Caring Headlines
January 23, 2013

Help contain the flu

Get a flu shot.

Follow proper infection-control practices.

And stay home from work if you feel sick.

(See story on page 4)

Staff nurse, Yasmine Zeid, RN, receives flu shot from colleague, Amy Israelian, RN, nurse practitioner, on the Bigelow 13 Burns and Plastics Unit.

The newsletter for Patient Care Services
Massachusetts General Hospital

A culture of safety

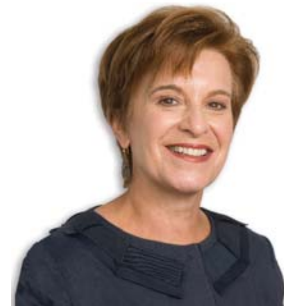
No one performs at his or her best in an environment of fear. At the same time, improving healthcare systems cannot be achieved without the active participation of the entire workforce. What this means to healthcare organizations across the country is that we need to find a way to encourage safety reporting without creating a culture of finger-pointing or shame. We need to recognize safety reporting for what it is—an invaluable tool in the prevention of medical errors and a source of insight for improving patient care.

We need to recognize safety reporting for what it is—an invaluable tool in the prevention of medical errors and a source of insight for improving patient care.

In most industries, including health care, errors are the result of systems failures that lead to human error. Designing systems that make it harder for individuals to make mistakes is one of the best defenses we have against medical errors. And the best way to achieve this is with a vigilant and proactive workforce that's empowered and *encouraged* to report safety issues—or as we've come to call it—fostering a culture of safety.

The safety-culture concept originated with an examination of organizations that were consistently able to minimize adverse events despite the complex and hazardous nature of their work. It was found that these 'high-reliability' organizations embraced four key tenets:

- acknowledging the high-risk nature of their work and committing to achieve consistently safe operations
- fostering a blame-free environment where individuals are able to report errors and near misses without fear of reprimand or punishment



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

- collaborating across ranks and disciplines to seek solutions to safety problems
- committing organizational resources to address safety concerns

More and more, healthcare organizations are recognizing the value of a blame-free environment. It removes the stigma from those who make mistakes and encourages everyone to actively participate in safety reporting. I've seen first-hand the healing effect of saying to a guilt-ridden employee, 'It wasn't your fault.' In my mind, when someone makes a mistake, the appropriate question is, "Did you commit this error on purpose?" If the answer is No, then the error is the fault of those who designed the system—not the individual.

I recently had an opportunity to review the results of our 2012 Safety Culture Survey, which have also been shared with nursing directors and department heads throughout Patient Care Services. This survey, conducted via e-mail, was administered to hospital employees whose work directly impacts patient care: nurses, therapists, physicians, support staff, pharmacists, and others. Almost 7,000 MGH employees responded. The survey sought to measure

continued on next page

More and more, healthcare organizations are recognizing the value of a blame-free culture. When someone makes a mistake, the appropriate question is, "Did you commit this error on purpose?" If the answer is No, then the error is the fault of those who designed the system—not the individual.

our safety culture in 13 specific categories, such as non-punitive response to errors; feedback and communication about errors; hand-offs and transitions; and openness of communication, to name a few.

I was happy to see an upward trend in the overall frequency of safety reporting since our last survey (in 2008). Results showed an increase in the reporting of errors caught before they could affect patients and errors that posed no potential harm to patients.

Filing a safety report is as simple as clicking the Start button on your computer, navigating to Partners Applications and selecting, Safety Reporting MGH. You're prompted to supply a complete account of whatever issue you're reporting, then simply press Submit. All safety reports go directly to the MGH Center for Quality & Safety (CQS) where they're triaged according to urgency:

- Level A events are considered serious and merit further investigation by the CQS
- Level B events require more information; it's unknown whether any injury occurred
- Level C events are investigated at the local or unit level; no harm was reported, the issue resulted in a near miss

To ensure safety issues are addressed in a timely fashion, quality assessment chairs have been identified in every service throughout the hospital. After being reviewed in the CQS, safety reports are referred to the appropriate quality assessment chair who (in Patient Care Services) works with staff of the PCS Office of Quality & Safety, nursing directors, and clinical nurse specialists, to resolve the issue.

All safety reports filed with the CQS are acknowledged with a confirmation e-mail. A second communication is issued a day or two later informing the filer of which department(s) have been notified to take action. And starting in November, 2012, to help close the loop on safety reporting and keep staff informed of the status of their reports, one more communication was added. If warranted, that is, if the event is serious, a third and final communication is issued by the quality assessment chair (or his/her designee) explaining the action being taken and any next steps.

The Safety Culture Survey contains helpful feedback to guide our safety-improvement efforts. If they haven't already, nursing directors and department leadership will begin sharing survey results with staff in the coming weeks. I urge you to engage your colleagues in dialogue about these findings. Review the data. Identify areas that need attention. Brainstorm ideas to improve teamwork and communication, hand-offs and transitions, event reporting, and other areas that would yield positive change. Resolve to identify at least one actionable step that your unit or department can take to promote vigilance and enhance our culture of safety.

Fostering a culture of safety and perpetuating a blame-free environment go hand-in-hand. Every safety report filed is an opportunity to learn, to adapt systems, improve care, and keep our patients safe.

In this Issue

Help Contain the Flu 1

Jeanette Ives Erickson 2
- A Culture of Safety

Severe Flu Season Contributes to Public Health Emergency 4

Clinical Narrative 6
- Susan Barisano, RN

Magnet Lunch Forum 8

Fielding the Issues 9
- Spiritual Rounds

Announcements 10

Magnet Notice 11

Professional Achievements 12

Severe flu season contributes to public health emergency

As you know, because of the severe flu season, Mayor Tom Menino recently declared a public health emergency in the city of Boston. Menino called it, "the worst flu season we've seen since 2009." He encouraged residents to get vaccinated and stay home from work if they're sick.

At MGH, the increase in overall patient volume has been attributed not only to the flu, but an increase in the number of patients with other clinical issues, sicker patients staying longer, and discharge delays. This has put a strain on capacity. Many inpatient beds have been closed in order to isolate influenza patients, and staffing in primary-care practices has been affected, as well.

At MGH, an increase in overall patient volume has put a strain on capacity. To help manage patient flow and contain the spread of the flu, it is imperative that all employees adhere to proper infection-control practices.

It is imperative that all employees adhere to proper infection-control practices. To help manage patient flow and contain the spread of the flu, please familiarize yourself with the following information, and encourage your colleagues to do the same:

- Staff with flu-like symptoms should leave work and *stay home* according to the protocols of Occupational Health:
  - Do not come to work if you have a fever of 100.5°F or one or more of the following symptoms:
    - runny nose or nasal congestion
    - sore throat
    - cough
    - body aches
  - If symptoms start at work, report symptoms to Occupational Health 617-726-2217 at once and leave work immediately; you are potentially infectious.
  - If you have the flu (or suspect you have the flu) you're required to stay out of work until your fever is gone for 24 hours without the use of anti-fever medication.
- Follow protocols for giving patients and visitors masks at the earliest opportunity.
- Continue to encourage colleagues to get the flu vaccine. This can be done by appointment with Occupational Health (6-2217) or on a walk-in basis, 7:00am–5:00pm, Monday through Friday.
- When providing direct patient care, staff who have not yet had a flu shot must wear masks, per MGH policy. *All* staff (vaccinated or not) should wear a mask when caring for patients with the flu (or suspected to have the flu).

The hospital is experiencing ongoing capacity issues, and as a result there may be delays. Should you anticipate delays for patients in need of acute care, notify clinical leadership and/or the associate chief nurse immediately. Resources or volunteer assistance will be deployed to help with patient discharge.

Patients with influenza

- Patients with influenza must be placed on Droplet Precautions
- Cohorting patients:
  - Patients who've tested positive for influenza but the type has not been identified may not be cohorted together until influenza type is known

continued on next page

Signage has been posted throughout the hospital and at entrances to inpatient units discouraging people from visiting if they have a cough or fever. If they do visit, they're asked to wear a mask and perform proper hand hygiene.

STOP

If you have a cough or fever ...

If you are a visitor
Please **DELAY YOUR VISIT.**

If you must visit,
go to the nurse's station and obtain a mask to wear

GUIDELINES

- **Wear a mask at all times.**
- **Use tissues and cover your mouth when coughing or sneezing or cough into your upper sleeve.**
- **Discard tissues in trash.**
- **Wash your hands with soap and water or use an alcohol-based hand rub (Cal Stat) to clean your hands**

- Patients identified as having laboratory-confirmed influenza A may be co-horted with each other
- Patients identified as having laboratory-confirmed influenza B may be co-horted with each other.
- As always, cohorting is allowed as long as there are no other reasons that patients should not be together (e.g., MRSA or VRE status)

Patients with RSV

- Patients with laboratory-confirmed RSV are placed on Contact Precautions
- Patients with laboratory-confirmed RSV may be co-horted together as long as there are no other reasons that they should not be together (e.g., MRSA or VRE status)

The MGH Isolation Policy and other important influenza information are posted on the MGH Influenza Information SharePoint site, accessible on MGH desktop computers by clicking Start >Partners Applications >Clinical References >MGH Influenza Information, or by going to the website:

http://sharepoint.partners.org/mgh/influenza/default.aspx

For more information, contact a nursing supervisor, your unit- or practice-based infection-control practitioner, PCS leadership, and/or call the MGH Infection Control Unit at 617-726-2036.

Time after time, it's the little things that make a big difference

My name is Susan Barisano, and I'm a staff nurse/team leader in the Lunder 3 Post-Anesthesia Care Unit (PACU). The story I'm writing about took place when I worked in the Ellison 3 PACU. One afternoon, I admitted Mr. J, a 61-year-old man who had come to MGH from out of state for a partial laryngectomy and tracheostomy for laryngeal cancer. Mr. J's surgical course was uneventful; he arrived in the PACU in stable condition. During my years as a nurse working in many critical-care settings, I've cared for countless patients with tracheostomies, so I was comfortable initiating a plan of care for Mr. J. I assessed his airway to ensure he was oxygenating and ventilating adequately. He was hemodynamically stable. I assessed him for pain. He was still somnolent from the anesthesia, but was able to shake his head, No, when asked if he had pain. Working with the respiratory therapist, we determined that Mr. J's airway was clear, and he was placed on 40% oxygen with heated humidity via a trach mask.

One afternoon, I admitted Mr. J, a 61-year-old man who had come to MGH from out of state for a partial laryngectomy and tracheostomy for laryngeal cancer.

Satisfied with my post-operative assessment, I moved on to his communication needs. Over the years, I've developed certain skills in assessing and managing complex airways and techniques to communicate with patients who are unable to speak.

Susan Barisano, RN, team leader
Lunder 3 PACU

Patients with tracheostomies need to rely on staff's ability to lip-read, interpret gestures, or decipher hand-written notes. My goal was to ensure Mr. J had a means of communication as he came out of anesthesia. I obtained a communication board, a pad of paper, and a pen for him. I provided him with a call light and educated the operations associates about Mr. J's inability to speak and the plan for communicating with him. I opened the curtain to his area so we could have visual access to Mr. J during this immediate post-operative phase and he could signal us, if needed.

As time passed, and Mr. J became more awake, he complained of increasing throat and neck pain. Laryngeal surgery doesn't typically cause a considerable amount of pain, but Mr. J had been taking narcotics on occasion at home to control chronic lower-back pain. As a result, he had a higher than average pain-medication requirement. I collaborated with

continued on next page

Reflecting back on the care I provided to Mr. J, I feel I was able to attend, not only to his clinical needs, but to the psycho-social needs of both Mr. J and his wife. It's this ability to assist patients and family members in need and make a difference in their lives that truly guides my practice.

the PACU anesthesia and thoracic surgical teams to initiate a patient-controlled analgesia (PCA) for improved pain-management and educated Mr. J in the nuances of patient-controlled analgesia. Within a short period, Mr. J and I were satisfied with the effects of the PCA.

As Mr. J continued to recover from anesthesia, he became more aware of his surroundings. I stayed at his bedside, reassuring him and providing information about the surgery and plan of care. I began the process of educating him about the care and management of his tracheostomy, allowing myself ample time to be thorough. Because I've seen many patients with tracheostomies become frustrated or frightened by their inability to speak, I made sure Mr. J knew he could get the information he needed by writing his questions down. Mr. J began conversing with me in writing but soon discovered that if he 'spoke,' he was easily understood, which made communication between us a little more natural.

Next, I set about locating Mr. J's wife. Family members aren't often present in the PACU during the immediate post-operative phase, but I thought in this instance that Mrs. J's presence would be a comfort to her husband. And because Mr. J had a new tracheostomy, I wanted him to have the company of his wife as he became more accustomed to this new device. When Mrs. J arrived, she had many questions and concerns, but was happy to see her husband. I updated her on Mr. J's progress and plan of care. She sat with him as he continued to recover, and Mr. J appeared to rest more comfortably with his wife at his side.

I was informed that a bed would not become available for Mr. J until later that evening. Staff on the unit where he was to be transferred wanted to be able to situate him in a room close to the nurses' station, given that he had a new tracheostomy. I relayed this information to Mr. and Mrs. J, and encouraged Mrs. J to return to the hotel, as it had been a very long day for both of them. To alleviate any anxiety she might have about leaving her husband, I provided her with phone numbers and information as to how she could stay in touch overnight by telephone. I suggested she return to the hospital in the morning, when she and Mr. J would both be better rested.

Mrs. J agreed and gathered her belongings. As she was getting ready to leave, she asked for help finding her way back to her hotel in Winthrop. Her plan was to walk to the subway station, take the subway, then a bus, then walk the rest of the way to her hotel. She said she wasn't a 'city girl' and had never taken public transportation. I could see she was nervous; and Mr. J could see it, too. The idea of taking public transportation after dark in a strange city was daunting.

I consulted the case manager on-call to see if I could obtain a taxi voucher for Mrs. J (something I had done on occasion when I worked in other settings, but I'd never needed it in the PACU). The case manager agreed with our concerns and arranged for a taxi voucher to be brought to the PACU. I gave it to Mrs. J, and both she and her husband were greatly relieved.

Before she left, I encouraged Mrs. J to use the phone numbers I'd given her to check on her husband any time throughout the night. I assured her that I'd call when her husband was transferred to the unit and settled into his room. Then I asked one of our patient care associates to escort Mrs. J to the taxi stand in front of the hospital, ensuring that all her transportation needs were being met.

Reflecting back on the care I provided to Mr. J, I feel I was able to attend, not only to his clinical needs, but to the psycho-social needs of both Mr. J and his wife. It's this ability to assist patients and family members in need and make a difference in their lives that truly guides my practice.

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

Susan's experience caring for patients with tracheostomies is clearly evident in this narrative. But that experience didn't breed complacency—rather, it allowed her to anticipate Mr. J's needs and intervene before he even realized he had needs. Susan recognized that a higher level of narcotics was necessary, and she worked with the team to ensure Mr. J's comfort. Her concern for Mrs. J's safety and peace of mind was equally proactive and patient-focused. This is a lovely example of expert practice achieved through active engagement with the patient and a true understanding of theoretical knowledge.

Thank-you, Susan.

If it's Thursday, it must be Magnet Lunch Forum day

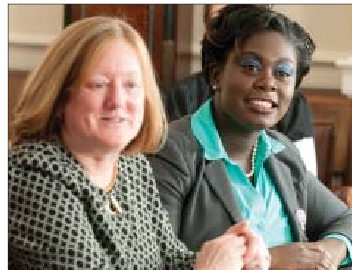
—by Mary Ellin Smith, RN, professional development manager

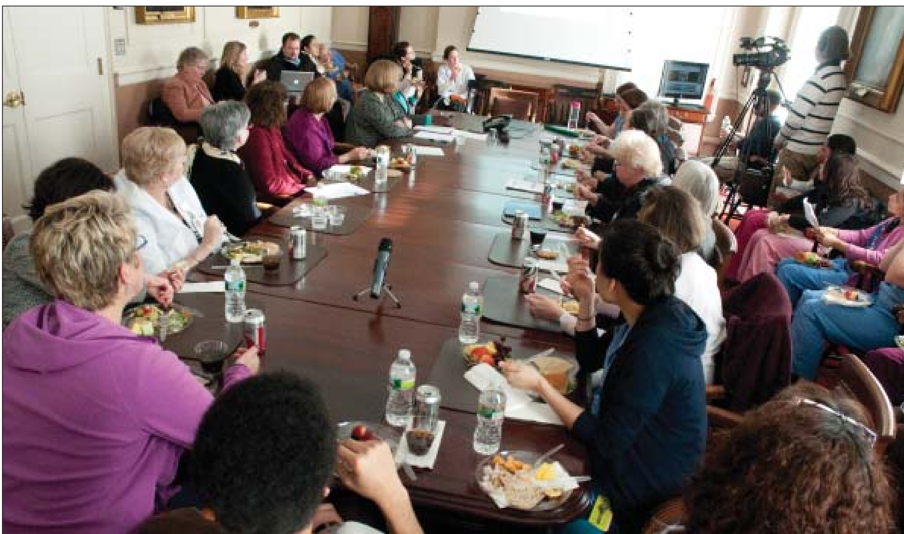
As you know, MGH is in the process of seeking Magnet re-designation with our Magnet site visit scheduled for March 4–7, 2013. More than 5,000 pages of evidence were prepared and submitted. Nurses at all levels contributed to the multi-volume documentation required by the ANCC as part of its application process.

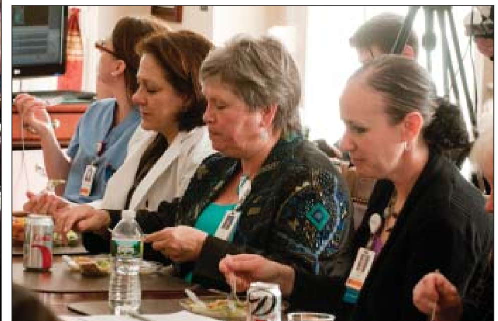
A number of strategies are being employed as part of a comprehensive communication plan to ensure staff are informed about the upcoming visit and prepared to receive our Magnet appraisers. Every week, staff and leadership throughout MGH receive a copy of *Magnet Monday*, an electronic newsletter focusing on various aspects of our structure, processes, and outcomes to help staff articulate our accomplishments.

To further engage staff, *Magnet Lunch Forums* are held every Thursday from 12:00–1:00pm in Lunder 234, where staff have an opportunity to delve deeper into topics such as quality and safety, professional development, and our professional practice model. These weekly forums are video-conferenced to the MGH health centers and other locations and are available on the Magnet EED portal page: http://www.mghpcs.org/PCS/Magnet/index.asp. For more information about *Magnet Mondays*, weekly *Magnet Lunch Forums*, or anything to do with the upcoming Magnet visit, please call Marianne Ditomassi, RN, at 617-724-2164.

Staff attend weekly Magnet Lunch Forum to discuss relevant topics of the day.







(Photos by Paul Batista)

Chaplaincy offers Spiritual Rounds to help support staff

As part of the Innovation Unit initiative and in an effort to meet the spiritual and emotional needs of clinical teams, the Chaplaincy is initiating Spiritual Rounds. Spiritual Rounds are tailored to meet the needs of each unit with timely and meaningful support

Question: With patient volume so high due to the flu and other factors, are chaplains available to provide spiritual support to staff?

Jeanette: As part of the Innovation Unit initiative and in an effort to meet the spiritual and emotional needs of clinical teams, the Chaplaincy is initiating Spiritual Rounds. Spiritual Rounds are tailored to meet the needs of each unit with timely and meaningful support:

- *Spirit and Values,* a five-month pilot program on the Psychiatric Unit has been launched by Reverend Angelika Zollfrank, who meets monthly with staff nurses and clinical nurse specialists to address issues and re-connect to the core values that led nurses to the profession in the first place
- *Caregiver Gatherings,* led by pediatric chaplain, Kate Gerne, a pediatrician, and a pediatric psychiatrist, is for inter-disciplinary team members who may need support following the death of a patient
- *Hearts and Minds,* which began in 2007, meets monthly to provide time and space for personal reflection for gynecology-oncology staff on Phillips 21 (formerly Bigelow 7). Facilitated by oncology chaplain, Katrina Scott, the hour is spent processing whatever's on staff's minds
- *Mindfulness Mediation/Relaxation.* Meaghan Rudolph, RN; Barbara Cashavelly, RN; and oncology chaplain, Katrina Scott, are developing a program for Lunder 9 to support staff caring for critically ill patients. Plans include in-services on guided meditation techniques, group reflection, and relaxation

Question: Does the Chaplaincy offer any other spiritual resources for staff?

Jeanette: Every October during Spiritual Care Week, the Chaplaincy offers the Blessing of the Hands for employees as an affirmation of their valuable work as providers of excellent patient care. Chaplains offer the blessing away from the busyness of the day with words like, "May your hands be blessed with tenderness and strength, with compassion and courage. May your hands be messengers of healing and hope."

Ash Wednesday is another opportunity for spiritual support as chaplains offer the sign of the cross in ashes to patients, families, and staff on each unit and in the chapel. This annual Christian and Roman Catholic ritual marks the beginning of the 40-day season of Lent, reminds the faithful of our human frailties, and invites us to repent and turn toward God in preparation for Holy Week and the Festival of the Resurrection—Easter Day. Long work hours often prevent staff from attending their local churches to receive ashes. The Chaplaincy is honored to provide the ritual as a sign of support and encouragement.

Question: How would we go about starting Spiritual Rounds on our unit?

Jeanette: The Chaplaincy is committed to finding ways to support every team and every team member. To begin the process of offering Spiritual Rounds on your unit, talk to your liaison chaplain or call the Chaplaincy at -62220.

Announcements

Magnet Site Visit scheduled

The Magnet appraisal team will conduct its re-designation site visit, March 4–7, 2013. Details will be shared as they become available.

Congratulations to staff for earning the opportunity to showcase our inter-disciplinary patient- and family-centered care during this important external review.

For more information, or to stay abreast of all our Excellence Every Day activities and Magnet preparations, go to: www.mghpcs.org/PCS/Magnet

ACLS Classes

Certification:

(Two-day program
Day one: lecture and review
Day two: stations and testing)

Day one:
February 11, 2013
8:00am–3:00pm
O'Keeffe Auditorium

Day two:
February 25th
8:00am–1:00pm
Their Conference Room

Re-certification (one-day class):
March 13th
5:30–10:30pm
Founders 130 Conference Room

For information, contact Jeff Chambers at acls@partners.org

Classes are subject to change; check website for current dates and locations.

To register, go to: http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

The Connell Ethics Fellowship

Two ethics fellowships available (20 hours/week for one year)

Nurses, social workers, chaplains, and allied health professionals with master's degree or higher may apply.

Application Deadline:
Thursday, January 31, 2013

Interviews scheduled by appointment, February–March

Fellowship begins
Monday, June 3, 2013

Submit CV and goal statement by e-mail to erobinson1@partners.org,or hand deliver to Founders 341.

Applicants will be notified of their acceptance via e-mail in spring of 2013.

For more information, call 4-1765.

Ash Wednesday

February 13, 2013
MGH Chapel

- Ashes distributed in the Chapel 9:00am–5:00pm
- Roman Catholic Mass, 11:00am
- Ecumenical Ash Wednesday Service, 12:15pm
- All Chapel services broadcast on MGH Channel 16
- Catholic TV is available 24/7 on Channel 17
- Ashes distributed on patient care units once between 8:00am and 4:00pm

Ashes will also be distributed at:
the Charlestown Navy Yard
Charlestown Health Center
Chelsea Health Center
Revere Health Center
Schrafft Center
Massachusetts Eye and Ear Infirmary

For more information, call 6-2220.

Celebrating the legacy of Martin Luther King, Jr.

Friday, February 15, 2013
1:00–2:00pm
Shriners Auditorium
Shriners Hospitals for Children
51 Blossom Street
speaker:
Carol R. Johnson, superintendent of Boston Public Schools

For more information, call 617-724-3965.

Fundamentals of Medical Terminology I

Space is available in the 10-week, Fundamentals of Medical Terminology course for employees considering transitioning to a clinical role. $120 fee includes textbook. Class meets on Tuesdays, March 5–May 15, 2013
5:00– 7:00pm
Haber Auditorium

Enroll via PeopleSoft.

For more information, call 617 724-3368.

Blum Center Events

Harp Music
Wednesday, January 23rd
12:00–12:30 and 12:40–1:00pm
Harpist: Becky Wertz

Shared Decision-Making:
"Low Back Pain"
Wednesday, January 30th
12:00–1:00pm
Speakers: Steve Atlas, MD, and Thomas Cha, MD

Programs are free and open to MGH staff and patients.

All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

Senior HealthWISE events

All events are free for seniors 60 and older

Lecture series
"The Latest in Cardiac Tests"
Thursday, January 31st
11:00am-12:00pm
Haber Conference Room
Speaker: Dorothy Sullivan, RN, nurse practitioner, MGH Heart Failure and Transplantation Unit.

Hypertension Screenings:
Monday, January 28th
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood-pressure checks with wellness nurse, Diane Connor, RN.

For more information, call 4-6756.

Call for Nursing Research Expo abstracts

Are you working on a research or performance-improvement project? Are you part of an Innovation Unit? Perhaps you'd like to submit an abstract for the annual Nursing Research Expo to be held May 6–10, 2013.

Abstracts are due by February 1st.

For more information, visit the Munn Center website (http://www.mghpcs.org/MunnCenter/Expo_Index.asp) or call Linda Lyster at 617-643-0431.

Staff Notice
Magnet Recognition Program®
Site Visit

- Your organization has applied to the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® for re-designation of the prestigious Magnet designation. This designation recognizes excellence in nursing services.

- You have an opportunity to participate in the evaluation process and are encouraged to do so. We will be coming to your hospital, **March 4, 5, 6, and 7, 2013**, for a site visit.

- You may talk with the appraisal team when they arrive, or you may fax or e-mail comments to the Magnet Program Office. **All phone comments to the Magnet Program Office must be followed up in writing.** YOUR COMMENTS ARE CONFIDENTIAL AND NEVER SHARED WITH ANYONE IN YOUR ORGANIZATION. IF YOU CHOOSE, YOUR COMMENTS MAY BE ANONYMOUS, BUT MUST BE IN WRITING.

- YOUR COMMENTS MUST BE RECEIVED BY **FEBRUARY 22, 2013**.

  PHONE: 866-588-3301 (TOLL FREE)

  FAX: 301-628-5217

  E-MAIL: MAGNET@ANA.ORG

  WRITE: AMERICAN NURSES CREDENTIALING CENTER
MAGNET RECOGNITION PROGRAM
8515 GEORGIA AVENUE, SUITE 400
SILVER SPRING, MARYLAND 20910-3492

Your organization has submitted written documentation for the appraisal team to review. That information is available to you for review on-line at www.mghpcs.org/PCS/Magnet or written evidence is available 24/7 in the Clinical Supervisor's Office on Bigelow 1406D on the MGH Main Campus, phone 617-726-6718, pager 617-726-2000 #2-5101.

Notice to Registered Nurse Staff

Although you are not required to identify the organization in which you work, doing so will provide the appraisal team with valuable information that can be considered in the evaluation. If you do choose to indicate your organization, rest assured your comments are received anonymously and the Magnet Program Office has no way of identifying you. (To assure complete anonymity, submit comments from a home computer.)

Published by
Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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

Managing Editor
Susan Sabia

Editorial Advisory Board

Chaplaincy
Reverend John Polk, DMin

Disability Program Manager
Zary Amirhosseini

Editorial Support
Marianne Ditomassi, RN
Mary Ellin Smith, RN

Medical Interpreters
Anabela Nunes

Materials Management
Edward Raeke

Nutrition & Food Services
Donna Belcher, RD
Susan Doyle, RD

Office of Patient Advocacy
Robin Lipkis-Orlando, RN

Office of Quality & Safety
Kevin Whitney, RN (interim)

Orthotics & Prosthetics
Mark Tlumacki

PCS Diversity
Deborah Washington, RN

Physical Therapy
Occupational Therapy
Michael Sullivan, PT

Police, Security & Outside Services
Joe Crowley

Public Affairs
Emily Lemiska

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech, Language & Swallowing Disorders and Reading Disabilities
Carmen Vega-Barachowitz, SLP

Training and Support Staff
Stephanie Cooper

The Institute for Patient Care
Gaurdia Banister, RN

Volunteer Services
Wayne Newell

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
February 7, 2013

Professional Achievements

Chang presents

Lin-Ti Chang, RN, staff specialist, presented the 5th annual Advanced Disaster Medical Response Course, to staff at the Alice Ho Miu Ling Nethersole Hospital, in Hong Kong, December 10–11, 2012.

Pischke presents poster

Karen Pischke, RN, reiki provider, Cancer Center HOPES Program, presented her poster, "The Emerging Role of Reiki Therapy in the Acute Care Setting: Bringing Holism to the Bedside," at the 4th annual Spirituality and Nursing Conference, in Boston, November 3, 2012.

Inter-disciplinary team publishes

Deborah Wexler, MD; Catherine Beauharnais; Susan Regan; David Nathan, MD; Enrico Cagliero, MD; and Mary Larkin, RN, authored the article, "Impact of Inpatient Diabetes Management, Education, and Improved Discharge Transition on Glycemic Control 12 Months After Discharge," in *Diabetes Research and Clinical Practice*, in November, 2012.

Pischke publishes

Karen Pischke, RN, reiki provider, Cancer Center HOPES Program, authored the article, "An Integrative Model for Orthopaedic Nursing Incorporating Reiki Therapy," in the National Association of Orthopaedic Nurses (NAON) newsletter, in September, 2012.

Dorman honored

Robert Dorman, PT, physical therapist, received the Excellence in Clinical Practice Award from the American Physical Therapy Association of Massachusetts, in Wellesley, November 3, 2012.

Inter-disciplinary team publishes

Michael Balboni, MDiv; Adam Sullivan; Adaugo Amobi; Andrea Phelps, MD; Daniel Gorman, RN; Angelika Zollfrank, MDiv; John Peteet, MD; Holly Prigerson; Tyler VanderWeele; and, Tracy Balboni, MD, authored the article, "Why is Spiritual Care Infrequent at the End of Life? Spiritual Care Perceptions Among Patients, Nurses, and Physicians and the Role of Training," in the *Journal of Clinical Oncology*, December, 2012.

Dolan Looby appointed

Sara Dolan Looby, RN, nurse practitioner, Nutritional Metabolism, was appointed a fellow of the American Academy of Nursing in Washington, DC, in October, 2012.

Inter-disciplinary team presents poster

Gaurdia Banister, RN, executive director, The Institute for Patient Care; Sharon Badgett-Lichten, LICSW, senior project manager; Edward Coakley, RN, project manager; Ronald Doncaster, director of Operations Management; Richard Evans, director of Service; Brian French, RN, director of The Maxwell & Eleanor Blum Patient and Family Learning Center; Debra Frost, RN, staff specialist; Cynthia LaSala, RN, clinical nurse specialist; Liza Nyeko, staff of the Office of Quality & Safety; Kate Roche, RN, clinical nurse specialist; Jennifer Sargent, RN, nursing director; and Meridale Vaught Baggett, MD, presented their poster, "The 'Always Responsive' Quality Demonstration Project," at the 24th annual National Forum on Quality Improvement in Health Care, in Orlando, Florida, December 9–12, 2012.

Clinical Recognition Program

Clinicians recognized
September 1, 2012– January 1, 2013

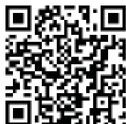
Advanced Clinicians:

- Jennifer Casella, RN, Pediatric Intensive Care
- Christina Jewell, RN, Electrophysiology Laboratory
- Meghan Lortie, RN, Cardiac Interventional Unit
- Amy Lizotte, RN, General Medicine
- Laura Bonnet, RN, Thoracic/Medicine
- Suy-Sinh Law, PT, Physical Therapy
- Amy Murphy, RN, Neuroscience
- Nicole Moran, RN, Vascular Surgery
- Erin Daly, SLP, Speech Language Pathology & Swallowing Disorders
- Stefanie Michael, RN, General Medicine
- Theodora Abbenante, RN, Vascular Surgery
- Patricia Harron, RRT, Respiratory Therapy
- Jennifer McAtee, OTR/L, Occupational Therapy
- Leslie McLaughlin, OTR/L, Occupational Therapy

Clinical Scholars:

- Sandra Masiello, RN, Family/Newborn Unit
- June Guarente, RN, Endoscopy
- Gertrude Colburn, RN, Radiation Oncology
- Tara Hutchings, RN, Labor & Delivery
- Mary Susan Convery, LICSW, Social Work
- Anna Carson, RN, Case Management
- Nancy Aguilar, RN, Surgical Intensive Care

Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696



First Class
US Postage Paid
Permit #57416
Boston, MA