

Caring

Headlines

November 15, 2018

Shhhhhh...
a gentle reminder that quiet is healing



See story on page 6

Staff nurse, Sarah Megan, RN, reminds colleagues (l-r): Devin Bertolami, RN; Marissa Dupre, RN; Keith Lyttle, RN; and Erin Zager, RN, to keep their voices down outside patient room.

Debbie Burke

2018 Magnet Conference

learning, sharing, and bonding with colleagues from around the world

I had the privilege of attending the ANCC National Magnet Conference in Denver last month with some of the most amazing, distinguished, and enthusiastic MGH nurses. It was an invigorating event with many opportunities to share our knowledge and vision and hear from other nurses about what they're doing to improve care for patients and families.



MGH was well represented. Nursing director, Adele Keeley, presented, "Top-Performing Nurse Manager Outcomes: Pearls for Practice," about the power of connecting with staff around advancing innovation.

Nursing director, Theresa Capodilupo, staff nurse, Brenda Pignone, and staff specialist, Patti Shanteler, presented their poster, "Unleashing the Potential of Nursing Peer Review."

And our own chief nurse emeritus, Jeanette Ives Erickson, was named chairperson of the Commission on Magnet.

Some of the biggest take-aways from the conference were the importance of effective communication; evidence-based decision-making; life-long learning and certification; and cultivating therapeutic presence in all our interactions.

Perhaps my fellow attendees said it best when they described the experience this way:

"The conference re-confirmed why I love being a nurse. I'm so proud to work at MGH—not only for the quality care we provide but because of the culture of caring for one another."

"Walking across the stage during the Magnet Recognition parade representing MGH was my favorite moment."

"I enjoyed the camaraderie of being with fellow nurses from around the world. The pride for the nursing profession was palpable."

I couldn't have said it better myself. I'm so proud to be chief nurse at the greatest Magnet hospital in the world.



A note about Question #1

Colleagues,

On November 6th, Massachusetts voters turned down Ballot Question #1, the proposal to mandate nurse staffing ratios in every hospital throughout the state. While there were differing opinions about the approach proposed in Question #1, the overarching goal—delivering the best possible care to patients—is one that unites us all. Regardless of how you voted, I applaud your efforts to add your voice to the conversation.

As we move forward, we must re-focus our collective energy on doing what we do best: providing the highest quality and safest care to our patients and families. I am fully committed to continuing to examine our staffing practices and addressing the challenges, opportunities, and enhancements that will best support you in your practice.

Health care will always be unpredictable, fast-paced, demanding and evolving. It's the nature of our chosen professions. Because of this, we must continually assess the ways we deliver care and the systems designed to support our practice. As always, your voice is critical to guiding this process.

Best,


Debbie Burke

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Disability Awareness



At left: speakers, Chloe Slocum, MD, and David Estrada, from Spaulding Rehabilitation Hospital. Lower left: staffing information table are (l-r): Lisa Susser, co-chair, CoDA Education & Awareness Subcommittee; Ellen Forman, LICSW, co-chair, CoDA; Amy Sam, health education project specialist; and Sheila Golden-Baker, RN, chair of CoDA, who provided information on eCare, service animals, the Disability Program, the MGH Accessibility Resource Site, and much more to those who stopped by to learn about resources available to individuals with disabilities at MGH.



(Photos by Yauri Batista)

Access MGH

Disability Awareness Month at MGH

—by Zary Amirhosseini, disability program manager

On October 17, 2018, the Council on Disability Awareness (CoDA) and the Knight Nursing Center hosted, “Improving Care for People with Disabilities and Spinal-Cord Injuries,” with presenters, Chloe Slocum, MD, and David Estrada from Spaulding Rehabilitation Hospital.

Slocum reviewed some complications of spinal-cord injury, which can affect every organ in the body and include pressure injuries and muscle spasms. Autonomic dysreflexia, a syndrome in which there’s a sudden onset of excessively high blood pressure, can lead to seizures, stroke, or death if not treated properly. And Estrada shared some of his own experiences as a patient with spinal-cord injury.

For healthcare providers and patients with disabilities, Slocum and Estrada recommend that you:

- communicate: all parties need to communicate effectively about the situation/problem
- collaborate: work together to figure out best medical solution/outcome
- troubleshoot: figure out how best to get to the desired outcome
- plan: know what the clinician and patient need to do to prepare for future care or treatment

The Council on Disability Awareness would like to hear from you. If you have any questions or suggestions, call Zary Amirhosseini, disability program manager, at 617-643-7148, or send e-mail to: MGHAccessibility@partners.org.

Physical Therapy Month at MGH

—by physical therapists, Julie Bosworth, PT; Lauren McGlone, PT; and Lisa Moran, PT

October was National Physical Therapy Month, a time to celebrate the contributions physical therapists across the country and right here at MGH make in the lives of patients and the community every day.

MGH Chelsea presented, “Better Balance for Better Health.” Recognizing that complex medical histories and social factors can increase fall risk, this presentation provided fall-prevention strategies and advice on how to find help.

MGH West offered a display on opioid awareness (#ChoosePT) and back care with lifting and office set-up.

MGH Revere, as part of the Youth Scholars Program, hosted students on-site, providing weekly hands-on

programs about health care, related careers, and college readiness.

On the main campus, therapists shared how physical therapy can restore function, save healthcare dollars, and improve outcomes for a variety of conditions.

On October 24th, physical therapists gathered to hear Meaghan Costello, PT, and Michael Orpin, PT, share excerpts from their professional journeys.

Costello, an inpatient therapist and faculty member of the MGH Neurology Residency Program, spoke of how the strong mentoring and inter-disciplinary culture at MGH helped shape her career. The major themes of her career have been, “failure, mentoring, being

comfortable being uncomfortable, and reflection—a lot of reflection.”

Orpin, an outpatient clinical specialist, echoed Costello’s sentiment that mentoring had played a key role in his development. He called PT a ‘nuanced practice,’ where the mentor doesn’t necessarily teach, but rather instills a sense of curiosity and wonder in the student—something he strives to do in his own mentoring relationships.

Both speakers exemplified the dedication and excellence that are the hallmarks of Physical Therapy at MGH.

For more information about physical therapy services at MGH, call 617-726-2961, or go to: www.mass-general.org/physical-therapy/.



(L-r): physical therapists, Michael Orpin, PT, and Meaghan Costello, PT; director of Physical & Occupational Therapy, Michael Sullivan, PT; and (above) members of the department enjoy the speakers at this year’s Physical Therapy Month celebration.

Shhhhhh...



Quiet, please!

*quiet at night has
big impact on
patient health and
satisfaction*

—by Cindy Sprogis, senior project manager,
Office of Patient Experience, and Kerry
Maloney, administrative fellow

Rest and sleep are essential to patients' physical and emotional health—especially during times of healing and recovery. Loud conversations, unpleasant sights and sounds, harsh lighting, and noisy alarms interrupt sleep and interfere with the healing process. Maintaining an environment conducive to healing is so important that MGH has selected quiet at night as one of our internal performance framework measures for the past several years.

According to our patient-experience surveys (HCAHPS), in 2017, 52.6% of our patients reported 'always' having a quiet experience at night. So far in 2018, 52.7% have reported 'always' having a quiet experience at night. But in order to reach our target of 53.6%, we need to do better.

Says Debbie Burke, RN, senior vice president for Patient Care, "We're asking everyone in the MGH community to champion this issue. We all need to be mindful of how loud we're speaking; consider the location of our conversations; and remind colleagues and visitors to speak quietly outside patient rooms. Offering patients headphones and/or sleep masks can help ensure they get a restful night sleep."

For more information, contact Cindy Sprogis, senior project manager, at 617-643-5982, or Mary Cramer, chief experience officer, at 617-724-7503.

Weight stigma

and the emotional cost of weight bias in the care setting

—by Deborah Washington, RN, director of Diversity for Nursing & Patient Care Services

Many subset communities find themselves marginalized or stigmatized by mainstream society. The conscious or unconscious bias behind that marginalization can be based on skin color, ethnicity, religion, gender, gender-identity—the list goes on.

The overweight or obese population is an example of a group that's stigmatized by those closer to the center of the weight bell curve. Something as simple as weight sometimes determines how a person is treated; it's the source of disrespect and other assaults on a person's dignity.

I've had my own learning curve related to this complex issue. I've seen how weight bias can influence social interactions and care experiences. If not mindful, health professionals can create a shaming experience for those whose body shape doesn't conform to the size of the gowns, blood-pressure cuffs, or chairs we provide. Are you unwittingly traumatizing those who fall outside the 'norm' with inadvertent comments or assumptions that may be received as hurtful or disparaging?

Nursing & Patient Care Services in collaboration with the Department of Psychiatry's Center for Diversity



(L-r): Anne Emmerich, MD; Jerrold Rosenbaum, MD; and Lisa DuBreuil, LICSW

presented a workshop on weight stigma using the framework, Health at Every Size (HAES).

Lisa Du Breuil, LICSW, of the West End Clinic, leading expert on weight stigma, formed a Size Diversity Committee and developed an educational offering. Said Du Breuil, "Given the significant impact weight bias and internalized weight stigma has on health and well-being, I was happy to see so many employees at the workshop."

Speaker, Anne Emmerich, MD, acknowledged the complexity of the issue, saying, "There's much to think about as we work to create a care environment that is affirming and bias-free."

Jerry Rosenbaum, MD, chief of service for the Department of Psychiatry, spoke of the importance of the workshop. "Today's event makes me hopeful that we'll continue to see new waves of understanding and a commitment to de-stigmatize differences. The issue of body size may come as a surprise to those who've never considered their own biases, their impact on health care, and the emotional cost to those they provide care to."

For more information, contact Deb Washington, RN, director of Diversity for Nursing & Patient Care Services, at 617-724-7469.

Collaboration, meaningful patient-education, lead to positive outcome for PT patient

My name is Amanda Tetreault, and I am a physical therapist. 'Mary' was a 45-year-old woman who had undergone ACL (anterior cruciate ligament) reconstruction five months before I met her. She had seen another therapist post-operatively, and when she moved out of state, I took over her care. I didn't meet Mary for several weeks after she stopped seeing her other therapist, and when we did finally meet, she admitted to non-compliance with her home exercise program due to a busy schedule and said her knee had been bothering her.

I told her we'd start with a clean slate, since I hadn't worked with her before. I told her I'd perform a new assessment of her quality of movement, range of motion, and strength, and we'd move forward with a simple, effective, home exercise routine that wouldn't require her to go to the gym. I thought that would encourage better compliance.

When Mary stood, I could see that her surgical knee was in more of a valgum position (outward angulation) and slightly flexed compared to her other knee. When I assessed her gait, her surgical side went into internal femoral rotation, slight genu valgum and external tibial rotation. Her weakened core and diminished motor control were evident; it made sense that she was still symptomatic.

Mary's range of motion was excellent, but she lacked lower-extremity strength in both legs, the surgical side being more deficient as demonstrated by her gait. Through a series of tests I noted that Mary's vastus medialis (muscle at the back of the thigh) was atrophied, she had a small amount of joint effusion, but her ACL was clinically very stable.

I decided to assign Mary four exercises that focused on gluteal and quadriceps recruitment and strengthening to maximize stability and motor control with dynamic movement. Mary demonstrated excellent form from having performed the exercises previously with her original therapist. It was clear that the problem wasn't lack of understanding, but lack of compliance.



Amanda Tetreault, PT
physical therapist

A month passed before Mary came in for another appointment (she canceled two sessions). In the interim, I received an e-mail from her surgeon's physician assistant requesting I perform a limb symmetry index (LSI) to compare the strength of each of her legs. I'd never performed an LSI before; I had observed a couple and felt it was a simple enough test. But I wanted to be sure I did it correctly.

My colleagues recommended I observe a functional movement assessment (FMA) performed by a therapist who specializes in post-ACL surgery. Since the LSI is a compo-

continued on next page

Clinical Narrative (continued)

ment of the FMA, I'd be able to see it performed, ask questions, and re-familiarize myself with the process. The FMA is used to determine if a patient is ready to return to sports based on how well the surgical leg compares to the non-surgical leg during functional activities.

My observation of a functional movement assessment went well. My colleague explained the details to me as she took her patient through the steps. It reinforced my recollection that the hamstring and quadriceps were both tested in 60-degree flexion and that all three muscle groups (knee extensors, flexors, and hip abductors) were tested three times in order to get an average of both sides. The patient undergoing the FMA performed at 90% or less on the surgical side, and it was interesting to see how the strength deficits carried over to other aspects of the assessment, most notably, hopping for distance.

When I performed the LSI on Mary, it went as I expected. The muscle groups in both legs demonstrated weakness, the operative side more than the other. Her gluteus medius was roughly 90% and quadriceps only 80% as strong as the other side.

Mary was not working out regularly. This was concerning because she'd mentioned that she and her family were planning a challenging hike in just a few months.

To get Mary to recognize the muscle group we were trying to recruit, I manually resisted her during a side-lying abduction exercise. I wanted her to feel her gluteal muscles working. We focused on control with stair descent in front of a mirror, so she could see how her knee fell inward if she didn't contract her glutes. She was able to perform the move well with cuing and finally realized the connection between the side-lying exercise and the functional one.

Before she left, I educated Mary on the need to do some cardio exercises so she'd be able to tolerate the elevation when she went on her hike. I knew she had access to a gym, but she wasn't going often enough to make a difference. I told her that using the elliptical machine on an incline for up to 30 minutes would be beneficial, but just walking the neighborhood or swimming with her kids would also help. She said she understood and would find the time to make it happen.

Over the next six weeks, Mary made vast improvement. She reported minimal knee pain and decreased swelling. She was making it to the gym once a week to work on the elliptical and doing her home

exercise program. And twice a week she walked 30 minutes during her lunch hour. She managed to do her home exercise program at night after the kids went to bed, sometimes as much as five times a week.

Mary was excited to have the LSI performed again because she felt much stronger. And that feeling was justified as she scored 95% on all muscle groups tested. Not only was the surgical leg much stronger, but the non-surgical side had improved, too.

I recommended that Mary continue with her current routine that now included jumping and agility drills, and I advised her on how to progress her exercise program in about a month. I looked forward to hearing how Mary did on her hiking trip.

My experience working with Mary taught me how necessary it is to ask for help, both to ensure my patient's success and to ensure I'm providing the best possible treatment. It excites me to continually provide great care, learn from my colleagues, and meet the challenges that arise along the way as I was able to do with Mary.

Trauma-informed care in the mental health setting

—by Connie Cruz, RN, psychiatric clinical nurse specialist

Trauma Informed Care (TIC) is a patient-centered, strengths-based approach to care that acknowledges or assumes the presence of trauma in all or most individuals. It is not a treatment for trauma, per se; it's an approach that recognizes the profound psychological, neurological, biological, and social effects of both physical and psychological trauma. Considered a universal precaution, the intent of TIC is to avoid traumatizing or re-traumatizing individuals (patients, visitors, and staff).

TIC is an integral part of the care provided on the inpatient Psychiatry Unit. Through the lens of TIC, staff understand that trauma can impact the way we think and feel. Experiences reminiscent of trauma, such as feeling a lack of control, can result in a fight-or-flight response. In the healthcare setting, many situations can leave a person feeling as

if they have little control—being away from home, depending on staff for basic needs, missing loved ones, illness, mental illness, etc. Universal Precautions are in place to reduce the likelihood of instilling a fight-or-flight reaction by providing patients with a greater sense of control.

The environment on the Psychiatry Unit is designed to be calming, from the color choices to the aquarium in the Sensory Room. On admission, patients are screened for trauma and asked about their anxiety triggers. We engage them in discussions about what we can do to mitigate their anxiety.

Modifications to the environment might include changing rooms or roommates, altering lighting, or providing calming music. Behavioral modifications could include giving patients control over how and when they interact with staff, take their

meals, perform activities of daily living, receive medical treatment, or how frequently they attend group sessions.

TIC has been part of inpatient psychiatry at MGH for 20 years, and we continually look for ways to improve our practice. TIC guides all our professional interactions; it provides a sense of safety, trust, transparency, empowerment, and cultural sensitivity. TIC can be practiced in any service, setting, or organization.

“Trauma Informed Care: Building Resilience and Improving the Patient Experience” will be held December 14th, 8:00am–12:30pm in O’Keeffe Auditorium. To register, go to: <http://www.trauma-informed-care.com>. For more information, contact clinical nurse specialist, Connie Cruz, RN, at 617-726-7705.



Flanking the aquarium in the Sensory Room on the Psychiatry Unit are, (l-r): Stacey Leblanc, RN; Michael Sills, RN; Colette Martel-Ashby, RN; Connie Cruz, RN; Donna Tito, RN; and Anastasiia Nastavchuk, RN.

Idea Grants

using creativity and problem-solving to meet existing needs in new and different ways

—by Mary Ellin Smith, RN, professional development manager

The IDEA Grant program was created in 2015 to strengthen our spirit of innovation—to provide a platform for using creativity and problem-solving to identify a strategy, product, or service that meets a need in a new and different way. We're talking about innovation as it relates to improvement in quality, cost-effectiveness, or efficiency. And for the third straight year, staff in Nursing & Patient Care Services came forward with some very inventive ideas.

This year, grants were given to occupational therapists, Helena Diodati, OTR/L, and Sara Basiliere, OTR/L, for their proposal, "Percutaneous Endoscopic Gastrostomy (PEG) Tube Management Adaptation Kit"; and informatics project manager, Shelley Stuler, RN, and staff nurse, Bernadette Quigley, RN, for their proposal "Medication Step Saver."

Diodati and Basiliere's idea addresses the debilitating effects of ALS for patients who suffer upper-extremity



IDEA grant recipients, Shelley Stuler, RN (left), and Bernadette Quigley, RN

weakness. Many of these patients have PEG tubes to avoid aspiration with self-feeding. The PEG Management Adaptation Kit will allow patients to grasp the tubing and syringe so they can independently initiate and terminate feedings.

Stuler and Quigley's idea addresses the challenge of ICU nurses who may have to deal with numerous medication pumps in patients' rooms, inconveniently located away from the computer, resulting in a time-consuming and inefficient medication-administration process. Their idea calls for the installation of a tablet and scanner right on the in-



Recipients, Sara Basiliere, OTR/L (left) and Helena Diodati, OTR/L

fusion pump so nurses can administer medications more efficiently.

In this rapidly changing healthcare environment, we commend this year's IDEA Grant recipients for their thoughtful ideas to innovate care and improve the patient experience.

For more information about IDEA Grants, contact Mary Ellin Smith, RN, professional development manager, at 617-724-5801.

Pediatric Global Health Summit

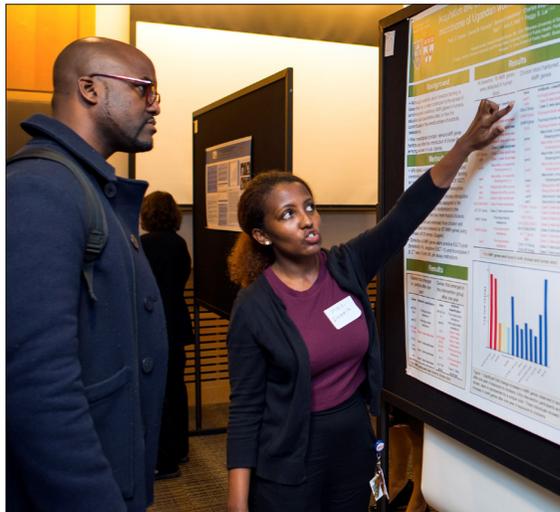
—by James Cook, communication specialist, MGH Center for Global Health

On October 15, 2018, the Mass-General Hospital for Children and the MGH Center for Global Health hosted the 2018 Pediatric Global Health Summit, featuring presentations by pediatricians from around the world.

Agnes Binagwaho, MD, vice chancellor of Rwanda's University of Global Health Equity, spoke about, "Rwanda's Journey to Reduce Child Mortality," recounting the uphill battle she's faced as Rwanda's Minister of Health. She described the post-genocide state of her nation and the strategies they employed to achieve a 75% reduction in infant mortality in the last decade. She emphasized the importance of both evidence and equity—policy decisions need to be driven by data and the need to ensure that no children are left behind. Said Binagwaho, "We must always ask, 'How can we do better?'"

Panel discussions focused on: Borders, Families, and Child Health (led by Julia Koehler, MD); Nursing and Global Health (led by Pat Daoust, RN, and Kara Olivier, RN); International Partnerships and Global Health (led by Ryan Carrol, MD, and Stephen Asiimwe, MD); and Technology and Global Health (led by Kris Olson, MD).

Jobayer Chisti, director of Clinical Research at the International Centre for Diarrhoeal Disease Research,



At left: Meti Debala, MGH Division of Infectious Disease, presents poster at Pediatric Global Health Summit. Below (l-r): Agnes Binagwaho, MD; Yap Boum II; and Stephen Asiimwe, MD.



Bangladesh, described his pioneering work on bubble-CPAP which has reduced the mortality of severe pneumonia by more than two thirds. Yap Boum II, regional director of Epicentre Africa, spoke about the need for equitable international partnerships to advance pediatric health.

The summit concluded with grand rounds presented by Marsha Griffin, MD, director of Child and Family Health at the University of Texas School of Medicine, who spoke of

the trauma being inflicted on children crossing our southern border, emphasizing the need to understand patients' journeys beyond the interactions we have with them in hospital settings. Said Griffin, "When you wonder what we can do in this world we've created, the answer is: Do what's in front of you."

For more information about the Pediatric Global Health Summit, contact James Cook at 617-724-0284.

Data analytics: what is it and how does it affect you?

—by Antigone Grasso, director, PCS Management Systems and Financial Performance

Question: I'm hearing a lot about data analytics. What is that?

Antigone: Health care is a complex environment everywhere—highly regulated, many stakeholders, consumer-driven, with downward pricing pressure—but particularly at MGH and other teaching hospitals where we're focused on delivering high-quality care in an academic medical setting. Clinical applications (eCare) and administrative applications (financial, acuity, productivity, scheduling, payroll, etc.) all generate a lot of data.

Question: How do we use that data to drive decisions?

Antigone: The goal is to find ways to accurately and efficiently turn that data into useful, easy-to-access information that's readily available to those who need it to make data-driven decisions. That's why we've been developing a PCS data warehouse.

Question: What is a data warehouse?

Antigone: A data warehouse is a repository of data from multiple sources that establishes a common denominator across all data sets so it can be analyzed and reported on in a consistent manner.



Antigone Grasso, director, PCS Management Systems and Financial Performance

Question: Who's creating this warehouse?

Antigone: PCS has contracted with the MGPO Analytics & Business Intelligence Department to help develop the warehouse. That partnership leverages the data infrastructure and data-management capabilities of all its respective entities allowing us to create a PCS data warehouse in an efficient and cost-effective way. We were thrilled to be able to partner with the MGPO on this effort.

Question: What does the PCS data warehouse currently contain?

Antigone: The PCS data warehouse has feeds from 12 data sources, populating 30 different categories such as Vision financials, Acuity

Plus nursing workload, OneStaff scheduling, PeopleSoft workforce, Nurse Sensitive Indicators with benchmarks, HCAHPS, RL Solutions, and eCare.

Question: How is the data used?

Antigone: Data in the warehouse can be connected to dashboards we've developed (like the budget variance dashboard) and to create report templates that automatically update when new information is available (like quarterly NSI reporting). It's also available for data mining and ad-hoc querying. The goal is for the warehouse to feed a central PCS portal to provide one-stop shopping for unit/department leadership when they need specific information.

The healthcare environment continues to increase in complexity demanding fact-based decision-making at an increasingly rapid pace. Having timely, accurate data transformed into easily accessible information supports all users by minimizing time spent hunting for and compiling data.

For more information, feel free to call me at 617-724-1649.

Announcements

Nurses and patient care associates

do you want to influence policies that directly affect you?

Last reminder!

Be part of the *Be Well Work Well* survey and make your voices heard.

The 2018 survey has been e-mailed to randomly selected nurses and patient care associates. Participants receive a \$10 Amazon gift card and a chance to win FitBits, massages, and other prizes.

Check your e-mail. If selected:

- please participate. Your responses are needed to inform workplace policies and programs that affect you
- you can complete the confidential survey on-line

Help make your workplace the best it can be.

For more information, contact Mary Vrinotis at 857-282-7487, or e-mail bewell@partners.org

Trauma Informed Care seminar:

building resilience and improving the patient experience

**Friday, December 14, 2018
8:00am–12:30pm
O’Keefe Auditorium**

Trauma Informed Care (TIC) is based on the increasing understanding that many individuals have endured traumatic experiences that have lasting impact. TIC recognizes the prevalence of trauma and seeks to avoid re-traumatizing patients by inadvertently triggering reminders of traumatic experiences.

This inter-professional program will explore strategies for understanding and implementing TIC.

To register, go to: <http://www.trauma-informedcare.com>.

For more information, contact clinical nurse specialist, Connie Cruz, RN, at 617-726-7705, or professional development specialist, Pamela Quinn, RN, at 617-726-9003.

Blum Center Events

Thursday, November 15th

“Ghosts of antibiotics past, present, and future”
Join Meagan Adamsick, PharmD, and Ramy Elshaboury, PharmD, to learn more about advancements in our understanding of antibiotics.

Monday, November 26th

“Food Allergy Boot Camp”
Join Michael Pistiner, MD, to learn food-allergy management skills, how to avoid food allergens, and how to ease day-to-day stress of living with food allergies.

Thursday, November 29th

“Self-management of Type 2 diabetes”
Join the Diabetes Center care team to learn how to manage your diabetes, including lifestyle changes.

Friday, November 30th

“SharingClinic: stories for health”
Join Annie Brewster, MD, to learn more about the SharingClinic, a hospital-based listening kiosk located in the Blum Center; where you can hear stories from patients, families, and caregivers about navigating the healthcare system.

Programs are free and open to MGH staff and patients. No registration required. All sessions held in the Blum Patient & Family Learning Center: from 12:00-1:00pm

For more information, call 4-3823.

Conversations with Caregivers

for families, caregivers, patients, and staff

an educational series sponsored by the Dementia Caregiver Support Program

**Tuesday, December 11, 2018
5:30-7:00pm
Haber Auditorium**

“Depression, Dementia, Delirium,” presented by, Cornelia Cremens, MD, geriatric psychiatrist MGH Outpatient Geriatric Medicine and Psychiatry Division of Palliative Care and Geriatric Medicine

Admission is free; seating is limited.

RSVP to: 617-724-0406.

For more information, call 617-643-8809.

100th anniversary of the influenza pandemic

—submitted by the MGH Nursing History Committee

During the 1918-1919 school year, 80 members of the MGH School of Nursing suffered, “the hardest year of continuous hard nursing,” ever endured in the school’s history. While caring for hundreds of influenza patients, more than half the class became seriously ill.

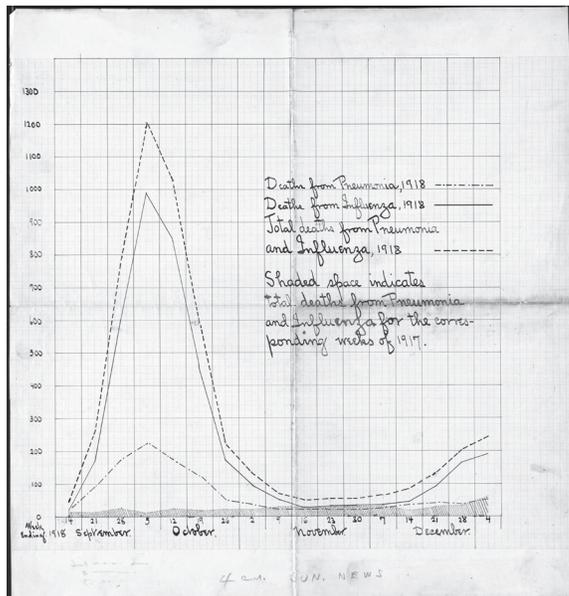
Those students who managed to avoid contracting the flu were severely overworked, becoming susceptible to other diseases, such as scarlet fever. On occasion, student nurses would be assigned to work on units alongside just one supervisor with as many as 80 patients to care for. Classes were suspended during the worst of the epidemic.

MGH physician, Thomas Cunningham, recalled that surgical wards were converted to medical units, and physicians never left the hospital. Many patients arrived via ambulance already deceased or died within an hour of arrival. Symptoms included hallucinations, delirium, fever, hemorrhaging, and suffocation. More than 50% of those admitted died, and because the morgue was so full, “bodies were stored in [medical] students’ rooms.”

Because World War I was raging in Europe, many nurses were overseas resulting in a severe nursing shortage here at home. MGH called on nurses who had already graduated from the School of Nursing, nurses aides, and Red Cross nurses to staff the over-crowded wards.

Boston was one of the hardest-hit cities. Infants and young children in poverty-stricken neighborhoods were orphaned overnight. By the time the pandemic was over, influenza had claimed 50 million lives worldwide, 675,000 in the US, 22,000 in Massachusetts, and more than 4,000 in Boston.

Though researchers began producing influenza vaccine in 1918, widespread use of the vaccine wasn’t initiated until World War II.



The above ‘Boston Influenza Chart’ accompanied a January 12, 1919, article in the *Sunday News*. It compared the deaths from pneumonia and influenza in Boston during September and October, 1917 and 1918.

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Submissions

All stories should be submitted to: ssabia@partners.org

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Next Publication

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Debbie's Photo Gallery



Great to spend time with my colleagues on the Ellison 19 Thoracic Unit (left); and always great to hear from our MGH Global Disaster Response team aboard the *USNS Comfort* (below) working in Central and South America as part of the US Southern Command's Enduring Promise initiative. Looks like they're managing to keep up with current events back home. Go Sox!



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