadors, and LVC Retail Services
Pat Rowell

Distribution
Ursula Hoehl, 617-726-9057

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

Next Publication
September 18, 2008

Educational Offerings – 2008

September 9

BLS/CPR Certification for Healthcare Providers

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

September 9

Chaplaincy Grand Rounds

Yawkey 2-220
11:00am – 12:00pm
No contact hours

September 10

Phase I Wound-Care Education Program

Simches Conference Room 3120
8:00am – 4:30pm
Contact hours: 6.6

September 10

Nursing Resilience: Bouncing Back

Charles River Park
8:00am – 4:30pm
Contact hours: TBA

September 10

Nursing Grand Rounds

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

September 10

OA/PCA/USA Connections

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

September 10

Nursing Research Committee's Journal Club

Yawkey 2-210
4:00 – 5:00pm
Contact hours: 1

September 11, 16, 18, 23, 30 and October 2

Greater Boston ICU Consortium Core Program

BMC
7:30am – 4:30pm
Contact hours: TBA

September 12 & 15

Neuroscience Nursing Certification Course

Simches Conference Room 3110
8:00am – 4:30pm
Contact hours TBA

September 12

Basic Respiratory Nursing Care

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

September 12

Assessment and Management of Psychiatric Problems in Patients at Risk

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

September 17

Simulated Bedside Emergencies for New Nurses

POB 448
7:00am – 2:30pm
Contact hours: TBA

September 18

Workforce Dynamics: Skills for Success

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

September 18

Oncology Nursing Concepts

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

September 23

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00 – 11:00am
Contact hours: TBA

September 25

Nursing Grand Rounds

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

September 25

Caring for Patients with Heart Failure

Simches Conference Room 3110
8:00am–4:30pm
Contact hours: TBA

September 26

MGH School of Nursing Alumni Program

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

September 26

Ovid/Medline: Searching for Journal Articles

Founders 334
9:00–11:00am
Contact hours: 2

September 26

Simulated Bedside Emergencies for New Nurses

POB 448
7:00am – 2:30pm
Contact hours: TBA

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

Caring for older patients just got 'GREAT'

—by Georgia Peirce, director, PCS Promotional Communications and Publicity

MGH nurses, Deborah D'Avolio, RN, geriatric specialist (mentor), and Susan Gordon, RN, nursing director, Ellison 16, General Medical Unit (fellow), are creating an inter-disciplinary collaboration in the form of a new rounding process to disseminate best practices for geriatric patients. Called Geriatric Rounds to Evaluate, Assess, and Teach (GREAT), the project is based on evidence that many geriatric syndromes are preventable and may signal a need for further assessment and intervention.

> "In the next thirty years, the number of people over the age of 62 is projected to double from 40 to 80 million. This initiative stems from our commitment to meet and exceed the needs of older patients who seek our care."
>
> —Jeanette Ives Erickson, RN, senior vice president for Patient Care

Says Jeanette Ives Erickson, RN, senior vice president for Patient Care, "In the next thirty years, the number of people over the age of 62 is projected to double from 40 to 80 million. This initiative stems from our commitment to meet and exceed the needs of older patients who seek our care."

In 2004, MGH became the first hospital in Massachusetts to be designated a NICHE (Nurses Improving Care for Health System Elders) site by the John A. Hartford Foundation. Building on the NICHE philosophy, MGH expanded the program to include other disciplines, calling it 65*plus*. The GREAT project, which is being conducted in partnership with 65*plus*, is part of the 18-month Geriatric Nursing Leadership Academy offered by Sigma Theta Tau International. The academy, funded by the John A. Hartford Foundation in partnership with the Hartford Foundation's Centers of Geriatric Nursing Excellence, was developed to prepare and position nurses to influence practice and patient outcomes in geriatric care. The training enables nurses to lead inter-disciplinary teams in improving health care for older adults and their families.

For more information about the program, contact Deborah D'Avolio at 3-4873.

Caring Headlines
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