

Caring

Headlines

July 20, 2017

Clinical research nursing

*now formally recognized by the American Nurses Association
as a specialty nursing practice*

(See story on page 4)



Clinical research nurse, Elyse Raymond, RN, reviews blood-sugar levels with patient, Tony Monteiro, in the MGH Diabetes Research Center.

Our Magnet journey: *how we got here, why it's important, and where we go from here*

You may recall that the Magnet Recognition Program grew out of a research study in the 1980s to determine what characteristics of healthcare organizations were responsible for attracting and retaining quality nurses.

On June 1, 2017, MGH submitted its application and supporting evidence to the American Nurses Credentialing Center for re-designation as a Magnet hospital. You may recall that the

Magnet Recognition Program grew out of a research study conducted in the 1980s to determine what characteristics of healthcare organizations were responsible for attracting and retaining quality nurses—especially during times of nursing shortages. Those characteristics became known as the Forces of Magnetism and provided the framework for the original Magnet Recognition Program.

In 2008, the American Nurses Credentialing Center developed a new model incorporating the Forces of Magnetism into a simpler, more concise framework comprised of five components:

- Transformational leadership
- Structural empowerment
- Exemplary professional practice
- New knowledge, innovation, and improvements
- Empirical quality results

The new model (see opposite page) is set against an overarching backdrop of Global Issues in Nursing & Health Care, which, while not a component of the model itself, acknowledges the many global factors that impact nursing and health care today.

Magnet re-designation occurs every four years. We earned our original Magnet recognition in



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

2003 and were re-designated in 2007 and 2013. The evidence we submitted on June 1st reflects the collaborative work and exemplary practice of nurses throughout MGH, including the health centers and ambulatory practices on the main campus, in Waltham, and Danvers. It is humbling to see the breadth and depth of this evidence that captures the innovative programs, initiatives, and outcomes of this incredible workforce, including evidence-based practice; the acquisition of new knowledge driven by research; leadership; advocacy; clinical and professional development; and the positive trending of nurse-sensitive indicators.

Our evidence is currently in the hands of four Magnet appraisers, who will review the information and determine whether to request additional evidence or move forward to schedule a site visit.

As you know, the window is now open for our next survey by The Joint Commission. We anticipate the Joint Commission survey will occur some

continued on next page

time between now and April, 2018. In the spirit of collaboration and Excellence Every Day, staff and leadership throughout the hospital are working together to align our preparations for both the Joint Commission and Magnet re-designation site visits.

I'd like to thank Marianne Ditomassi, RN, executive director for PCS Operations, for taking on the Herculean task of coordinating our re-designation efforts and shepherding the multi-year, multi-faceted process of preparing our evidence for submission.

The PCS Office of Quality & Safety and the MGH department of Patient Experience were helpful in providing quality and patient- and staff-satisfaction data.

The Magnet Writers Group (Chris Annese, RN, staff specialist; Meg Bourbonniere, RN, nurse scientist; Mandi Coakley, RN, staff specialist; Brian French, RN, director, Blum Patient & Family Learning Center; Amy Giuliano, senior project specialist; Antigone Grasso, director, PCS Management Systems and Financial Performance; Janet Madden, RN, staff specialist; Patti Shanteler, RN, staff specialist; Mary Ellin Smith, RN, professional development coordinator; and Nancy Raye, RN, staff specialist)

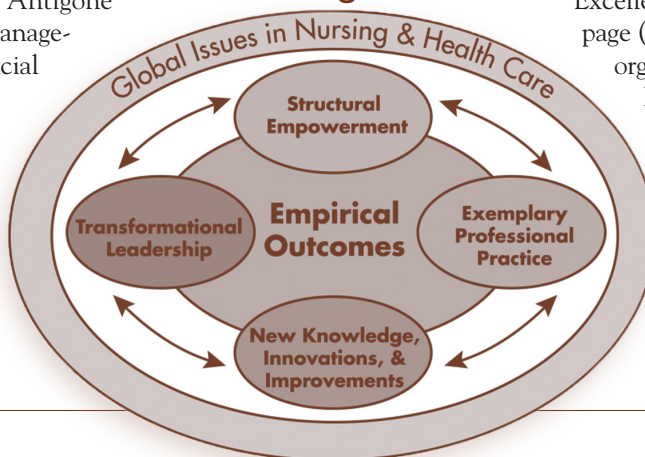
worked tirelessly to identify and synthesize evidence from numerous sources.

Jess Beaham, web developer and project manager; and Georgia Peirce, project manager, designed and developed our Magnet website application; and our collaborative governance champions played a pivotal role in disseminating quality and safety information to colleagues on their units.

But I think it's important to understand that Magnet recognition is not about the quality of evidence we submit. Magnet recognition is validation and public acknowledgment of our exemplary day-to-day practice, professionalism, and commitment to excellence. And for that, I thank staff and leadership throughout the hospital for putting patients first, every moment of every day.

As we await word on the status of our Magnet application, I want to call your attention to three excellent resources: the PCS Excellence Every Day portal page (http://www.mghpcs.org/eed_portal/); our Magnet website (<http://www.mghpcs.org/PCS/Magnet/index.asp>); and our regulatory readiness page (<http://www.mghpcs.org/RR/index.asp>).

Current Magnet Model



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(Photo on page 6 by Paul Batista)

Clinical Research Nursing:

the history and evolution of this newly recognized specialty practice

—by Mallory Hillard, RN; Courtney Balliro, RN; Mary Larkin, RN, MGH Diabetes Research Center

Formal recognition of clinical research nursing means the establishment of standards and scope of practice for clinical research nurses, greater opportunities for leadership-development, and it lays the groundwork for future certification.

In August, 2016, the American Nurses Association formally recognized clinical research nursing as a specialty nursing practice. That recognition was a pivotal milestone for the field and for clinical research nurses. Formal recognition of clinical research nursing means the establishment of standards and scope of practice for clinical research nurses, greater opportunities for leadership-development and advancement, and it lays the groundwork for future certification.

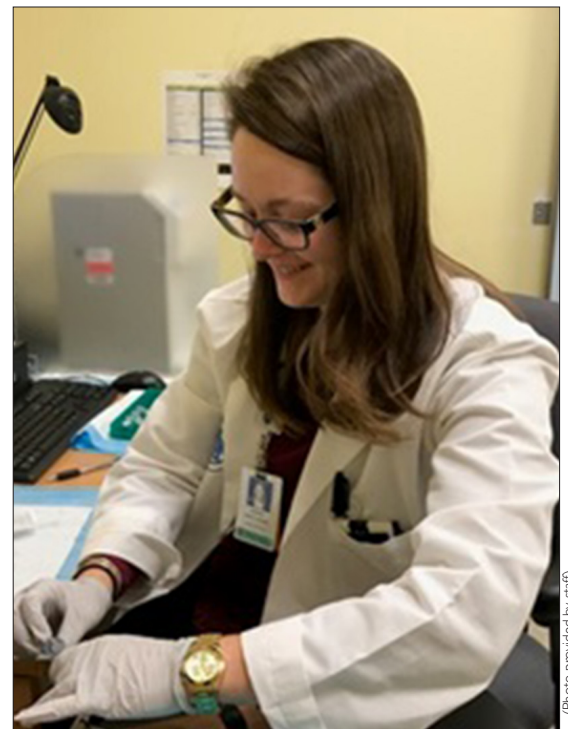
Clinical research nursing at MGH dates back to 1925 in what was then the Mallinckrodt Unit or Bulfinch Ward 4, comprised of ten beds adjacent to a research laboratory. The Mallinckrodt Unit was staffed by nurses dedicated to both research and providing quality care to their patients. Marion Bates, MGH School of Nursing alumna, class of 1934, recalled, “I was put on night duty my first year on Ward 4, the Bulfinch research ward, run by Dr. Fuller Albright. Everything was precise, we had to measure, test, and record everything and anything that went into the body or out of it.”

That diligence and precision is the cornerstone of clinical research nursing and has been the mainstay of the practice for the better part of a century. Clinical research nurses must possess a specific set of skills and knowledge; they must be mindful of standards of care, the disease being

studied, and the requirements of the research protocol, all while ensuring patient safety and satisfaction.

While research nurses had used these specialized skills in practice since the early 1900s, it wasn't until the 1960s that ‘clinical research nurse’

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Clinical research nurse, Kimberly Martin, RN, performs bionic pancreas research visit at the MGH Diabetes Research Center.

(Photo provided by staff)

While research nurses had used these specialized skills in practice since the early 1900s, it wasn't until the 1960s that 'clinical research nurse' actually became a designated role, eventually becoming a career path for countless nurses in the 1980s and 90s.

actually became a designated role, eventually becoming a career path for countless nurses in the 1980s and 90s. As the role evolved, clinical research nurses have utilized the experience gained through patient care, protocol-implementation, and study coordination to lend nursing expertise to developing and implementing protocols and analyzing data. Nurses serve as investigators and collaborators and are integral members of the interdisciplinary, scientific endeavor. This evolution has led to significant contributions by clinical research nurses to research and science through independent investigations, publications, and participation in professional organizations.

One organization in particular, the International Association of Clinical Research Nurses (IACRN), was established to delineate clinical research nursing practice, aid in the recognition of the specialty, and promote leadership and professional development. The IACRN held its first conference in 2009, and the first local chapter was established here in Boston in 2013. Since its inception, the IACRN has remained true to its vision of deliver-

ing safe, quality care while maintaining research integrity through specialty nursing practice. The efforts of the IACRN were a major catalyst in the American Nurses Association's recognition of clinical research nursing as a specialty last year. As we celebrate this auspicious milestone, it's worth noting that this recognition is a vital stepping stone toward establishing standardized training for clinical research nurses and developing a certification process, both of which enhance the quality of care we deliver and the research we conduct.

The next annual IACRN conference will be held October 18th–20th, in Providence, Rhode Island. The Boston chapter is scheduled to meet November 7th. For more information about clinical research nursing or the International Association of Clinical Research Nurses, go to: <http://iacrn.memberlodge.org/aboutus>. If you're interested in joining the IACRN Boston chapter, please contact bostoniacrn@gmail.com. Meeting schedules are available at the IACRN website above.



Mallory Hillard, RN
clinical research nurse
MGH Diabetes Research Center

Reflections of a clinical research nurse

Research has always been a passion of mine. As a new graduate nurse, I knew I wanted to begin my practice as a clinical research nurse. Prior to nursing school, I worked for five years as a research coordinator in type 1 diabetes studies at the MGH Diabetes Research Center. My interactions with patients, the critical approach and analysis to exploring disease processes, and the strong mentorship and guidance I received from experienced nurses solidified my decision to become a nurse, particularly a clinical research nurse. Clinical research nursing requires a dual focus on the research endeavor and scientific process while at the same time keeping the patient's needs and safety, and standards of care at the forefront of practice. This allows for the exploration of important questions related to disease management, challenges faced by clinicians and patients, and insight into the patient experience, all of which have the potential to enhance the quality care we provide to patients.

(Photo by Jeffrey Andree)

End-of-life care in the SICU is an art and a privilege

Mr. D was admitted to our unit as an unknown trauma male requiring immediate care. The brief report we received prior to his arrival was simply, 'an elderly pedestrian found down after being struck by a motor vehicle.'

My name is Karla DeJesus, and I have been a nurse at MGH for 14 years, most recently in the Ellison 4 Surgical ICU. I've cared for many patients, but one patient and family really stand out in my mind.

Mr. D was admitted to our unit as an unknown trauma male requiring immediate care. The brief report we received prior to his arrival was simply, 'an elderly pedestrian found down after being struck by a motor vehicle.' He was initially alert at the scene but unable to move his extremities. While en route to MGH, his mental status declined, and he was intubated prior to arrival. He was given paralytics and sedation for insertion of the breathing tube, and mannitol and hypertonic saline for possible traumatic brain injury. He was brought to the SICU after a brief stop in the Emergency Department.

Mr. D arrived with a heart rate in the 30s and low blood pressure. He was treated with medications for his hemodynamic instability. I was extremely pleased with our teamwork and how swiftly all disciplines acted to help stabilize Mr. D.

I knew from experience that once we established acceptable IV access and he was hemodynamically safe to travel, I'd take him to Cat Scan so we could evaluate his internal injuries.

In Cat Scan, Mr. D required frequent titration of medications to maintain safe vital signs. When the CAT scan was completed, the ICU doctor and I were informed that Mr. D had an unstable cervical fracture. I strategically placed Mr. D and all his life-sus-



Karla DeJesus, RN, staff nurse, SICU

taining equipment back on the ICU bed and returned to the SICU for further care.

Settling Mr. D back into the SICU, I had a quiet moment in which to conduct a neurological exam. When his sedating medications were turned off, Mr. D opened his eyes quickly, meaning he was probably intact neurologically. His clear blue eyes made contact with mine, and my heart sank. I knew he was afraid, so I asked him if he was in any pain. He shook his head 'No,' which was reassuring. I was excited to be able to communicate with him. His cervical fracture was unstable; despite having a cervical collar on, he was at risk for harm if he moved his neck. We developed a communication system whereby he could answer my questions by blinking his eyes. I explained that I was going to give him some medication so he'd fall asleep, and soon he was fast asleep with tears rolling down his cheeks.

Mr. D's family arrived, and I greeted them in our waiting room. I prepared them as best I could to see their injured loved one. I took the time to explain the medical equipment and the environment while escorting them into Mr. D's room.

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all the time,
but families
do not.

The rest of my shift was spent in Mr. D's room providing care and developing a plan with the critical care doctors. During that time, I maintained open communication with the family. Everyone agreed that the most important goal was to ensure Mr. D was comfortable. But the family slipped into despair as the hours passed. We set up a family meeting, and the team updated the family with the devastating news that Mr. D was paralyzed. We supported the family and answered their questions, and soon, they all went home to rest.

The next day, when I assessed Mr. D's neurological status, he was able to open his eyes. I reinforced the importance of using the non-verbal communication system we'd established to answer my questions.

Soon after, Mr. D's son, daughter, and elderly wife arrived. I spent time with them answering questions and informing them of his intact mental status. I told them he had awoken and inquired about walking. The family wanted to be completely honest with him, but they were heartbroken to learn that Mr. D was fully aware of what was going on. They wanted to wake him and comfort him but couldn't handle the idea of seeing him frightened and in this state. The family was adamant that Mr. D would not want to live on a ventilator, in a nursing home, or be dependent on anyone for care. I knew this family needed support. I tried to develop a rapport while offering support and consoling them. Throughout the day, we had time to talk about Mr. D's life while sharing tears and sadness.

A family meeting was called with the multi-disciplinary team to inform the family of Mr. D's very poor prognosis. The family decided not to escalate care and to make Mr. D a DNR (Do not resuscitate). After the meeting, the family went home to process all the information. I felt good about the decisions the family had made. Though they had been emotionally unable to speak with him, I knew I had helped advocate for his best wishes.

As I cared for Mr. D that day, his eyes filled with tears. I put my hand on his head, and I teared up with him. I told him how sorry I was that this had happened to him and assured him my goal was to make him feel safe and pain-free. He mouthed that he, "did not want to live this way." I assured him that his family would honor his wishes. I told him how much they loved him and how lovely they all were.

I could have talked to him for hours, but it was time to sedate him and let him rest. His last words before he fell asleep were, "Thank you," which made me tear up more as he drifted off to sleep.

As I drove into work the next day, I was anxious about withdrawing care from Mr. D. I was unsure if his family would be able to say good-bye to him. When I entered Mr. D's room, his eyes were open. It felt like he'd been waiting for me, and as soon as he saw me he mouthed the word, "Family." I gently reminded him that his family was hesitant to see him as they didn't want to distress him. He nodded and mouthed, "I need to say good-bye." I was happy he wanted closure and to say good-bye to his family. I felt a sense of fulfillment to be able to connect with Mr. D and his family during this traumatic time.

Mr. D's family arrived early. I sat with them in the waiting room and updated them on my conversation with Mr. D. I had to let his family know how he felt. I needed to do this delicately, because I knew that these memories would stay with the family long after his death. They were extremely appreciative and decided they needed to go in and say good-bye to Mr. D.

That time between withdrawing care and when the patient dies can be the most important time in a family's life. I try to make that time as comforting as I can. Caregivers may see end-of-life situations all the time, but families do not. Being sensitive to their needs, their questions, and concerns, can make a difference in their experience of care.

As I ended my shift, I felt a sense of pride and honor to be able to care for patients and families during these devastating times. I had developed a strong connection while supporting Mr. D and his family. I'll never forget the look in Mr. D's eyes as he passed away peacefully and with dignity.

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

Working in a hospital, we're constantly reminded of the fragility of life. We're present with patients and families as they cope with unexpected tragedies and complications. Experienced clinicians like Karla bear witness to their pain and are able to bring strength and comfort to these untenable situations. Karla gently and masterfully helped this family come together to say a goodbye—giving Mr. D and his family the closure they desired but couldn't quite manage on their own.

Thank-you, Karla.

The Carol A. Ghiloni Oncology Nursing Fellowship

—by Mandi Coakley, RN, staff specialist

Below: Fellowship namesake, Carol Ghiloni, RN (left), with (l-r) fellows, Bridget Lynch, and Kerry Chen, and fellowship coordinator, Mandi Coakley, RN. Below right: Ghiloni fellows, Lynch and Chen, review information on the Lunder 9 Oncology Unit.

For 17 years, the Carol A. Ghiloni Oncology Nursing Fellowship has provided educational opportunities for student-nurse oncology fellows. As fellows, nursing students spend ten weeks learning and observing in various settings within the Oncology Nursing Service. The experience allows them to see first-hand the variety of roles held by nurses and the many career opportunities available to them upon graduation. The Ghiloni Oncology Nursing Fellowship was created in 2001 to give student nurses an opportunity to learn about the specialty of Oncology Nursing with the hope of recruiting them into oncology nursing positions at MGH upon graduation.

This year, the program included fellows, Kerry Chen and Bridget Lynch, both rising seniors at the University of Massachusetts, Amherst.

Chen and Lynch spent time on Lunder 9 and 10 and Phillips House 21; they had observational experiences in Radiation Oncology, the Infusion Unit, and the Yawkey outpatient disease centers. They spent time in the Blum Center, Palliative Care, Interventional Radiology, and took advantage of many other learning opportunities within the Cancer Center.

The Carol A. Ghiloni Oncology Fellowship receives funding from a variety of sources including the Hahnemann Hospital Foundation.

For more information, call Mandi Coakley, RN, staff specialist, at 617-726-5334.



Preparing to welcome the Joint Commission

Question: I've heard that the Joint Commission could visit MGH in the near future. Is that right?

Jeanette: Yes, it is. Usually, the Joint Commission visits hospitals every three years, and they prefer to arrive unannounced. Our last survey was in April of 2015, so we're currently in that 'window of opportunity' where we could reasonably expect a visit. However, based on past experience, we expect the Joint Commission visit to occur some time between January and April of 2018.

Question: Is there anything we should be doing to prepare for the Joint Commission visit?

Jeanette: We're doing it already. Our Excellence Every Day philosophy ensures we're continually ready for the scrutiny of any regulatory agency. Our Excellence Every Day approach grew out of our commitment to do right by our patients in every moment of every day; so by extension, that means we're perpetually prepared for the Joint Commission. In the coming months, we'll continue to highlight quality-and-safety issues that align with the Joint Commission's National Patient Safety Goals as well as areas of focus specific to MGH and Nursing & Patient Care Services.

Question: My co-workers mentioned that a mock Joint Commission survey was conducted recently. How did that go?

Jeanette: Themes that emerged during the mock survey and subsequent discussions with leadership were:

- Ensure safe care of at-risk populations, including patients at risk for suicide
- Adhere to infection-control efforts, including transport of instruments to central processing
- Ensure that the environment of care is as safe as possible, especially related to fire safety
- Special attention should be paid to expired medications and medication safety
- Use eCare functionality as it was designed for medication and order reconciliation

Questions: Is there anything else we should know?

Jeanette: Participating in weekly inter-disciplinary tracers on patient care units can be very informative. These exercises help identify what units are doing well and where they may need improvement. They can also be instrumental in identifying and formulating solutions.

We will continue to communicate with staff to share best practices and raise awareness about key quality and safety issues. But if we stay true to our Excellence Every Day philosophy, I know we'll have another successful Joint Commission visit.

For more information about the Joint Commission or Excellence Every Day, call Colleen Snyderman, RN, director of the PCS Office of Quality & Safety, or go the Excellence Every Day portal page at: http://mghpcs.org/eed_portal/EED_CAUTI.asp.

Usually, the
Joint Commission
visits hospitals
every three
years, and they
prefer to arrive
unannounced. Our
last survey was in
April of 2015, so
we're currently
in that 'window
of opportunity'
where we could
reasonably
expect a visit.

Announcements

Why hasn't anyone thought of that?

Because they're waiting for you! Applying for an IDEA grant can help make your idea a reality. Created in 2016, IDEA (Innovation, Design, Excellence, Awards) grants fund one or two members of Nursing & Patient Care Services with up to \$5,000 to turn their ideas into a reality.

Last year, Jared Jordan, RN, was funded for his idea to provide harnesses to patients to help prevent falls in the bathroom. Lillian Ananian, RN; Jeanette Livelo, RN; Paul Currier, MD; and Dominic Breuer, MD, were funded for their idea to use flip boards to reduce the number of CLABSI in the MICU.

Your idea should address one of the following:

- Alignment with our mission (patient care, research, education, or community)
- Care delivery
- eCare
- Work environment
- Patient experience
- Staff engagement
- Cost-containment

Got an idea? Apply.

Got "kind of an idea"? No problem, e-mail Mary Ellin Smith, RN, or call her at 617-724-5801, and talk it through.

Applications are available at:
<http://www.cvent.com/d/j5qdkj>

Applications are due by September 1, 2017.

So what are you waiting for?

Call for nominations

2017 Brian A. McGovern, MD, Award

The MGPO is now accepting nominations for the 2017 McGovern Award for Clinical Excellence. Nominate a physician who is patient-focused, a superb clinical role model, and considered an 'unsung hero.' Physicians in good standing in every clinical department are eligible to be nominated.

Anyone associated with MGH can nominate a physician, including attending and trainee physicians, nurses, other employees, volunteers, students, and patients.

Nominations are due by July 17, 2017.

To submit a nomination, go to <https://mgpo.massgeneral.org/mcgovern/>, or e-mail project specialist, Emma Leestma.

For more information, call 617-724-7337.

AMMP Scholarship

2017 AMMP
(Association of Multicultural Members of Partners)
Scholarship Opportunity

Are you an AMMP member?
Are you currently in school?

Applications are now being accepted for the 2017 AMMP scholarship.

Applications are available at the Employee Access Center in Bulfinch 107 or on the AMMP website at: <http://AMMP.massgeneral.org>

See application for eligibility.

For more information, go to the AMMP website at <http://AMMP.massgeneral.org>; or call AMMP Scholarship chair, Sandra Thomas, at 617-643-0140.

Application deadline is Wednesday July, 12, 2017.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

ACLS classes

Two-day certification program

Day one:
September 11, 2017
8:00am–3:00pm

Day two:
September 25, 2017
8:00am–1:00pm

Re-certification (one-day class):
August 9, 2017
5:30–10:30pm

Location to be announced.
For information, e-mail: acls@partners.org, or call 617-726-3905

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

The MGH Blood Donor Center

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

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

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

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

Friday, 8:30am – 3:00pm

Appointments are available

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

Algeri named new associate chief nurse

Nursing & Patient Care Services is pleased to announce the appointment of Suzanne Algeri, RN, to the role of associate chief nurse, filling the vacancy created by Kevin Whitney, RN, who became chief nursing officer and senior vice president for Patient Care at Newton-Wellesley Hospital earlier this year.



Suzanne Algeri, RN
associate chief nurse

Algeri is a highly qualified nurse leader, regarded by all as a skilled, knowledgeable, caring nurse. Under Algeri's leadership as nursing director of Lunder 7, her unit consistently performed well on National Database of Nursing Quality Indicators; scored in the top 5% in HCAHPS scores for Nurse Communication, Staff Responsiveness, Pain-Management, and Quiet at Night; and has achieved high nurse-satisfaction scores in recent surveys.

Algeri has been active in many Neuroscience and hospital-wide initiatives; she was selected from an impressive field of candidates; she assumed her new position, July 17, 2017.

Said senior vice president for Patient Care, Jeanette Ives Erickson, RN, "We're grateful to have had the benefit of Kevin Whitney's wisdom and experience as associate chief nurse for as long as we did. I'm thrilled that Sue will be joining our executive team, and I look forward to working with her in this new role."

Says Algeri, "I'm excited to be assuming the position of associate chief nurse for Surgery, Orthopedics, and Neurosciences. This is such a talented group of leaders and staff; I look forward to supporting the tradition of excellence in patient care that has been so well established in this division."

Algeri is a highly qualified nurse leader, regarded by all as a skilled, knowledgeable, caring nurse... She was selected from an impressive field of candidates; she assumed her new position, July 17, 2017.

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Submissions

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

Next Publication

August 3, 2017

High-school graduates named Partners Charlestown Merit Scholars

Partners Charlestown
Merit Scholars (l-r):
Caroline Collier, Brian
Askew, and Emily Pardy.
Not pictured: Livia Kelly.

Charlestown residents and high-school graduates, Brian Askew, Caroline Collier, Livia Kelly, and Emily Pardy, have been named recipients of this year's Partners HealthCare Charlestown Merit Scholarships. The \$2,000 scholarships have been given annually for

the past nine years by Partners affiliates, the MGH Institute of Health Professions, MGH Charlestown HealthCare Center, and the Spaulding Rehabilitation Network.

Askew, a graduate of Charlestown High School, plans to enter the Biomedical Engineering Program at the University of New Hampshire in the fall.

Collier graduated from Boston Latin and plans to pursue a degree in Speech-Language Pathology at the University of Maine.

Kelly, also a graduate of Boston Latin, will attend McGill University and major in Psychology.

Another Boston Latin graduate, Pardy plans to attend Harvard College and begin working toward a doctoral degree in Physical Therapy.

The MGH community congratulates this year's merit scholars and wishes them continued success in their studies. For more information about the Partners HealthCare Charlestown Merit Scholarships, contact Andrew Criscione, senior communications coordinator, at 617-726-0968.



(Photo provided by staff)



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