Caring Headlines
October 15, 2009

Safe Patient Handling

Equipment fair features state-of-the-art assistive devices to help keep patients and staff safe

—by Tucker O'Day, PT, program manager, Ergonomics

The health and safety of patients and caregivers was the focus of the second annual Safe Patient Handling Fair, October 1, 2009, under the Bulfinch Tent. Hosted by The Institute for Patient Care, The Norman Knight Nursing Center for Clinical & Professional Development, Occupational Health Services, and Partners Healthcare Ergonomics, the fair provided an opportunity for staff to see and try state-of-the-art patient-handling equipment, such as ceiling lifts, lateral transfer devices, motorized chairs, portable lifts, sit-stand devices, slide sheets, and much more.

As caregivers devote themselves to providing patient care and comfort, some repetitive and strenuous actions have the potential to cause injury or strain. Musculoskeletal disorders, or strains, account for the majority of work-related injuries, missed work time, and medical costs. And heavy lifting, transferring, and re-position-

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Staff have opportunity to try out state-of-the-art, safe patient-handling devices at recent equipment fair under the Bulfinch Tent.

Jeanette Ives Erickson

What does 'responsiveness' mean to you?

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

As is so often the case in health care, the answers to many pressing questions can be found in the Golden Rule: "Do unto others as you would have them do unto you." This simple adage is at the core of the national debate on healthcare reform, and it's the universal guiding principle for all the caring professions. It's the basic tenet that should guide our thinking when we talk about responsiveness.

One dictionary defines responsiveness as: "the ability of a system to adjust quickly to suddenly altered conditions and resume stable operations without undue delay." When I asked Gino Chisari, RN, our director of The Knight Center for Clinical & Professional Development, what he thought about responsiveness, he said, "Responsiveness has to do with caring enough to look beyond our own interests to help other people. It's 'the thing' that makes us willing to reach out to one another. It's about being present."

I *like* that definition.

We know from our patient-satisfaction data that our ability to respond quickly to patients' needs is very important. It enhances the patient experience and contributes to numerous positive outcomes including a decrease in falls and pressure ulcers. Research shows that a prompt response to patients' call bells instills a sense of safety and security and contributes to a trusting relationship with caregivers. But as Gino reminds us, responsiveness isn't *just* about speed.

When it comes to responsiveness, we need to be careful not to limit our thinking. Responsiveness is more about attitude than prompt responses to patients' call bells.

When it comes to responsiveness, we need to be careful not to limit our thinking. Responsiveness is more about attitude than prompt responses to patients' call bells. It affects every aspect of health care: managing pain, respecting differences, answering telephones, keeping people on hold, accommodating preferences—it is integral to every dimension of our practice.

We are fortunate at MGH to enjoy a reputation as a world-class hospital. We employ the best and the brightest so we can provide the highest quality care to a diverse and complex patient population. But expertise alone does not earn a patient's trust. It is the human factor—kindness, compassion,

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communication, and responsiveness—that translates into patient satisfaction and loyalty.

Laurel Radwin, RN, nurse researcher in The Yvonne L. Munn Center for Nursing Research, has conducted a number of studies on the nature and impact of patient-centered care. Responsiveness has emerged as a key element in her research. In her studies, patients identified eight attributes of excellent care, three of which are: caring, attentiveness, and rapport—a sense that patients feel heard and that their needs are being met. In each study, attributes such as proficiency, a sense of concern, the ability to nurture, and the ability to provide individualized care were just as important to patients as speed and promptness. This is a significant finding.

Responsiveness doesn't just apply to nurses, and it extends beyond the inpatient setting. Every clinician, every discipline, every role group plays a part in meeting patients' needs. The more collaborative our practice, the more effective and responsive our care.

We've talked before about hourly rounding and the '7 Ps.' Some units have already adopted this approach. Every time a clinician checks on a patient he or she evaluates: Person, Plan, Priorities, Personal Hygiene, Pain, Positioning, and partnering through Presence. We're already seeing that this practice minimizes the risk of patient falls and has a positive effect on patient satisfaction. This is the essence of patient-centered care.

We call it 'responsiveness,' but we're really talking about being proactive in the care we provide. We're talking about anticipating patients' needs and taking actions to meet those needs before the patient experiences any stress, discomfort, irritation, or frustration. We're talking about doing for others what we would want done for us if we were patients in this hospital.

Our commitment to excellence stems from our desire to do right by our patients. It's more than a clinical concern, it's a moral and ethical concern. It's the reason no one at MGH says, "That's not my job." If it improves the patients' experience of care, it's everyone's job. It's everyone's concern.

I'm happy to see so many caregivers and support staff engaged in efforts to improve the patient experience. I hope you'll continue to share your best practices so all our patients can benefit from your wisdom and creativity.

Update

I'm pleased to announce that Mary Ellin Smith, RN, professional development manager, will become the new co-chair of Collaborative Governance. And I'd like to thank Susan Lee, RN, for her past leadership.

In this Issue

Annual required training easier than ever before

—by R Gino Chisari, RN, director,
The Norman Knight Nursing Center for Clinical & Professional Development

With the implementation of HealthStream, we've been able to realize a significant savings in the costs associated with annual training and at the same time decrease the amount of time required to complete the courses.

October 1, 2009, was the official start of the new fiscal year at MGH. This coincides with our annual performance-review cycle. All Patient Care Services employees are expected to complete required training in preparation for their performance reviews. In the past, this training has been referred to as, "annual competencies" or "annual required training." The new, more accurate, term is Regulatory Compliance Training for Fiscal Year 2010. This is more than a title change; it is a process change.

In the past, the process of preparing the annual re-training program was a complicated system involving multiple steps and numerous people to produce and distribute the materials throughout Patient Care Services. With the implementation of HealthStream, we've been able to realize a significant savings in the costs associated with annual training and at the same time decrease the amount of time required to complete the courses.

To prepare for performance reviews in the past, staff spent a good deal of time gathering and collecting paperwork to submit as part of their review packets. On average, staff collected, signed, dated, attached, and submitted anywhere from 12 to 15 pieces of paper only to have the nursing director review, sign, date, copy, and submit them in duplicate or triplicate. The process was tedious and contributed to delays in completing annual performance reviews.

HealthStream has helped make the process more efficient. New this year are two regulatory training courses about which staff will be automatically reminded. The first, Nursing Providers Regulatory Compliance Training 2010, is required by all nurses who provide direct patient care. The course includes content specific to nurses, such as restraint education.

The second course, Hospital Regulatory Compliance Training 2010, is required by all other employees in the department of Nursing and is applicable to disciplines across Patient Care Services. Both programs meet current Joint Commission standards and our own institutional competencies. The courses have been reformatted, but the content is unchanged.

Point-of-Care Testing re-training, the Credo-Mission-Boundaries Statement, and attestation for current license and/or CPR/BLS certification have also been added to the HealthStream catalogue. Required courses are automatically 'assigned' to staff by HealthStream based on their review dates, and each staff member receives an e-mail notification from HealthStream reminding them to complete the course. When you receive the e-mail notice, you should begin to complete your regulatory compliance training so you're ready for your performance review.

Being in compliance with regulatory training is easier and more efficient than ever before. For more information about these changes please talk to your nursing director or manager, or contact me at 3-6530.

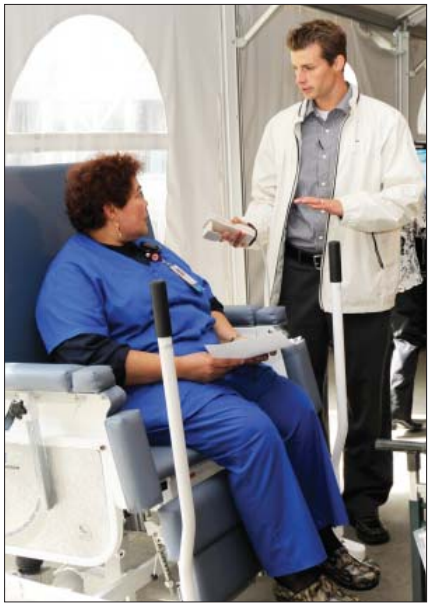
More than 1,000 staff members turned out for the Safe Patient Handling Fair, October 1, 2009. Staff nurse, Claribell Diaz, RN, won the raffle for the Wii fitness program.

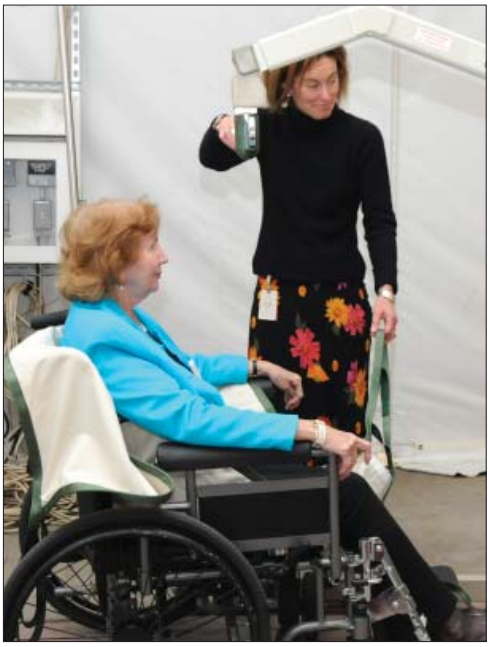
ing patients are the most commonly reported causes of work-related injuries. Using safe patient-handling equipment, such as the devices showcased at the fair, reduces physical strain on caregivers and minimizes discomfort for patients.

Said Gaurdia Banister, RN, executive director for The Institute for Patient Care, "The fair was an extension of the work of the Safe Patient Handling Task Force and an example of our commitment to fostering a safe environment for patients and staff."

As a bonus, fair-goers were able to receive their seasonal flu shots, try their skill on a Wii fitness program, participate in a raffle to win a Wii fitness program, and enjoy free snacks provided by Whole Foods and boYo Yogurt.

Plans for next year's fair are already underway. For more information, to suggest a piece of equipment, or to request an ergonomic consult, contact Tucker O'Day, PT, program manager for Ergonomics, at 6-6548.









Annual Collaborative Governance Grand Rounds

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

On September 17, 2009, collaborative governance celebrated its 12th anniversary with a special grand rounds highlighting the achievements of the seven collaborative governance committees. Gaurdia Banister, RN, executive director, The Institute for Patient Care, reminded attendees that they have much to be proud of this year, including helping MGH achieve the most successful Joint Commission survey ever.

In what were sometimes emotional tributes to outgoing collaborative governance figures, attendees said good-bye to:

- Carly Jean-Francois, RN, co-chair, Diversity Steering Committee
- Gayle Peterson, RN, co-chair, Ethics in Clinical Practice Committee
- Edna Riley, RN, co-chair, Nursing Practice Committee
- Victoria Morrison, RN, co-chair, Nursing Research Expo Sub-Committee
- Susan Croteau, RN, co-chair, Nursing Research Did You Know Poster Sub-Committee
- Angela McColgan, RN, co-chair, Patient Education Committee
- Ellen Robinson, RN, advisor, Ethics in Clinical Practice Committee
- Doreen Deluca, staff assistant to collaborative governance
- Susan Lee, RN, co-chair, collaborative governance

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, compared the outcomes of collaborative governance to the leadership attributes described by James Kouzes and Barry Posner in their book, *A Leaders Legacy*:

- Significance: what's really important, the difference you make
- Relationships: the importance of cultivating a network of colleagues
- Aspirations: the ability to envision a preferred future, charting the course
- Courage: the will to take a risk to achieve results

Said Ives Erickson, "I'm humbled by the achievements of our collaborative governance committees. It would be impossible to quantify the impact collaborative governance has had on our practice and on our organization."

Banister shared the reflections of OR nurse, Pat Wright, RN, who said, "Collaborative governance ignites us to want to do better. We own our practice. We don't focus on individual problems; we look at systems and how to make those systems work more effectively. We set our standards high. We are very lucky and very blessed."

To learn more about collaborative governance committees, visit: http://www2.massgeneral.org/pcs/The_Institute_for_Patient_Care/C_G/CG_Gov.asp, or contact Gaurdia Banister at 4-1266.

(Photos by Abram Bekker)






From top left: Jeanette Ives Erickson, RN; Gaurdia Banister, RN; Victoria Morrison, RN: Carly Jean-Francois, RN: Gayle Peterson, RN: Angela McColgan, RN: Edna Riley, RN; Ellen Robinson, RN; Susan Lee, RN; Susan Croteau, RN; and Doreen Deluca

AMMP recognizes educational achievement

—by Olako Agburu and Sandra Thomas

Every year, the Association of Multicultural Members of Partners recognizes outstanding efforts in continuing education by MGH employees through its annual AMMP Scholarship Program. At this year's presentation ceremony, held September 10, 2009, ten employees were awarded a total of $12,500 to support their education and career-advancement. Recipients are selected through a competitive process that includes an essay describing their career goals. Of the ten recipients, six are pursing degrees in Nursing

Carmen Vega-Barachowitz, SLP, chair of the Selection Committee, read some of the recipients' stories. Fatimazahra Ferrimy, patient care associate on the Blake 11 Psychiatric Unit, wrote, "I work hard to meet my commitments and effect change in society. To have a positive impact on someone's life is rewarding to me."

Nghi Huynh, staff assistant, is pursuing a master of Science degree in Nursing at Massasoit Community College. Huynh says her enthusiasm for becoming a nurse stems from, "a deep desire to help others and improve the quality of life for individuals less fortunate than myself."

Sabyne Denard, of Nutrition & Food Services, is pursuing a Nursing degree at the University of Massachusetts. She wants to make a difference in patients' lives, one patient at a time.

Serey Vorn, patient care associate on the Blake 4 Endoscopy Unit, says her life-long dream to become a nurse stems from her belief that under-represented communities deserve to have exceptional nurses who provide quality, compassionate care.

Jonathan Alicea, a surgical technician in the Same Day Surgical Unit, says, "My work shows that I have the technical skills to be a nurse and the patience and compassion to respect the profession as an art and a science."

Tandeka Hicks, operations associate, has a passion for nursing. She plans to advocate for healthcare awareness in the community through teaching and clinical care.

Said Vega-Barachowitz, "We wish these students well and look forward to working with them as they move forward in their careers at MGH." For more information about the AMMP Scholarship Program, send e-mail to: phsammp@partners.org.

Scholarship recipients Back row (l-r): Harold Roy, Tandeka Hicks, and Jonathan Alicea. Front row: Anastasia Howard, Fatimazahra Ferrimy, Serey Vorn, Nghi Huynh, and Nancy Kingori.

(Photo by Abram Bekker)

Listening, compassion, and respect: powerful interventions at the end of life

Elizabeth Henderson, RN
staff nurse, Emergency Department

My name is Elizabeth Henderson, and I am a nurse in the Emergency Department. I was working a recent Friday night shift when I assumed care of Mr. O, an 87-year-old man who'd been brought in by ambulance complaining of abdominal pain. It became clear right away that Mr. O needed a nurse, not only to tend to his physical needs, but to provide empathy, comfort, and compassion, as well.

For the first two hours of Mr. O's stay, discussion revolved around determining the best treatment for him. While physicians worked to figure out the best course of action, I had the pleasure of getting to know Mr. O. I learned about his life as a bachelor, the places he'd visited, and the places he wished he'd visited. I learned about a love he had lost and relationships he cherished; about his core values and beliefs and what gave him that sparkle in his eye.

A CT scan revealed that Mr. O was suffering from a dissecting abdominal aneurysm that would likely become life-threatening without surgical intervention. Despite Mr. O's age, the surgeon was certain he could repair the aneurysm, but uncertain as to whether Mr. O would survive the surgery. I watched as the surgeon explained the diagnosis and surgical option to Mr. O, who remained calm and cheerful. The surgeon's voice was anxious as he reviewed the risks of the surgery with Mr. O, a consent form at the ready.

A smile came over Mr. O's face as he listened to the surgeon. He politely allowed him to finish before turning to me and saying, 'He's a handsome fellow isn't he, and so young."

I looked into Mr. O's eyes, which revealed the slightest bit of sadness. I assured him the surgery would not take place without his consent. He smiled and reached for my hand.

"Thank-you," he said.

"For what?" I asked.

"For listening."

I smiled. I knew Mr. O had made up his mind.

The surgeon looked baffled, thinking perhaps Mr. O was confused. There was something almost serene about Mr. O, something that told me he was at peace. He wasn't confused, he wasn't scared. He understood the gravity of the situation.

The surgeon tried a second time to explain the surgery, but Mr. O promptly refused, saying, "I've lived a good life, Son. I don't want the surgery."

The surgeon assured Mr. O one more time that he had the skill to fix the aneurysm. Mr. O started to become agitated, having made what he believed was an informed decision. Sensing Mr. O's agitation, I asked the surgeon to step outside and give me a moment with my patient.

I looked into Mr. O's eyes, which revealed the slightest bit of sadness. I assured him the surgery would not take place without his consent. He smiled and reached for my hand.

"Thank-you," he said.

"For what?" I asked.

"For listening."

I went to the surgeon and explained that Mr. O was at peace with his diagnosis and his fate. I empathized

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with the surgeon, knowing he only wanted what he thought was best for Mr. O. But it was my job to advocate for my patient whose moral compass and spirituality had guided him to this decision.

"Please," I said, "Mr. O knows what's wrong with him. He's listened to you. Now you need to listen to him."

When we returned to Mr. O's room, Mr. O explained that some things weren't meant to be fixed. Disappointed, the surgeon left to report that there would be no surgery. When I saw him later, I commended him on his genuine desire to help Mr. O and his thorough explanation of the risks and benefits of the procedure. But sometimes, despite our medical capabilities, what's best for the patient is respecting his right to choose, and in so doing, maximize his independence. I wanted the surgeon to know that he had done Mr. O a great service in allowing him to make an informed decision.

The most effective intervention I performed that night was simply listening to him. Mr. O and I had communicated so candidly, we were able to form a strong relationship based on mutual respect and trust. He appreciated my sincerity and my ability to see him as a human being, not a victim of circumstance.

Over the next couple of hours Mr. O's condition deteriorated. His blood pressure dropped despite medical interventions, and his spirits seemed to fade. I realized that Mr. O probably wouldn't make it though the night. The resident had requested a bed for Mr. O on a unit, but I wanted to see Mr. O to his afterlife to make sure he was comfortable and didn't suffer. I had established a trust with him that made me want to remain his advocate to the end. I was in awe of his belief in fate and in his commitment to his beliefs. The resident was sympathetic and cancelled the request for a bed, giving me the opportunity to comfort Mr. O in his final hours.

Thanks to my colleagues, I was able to spend the next four hours sitting with Mr. O. We talked with ease, as if we'd known each other for years. He told me about his adventurous childhood and his years as a bachelor. He never married, and over the years, he became a bit of a hermit. He was well read, as evidenced by his vocabulary. I asked if there was anyone I could call for him and a silence came over the room.

"No," he said. "There's no one to notify. I don't have anyone."

His eyes became teary. I couldn't believe someone so interesting and sincere would have no one to call. We sat in silence for a while. I made sure he had blankets and pain medicine, though his pain had begun to subside as the time passed.

Finally, he said, "I have a brother. We haven't spoken in fifteen years. I regret that, but I don't want to call him today. I don't want him to feel sad or guilty."

I had respected Mr. O's wishes before. Now I struggled with my own desire to call his brother so he could say good-bye. But I didn't make the call. I tried to make Mr. O comfortable. We sat together, and I held his hand as he slowly began to drift off. He woke intermittently and smiled. His blue eyes seemed brighter each time. Just when I thought he had fallen asleep for the last time, he opened his eyes and asked for his scully cap (an Irish knit hat). I placed it on his head. Even in his dying hour, Mr. O's personality shone through.

I held his hand a little tighter. I thanked him for letting me sit with him and get to know him. He was slipping away, but I knew he had heard me. I held his hand for 37 more minutes until he finally passed away. I had tears in my eyes. Part of me was embarrassed for being so emotional over someone I'd only known for eight hours. Initially I was sad because I desperately wished he'd been able to die with family. But knowing I had followed his wishes and stayed by his side assuaged my heavy heart. He hadn't died alone.

I began to prepare Mr. O for post-mortem care. Though sad, I was comforted knowing that Mr. O had died with dignity. He had not suffered, of that I was certain. I had watched a brave man confront death with unwavering pride and confidence. I, too, believe in fate, and I had watched a man of conviction embrace his fate without fear. The most effective intervention I performed that night was simply listening to him. Mr. O and I had communicated so candidly, we were able to form a strong relationship based on mutual respect and trust. He appreciated my sincerity and my ability to see him as a human being, not a victim of circumstance. I will always remember Mr. O and be grateful for the lessons he taught me. Not everyone can be cured. Not everyone wants to be. Sometimes, despite all the options available, the patient just needs to be heard.

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

What a powerful narrative. Elizabeth's presence and advocacy were truly heroic. In a very short time, Elizabeth was able to forge a trusting relationship with Mr. O, one that ultimately allowed him to die with peace and dignity. The heart-wrenching account of her final moments with him make us appreciate the critical role nurses play in end-of-life care. We should all be lucky enough to have a nurse like Elizabeth 'usher us to the afterlife.' I'm so happy Mr. O did.

Thank-you, Elizabeth.

Acute Care Documentation project reaches critical mass

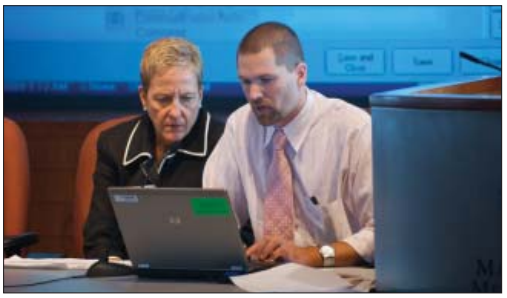
On September 14, 2009, more than 120 clinicians from MGH and BWH, participants in the Acute Care Documentation project, convened for a day-long retreat. The Acute Care Documentation project, slated to be piloted at MGH and BWH in 2010, will transition the hospitals from paper to electronic documentation (including inpatient medical records, flow sheets, assessments, and notes). The retreat was an opportunity for clinicians from both institutions to review the content that has been developed over the past six months and see a demonstration of the new system.

Using a mock patient-care scenario that involved numerous disciplines, participants saw how the new system will integrate clinical work-flow. Those who'll actually be using the system had an opportunity to see how it works and provide feedback for enhancements.

Christine Mace, RN, of the White 9 Medical Unit, was impressed with the progress that's been made. Said Mace, "It was great to see how quickly and easily nurses, doctors, and therapists will be able to enter and retrieve documentation with the new system. We all rely so much on the information provided by our colleagues in other disciplines—having that information available electronically is going to be very helpful."

For more information about the ACD project, contact Michele Cullen, RN, Information Systems ACD project manager, at mcullen1@partners.org.





(Photos provided by staff)

Representatives from MGH and BWH convene for day-long retreat to review progress in the Acute Care Documentation project.

Nursing Research Committee Journal Club

—submitted by the Nursing Research Committee

In three separate presentations, the Nursing Research Committee Journal Club recently heard from MGH nurse researchers, Jennifer Repper-DeLisi, RN; Amanda Coakley, RN; Carol Ghiloni, RN; and Deborah D'Avolio, RN.

Repper-DeLisi talked about her study, "Successful implementation of an alcohol withdrawal pathway in a general hospital," published in the July-August, 2008, *Psychosomatics*. Her multi-disciplinary task force developed a standard to help recognize and treat alcohol withdrawal syndrome in medical-surgical patients. Repper-Delisi described the extensive review of literature and charts conducted as a first step. She shared the results of her study utilizing 40 patients pre- and post-pathway implementation. Data suggested that the pathway helped identify those at risk so that treatment could be initiated prior to the onset of symptoms, and patients already in withdrawal could be aggressively treated .

In July, Coakley and Ghiloni shared the findings of their study, "Evaluating the Carol A. Ghiloni Oncology Fellowship Program," published in the April 8, 2009, issue of *Creative Nursing*. Coakley and Ghiloni described the development of the fellowship program and its goal to increase the exposure of nursing students to oncology nursing between their junior and senior years. They conducted a focus group with graduates of the fellowship program and found that participants reported that the fellowship provided: a confidence-building experience; an opportunity to make informed career choices; an experience of preceptor role-modeling; and an opportunity to develop relationships with staff, patients, and families. The fellowship was also an effective educational and recruitment tool that could be replicated for other specialty nursing areas.

In September, Deborah D'Avolio, RN, presented her original research, "Access to care and health-related quality of life among older adults with non-urgent emergency room visits," published in *Geriatric Nursing* in 2008. Her research team interviewed emergency-room patients over the age of 65 who sought care for non-acute health problems. They followed up with a telephone interview 30 days later. Her findings showed that 83% of those interviewed had a primary care provider, but 85% did not call their providers before going to the emergency room. D'Avolio observed that barriers to accessing care for this vulnerable population continue to be an issue and that these disparities need to be addressed at an organizational level as well as individually.

The next Journal Club meeting will be held November 11, 2009, at 4:00pm in Yawkey 2-210. The speaker will be Janice Meisenhelder, RN, who will present her research findings on, "Gender differences in religiosity and functional health in the elderly."

Jennifer Repper-DeLisi, RN

Amanda Coakley, RN

Carol Ghiloni, RN

Deborah D'Avolio, RN

(Photos by Abram Bekker)

New policies around interactions with vendors

As of October 1, 2009, a number of new policies around conflict of interest went into effect... Any questions you may have should be directed to the entity compliance officers.

Question: Is it true that some new policies have been introduced around conflict of interest with outside vendors?

Jeanette: Yes. As of October 1, 2009, a number of new policies went into effect. Below is a partial list of policies that have the most impact on Patient Care Services:

- Gifts. There is a comprehensive ban on all gifts to Partners faculty and staff from pharmaceutical companies, medical-device companies, and all other vendors.
- Speakers Bureaus. There is a ban on participating in speakers bureaus. (Existing commitments may be honored through December 31, 2009.)
- Ghost-Writing. There is a ban on ghost-writing.
- Royalties. Partners entities may not benefit from royalties on sales of products made to that entity.
- Purchasing Transactions. Stronger oversight will be applied to purchases to ensure that personal relationships between Partners individuals and vendors are appropriately vetted and managed.
- Outside Activities of Senior Officials. Effective January 1, 2010, new restrictions will place limits on the amount and type of compensation senior institutional officials can receive for serving on the boards of directors for companies that may do business with Partners entities.

Question: How will these new policies be managed?

Jeanette: Three new organizational structures have been put in place to manage these new policies. They are:

- The Conflicts of Interest Committee, which will handle the day-to-day issues related to conflict of interest.
- The Education Review Board, which will oversee industry support of Partners educational activities.
- The Office for Interactions with Industry, which will provide oversight of industry interactions.

Question: Are these committees up and running now?

Jeanette: These committees represent the beginning of the infrastructure that will oversee these new policies. They will become fully staffed and operational in the coming months. Any questions you may have should be directed to the entity compliance officers. Once the Office for Interactions with Industry is staffed early next year, that office and its website will be an additional resource.

Know the facts about seasonal flu shots

Some frequently asked questions

Question: Do I really need to get a seasonal flu shot?

Jeanette: It is highly recommended that employees receive the seasonal flu vaccine. It's the best way to prevent the spread of the influenza virus. Flu vaccine is recommended for healthcare workers to reduce the spread of transmission to patients, co-workers, family members, and friends.

Question: How is the seasonal vaccine different from the H1N1 vaccine??

Jeanette: The H1N1 vaccine provides protection from the H1N1 virus, which is different from the usual seasonal flu virus. A separate H1N1 vaccine will provided in the coming weeks.

Question: Is it true that the seasonal flu vaccine can cause influenza?

Jeanette: No. This is a common misconception. The injectable influenza vaccine contains only dead viruses and cannot cause influenza. Less than 1% of people who are vaccinated develop mild influenza-like symptoms, which are side-effects of the vaccine.

Question: If I get the seasonal flu vaccine in the fall, will I be protected through the winter?

Jeanette: Yes. Immunity from the vaccine lasts up to 52 weeks.

Question: When will the seasonal flu vaccination program start?

Jeanette: The employee vaccination program started in mid-September and will continue as long as is necessary.

Question: When is a person with influenza contagious?

Jeanette: The virus is most apt to be passed on from one day before the onset of symptoms to up to seven days after symptoms begin.

Question: What should I do if I start feeling sick and think I might have the flu?

Jeanette: If you develop a fever of more than 100°F and a cough, sore throat, or muscle aches, stay home and contact Occupational Health at 617-726-2217. For influenza-type illness, you will need to remain out of work for seven days or 24 hours after resolution of symptoms, whichever is longer. You should contact Occupational Health before returning to work.

For more information, call Occupational Health Services at 6-2217.

Announcements

Eldercare

monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscowitz, LICSW, geriatric social worker for the Eldercare monthly discussion group, sponsored by the Employee Assistance Program. Come and discuss subjects relevant to eldercare.

Next session:
November 10, 2009
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome
Feel free to bring your lunch
For more information, call 6-6976 or visit www.eap.partners.org

Research Nurse Roundtable

Tuesday, October 27, 2009
12:15–1:15pm
Garrod/Mendel Conference Room
Simches Research Building
Lunch will be provided

The Research Nurse Roundtable provides a forum for nurses who work in clinical research to discuss issues common to their practice.

The Roundtable meets once a month and is led by experienced research nurses in collaboration with the MGH Clinical Research Program Education Unit.

Registration is required.
Please register at:
http://hub.partners.org/catalog

For more information about the Research Nurse Roundtable, contact Linda Pitler, RN, at 3-0686.

Sponsored by the MGH Clinical Research Program.

Meet the author

Eva M. Selhub, MD, senior staff physician at the Benson Henry Institute, will be discussing her book, *The Love Response: Your Prescription to Transform Fear, Anger, and Anxiety into Vibrant Health and Well Being*

October 19, 2009
12:00–1:00pm
Blum Patient & Family Learning Center

All are welcome
Stop by and bring your lunch
For more information, call 4-7352

Third annual

Best Practices in Acute Care for Older Adults Conference

2-day program provides evidence-based foundation to help improve knowledge and expertise in caring for older adults

Friday, October 16 and
Monday, October 26, 2009
8:00am–4:30pm
O'Keeffe Auditorium

Registration:
- MGH employees — no fee
- Partners' employees — $50 per day
- Non-Partners' employees — $100 per day

Pre-registration is required
Please contact:
The Norman Knight Nursing Center for Clinical & Professional Development
6-3111

Memorial service for Shean Marley, RN

The MGH community will hold a memorial service to celebrate the life of Shean Marley, RN

Friday, October 30, 2009
1:00pm
MGH Chapel

All are welcome
For more information, call 6-2220

Call for Abstracts

Nursing Research Expo 2010

Do you have data that could be presented via a poster? The PCS Nursing Research Committee will be offering classes in abstract-writing. Look for information in future issues of *Caring Headlines*.

Prepare now to submit your abstract to display a poster during the 2010 Nursing Research Expo

Categories:
- Original Research
- Research Utilization
- Performance Improvement

For ideas on getting started, contact your clinical nurse specialist. Co-chairs of the Nursing Research Expo Sub-Committee (Laura Naismith, RN, or Teresa Vanderboom, RN) can also offer assistance.

For abstract templates and exemplars, visit the Nursing Research Committee website at: www.mghnursingresearchcommittee.org

The deadline for submission of abstracts is January 15, 2010

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For more information, call: 617-724-1746

Next Publication
November 5, 2009

Educational Offerings – 2009

October 22

Psychological Type & Personal Style: Maximizing your Effectiveness

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

October 22

Nursing Grand Rounds

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

October 23

Health Care at the Crossroads: Ethics Symposium for Healthcare Providers

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

October 26

Intermediate Arrhythmia

Simches Conference Room 3-120
8:00–11:30am
Contact hours: 3.5

October 26

Pacing Concepts

Simches Conference Room 3-120
12:15–4:30pm
Contact hours: 3.75

October 26

BLS/CPR Re-Certification

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

November 2

CPR Mannequin Demonstration

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

November 2 & 16

ACLS Provider Course

Day 1: 8:00am–3:00pm
O'Keeffe Auditorium
Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hours

November 3

BLS/CPR Re-Certification

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

November 3

Phase I Wound-Care Education Program

Simches Conference Room 3-120
8:00am–4:30pm
Contact hours: 6.6

November 4

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

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

November 5, 6, 16, 17, 23 & 24

Boston ICU Consortium

Newton Wellesley Hospital
7:30am–4:30pm
Contact hours: TBA

November 6

PALS Re-Certification

Simches Conference Room 3-110
7:45am–4:00pm
No contact hours

November 9

Simulated Critical-Care Emergencies

POB 448
11:00am–3:00pm
Contact hours: TBA

November 9

Building Relationships in the Diverse Hospital Community: Understanding our Patients, Ourselves, and Each Other

Founders 325
8:00am–4:30pm
Contact hours: 6.8

November 9

Diabetic Odyssey

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

November 10

Chaplaincy Grand Rounds

"Spiritual Healing as an Alternative, Complementary, and Integrative Therapy: a Potentially Slippery Slope"

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

November 11

Nursing Grand Rounds

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

November 11

Nursing Research Committee's Journal Club

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

November 16

BLS/CPR Re-Certification

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

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

Sharing information on healthy aging

—by Jen Searl, health educator

Staffing the booth at recent Healthy Aging Open House are (l-r): Barbara Moscowitz, LICSW, program director, Senior HealthWISE; Jen Searl, health educator; Katie Trepanier, graduate student; and Deborah D'Avolio, RN, geriatric specialist, *65 Plus*.

On September 14, 2009, the Maxwell and Eleanor Blum Patient & Family Learning Center, in collaboration with *65 Plus*, and Senior HealthWISE, sponsored an 'open house' on Healthy Aging in the Main Corridor. The educational booth focused on five key points: healthy eating, physical activity, mental acuity, communicating with your doctor, and preventing falls. The booth was well attended by patients and staff.

Said Barbara Moscowitz, LICSW, program director, Senior HealthWISE, "It was surprising how many people approached the table with some reluctance, saying it wasn't for them. But once they saw the information on exercise, nutrition, and communication, they were immediately interested."

The open house series, sponsored by the Blum Center, is a way to help educate patients about healthy aging.

For information or to participate in a future open house, contact Jen Searl, health educator, at 4-3823.

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October 15, 2009

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