Caring Headlines
September 20, 2012

The Oral History Project

See story on page 4

The MGH Nurses' Alumnae Association is spearheading a project to connect with former graduates of the MGH School of Nursing (formerly the Boston Training School for Nurses) to gather oral remembrances of the early history of nursing at MGH. Watch future issues of *Caring Headlines* for installments in this series.

The newsletter for Patient Care Services
Massachusetts General Hospital

Magnet status isn't won... it's earned

Eight of the top ten medical centers on the US News & World Report *honor roll are Magnet organizations*

Achieving Magnet recognition involves a comprehensive period of evidence-collection followed by a thorough review of the evidence by Magnet appraisers, and culminates with a site visit to ensure that systems and practices within the organization support the evidence that was submitted.

Just like Joint Commission accreditation, Magnet-hospital designation (and re-designation) is an indication that an organization adheres to the highest standards of quality and safety. Magnet recognition has become synonymous with excellence in nursing practice, and by extension, excellence in patient care. Currently, approximately 395 hospitals (including five outside of the United States) have been recognized by the American Nurses Credentialing Center (ANCC) as Magnet hospitals.

Magnet status is achieved through one of the most, if not *the* most, rigorous application processes in all of health care. It involves a comprehensive period of evidence-collection followed by a thorough review of the evidence by Magnet appraisers, and culminates with a site visit to ensure that systems and practices within the organization demonstrate the evidence that was submitted. Earlier this month, under the capable direction of Marianne Ditomassi, RN, executive director of PCS Operations, the Magnet writers and Core Team delivered our evidence to the printer. On October 1st, that evidence— all 18 volumes, 5,025 pages of it— will be submitted to the ANCC in support of our application for Magnet re-designation.

You may recall the 14 forces of Magnetism that guided our evidence-collection during our last application process. In 2008, the ANCC introduced a new model that re-configures the 14 forces of Magnetism into a five-component model that focuses less on structure and processes and more on patient outcomes. The 14 forces are imbedded in the new model, which is comprised of the following components:

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

Transformational leadership

- This part of the model addresses how leadership at all levels creates a vision for the future and implements the systems and environment necessary to achieve that vision. This work establishes a context for strategic goals and quality planning. Leadership creates a culture that engages staff in change that results in improved clinical and organizational outcomes.

Structural empowerment

- Empowerment results when staff are engaged and involved in issues of importance to the organization. Access to information, personnel, material and financial resources, shared decision-making, and the opportunity to learn and grow are linked to empow-

continued on next page

The intent of the ANCC and the Magnet Recognition Program has not changed since the original Magnet study in 1983 that sought to identify the characteristics of hospitals that attracted and retained the best and the brightest... Like MGH and health care itself, the Magnet Recognition Program is evolving to reflect the needs of the patients, families, and communities we serve.

erment. Creating conditions that support and encourage staff involvement in community service and professional organizations contribute to structural empowerment.

Exemplary professional practice

- This component of the model looks at the organization's professional practice model, care-delivery system, shared leadership, and autonomous practice. Exemplary professional practice entails a comprehensive understanding of the clinician's role and the application of that role as it relates to patients, families, communities, and inter-disciplinary teams in achieving high-quality outcomes.

New knowledge, innovations, and improvements

- Magnet organizations are expected to innovate, redesign, transform, and expand knowledge to develop next-generation applications to ensure safe, effective, efficient, patient-centered care. Magnet organizations must demonstrate how the translation of new knowledge into practice has affected patient outcomes.

Empirical outcomes

- Magnet recognition assumes that good outcomes are the result of sound structures and processes. This over-arching component of the model asks organizations to describe specific structures and processes and delineate their link to certain outcomes related to all the other components of the model: transformational leadership; structural empowerment; exemplary professional practice; and new knowledge, innovations, and improvements. This is where the shift to a focus on outcomes is especially noticeable. The question is not, "What do you do?" or "How do you do it?" The question is, "What difference have you made?"

When an organization is seeking re-designation, as we are, the last two components of the model: new knowledge, innovations, and improvements; and empirical outcomes are more heavily weighted in the application process.

Though the model has changed since last time, the intent of the ANCC and the Magnet Recognition Program has remained the same since the original Magnet study was conducted in 1983. That study sought to identify the characteristics of hospitals that attracted and retained the best and the brightest, and that's what Magnet still does today. Like MGH and health care itself, the Magnet Recognition Program is evolving to reflect the needs of the patients, families, and communities we serve.

Our evidence will be submitted October 1st. We expect the review of the evidence to take several months, so our site visit will probably occur some time in early 2013. A four-person team will spend three days evaluating our practice, systems, and environment of care (here at the main campus and at health centers and ambulatory sites).

Magnet recognition is not an award—you don't 'win' it—you earn it. It's the highest stamp of approval a healthcare organization can receive from a non-regulatory agency, and I'm confident we'll retain our Magnet status upon review of the evidence. Well done, colleagues. Stay tuned.

In this Issue

MGH Nurses' Alumnae Association presents at international nursing history meeting

—by Mary Larkin, RN, and Susan Fisher, RN, for the MGH Nurses' Alumnae Association

The MGH Nurses' Alumnae Association (NAA) presented the results of its Oral History Project, *Voices Echoing Forward*, at the International Association for the History of Nursing, held in Denmark, August 9–11, 2012. The meeting attracted attendees from 27 countries and featured numerous perspectives on the history of nursing from medieval times to present day.

(Photo provided by staff)

Mary Larkin, RN, chairperson, of the MGH Nurses' Alumnae Association, presents in Denmark

The history of nursing education at MGH closely reflects the evolution of the profession. The MGH School of Nursing (formerly the Boston Training School for Nurses) founded in 1873, was one of the original Nightingale Schools in the country. The school graduated 7,032 nurses before closing in 1981. Early graduates were leaders in the profession. They pioneered the establishment of institutions such as the American Nurses Association, the *American Journal of Nursing*, and alumnae training schools across the country. They played a part in establishing licensure standards and defining military nursing service.

The school's archival holdings reach back to its beginnings and provide a glimpse into its curriculum, policies, and origins of our rich tradition of nursing leadership. Preserving the history of the MGH School of Nursing and its graduates is a primary goal of the NAA. Members of the NAA participated in the Oral History Project; collaborated on *Nursing at 200*, the commemorative book produced for the MGH bicentennial; and continue to volunteer at the archives.

In 1998, Karen Wolf, RN, then nursing faculty at the MGH Institute of Health Professions, and Linda Lass Orrell, RN, (class of '67) historian of the Alumnae Association, began a research project entitled, "Nursing Education at the MGH: an Evolution Tied to Societal Events and Changes." Questionnaires were sent to more than 2,000 graduates. Approximately 500 were returned, and more than half agreed to be interviewed. The personal reflections and professional journeys of these graduates reveal much about the economic constraints, technological developments, nursing shortages, social re-definition, barriers to collegiate degrees, wartime nursing, and the changing roles of women.

The Oral History Project is ongoing and has been re-invigorated by new chairperson, Mary Larkin, RN, (class of '76). The committee includes Wolf, Lass Orrell, Susan Fisher, RN, (class of '66 and co-historian for the NAA), and Ann Collins, RN, (class of '66). This past year, five graduates all over the age of 90, were interviewed: Marion Bates, RN (class of '34); Hazel Simms McNeil, RN (class of '37); Grace Rae Gatcomb Babcock, RN (class of '39); Elizabeth Matricaria Crossland, RN (class of '39); and Mary Larkin Heney, RN (class of '42).

While the history of the school and its alumnae are unique in their individual stories, more than 130 years of records provide a look at the evolution of nursing on a broader scale. More than a walk down Memory Lane, the Oral History Project is a source of pride and learning for future generations of nurses. Look for more Oral History stories in future issues of *Caring Headlines*.

For more information, call Mary Larkin at 4-8695.

MGH community welcomes new director of Chaplaincy

On July 2, 2012, Patient Care Services and the MGH community welcomed Reverend John Polk, DMin, as the new director of the MGH Chaplaincy. Polk comes to MGH from Kansas City, Missouri, where he was the interim director of the Spiritual Wellness Department and lead chaplain for the Mid-America Heart Institute at Saint Luke's Hospital. He has served as a pastor in a number of settings, including the Children's Memorial Lutheran Church and the Prince of Peace Lutheran Church, also in Kansas City. He is a professional leadership coach and trained as a spiritual care provider for patients, families, and staff of the Cancer Institute at Saint Luke's. Polk has experience ministering to diverse, urban congregations with congregants from virtually every continent in the world.

Reverend John Polk, DMin, new director of the MGH Chaplaincy

Known for his unique blend of leadership and compassion, Polk is an effective communicator who prides himself on his creativity and ability to think outside the box. His leadership style is characterized by a strong desire to listen, teach, and empower.

Says Polk, "I'm grateful for the warm welcome I've received and excited by the opportunity to work with such a talented and compassionate team. After two months of listening and learning, both within the Chaplaincy and throughout the hospital, I'm eager to start meeting the challenges that lie ahead. Building on a strong foundation and a shared interest in holistic health (healing the body, mind, and spirit), the Chaplaincy will be launching a four-point, 12-month strategic plan focusing on developing patient-centered best practices; strengthening our educational programs; laying a groundwork for evidence-based pastoral care; and reinforcing the infrastructure of the Chaplaincy team and department."

Originally from New England, Polk is happy to be back in the northeast, enjoying Boston's art galleries, museums, theater, and music. His two grown sons were also excited about the move, giving them an opportunity to take in a game at Fenway Park. Unfortunately, their trip to the ball park didn't include seeing the home team win.

Polk succeeds Michael McElhinny, MDiv, who continues to lend his wisdom and compassion to MGH as a staff chaplain.

For more information about the services offered by the MGH Chaplaincy, call 6-2220.

Inter-disciplinary teamwork a *must* in emergent situations

I was told I was needed right away to assess a patient in respiratory distress. I couldn't get any more details because the nurse who paged me was in the midst of tending to the patient at the bedside.

My name is Gloria Mendez-Carcamo, and I have worked as a respiratory therapist since 1998 (and since 2005 at MGH). During my time at MGH, I've developed many collaborative relationships with nurses and physicians, so I'm often consulted for asthma instruction, educating patients on how to manage newly placed tracheostomies after they're discharged, and assisting with oxygen therapy. I'm frequently consulted by nurses and physicians to help assess and treat patients in respiratory distress and respiratory failure. When I respond to these calls, I'm confident in my ability to assess the patient and make recommendations to the team as to the most appropriate respiratory therapy. I'll never forget one seemingly routine page that quickly turned into a close call.

I responded to the page by phone to inquire about the situation. I wanted to be able to anticipate any equipment I might need and consider potential treatment options. I was told I was needed right away to assess a patient in respiratory distress. I couldn't get any more details because the nurse who paged me was in the midst of tending to the patient at the bedside. I quickly stopped by the Respiratory Care Office and grabbed a non-invasive ventilator in anticipation of

Gloria Mendez-Carcamo, RRT, respiratory therapist

acute congestive heart failure (CHF) or exacerbation of chronic obstructive pulmonary disease (COPD).

When I arrived on the unit, I was met by several nurses who directed me to the patient's room. As I approached the door, I heard a sound that immediately eliminated CHF or COPD exacerbation as the source of the problem. The stridor (the loud, crowing sound with inhalation) told me this patient would likely need a much more complex intervention. When I stepped into the room, I saw a 40-year-old man sitting up in bed with both elbows perched on the bedside table (tripod position) gasping for air. There was panic in his eyes. The distinctive, high-pitched sound he was producing suggested severe acute upper-airway obstruction. This was a medical emergency.

The nurse told me he had developed difficulty breathing a few minutes after initiating his first chemotherapy session. The chemotherapy was terminated, but the patient continued to gasp for air. I knew the

continued on next page

A few weeks later, I saw this patient again on the same unit where I'd been paged to care for him. This time, it was a very different encounter. He recognized me and thanked me for helping him in that scary situation... This case reinforced my belief that teamwork is essential in the care of every patient, but especially in emergent situations.

treatment for stridor was aerosolized epinephrine to minimize or slow the swelling of the airway. Epinephrine can provide rapid relief of subglottic edema and, in some cases, breathing rapidly improves. A physician had already asked the nurse to get epinephrine and a nebulizer, so it was there when I arrived. We immediately administered the treatment. But I suspected, because of the severity of the stridor, that it wasn't going to open his airway enough to relieve his respiratory distress. I asked the team to stat-page the anesthesia team for probable intubation.

While waiting for the anesthesia team, we elevated the patient's head to 45 degrees for optimal airway position. I asked one of the nurses to call my supervisor and request a tank of helium-oxygen (heliox). The low-density mixture can improve breathing in the case of severe partial upper-airway obstruction. I started to make the necessary preparations for intubation, but the patient became increasingly restless. His stridor became more acute to the point where he started grunting and gasping for air. The anesthesia team arrived and immediately started to intubate. But when the attending anesthesiologist assessed the airway, he saw that the throat was completely closed. He called for the surgical airway team, stat.

While we waited for them to arrive, the anesthesiologist held a resuscitation mask in place while I manually ventilated the patient, which was extremely difficult due to his obstructed airway. The anesthesiologist had to kneel on the bed to achieve a tight enough mask seal while I forced air into the airway. As we worked, we saw the patient's chest rise and his oxygen saturation level improve. Within a few minutes, the surgical team arrived and prepared for an emergent surgical cricothyrotomy, a procedure in which a tube is passed through the neck into the trachea.

The surgeon performed the procedure in less than five minutes. Once the airway was established and the patient was ventilating better, vital signs returned to normal. The emergency was over. Everybody in the room—surgeons, physicians, nurses, and respiratory therapists—breathed a sigh of relief (as did the patient!) I had worked closely with this surgeon before. After discussing the plan of care with the team, he turned to me and asked if I was satisfied with the tracheostomy. I told him everything looked fine; there didn't seem to be any issues with the airway.

"Then I can leave," he said. "I know the patient is in good hands."

I connected the patient to a transport ventilator, and we transferred him to the intensive care unit.

A few weeks later, I saw this patient again on the same unit where I'd been paged to care for him. This time, it was a very different encounter. He recognized me and thanked me for helping him in that scary situation. He was now ready to try a speaking valve, and I was the respiratory therapist assigned to him. A speaking valve is a valve placed on the tracheostomy tube to assess a patient's ability to breathe in through the tube and out through his/her upper airway. Utilizing a speaking valve allows us to assess the patient's level of recovery from a prior upper-airway obstruction. I placed the speaking valve, and the patient was able to breathe comfortably and talk for the first time since his emergency tracheostomy procedure. The speech-language pathologist was consulted to evaluate his risk of aspiration. After assessing him together for a few days, we recommended removal of the tracheostomy tube. The tube was removed, and the patient was discharged two weeks later.

This case reinforced my belief that teamwork is essential in the care of every patient, but especially in emergent situations. It's much less stressful when clinicians from different disciplines work together seamlessly and effectively as they certainly did in this case. And it's nice to be recognized and appreciated as part of the team that provides excellent, patient-focused care.

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

From the moment Gloria received that 'routine' page, she started anticipating what to expect and what she would need. Her intuition, experience, and preparation were pivotal to the outcome of this patient. Because she and other members of the team responded quickly and efficiently in this critical situation, there was no wasted time, no delayed action. Instinct and expert practice took over. Every time a clinician has the benefit of a skilled team at his or her side in an emergent situation it builds confidence and readiness for the next time. Clearly, Gloria was an integral part of a very skilled team.

Thank-you, Gloria.

Always Responsive Project increases patient- and family-satisfaction

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

"Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion."

—Florence Nightingale

The Picker Institute has identified certain aspects of interactions between healthcare professionals and patients and families that should always occur—'always events.' The goal of the Always Responsive Project was to ensure patients' and families' needs were met by ***always*** being responsive.

An inter-disciplinary team comprised of representatives from Nursing, Medicine, the MGH Center for Quality & Safety, the PCS Office of Quality & Safety, Social Services, MGH Practice Improvement, and Newton-Wellesley Hospital Operations Management recently completed the year-long Always Responsive Project to explore ways to improve the patient and family experience, decrease patient falls, and reduce the number of hospital-acquired pressure ulcers.

The project was based on a guiding principle of The Picker Institute, an independent, non-profit organization dedicated to advancing patient-centered care. The Picker Institute has identified certain aspects of interactions between healthcare professionals and patients and families that should always occur—'always events.' The goal of the Always Responsive Project was to ensure patients' and families' needs were met by *always* being responsive.

The Phillips 20 and White 8 medical units tested seven interventions; four focused on the patient and family experience, three focused on the efficiency of unit systems. Interventions included hourly safety rounds, the use of white boards in patient rooms, care-team face sheets, and a newly developed welcome video. Care-team face sheets were given to patients upon admission—they included pictures of staff, role descriptions, and what to expect from each member of the team. The six-minute welcome video was available in English and Spanish on hospital television with captioning for deaf and hearing-impaired patients.

Support service report cards were used to improve efficiency and communication between disciplines and departments. Communication boards were used to display important quality information for staff. And learning coaches led discussions with staff and leadership and guided group decision-making.

Patients and families were interviewed about their experiences. Some of their responses were:

"Whenever I pressed the call button, people came immediately."

"The attentiveness of nurses was excellent."

"Nurses were right there when I was having a bad day. They sat with me and helped me get through the tough times."

"Caregivers were all on the same page."

"White board was great. Keep it updated."

Hourly safety rounds and white boards are being implemented throughout the hospital. Care-team face sheets are now included in the Patient & Family Notebooks being tested on the 12 innovation units. Because feedback has been so positive, a version of the notebook will soon be rolled out hospital-wide.

During the study, patient-satisfaction scores on the pilot units increased, and comments were overwhelmingly positive. The level to which falls and pressure ulcers decreased varied, and those efforts will continue throughout the hospital.

Thank-you to the Picker Institute for supporting this project. For more information, contact Gaurdia Banister, RN, at 4-1266.

MGH, RWJF, and Mass Action Coalition join forces to advance nursing education

—by Georgia Peirce, project manager

MGH Nursing was front and center at the State House on August 21, 2012, as Lt. Governor Timothy Murray announced a $300,000 Robert Wood Johnson Foundation (RWJF) grant to the Commonwealth of Massachusetts to support academic nursing preparation. Currently, 55% of Massachusetts nurses hold bachelor of Science degrees in Nursing (BSNs) or above. The Institute of Medicine (IOM) recommends 80% of nurses be educated at the BSN level or higher.

Only nine states received RWJF grants. Massachusetts will use the funding to advance collaboration between the Department of Higher Education (DHE) and the Organization of Nurse Leaders (ONL). Associate chief nurse, Kevin Whitney, RN, past-president of ONL, and Gino Chisari, RN, president of the Massachusetts Association of Registered Nurses and director of The Norman Knight Nursing Center for Clinical & Professional Development, were integrally involved in advancing the grant-application process through the Mass Action Coalition, and the MGH department of Nursing provided considerable support.

Among those invited to speak at the State House was Jeanette Ives Erickson, RN, senior vice president for Patient Care, who reminded legislative officials, nurse educators, nursing leaders, and more than two dozen MGH nurses in attendance that, "Nurses are the heart and soul of our healthcare system. This funding will allow nursing educators and those in the clinical setting to tailor nursing education to meet the demands that arise on the front lines of health care. The real beneficiaries will be the countless patients and families who entrust us with their care."

For more information about the Robert Wood Johnson Foundation grant, contact Kevin Whitney at 4-6317.

(L-r): Richard Freeland, commissioner, DHE; Patricia Crombie, RN, project director, Mass Action Coalition; Jessica Alvarez-Montano, RN, 2012 graduate of UMass Lowell; David Cedrone, associate commissioner for Economic and Workforce Development; Lt. Governor Timothy Murray; Sharon Gale, RN, chief executive officer, ONL; Jeanette Ives Erickson, RN, senior vice president for Patient Care; JudyAnn Bigby, MD, secretary of Health and Human Services; and Senator Richard Moore, chair of the Joint Committee on Health Care Financing.

Patient-safety spurs name change

Question: I heard that the Modified Barium Swallow Study is now called the Video Swallow Study. Why is that?

Jeanette: Sometimes, the two radiographic examinations, Modified Barium Swallow and Barium Swallow, were used interchangeably, and that wasn't accurate. The two examinations are different and have different purposes. We decided to change the name of the Modified Barium Swallow Study to the Videofluoroscopic Swallowing Study (shortened to Video Swallow Study) to ensure patient safety.

Question: Can you explain the difference?

Jeanette: The Video Swallow Study (formerly Modified Barium Swallow Study) is the most frequently used method of visualizing mastication and swallowing. It's used to better understand the patient's oral and pharyngeal swallow dysfunction and evaluate the effectiveness of therapies aimed at increasing swallowing safety and efficiency.

The goal of the Barium Swallow Study is to examine the upper GI tract, primarily esophageal function, from the entrance of the esophagus to the entrance of the stomach. This study examines esophageal mucosa for signs of abnormalities. And it evaluates esophageal motility and potential obstructions.

Occasionally, the wrong test was requested due to the similarity of the names, so we changed the name to make it more reflective of what it does. The name has been updated in Provider Order Entry (POE), and the chart on this page explains the difference between the two studies.

Video Swallow Study	Barium Swallow
Performed by a speech pathologist with radiology assistance (radiologist or radiology technologist)	Performed by a radiologist and radiology technologist
Evaluates oropharyngeal swallowing including oral cavity, pharynx, larynx, and cervical esophagus; screens esophageal clearance	Evaluates esophageal swallowing from entrance to the esophagus to entrance to the stomach
Detects presence and causes of aspiration	Detects esophageal mucosal abnormalities and signs of dysmotility
No specific patient preparation is necessary prior to the test	At times, patients must refrain from eating or drinking for 12 hours prior to the study
Use of contrast: controlled volumes of a variety of consistencies containing barium, including thick and thin liquid, semi-solids, and solids	Use of contrast: single contrast—one or two cups of thick and thin barium; double contrast—effervescent granules and thick barium and barium tablet
Patient is positioned upright, seated or standing	Patient is positioned upright in supine posture
The entire study is digitally recorded for later play-back and analysis	Single spot images are taken while the patient is swallowing
Efficiency of mastication, pharyngeal propulsion, and airway protection are evaluated	Mucosal abnormalities, esophageal motility, and potential obstructions are evaluated
Test duration is less than five minutes of fluoroscopic imaging; total duration of study about ten minutes	Test duration approximately five minutes of fluoroscopic imaging, but sometimes further images are required after the barium is ingested
If patient aspirates, therapeutic strategies are introduced in an attempt to reduce the aspiration	If patient aspirates the procedure is terminated
The speech pathologist reports the findings of the procedure and makes recommendations for further management of the patient's swallowing dysfunction	The radiologist reports the findings to the referring physician who manages the patient further

Question: Do we continue to consult a speech-language pathologist for a swallow evaluation when a patient shows signs of difficulty swallowing?

Jeanette: Yes, the process has not changed. When a patient shows signs of oropharyngeal dysphagia, a speech-language pathologist will conduct a swallow evaluation at the bedside and determine whether an instrumental exam (Video Swallow Study, for example) is warranted.

Question: How can we learn more about swallowing disorders

Jeanette: HealthStream offers a tutorial called, *Understanding Swallowing, Dysphagia and Aspiration*, or call 6-3946 for more information.

Announcements

Mentors Make a Difference

MGH Youth Programs is seeking volunteers to mentor Boston middle school students through their science-fair projects two Friday mornings each month, from October through January.

For more information, call 617-643-6287.

SAFER Fair

Join collaborative governance champions from the Skin Care, Pain-Management, Fall-Prevention, Patient Education, Restraint Solutions, and Research & Evidence-Based Practice committees to learn how they're working to make a SAFER environment for patients and families.

Wednesday September 25, 2012
11:00am–2:30pm
Bulfinch Tent

For more information, call 4-5801.

The Inaugural Blum Visiting Scholar Program

Inter-Disciplinary Grand Rounds

"Becoming a Health-Literate Organization: Soup to Nuts Strategies"

presented by
Cindy Brach, senior health policy researcher, AHRQ

Thursday, October 18, 2012
1:30–2:30pm
O'Keeffe Auditorium

For more information, call 4-7352.

Continuing Education

Presented by MGH Nurses' Alumnae

"Women's Health Issues: an Update"

Friday, September 28, 2012
8:00am–4:30pm
Simches Research Building, Charles River Plaza

Presenters include:
keynote speaker,
Karen Carlson, MD
"Shared Decision-Making"

Mary Larkin, RN
"Diabetes update"

$40 for alumnae and employees
$50 for non-Partners employees

For more information, or to register (by September 14th) call the Alumnae Office at 6-3144.

October is Domestic Violence Awareness Month

The Domestic Violence Working Group will host events throughout the month:

Information Booth

October 3, 2012
10:00am–2:00pm
Central Lobby
Enter for a chance to win a raffle

"In Her Shoes"

An interactive event to increase understanding of domestic violence. Discussion to follow.

October 11th
11:45am–1:30pm

Light refreshments. Social Work CEUs pending.
Please RSVP to: 617-726-6976

"The Commercial Sexual Exploitation of Children"

Social Work Grand Rounds with Lisa Goldblatt-Grace, LICSW, of My Life, My Choice

October 18th
10:00–11:30 am
O'Keeffe Auditorium

Light refreshments.
1.5 Social Work CEUs

For more information, call 6-7674.

Collaborative Governance

Applications are now being accepted for collaborative governance.
Applications are due by October 5, 2012.

For more information, call 4-5801.

Blum Center Events

Shared Decision Making

"Women's Health"
Thursday, October 4, 2012
Join Karen Carlson, MD, and Kathleen Ulman for an in-depth discussion about women's health issues.

Harp Music

Wednesday, October 10th
Enjoy relaxing music with harpist, Becky Wertz.

Chair Yoga

Friday, October 19th
Join Laura Malloy, LICSW, of the Benson Henry Institute for Mind-Body Medicine to learn healthful chair yoga techniques accessible to all levels.

Book Talk

Chicken Soup for the Soul: Boost Your Brain Power
Wednesday, October 24th
O'Keeffe Auditorium
Learn how to be smarter, think faster, and have a better memory with author Marie Pasinski, MD

National Health Observances Talk

"Selecting the Right Shoe for You"
Tuesday, October 30th
Join Marie Figueroa, PT, for a discussion about the importance of selecting the right shoes.

Programs are free and open to MGH staff and patients.

No registration is required.
All sessions held from noon–1:00pm in the Blum Patient & Family Learning Center unless otherwise specified.
For more information, call 4-3823.

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For more information, call: 617-724-1746

Next Publication
October 4, 2012

Professional Achievements

Pacious certified

Amy Pacious, RN, staff nurse, Cardiac ICU, became certified as a critical care nurse by the American Association of Critical Care Nurses, in August, 2012.

Washington appointed

Deborah Washington, RN, director of PCS Diversity, was appointed chair of the National Black Nurses Association Diversity Committee at the national conference, in Orlando, Florida, August 7, 2012.

Costa honored

Mary Jane Costa, RN, staff specialist, received the Alexander 'Sandy' Craig Award for Leadership, from the Board of Trustees of the Nantucket Cottage Hospital during their annual hospital meeting, in Nantucket, in June, 2012.

Botsford certified

Jennifer Botsford, OTR/L, occupational therapist, MGH Foxborough, became certified as a lymphedema therapist by the Norton School of Lymphatic Therapy, in Charlestown, August 22, 2012.

Boucher certified

Andria Boucher, OTR/L, occupational therapist, MGH Waltham, became certified as a lymphedema therapist by the Norton School of Lymphatic Therapy, in Charlestown, August 22, 2012.

Devine certified

Sophia Devine, PT, physical therapist, MGH Chelsea, became certified as a lymphedema therapist by the Norton School of Lymphatic Therapy in Charlestown, August 22, 2012.

Fitton certified

Lindsay Fitton, RN, staff nurse, Radiation Oncology, became certified as an oncology nurse by the Oncology Nurses Certification Corporation, August 8, 2012.

Larkin presents in Denmark

Mary Larkin, RN, clinical research manager, Diabetes Research Center, presented, "Voices Echoing Forward: the MGH Oral History Project," at the International Nursing Conference at the International Association for the History of Nursing in Koldingfjord, Denmark, August 10, 2012.

Shine certified

Joy Shine, PT, physical therapist, MGH Foxborough, became certified as a lymphedema therapist by the Norton School of Lymphatic Therapy in Charlestown, August 22, 2012.

Tulchinsky certified

Ellen Tulchinsky, PT, physical therapist, MGH Foxborough, became certified as a lymphedema therapist by the Norton School of Lymphatic Therapy in Charlestown, August 22, 2012.

Velazquez certified

Cynthia Velazquez, RN, staff nurse, Transplant Unit, became certified as a transplant nurse by the American Board for Transplant Certification, in August, 2012.

Capasso presents

Virginia Capasso, RN, clinical nurse specialist and co-director of the MGH Wound Care Center, presented, "Pressure Ulcers and Wound Care," at the School of Osteopathic Medicine at the University of New England in Biddeford, Maine, August 15, 2012.

Dorman presents

Robert Dorman, PT, physical therapist, presented, "Functional Outcomes of Joint Arthoplasty: Can We Improve Them?" at the Geriatric Special Interest group meeting of the American Physical Therapy Association of Massachusetts in Waltham, August 12, 2012.

Nurses publish

Todd Hultman, RN, nurse practitioner; Amanda Bulette Coakley, RN, staff specialist; Christine Donahue Annese, RN, staff specialist; and, Sharon Bouvier, RN, nursing director, authored the article, "Exploring the Sleep Experience of Hospitalized Patients," in the November 3, 2012, *Creative Nursing*.

Nurses publish

Mary Larkin, RN, clinical research manager, Diabetes Research Center; Catherine Griffith, RN, staff nurse, Clinical Research Center; Linda Pitler, RN, research study nurse, Thoracic Aortic Center; Lauren Donahue, RN, BWH; and, Amy Sbrolla, RN, staff nurse, Infectious Disease Unit, authored the article, "Building Communities of Practice: the Research Nurse Round Table," in *Clinical and Translational Science*, published on-line by Wiley Online Library.

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