

Caring

OCTOBER 2022



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A Healthy Environment



**Debbie Burke, RN, DNP,
MBA, NEA-BC**
Senior Vice President for Patient
Care and Chief Nurse

A letter from Debbie

Recently, Mass General Brigham (MGB) shared a new systemwide Code of Conduct policy highlighting the importance of ensuring a safe and respectful environment for the thousands of employees that work across MGB. I am particularly proud of this policy as it finds some of its grassroots in our very own hospital, then through the work of countless people across the MGH and the Mass General Brigham system, the policy was presented to our employee and patient community. In the current environment of addressing increases in workplace violence, this timely policy stresses the importance of the physical, emotional and mental safety of our staff.

The Code of Conduct's main points include:

- Commitment to a safe, inclusive, respectful and non-discriminatory workplace for all
- Intolerance of physical or verbal assaults, threats, unwanted communications and other inappropriate acts and language.
- Prevention of discriminatory requests or demands for specific types of workforce members to care or not care for patients.
- Use of the SAFER Model (i.e., speak up, support, assess, address, focus on values, explain, reinforce, report) approach for responding as a team to behaviors that violate the code.
- Instances in which behavior might not fall within the code or when response will need to be escalated up the chain of command to resolve the situation.



Staff can scan the QR code to access the policy on Ellucid

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Photography Department

To submit story ideas to *Caring, the Mass General Nursing and Patient Care Services* newsletter, please contact Mae Driscoll, at mdriscoll0@partners.org

Everyone should feel safe and valued within our walls. As the SAFER Model suggests, speak up for yourself or a colleague and report discriminatory or harassing behavior.

On airplanes we are told to put our oxygen masks on before helping others. In doing so, we safeguard our ability to provide aid to people who might need it. I hope you will think of this policy in a similar way. You provide excellent care for our patients and their families. Intolerance of physical or verbal assaults, discriminatory behaviors or inappropriate acts preserves our ability to provide that care to the patients and families seeking our help. Healthcare is a team sport, and each of you play a key role in maintaining a respectful and welcoming space for healing.

Thank you for all that you do.



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On the cover:
In recognition of Respiratory Care Week, Heba Eid, RT, in the Pediatric Intensive Care Unit.



Celebrate with Caring
September: Nursing Professional Development Week, Surgical Tech Week, International Translation Day
October: Physical Therapy Month, Advanced Practice Provider Month, Respiratory Care Week, Spiritual Care Week

Take a moment to pause

The Spiritual Care Department at MGH recognized its 10 staff members and four students during Spiritual Care Week October 23-29 with outreach programming for both patients and staff. Below, members of the Spiritual Care Department share one of their favorite blessings or meditations.



A heart meditation

Take a nice deep breath. Inhale - filling up your belly and your lungs. Release the breath with an audible sign out of your mouth. Take three more breaths like this, accessing the wisdom within your body and letting your body know that you are fully present and that it is safe to breathe.

You can place your left hand over your heart, and your right hand over your left hand in a gesture of love. Letting your heart, your mind, your body, and your soul know that right now you are safe. Feeling your chest rising and falling beneath your hands. Noticing your heartbeat, how is it beating? Fast or slow? With tension or softness? Is there a heaviness or lightness? Take a moment to connect with your heart, letting your heart know that you are here, and it is safe to soften. *My precious, precious heart I am here with you, I feel you, I am listening to you now. What is it that you need me to know?* And simply be with whatever comes into your consciousness. This is the voice of your one and only precious heart.

Take a moment to thank our hearts for showing us exactly what it is we need to know. Breathe into your heart and fill it up with

warmth. *I receive this love into my own heart. And breathing out this*

warmth, I fill up my own heart.

Breathing into your heart and filling it up with warmth, *I receive this love into my own heart, and breathing out this warmth, I share this love with the hearts of others.*

- *Katey Santilli, MDiv*



A breath prayer for anxious times

Inhale: Breath that fills my lungs

Exhale: Quiet my heart with promise

Inhale: Relieve my spirit of burden

Exhale: Carry me to solace

- *Roxan Del Valle, MDiv*



A self-compassion practice

A self-compassion practice:

May I love myself

May I accept myself

May I have compassion for myself

May I love all parts of myself

May I accept all parts of myself

May I have compassion for all parts of myself

- *Julie Supple, BCC*



A prayer for connection

I use this prayer to focus me and steep my practice in connecting to a higher power before I start my day.

Come Holy Spirit, come! Fill me with life anew, that I may love the things you love and do what you would do.

- *Kate Gerne, BCC*



Celebrating a milestone in professional practice

The Clinical Recognition Program (CRP) turns 20!

The CRP program was designed to recognize excellence in clinical practice based on the work of Patricia Benner, PhD, RN, FAAN, who took the Dreyfus brothers' "Model of Skill Acquisition" and applied it to nursing practice. "Skill acquisition" refers to the evolution of expertise from "novice to expert." In our CRP program, there are four levels of practice: Entry, Clinician, Advanced Clinician and Clinical Scholar.

The Clinical Recognition Board reviews applications of candidates interested in advancing to the advanced clinician and clinical scholar levels which is associated with a salary increase.

Applicants demonstrate their expertise by pulling together a portfolio which includes a clinical narrative — a patient scenario that illustrates how the clinician critically thinks and engages in their practice. This is followed by an interview with a subset of the CRP Board which allows for an additional opportunity for the applicant to share experiences and reflections from clinical practice.

Since its inception in April 2002, over 980 clinicians in Patient Care Services have been recognized at either the Advanced Clinician or Clinical Scholar level. Front-line Nurses, Speech/Language Pathologists, Occupational Therapists, Physical Therapists, Respiratory Therapists and Social Workers can all apply.

Interested in applying?

If you are interested in applying, check out the Clinical Recognition Program criteria grid, which is found on the Clinical Recognition Program website (www.mghpcs.org) and outlines the benchmarks for each level of practice.

The CRP criteria is organized within the following themes of practice:

- Clinician/Patient Relationship
- Clinical Knowledge and Decision Making
- Teamwork and collaboration
- Movement (only for Occupational Therapy/Physical Therapy)

The website also provides step by step instructions on how to apply as well as many resources to guide you. There are sample narratives, interview questions and examples of influence on practice. Candidates are encouraged to speak with colleagues who have gone through the process as well as their supervisors for guidance both about their level of practice and moving forward with their application.

“Taking the time to reflect on my practice and write my narrative for Clinical Scholar recognition really helped verify the clinician I have become. I’m proud to work at MGH and I’m honored to be recognized for what I do here.”

- Mary Morris, OTR/L recognized as a Clinical Scholar in April 2022.

Frequently asked questions

- **Who is evaluating my portfolio?**
There is an interprofessional 16 member review board comprised of members of Patient Care Services.
- **How long does it take to apply?**
For most candidates, it takes between 2-3 months to complete their application and another 2 months to conduct their interview and receive notification.
- **How do I choose what to write for a narrative?**
Focus on telling a story about a patient and interaction that showcases who you are as a clinician. Be sure the narrative represents an example of your current practice.
- **Who should write my letters of support?**
You will need an endorsement from your manager/director, but letters of support should be from those who know your work best. One letter must be from someone outside your discipline.
- **What can I expect from the interview?**
Three members of the larger review board will meet with you in a casual setting for a conversation for about an hour. The questions are designed to clarify your portfolio and give you more opportunity to showcase your practice.



AN INTERVIEW WITH

Jillian Thornton, DNP, AGPCNP, and Carol McMahon, RN

The Clinical Recognition Program (CRP) was initiated at MGH in 2002 as a mechanism for staff to be recognized and compensated for their clinical expertise as Advanced Clinicians or Clinical Scholars. Among these clinicians are Carol McMahon, RN, clinical scholar in the Post Anesthesia Care Unit, and her daughter Jillian Thornton, DNP, AGPCNP, Ellison 16 Oncology, who was recognized as an advanced clinician while working as a staff nurse in the Emergency Department. In this interview, they discuss their journey and how the CRP has impacted their practice.

Why did you decide to seek recognition in the clinical recognition program?

Jillian: I worked in orthopedics for a few years before moving to the Emergency Department. My nursing director felt that my practice was at the advanced clinician level and encouraged me to apply.

Carol: I have been working in the Post Anesthesia Care Unit (PACU) since 1986 and have been involved in a number of unit-based projects. My nursing director had been encouraging me to go through the process for years, but it just seemed like a lot of work. I would start to put things together and then just put it aside. Honestly, it wasn't until Jill told me that she was going to apply that I felt like I had to do it too.

How did you decide which level of practice to apply to?

Jillian: I was able to reflect on my practice and the way that I delivered care. It seemed like the "advanced clinician" fit my level of practice at that time according to the grid that lays out the criteria for each level that I reviewed with my nursing director.

Carol: Similarly to Jillian, I reviewed the criteria and did a lot of reflection. The "clinical scholar" level seemed like the appropriate level to apply for. I take the lead on a lot of initiatives on my unit and had worked on some hospitalwide projects. My nursing director helped me to go through the criteria, and we felt that it was the most appropriate for me. I know some people feel like they have to go to one level and then the next. It really is based on your current practice, so it is not necessary to go one step at a time.

How did this experience influence your practice?

Jillian: I feel like the reflection about my practice made me realize all of things that I had done and made me feel good about the care I was delivering to my patients. The feedback that I received from my letters of recommendation made me realize that others saw what I was doing. I feel like the reflection gave me an opportunity to think about what my next steps would be. I felt more confident after the recognition, and it really helped to push me forward to pursue a nurse practitioner degree.

Carol: I have done a lot of different things over the years, and really have made a difference in the PACU. This gave me more confidence to take the initiative on improving practice. It made me realize that I didn't have to leave my role as a bedside nurse to enrich my career. I could continue to do the work I love, while working to make things better for patients and nurses and to identify issues and work on solutions.



MCMAHON AND THORNTON

We often hear from staff that one of the barriers to applying is their fear of the interview. What was the experience was like?

Carol: I am sincere when I say that it wasn't like an interview at all. I went back to my unit and told my peers that it was a lot like a conversation. It was very comfortable, I felt very relaxed.

Jillian: I was very nervous before the interview because I didn't know what to expect. My mother had done hers first, so she shared with me her experience. I honestly didn't sleep the night before but once I got there, I relaxed. It was awesome to talk to the interviewers. It was like we were chatting, not answering questions. I didn't feel like I had to defend my practice, I just needed to talk about what I do every day.

What advice would you give to someone who is considering applying?

Carol: I tell people don't feel like you have to sit down and do the whole thing right away. It really is a process. Just start taking notes about patients you care for or projects you've done. Start a rough draft on your computer and keep adding to it or

(Continued on page 6)

Providing critical language access

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Many clinicians and providers at Mass General speak a language other than English and wish to provide care in that language. To this end, 450 of them have passed proficiency assessments to become Qualified Bilingual Staff (QBS) and are thus designated to provide care in that language. This is in accordance with Section 1557 of the Affordable Care Act.

One provider who has taken, and passed, the QBS exam is Dr. Joseph Betancourt, MD, MPH, senior vice president, MGH Equity and Community Health.

The MGH celebrated the Medical Interpreter staff on International Translator and Interpreter Day, September 30.

BY THE NUMBERS [Medical Interpreters] FISCAL YEAR 2022

117 **240,463**

LANGUAGES INTERPRETED

PATIENT ENCOUNTERS

IN FISCAL YEAR 2021, THE NUMBER OF PATIENTS WITH LIMITED-ENGLISH PROFICIENCY WITH APPOINTMENTS AT MGH WAS

396,302

REPRESENTING A

25%

INCREASE OVER THE PREVIOUS YEAR

MEDICAL INTERPRETER SERVICES PROVIDED LANGUAGE ACCESS TO

60%

OF THESE ENCOUNTERS

- Clinical Recognition interview (cont.)

(Continued from page 5)

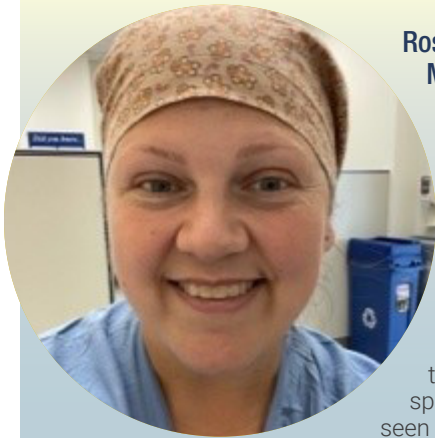
editing over time and utilize the resources. The CRP website is great, and the input of my leadership and colleagues was really helpful to me as I went through the process. It was so rewarding to me to be recognized for what I do every day.

Jillian: I agree. I just started as a rough draft and kept going back to it. I would suggest asking for the endorsement letters early on because that can be difficult. It's good not to rush it because picking the right experiences will really make a difference in your portfolio. I had some support as well from my Emergency Department colleagues. And, of course, my

mom helped me as well. It was great that we were both going through it at the same time. We kept bouncing things off of each other and motivating each other to complete it. It was such an amazing experience. I encourage others to take the time to participate in the program.

Supporting Surgical Technologists

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Rosemary Calarese, CST
MGH Waltham and Boston Main Campus

"There are so many different ways to care for a patient and the type of care that I get to be involved with is extremely rewarding. The line of work we do as surgical techs is extremely detail-oriented, engaging, educational, and best of all, we get to help our patients take another step closer to healing. It is a team effort when it comes to patient care, and the operating room is no different. Surgical techs make sure that the team has everything we need for a procedure and set up and maintain a sterile field, working as part of a team caring for our patients through surgery. It is a field that is constantly changing and improving - I'm excited to see and learn about new technologies and procedures as they develop. A bonus to loving what I do for work is that I also get to teach and share my experiences with our newer staff and help those learning new surgical specialties. I have been lucky enough to work with a variety of surgical specialties and I have seen and learned so much from being a surgical technologist for ten years here at MGH."

Stephen Whittaker, CST
MGH Labor and Delivery

"I have always enjoyed working with my hands, as a surgical tech you are in the middle of the action in the operating room. Being able to anticipate the needs of a surgeon and pass them the tool they need without having to ask for it, is very rewarding. I am very lucky to be able to work in a department with so many talented physicians, nurses and technicians all working toward one goal - the safe, quality care of the patient.

Sometimes in the operating room things don't go exactly as we have planned. Surgical complications can be very stressful. The best way to overcome it is by communicating well, knowing your role, and working together as a team to fix the problem."



Tiffany Cuzzupe, CST, FAST
MGH Operating Room

"Gastrointestinal Endoscopy may not be the traditional work environment for a surgical technologist but helping patients has no boundaries. Every time I work, I contribute to the fight against colon cancer by being a second pair of eyes during colonoscopies. Assisting with the care and education of patients with Gastrointestinal Motility Disorders is worthwhile. Gastroenterology is expansive and quite a special place."



Kristen Urbanek, CST, FAST
MGH Operating Room

"I began my career as a surgical technologist at MGH in 2003. I find that one of the best aspects of my job is knowing I help make a difference in a patient's life. Whether I am scrubbing a total hip replacement, a liver transplant or an emergent case, I am an active participant in our patient's care. In addition to that, one of the best aspects of my job is working with students and newly hired surgical technologists. Teaching allows me to share the knowledge my teachers and preceptors provided me while I was starting my career."



Clinical Narrative: Todd Mover, RRT ECMO Educator, Respiratory Services

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I arrived at work to start my shift on a Friday night. My assignment was the ECMO specialist for a patient transferred from an outside hospital, newly admitted to the Pediatric Intensive Care Unit (PICU). ECMO, short for extracorporeal membrane oxygenation, is a treatment in which blood is pumped outside of the body, run through a machine to add oxygen and remove carbon dioxide. This patient had recently been hospitalized many times over the course of several months with COVID-19-related complications. She was on home oxygen, eventually requiring high flow oxygen and experiencing persistent shortness of breath. A diagnostic lung biopsy was needed to see exactly what was going on at the tissue level of the lungs. During the procedure, she went into cardiac arrest. She regained circulation, but her lungs were filling with blood. She could not oxygenate or ventilate and was placed on Venovenous ECMO. ECMO allows for prolonged cardiac or pulmonary support in patients experiencing heart or in this case, lung failure. When people ask me what ECMO is exactly, I say, what happens when you break your leg? You rest it by not using it. What happens if your kidneys are broken? You go on dialysis. What if your heart or lungs are broken? Medications or a ventilator can usually suffice, but if they stop working completely ECMO can do the job of the heart and/or the lungs and allow them time to rest so they may heal and allow the patient to recover.

After taking bedside report, I assessed the patient and confirmed multiple concerns that needed to be addressed. I knew at this point I would need to pull ideas and therapies that may be standard of care in other intensive care settings but weren't routinely practiced in the PICU.

I noticed both her heart rate and blood pressure were elevated. I reviewed the continuous infusions which included sedation. The doses of sedation didn't seem to be enough as she appeared uncomfortable. The nurse agreed and tried to increase the dose and get the patient more comfortable. The medication order was for a range and already at the maximum dose, so I spoke with the PICU resident physician about increasing the range. They were a little hesitant at first to do so, but I explained that some drugs are prone to sequestration in the ECMO circuit, in other words, they bind to the circuit or get "eaten up" and the patient doesn't truly receive the full dose. For this reason, I suggested we go outside the normal parameters and titrate to effect. I mentioned in other ICUs patients that have been on the ECMO circuit for a long time are on high concentration and high doses. They agreed, took my advice and increased the range. With increased sedation, the heart rate and blood pressure came down and the patient appeared more comfortable.

I now addressed the chest tubes - they were leaking air the ventilator was delivering. After conferring with the resident physician, we turned down her ventilator as low as possible allowing the ECMO circuit to fully support her and the chest tubes immediately

stopped leaking, allowing full rest of her lungs, giving them time to heal. I then turned my attention to the amount of bleeding, which was very concerning as I was now having trouble running the ECMO circuit. Lab work revealed the patient needed multiple blood transfusions. The nurse and I checked the blood, and she hung it. I asked how long the blood will be hanging for. She responded that they typically give blood over an hour per policy. I explained I was having trouble running the ECMO circuit because of how profuse the bleeding was. Likely from too much anticoagulation medication prior to arriving at the PICU. These transfusions were considered emergent given the patient was 100% dependent on the ECMO circuit. If the ECMO circuit couldn't run because of how much she was bleeding, there was high risk of cardiac arrest. Instead of running the blood in slowly we ran the blood in as quickly as possible per policy.

Once stabilized, the patient's mother came in to see her daughter. I introduced myself and explained my role in her care. I explained how there will always be an ECMO specialist 24/7 at the bedside monitoring everything. I could tell by the look on her face she was very concerned. I asked if she had any questions I could answer. She expressed that the oxygen number on the monitor was only 87% and the doctor at the other hospital stated if it was below 90% then she wasn't getting enough oxygen. I explained to her that oxygen saturation is only one part of knowing if someone is getting enough oxygen. I talked about tissue perfusion and the color of her skin (pink, being oxygenated versus blue, lacking oxygen), organ function like the kidneys making urine, and lab work monitoring lactate and hemoglobin levels. The parent was relieved and thanked me for taking the time to explain that to her.

(Continued on following page)



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After my shift in the days following, I continued to follow this patient providing guidance to other ECMO specialists, nurses and doctors, not as her bedside ECMO specialist, but in the ECMO educator role. I would come in at 6:00 am to check on the night shift and address any concerns overnight. Most importantly, I would attend rounds not only to support the bedside ECMO specialist, but to continue ensuring the patient received the very best care. I followed the patient's care throughout her stay until days later when she was successfully taken off ECMO. I am proud to be a Respiratory Therapist and an intricate piece of the ECMO Team.



CENTER SPOTLIGHT: Since 2013, MGH has been designated a Center of Excellence at the Gold level by the Extracorporeal Life Support Organization (ELSO) - and 2022 was no different! On September 16, a group of ECMO specialists accepted the award from ELSO at the National Conference that was held at the Copley Marriot in Boston. MGH is one of the leading ECMO centers in number of patients supported and the only ECMO center in New England to care for all patient populations: neonate, pediatric, and adult.

Above, members of the MGH ECMO team - Clorinda Suarez, Carolyn La Vita, Danielle Doucette, Patricia Harron, Todd Mover, and Gary Collymore - receive the Gold level Center of Excellence Award presented by Dr. Robert Bartlett, MD, pioneer in ECMO therapy; and members of ELSO.

Training the next generation



In late August, MGH and the Norman Knight Nursing Center for Clinical & Professional Development (KNC) welcomed 218 newly licensed nurses to the Transition to Practice Program (TPP). These nurses will be working in over 48 nursing units, including General Medicine, General Surgery, Critical Care, Psychiatry, Oncology, Labor and Delivery, Mother & Baby, Pediatrics, Cardiac, Emergency Department, Operating Room, Center for Perioperative Care, and the Post Anesthesia Care Unit at MGH and Mass General Waltham.

“It is an exciting time for all of these Nurse Residents, and it is always such a pleasure to watch these novice nurses transition and grow into independent nurses delivering safe quality care,” says Jennifer Curran, RN, DNP, NPD-BC, program director of the TPP.

The TPP is accredited by the American Nurses Credentialing Center’s Practice to Accreditation Transition Program (PTAP). The Critical Care Nurse Residency Program began over 20 years ago, and the Oncology Residency Program was added in 2011. In April 2020, MGH became the first hospital in Boston to receive accreditation and the first in the country to be awarded “Accreditation with Distinction” under the more stringent 2020 standards. The TPP is sponsored by the KNC in collaboration with nursing leadership. The program assists newly licensed nurses in successfully transitioning to being an independent, professional nurse in the clinical practice environment.

Depending on the specialty, the newly licensed nurse is paired with a dedicated preceptor group for 12 to 26 weeks and attends monthly sessions in the Norman Knight Nursing Center for Clinical & Professional Development for twelve months. Topics during monthly classes include leadership, quality outcomes, professional role, and scholarship for nursing practice.

The Knight Center would like to thank all the people involved in this program. Debbie Burke, RN, DNP, MBA, NEA-BC, senior vice president for Patient Care and chief nurse; the associate chief nurses, the unit(s) nursing leadership, and all the preceptors who give their time and are willing share their expertise with the residents.



DRIVING PROFESSIONAL PRACTICE:

Members of the Knight Center team Danny Monger, Jen Curran, RN; Sheila Burke, RN; Michelle Doran, RN; and Gino Chisari, RN.

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Day in the life of Colleen Roddy, PT, DPT, Physical Therapist

5:30 AM: I wake up and work out at home before getting ready to leave for the day.

7:05 AM: I leave my apartment and take the train into work.

7:45 AM: I arrive in the Physical Therapy (PT) department. I pick up my Voalte phone, (our work iPhone to communicate with the care team). Then, I head up to my primary unit on Bigelow 13, the Respiratory Acute Care Unit (RACU), which is a step-down unit for patients with complex pulmonary conditions that may require mechanical ventilation.

8:00 AM: I attend brief morning rounds with the interdisciplinary team which includes nursing, respiratory therapists, case management, physicians and nurse practitioners. The nurses give a brief update of the patients' night including any changes such as oxygen or ventilator requirements. The responding clinician, then runs the list to review the plan for the day for each patient.

8:15 AM: I log in to EPIC (the electronic medical record) to organize my patient caseload for the day and review the medical record for each of my patients to determine their clinical appropriateness for physical therapy that day. I schedule time with the physical therapy aide to assist with patient care.

8:45 AM: I communicate and coordinate my treatment sessions with my patients' nurses to determine the best time for interventions based upon their readiness, medication schedule, and to avoid conflicting times with other competing clinical care needs such as procedures, surgeries, or other scheduled therapy services (speech or occupational therapy). I work closely with the unit's respiratory therapist to support my patients ventilatory status by using either a portable ventilator or changing the ventilator settings during exercise to maximize my patient's tolerance as needed.

9:00 AM-1:30 PM: I provide physical therapy sessions for four of my patients before heading to lunch. After each patient, I touch base with the nurse to update them on the patient's progress and share mobility recommendations for the day. Between patients, I document my treatments and patient's tolerance to the intervention so the interdisciplinary team can see each patient's progress and plan for where a patient should discharge to once they are medically ready to leave MGH. Often patients discharge to a rehabilitation facility for continued medical care and rehabilitation services.



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10:15 AM: PT session with my patient following a lung transplant on progressive walking distances and pacing using a thoracic walker made out of PVC piping with a seat attached. I coached her on her hand placement and foot alignment to achieve standing successfully and how to pace herself to tolerate increased distances while walking on supplemental oxygen provided through her tracheostomy tube.

11:00 AM: PT session with my patient post lung transplant that was still requiring mechanical ventilation. His respiratory therapist, Lexi, assisted with transitioning him to a portable ventilator and adjusting his settings to tolerate exercise. His nurse, Caitlin, assisted with managing the IV pole that held a portable monitor that records his heart rate, oxygen saturation levels and blood pressure as well as IV lines providing him with medication. Yashika, PT aide, assisted with setting up the chair and pushing it behind him so he could rest as needed as this was his first time walking down the hallway since surgery. I provided assistance to help him stand and gave verbal cues to him to facilitate his stepping so he could walk using a rolling walker. All of this care was coordinated with use of the iPad to allow for language translation.

1:30 PM: I attend a team meeting at lunch in the department.

2:00 PM: Head back to the RACU to see patients 5 and 6, communicate and collaborate with team and complete documentation.

4:00 PM: Return to the PT department for brief senior staff meeting discussing aide transition.

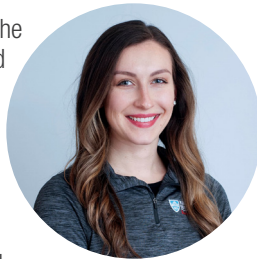
4:30 PM: Drop off my Voalte phone. Head out to teach dance.



A Spotlight on Advanced Practice Providers



"The most fulfilling part of my work is having the opportunity to pioneer for new services offered robotically at MGH. I have gained an immense amount of confidence and trust from my team and the surgeons with whom I work and have had the opportunity to help start our robotic donor nephrectomy program, training our team of PAs at the bedside. I also get to work very closely with the residents and fellows of various services to help with their training on the DaVinci robotic surgery system."



- Sarina Curiel, PA, Robotic Surgery Advanced Practice Manager

It never gets old to have the honor and privilege to perform a procedure safely for a patient and have them tell you at the end "that really wasn't so bad, maybe this whole journey won't be so bad." We are proud to be able to often book end a medical journey for a patient with a biopsy at the very beginning that perhaps made an initial cancer diagnosis to a port placement for the patient to use during chemotherapy to that day where they come back for their port removal because treatment is completed. It's a special privilege to have been able to have a meaningful role at the beginning and end of those patient journeys."



- Melissa Chittle, PA-C, MBA Interventional Radiology (pictured above at right)

"We as midwives do more than just 'catch babies'... don't get me wrong, there is no greater joy than helping to usher a new baby into this world, but we do so much more with women during their pregnancies!"



- Shannon Kelley, CNM, MSN

The MGH Advanced Practice Providers Wellness Committee, launched in June 2021 by Sylvia Perry, NP, Primary Care Boston and Avon Breast Center; set out to assess and explore issues related to wellness and well-being among advanced practice providers practicing across the hospital. The APP community is comprised of approximately 800 Nurse Practitioners, 195 Physician Assistants, 95 Certified Nurse Anesthetists, 23 Certified Nurse Midwives, and 10 Clinical Nurse Specialists. Our mission is to better understand drivers of well-being and burnout and to advocate for institutional programming and support to help buoy and preserve our core workforce. In short, we aspire to promote a state of thriving among the hospital's APP community. In the coming year, we are excited to expand our reach with a well-being innovator program and continued collaboration with PCS and MGPO clinician well-being initiatives.

"As a practicing nurse practitioner, I am continuously fulfilled by the privilege of taking care of patients, and I strive to bring my most well and energized self to this work."

- Sylvia Perry, NP, Primary Care Boston and Avon Breast Center



"Being a large, academic healthcare institution, MGH challenges me professionally and supports me personally. My work on the MGH APP Wellness Committee is an extension of this, where my opinions, experiences and research are valued when considering changes that impact the broader community."

- Josh Lea, DNP, MBA, CRNA, Anesthesia, Critical Care and Pain Medicine



PHILANTHROPIC SUPPORT IS CRUCIAL TO NURSING AND PATIENT CARE SERVICES as it allows us to seed innovative ideas, provide opportunities for career development and advancement and improve the way we deliver care. If you are interested in learning more please visit giving.massgeneral.org/nursing-and-patient-care-services/, or contact Maureen Perry in the Mass General Development Office, mperry19@mgh.harvard.edu.

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HEADLINES FROM MASS GENERAL NURSING AND PATIENT CARE SERVICES

 **Massachusetts General Hospital**
Founding Member, Mass General Brigham

