August 16, 2001

Caring HEADLINES

Girl Scouts visit MGH

"Be prepared." That simple, two-word directive has been the motto of the Girl Scout organization for almost a century. Coincidentally, it has also been the unspoken driving force behind Patient Care Services' strategic planning efforts since its inception six years ago (and more so now that we are facing a national shortage of healthcare workers). No wonder the coming together of these two service-based organizations seemed like such a good idea!

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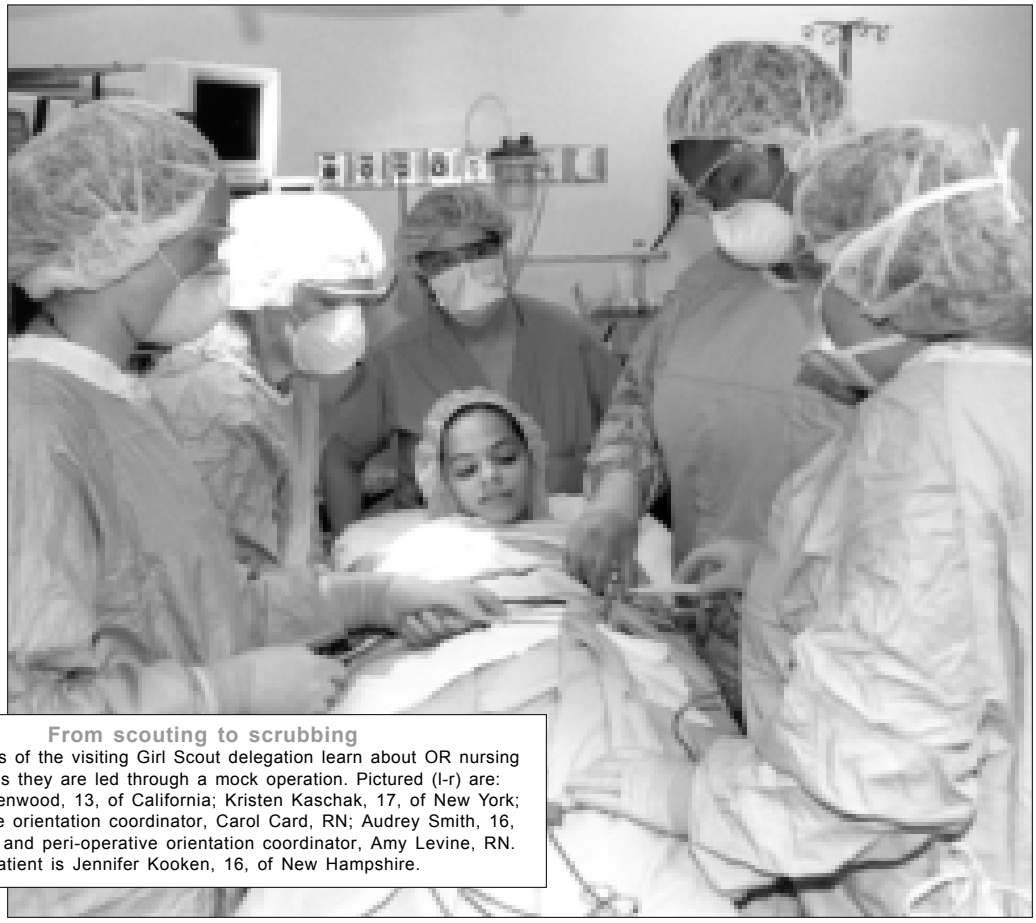
Inside:



From scouting to scrubbing
Four members of the visiting Girl Scout delegation learn about OR nursing first hand as they are led through a mock operation. Pictured (l-r) are: Vivianne Greenwood, 13, of California; Kristen Kaschak, 17, of New York; peri-operative orientation coordinator, Carol Card, RN; Audrey Smith, 16, of Maryland; and peri-operative orientation coordinator, Amy Levine, RN. Patient is Jennifer Kooken, 16, of New Hampshire.

MGH Patient Care Services
Working together to shape the future

Mandatory overtime:

dangerous directive, not sound solution

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

I have written about mandatory overtime before (April 20, 2000, *Caring Headlines*). While I remain adamant that this is an ineffective and unprofessional approach, mandatory overtime continues to be a topic of concern and debate in many hospitals locally and across the country. It is imperative that we continue this dialogue to dispel the idea that mandatory overtime is an acceptable solution to the shortage of healthcare workers or to any other issue facing health care today. Mandatory overtime is a 'quick-fix' that contradicts the very essence of the caring professions.

As a nurse, and as an administrator, I understand the fears, concerns, and logistical challenges that drive institutions to implement policies of 'forced' overtime. I am intimately aware of, and involved with, these challenges every day. But also as a nurse and an administrator, I can tell you that mandatory overtime is a misguided and short-sighted solution.

The problem, as we know, is multi-faceted:

- A workforce of health professionals that is steadily shrinking
- Increased demand for healthcare services
- Fewer students enrolled in healthcare curriculum
- The existing workforce is aging and retiring
- Longer life-expectancies; and overall population growth
- A higher expectation of health and well-being among the general public

All of which point to a growing chasm between supply and demand. And *that* is the issue we need to address. Yes, mandatory overtime may ease the crisis for today, this afternoon, this minute (while at the same time undermining the integrity and accountability of committed healthcare professionals). But it doesn't address the larger problem. We need to focus our energy and resources on creating systems to recruit and retain competent staff. We need to direct our attention to the source of the problem and begin to reduce and eliminate that shortfall between supply and demand.

There is legislation being introduced at the state and federal levels right now, aimed at alleviating the shortage through educational funding, reimbursement, and incentives to attract new clinicians. But we all need to look at our own systems and resources and come up with creative solutions that protect and optimize patient care, while at the same time respect and promote staff satisfaction.

Yes, mandatory overtime may ease the crisis for today, this afternoon, this minute (while at the same time undermining the integrity and accountability of committed healthcare professionals). But it doesn't address the larger problem. We need to focus our energy and resources on creating systems to recruit and retain competent staff.

Studies have shown that flexibility in scheduling is one of the most important factors identified by staff in terms of satisfaction with their work environment. The Magnet Hospital Study of the early 80s told us that autonomy, control over practice, and collaborative decision-making were highly valued as factors affecting staff- and patient-satisfaction, improved patient outcomes, and successful recruitment and retention efforts. This is important and powerful information. We need to listen to what these surveys are telling us as we strategize for the future.

Armed with this knowledge, if we are to solve our supply-and-demand problem, flexible scheduling options will play a key role in our solution, while mandatory overtime will only create more problems, more negative consequences, and more unrest among clinicians.

Ensuring an environment in which we can deliver safe, high-quality patient care is our first priority. That does not change just because we are facing a shortage. Now, more than ever, we need to protect clinicians' autonomy, control over practice, and contribution to decision-making. We need to continue to empower clinicians to be accountable for the care they provide. We need to respect their judgement. And we don't do any of those things by resorting to mandatory overtime.

We are fortunate at MGH that staff and leadership alike appreciate the complexities of this issue. We're proud of the work we do, and we remain committed to finding solutions… today, tomorrow and the next day… but not at the expense of quality, safety, or professionalism.

Letters from Africa

On July 2, 2001, MGH nurses, Christopher Shaw, RN, and Sheila Davis, NP, departed for South Africa as participants in the Nursing Partners AIDS Project (NPAP). They have agreed to share their experiences with readers of Caring Headlines. *Below is their most recent correspondence.*

Chris Shaw, RN, and Sheila Davis, NP, of the Partners AIDS Research Center and MGH Infectious Disease Associates

July 7th

It is early morning here in Durban. One of the things I miss most is daylight savings time. It stays dark until about 6:30am and gets dark in the evenings around 5:30. And it's very cold.

Yesterday we visited one of the black townships, inland from Port-Shepston, with nurses from the South Coastal Hospice team. They have approximately 500 HIV patients who live in very poor conditions with varying degrees of support. The children are on winter break and I keep wondering—if I'm cold staying in a guest house with all the modern conveniences, how do they feel this morning when the heat of the sun has not yet taken the bite out of the air. My heart broke for the children who sat outside their hut looking so sad, awaiting the imminent death of a parent. One woman lay under two or three tattered blankets shivering, complaining of severe bone pain. She was so thin it was hard to imagine she could stay warm. The nurses comforted her and tried to manage her pain.

Margaret, an African nurse who is trained in hospice and midwifery, prays on her knees with one family who is grieving the loss of their son earlier this week. In the hut, dimly lit with a candle, the family sits so silently. Sheila and I are welcomed into their space, and we sit quietly with our heads lowered. Without warning, the two nurses with us and the family's voices seem to blend into one beautiful Zulu hymn, and then Margaret leads them in prayer. It seems no words are expected, and none are spoken.

When we come out of the clay and grass hut there are four young children, their father is dead, their mother is sick, their sad faces speak volumes. They are incredibly beautiful.

We visit six or seven more families. In one hut, a grandmother lives with four young boys who just a year ago lost their mother to AIDS. They are now in the good and gentle hands of their grandma, bundled up in old sweaters and torn sneakers. They range in age from 3 to 11. The 8-year-old is sick, his skin a shade grayer and breaking out with rash. His body is thinner, his eyes sunken in. He, too, is beautiful, and it's evident that his brothers and grandmother love him. The nurses bring food, medicine and care, and are a comfort to this family. Sheila and I take pictures of them and show them their images on the digital screen and promise to send them copies when we return home. Their eyes light up at our advanced technology or at the beauty of their own souls shown in their eyes.

As we travel back to Durban with Busi Ncama, one of the nurses, we are for the most part, silent. It has been a long day. I ask Busi about the Apartheid years, and she tells me it was like an obstacle course to get an education. She started out as a general nurse 20 years ago and is now working toward her PhD in HIV prevention. She tells us the changes are not happening fast enough. The ravages of Apartheid are still deeply felt. We seem to be straddling the line in a world still divided, a country described as both a first- and third-world.

The international surfing competition is being held on Durban's beautiful coast. This is the same place where, just 10 years ago, the majority of the population would not have been allowed to come.

The land is dry now and nurses tell us that many of the children who come to the hospital these days come with severe burns. This happens every year at this time as youngsters fall into open fires trying to stay warm. Sheila and I saw some of these disfigured children on our visit to St. Mary's hospital just a few days ago. It seems a world apart from the Durban coast.

Forgive me for going on, but it feels good to share. On my last visit here in March, I was as struck by the dichotomy of rich and poor, black and white, educated and un-educated, as I was by the ravages of HIV/AIDS. In Botswana and Swaziland the mutual distrust between races and classes is palpable.

You had asked about our families. I have been in a relationship with my partner, Donald, for six years. He is African American and has always supported me in my desire to come and work in Africa. He, too, would like to come and explore his heritage. I miss him a lot and wonder what it would be like for him to be here in the midst of this struggle for equality. I think of him most when I see these young children; we have often talked about adopting. Children are the most vulnerable victims of this country's past and of the ravages of AIDS. Ironically, they are also its greatest hope.

As a nurse, I know how important it is to be a healer. Traveling with Sheila, one of the most incredibly compassionate and wonderful nurses I've ever met, makes this an even greater experience. We share stories about our families and take time to listen to each other. We laugh a lot together and with the nurses we've met. It's the universal language of healing.

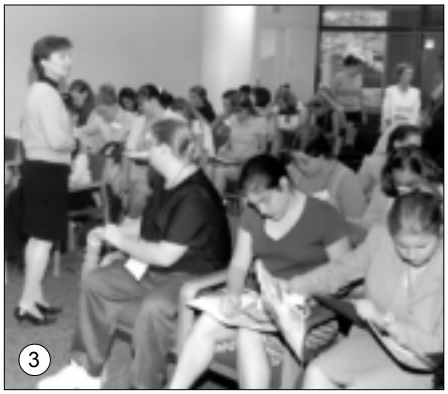
Special Visitors

Girl Scouts visit MGH

continued from front cover

On July 26 and 27, 2001, some 50 Girl Scouts visited MGH as part of an intensive 10-day leadership conference, organized by the Patriots' Trail Girl Scout Council of Greater Boston and Simmons College. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, spoke to the group about career opportunities in health care. Said Ives Erickson, "I'd like you to think about your visit to MGH as, 'a teachable moment,' a time when you are ready to learn something new, and perhaps ready to make a life decision. I cannot stress strongly enough the rewards of working in health care. Nowhere else can you impact the lives of so many people. In the next two days as you visit the different areas of MGH, I urge you to open yourselves up to the possibilities that a career in health care has to offer. Listen carefully. Ask questions. And let yourselves be inspired."

During their visit, scouts were given a tour of the Pharmacy, Radiology, Physical Therapy, Occupational Therapy and Respiratory Care Services. They lunched with leaders of Patient Care Services on the Bulfinch terrace, visited the Etherdome, and listened to presentations by Carmen Vega-Barachowitz, Karen Tanklow, Immacula Benjamin, Ann Martin, Donna Perry, Nancy Tarbell, Amy Levine and Deborah Washington.



(Photos 1-3 by Paul Batiste of the MGH Photo Lab)

Washington's presentation, entitled, "First Impressions: They're Not Always What They Seem," included an interactive game of 'Cultural Bingo!' a fun and educational way of learning about the various beliefs, traditions, and customs practiced by different peoples around the world.

Day two of the visit paired scouts with MGH clinicians for an up-close look at the day-to-day work of nurses, therapists, social workers and other health professionals. The visit, coordinated by Donna Perry, RN, of The Center for Clinical & Professional Development, provided this very motivated group of scouts with a lot of information and many memorable experiences. At the very least… they will "be prepared" to make an informed decision about their future career paths.

Photographs:

1) Girl Scouts arrive at MGH.
2) Ives Erickson greets scouts at entrance to the Wellman Building.
3) Ives Erickson introduces group to Patient Care Services.
4) Amy Levine, RN, peri-operative orientation coordinator for the Same Day Surgical Unit, demonstrates opportunities available in surgical specialties.
5) Deborah Washington, RN, director of PCS Diversity, leads discussion on the importance of cultural sensitivity in delivering healthcare services.
6) In the Etherdome, Nancy Tarbell, MD, director of the Office for Women's Careers, talks about emerging opportunities for women in healthcare.
7) Endoscopy nurse manager, Angelleen Peters-Lewis, RN, lunches with scouts on the Bulfinch terrace.
8) Girls play "Cultural Bingo," an exercise prepared by Washington to trigger discussion of various traditions practiced by different cultural groups.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The Girl Scout Mission

To inspire girls with the highest ideals of character, conduct, patriotism and service that they may become happy and resourceful citizens.

PATIENT CARE MGH 1811 SERVICES

Pin given to visiting Girl Scouts as 'merit badge' of participation

Girl Scout Law

I will do my best: to be honest, to be fair,
to help where I am needed, to be cheerful,
to be friendly and considerate,
to be a sister to every Girl Scout,
to respect authority,
to use resources wisely,
to protect and improve the world around me,
to show respect for myself and others
through my words and actions.

PCS Vision Statement

As nurses, health professionals, and PCS support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day. We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally competent workforce supportive of the patient-focused values of this institution. It is through our professional practice model that we make our vision a demonstrable truth every day by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.

CNS supports, empowers family advocacy

Joanne Empoliti, RN, MSN, APRN, ONC
clinical nurse specialist

My name is Joanne Empoliti, and I am a clinical nurse specialist for a medical and orthopaedic unit. I first met Mr. R and his family on a busy Tuesday afternoon in November. A 50-year-old gentleman, he had recently been diagnosed with cancer, malignant fibrous histocytoma, which is a soft-tissue sarcoma. The cancer was in his chest, causing respiratory complications.

A staff nurse asked if I would teach Mr. R about the use of metered-dose inhalers. As I was getting ready to go into Mr. R's room, the case manager informed me that the home health agency the family had requested would not be able to see him for several days. The staff nurse added that Mr. R's family was upset about this glitch. I thought, "Oh no. This could take a while. And I have so many things to do."

I gathered my supplies, and into the room I went. Mrs. R met me at the door with questions: who was I, what did I want? I introduced myself and explained that I was here to show them how to use the metered-dose inhalers, and also to see what could be done to help with the discharge process. Mrs. R proceeded to tell me what had already been done, and how it had been done wrong. They just wanted to go home, she said. She filled me in on how Mr. R had been diagnosed. He had complained of a cough in July, saw his primary care physician and was sent home with a diagnosis of URI and a plan for symptomatic care. His symptoms continued. A chest x-ray was done, which showed a mediastinal mass. A biopsy during this hospitalization confirmed their worst fears: cancer.

I knew I needed to take a deep breath, slow down, and listen to what she was telling me. I went over to Mr. R and introduced myself. He was sitting in a chair, looking tired, and he was short of breath. I suggested we review the medications and then I would see what was going on with the discharge plan. It was clear during the teaching session that Mrs. R was going to be the caretaker, and she was trying to gain some control over this new diagnosis and situation. I listened to more of their story. They were still reeling from the news and trying hard to understand what was happening.

Mrs. R and I discussed the discharge plan. They had requested a specific home health agency and didn't want to accept any substitute. I knew they had already been refused by their preferred choice, so I consulted with the case manager and we were able to convince the home health agency to accept Mr. R. Once the plan was set, Mr. and Mrs. R were able to return home.

Several weeks passed before Mr. R returned for his chemotherapy. His nurse and I both knew we would have to engage Mrs. R before we approached Mr. R. Again, Mrs. R wanted all the information she could get. She asked many questions —all completely appropriate.

With each admission Mrs. R became more involved, requesting information, seeking caregivers who would provide the precise care she requested. She had good reason for this. During one admission, Mr. R had arrived very short of breath, pale, and fatigued, with an oxygen saturation in the low 90s. These symptoms had started less than 12 hours earlier. When I went in to see how they were doing, Mrs. R told me about the ups and downs of the past three weeks, and also her concerns about Mr. R's current symptoms. Mr. R was sent down for a chest x-ray, and Mrs. R stayed to talk with me. She believed the cause of his symptoms was either mucus plugs in his bronchus or a collapsed bronchus. He'd had these symptoms in the past and that had been the problem. She was concerned that chemotherapy, combined with bronchial problems would make him even weaker. I agreed that Mr. R's symptoms should be worked up prior to chemotherapy.

I spoke with the resident covering Mr. R. After discussing the issues with him, it was clear that the attending physician needed to be consulted. Upon review, the attending ordered a bronchoscopy. The diagnosis was a collapsed bronchus, and Mr. R required a short stay in the ICU.

This incident further increased my respect for Mrs. R. She was going to fight for her husband with everything she had. She wasn't going to listen to anyone who wouldn't listen to her! She knew her husband better than anyone, and she was his advocate. I could see myself doing the same thing in her situation.

I had many discussions with staff regarding Mrs. R's strong, and sometimes seemingly officious, advocacy for her husband. Some interpreted her actions as an indication that she didn't trust us. I asked them how they would feel if they were in a similar situation. Mrs. R knew her husband, and she was fighting for his life the only way she could. We needed to figure out a way to support Mrs. R, and give the best possible care to Mr. R while not getting into a power struggle.

continued on next page

Direct deposit means direct savings for MGH!

Ten nurses were among the winners in the recent direct deposit promotional drawing, sponsored jointly by Human Resources and Payroll Services. Employees who switched to direct deposit during the promotion period received special gifts and a chance to participate in the final prize drawing.

In all, 595 employees switched to electronic deposit during the one-month promotion. This is an important step in lowering our administrative costs.

While the promotion has ended, Payroll staff are still available to help employees transition to the direct-deposit plan.

- Direct deposit is safe, reliable, private and convenient.
- Your pay is usually available several hours before paychecks are distributed.
- When you're out sick or on vacation, your pay continues to reach your account electronically
- With direct deposit, your pay can be distributed to as many as three accounts each pay day
- With direct deposit your funds can be sent electronically to almost any bank or credit union in the country.

Congratulations to the following nurses, who were winners in the July drawing.

- Jennifer McGaffigan
- Madeleine Spadea
- Arlan Manuel
- Nancy O'Brien
- Sonia Shea
- Donna Furlong
- Anne-Marie McDonough
- Joan Yankun
- Michael O'Connor
- Deborah Zapolski

For more information about direct deposit, or to request an application, please call 724-3088 or 724-5579.

Brain Aneurysm Awareness

Central Lobby
August 22, 23 and 24, 2001

"Bridging the gap between clinicians, patients and their families"

under the Bulfinch tent
August 23, 2001, 6:00–9:00pm

For more information call 723-3870

Exemplar

continued from page 6

Over a period of months, Mr. R had several admissions for chemotherapy. The plan was for Mr. R to have surgery to remove the primary tumor. However, when the time came, the surgery was not performed due to the discovery of metastatic disease.

Chemotherapy continued. Mr. R was admitted with metastatic disease in several parts of his body, requiring radiation, surgery and medications. As you can imagine, this was devastating to the Mr. R and his family. To us (his health care team), it was apparent that the prognosis was now poor, and the question became how to proceed. Do we talk openly about the prognosis? Do we wait for cues from them? I knew we had to follow Mrs. R's lead. If she asked frank questions, we would answer honestly. If she chose to side-step the issue, then we would provide whatever support they needed.

This also brought up questions about whether Mr. R knew and understood his prognosis. In talking with them it was clear that Mr. R had an understanding of what was going on. He never expressed it directly, but I felt he knew. I'm sure Mrs. R knew, but she was not going to give up until the very end.

Mr. R was readmitted with severe shortness of breath and fatigue. It was clear this would be his last admission. The attending physician discussed DNR status and supportive care with both Mr. and Mrs. R. At this point, there was a change in Mrs. R's disposition. She became quiet, subdued. She still sought out the caregivers she knew, still asked questions, and sought control of the situation. But it was different. She focused on protecting Mr. R from non-essential interruptions, and controlling the flow of people in and out of his room. She made sure there was a family member or friend with him until the end.

Late Friday afternoon, I knew Mr. R would not be here when I got back from a week-long conference out of town. I needed to say good-bye. Mr. R wasn't able to respond when I visited him. I located Mrs. R in the lounge. I told her I just wanted to check in and make sure everything was as she wanted it to be; and see if there was anything she needed. She knew I wouldn't be back for a week. She wished me well, and thanked me for all my help. She said good-bye.

Mr. R died that night.

When I returned from the conference, the staff and I talked about Mr. and Mrs. R, and how we had come to know them. There was a much fuller understanding and acceptance of why Mrs. R felt she needed to be such 'a watchdog.' It shows how *knowing* our patients supports the development of relationships between nurse and patient, and enhances our ability to provide competent, compassionate nursing care.

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

This is a wonderful example of recognizing an important opportunity, re-prioritizing, and really being present for the patient and his family. When other clinicians had difficulty interacting with Mrs. R, Joanne was able to help them appreciate the source of her concerns and see that she was acting out of the same kind of fear we would all feel in that situation and with singular knowledge about her husband. Joanne seamlessly blended direct patient care with patient- and staff- education to ensure optimal care for Mr. R.

Thank-you, Joanne.

Education key component of Emergency Department CNS role

June Guarente, RN-CS, CEN,
clinical nurse specialist
Emergency Department

—by June Guarente RN-CS, CEN
ED clinical nurse specialist

My name is June Guarente, and I am the clinical nurse specialist for the Emergency Department (ED). The CNS position encompasses many roles such as researcher, role model, change agent, and consultant. My primary role, however, has been that of educator. I would like to share with you a project I became involved with last winter in my role as educator.

Over the years, there have been many changes in my department including increased patient volume and acuity. In order to keep pace, approximately 75 new ED nurses have been hired in the past three years. Part of my job is to ensure that new nurses receive adequate orientation, and that upon completion of orientation they are competent to practice emergency nursing.

The ED has 46 beds located in six separate patient care areas, including designated pediatric and psychiatric areas. We are classified as a level 1 Adult, Pediatric, and Burn Trauma Center. MGH is the only hospital in New England designated as a level 1 center in all 3 specialties by the American College of Surgeons.

On average, the ED reports 200 patient visits per day. Forty three percent of those patients are usually admitted, which is roughly 50 patients per day. Our patients present with a variety of health issues and are admitted to all services within the hospital. Therefore, ED nurses must have a broad base of knowledge in order to care for patients with many different illnesses and/or injuries.

Our orientation process is competency-based. Each area, as well as Triage, has a separate set of competencies that must be achieved before the nurse can practice independently. Experienced staff nurses act as preceptors for new staff, providing orientation to each area of the ED. Once competencies for one area have been achieved, the new nurse moves to the next area of the ED. The orientation process is individualized, based on each nurse's needs. For example, many nurses have no prior pediatric experience. So orientation to the pediatric area usually takes a little longer. The Trauma-Acute Care area is generally the last area of orientation for the new staff nurse. By the time the orientee starts in Trauma-Acute Care he or she is competent to work in all of the other areas of the ED. I have found that this approach provides an opportunity for new nurses to gain the necessary knowledge, skills, and confidence they will need to work in the Trauma-Acute Care area.

Until recently, it was preferable for ED nurses to have had previous ED or ICU experience. However, the increased need for ED nurses combined with the shortage of experienced critical-care nurses has led us to hire nurses with no previous ED experience. The challenge has been to provide adequate education to prepare these new staff members to practice as emergency nurses.

The Boston Teaching Hospital's ED Consortium was created in 1993 as a spin-off of the original Boston Teaching Hospital's ICU Consortium. Rep-

continued on next page

Above: nurse educator, Pat Prawlucki, RN, of St. Elizabeth's Hospital Emergency Department, presents at Emergency Nursing Orientation Program.
At right: MGH Emergency Department staff nurse, Elise Cormier, RN (left), with other conference attendees.

Clinical nurse specialist

continued from previous page

resentatives from participating hospitals include nurse educators, clinical nurse specialists, staff nurses, and nurse managers. The purpose of the ED Consortium is to meet specific educational needs of ED nurses.

In January of this year, the ED Consortium created the Emergency Nursing Orientation Program. The purpose of the program is to provide an introduction to emergency nursing for nurses with no prior ED experience.

Members of the ED Consortium developed the curriculum; the list of topics is included below. (The course also includes a two-hour skills lab.)

- Role of the ED Nurse
- Law, Liability, and Mandated Reporting
- EMS-Where Do You Fit In
- Triage
- Assessment in the ED
- Infectious Diseases
- Airway Interventions and Management
- Respiratory Emergencies
- Diabetic Emergencies
- Pain Management and Conscious Sedation
- EENT and Dental Emergencies
- Soft Tissue Emergencies
- Medical Emergencies
- Cardiac Emergencies
- Orthopaedic Emergencies
- Shock
- Approach to Pediatric Care
- Pediatric Emergencies
- GI Emergencies
- GU Emergencies
- OB/Gyn Emergencies
- Neurological Emergencies
- Psychiatric Emergencies
- Social Assessment
- Ingestions

The initial Emergency Nursing Orientation Program was offered in April, 2001; MGH co-sponsored the program. Thirty nurses attended; eight were MGH Emergency Department staff nurses. Feedback and course evaluations were overwhelmingly positive. When asked about the program, Peggy Corliss, RN, who transferred from the NICU at MGH to the ED, observed, "I found the program to be not only very informative, but well organized. You could see how much time and effort staff put into bringing it all together. I consider myself lucky to have been able to attend."

Several ED staff members assisted in making the program a reality. Maureen Beaulieau, RN, Ann Morrill, RN, Sabrina Federico, RN, Patricia Mian, RNCS, psychiatric CNS, and Nancy Newman, LICSW, all contributed in some way.

The next program will be offered in October. It will be expanded to 6 days and will cover additional topics, including a lecture on forensic evidence-collection. Starting next year, we plan to offer the Emergency Nursing Orientation Program three times a year. The program will provide new staff with information that is current and consistent. Most importantly, it will provide a crucial knowledge base on which new nurses can build during their orientation.

Correction

Contrary to what was printed in the July 19, 2001, Professional Achievement section of *Caring Headlines*, Virginia Capasso, RN, would like you to know:
In a competitive application process, I was one of 40 participants selected for the "Research Training Program for Nurse Scientists," sponsored by the National Institute of Nursing Research and the Clinical Center at the National Institutes of Health. Applicants submitted an abstract for proposed studies which were reviewed and critiqued by the director of the Extramural Program. Program directors oversee grant applications and subsequent funding, if studies are approved by NINR review committees.
My participation in the program was supported by Harvard's Institute for Nursing Healthcare Leadership.

Negotiation Skills for Those Not Born to the Table

presented by Phyllis Kritek, RN, PhD, FAAN, internationally recognized author and scholar

Working in today's complex healthcare environment, negotiation skills are essential for our ability to manage conflict between individuals of different ages, cultures, disciplines and departments.

Conflict-management can also be a catalyst for change. Negotiation skills are key for those working in management or administrative positions.

November 2–3, 2001
8:30am–5:00pm
O'Keeffe Auditorium

For more information, contact Brian French at 724-7843, or Deborah Washington at 724-7469

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Please recycle

—Educational

When/Where	Description	Contact Hours
September 4 8:00am–5:00pm NEMC	**Chemotherapy Consortium** This program lays the foundation for certification in chemotherapy administration. Staff must complete a pre-test and pre-reading packet before attending program. (Materials available in The Center for Clinical & Professional Development on Founders 6). Post-program test and clinical practicum required for certification. For more information, call Joan Gallagher at pager #2-5410. Pre-registration is required. To register, call The Center for Clinical & Professional Development at 726-3111.	TBA
September 6 7:30–11:30am, 12:00–4:00pm VBK 401	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** Successful completion of this program re-certifies staff in AHA Basic Life Support. Priority will be given to staff required to have AHA BLS for their job. Others are encouraged to complete unit-based, age-specific mannequin demonstration to meet requirements. Participants must review the new AHA Health Care Provider Manual, which may be borrowed from the CCPD for a returnable $10 deposit. (Note: class has been extended to 4 hours due to changes in AHA requirements.) Pre-registration is required, as is proof of AHA Healthcare Provider certification within the last two years. For information, or to register, call The Center for Clinical & Professional Development at 726-3111.	- - -
September 6 1:30–2:30pm O'Keeffe Auditorium	**Nursing Grand Rounds** Nursing Grand Rounds are held on the first and third Thursdays of each month. This session will focus on: "Maltreatment of Children." For more information about this session call The Center for Clinical & Professional Development at 726-3111.	1.2
September 7 8:00am–4:30pm O'Keeffe Auditorium	**2001: A Diabetic Odyssey** This program is designed to enhance nurses' knowledge around the care of patients with diabetes. Topics will include patho-physiology of Type 1 and Type 2 diabetes; pharmacological interventions, monitoring and management of diabetes; nutrition and exercise; complications; and caring for special populations such as pediatrics, geriatrics, critically ill, and pregnant women. No fee for MGH employees. $30 for Partners employees. $75 all others. Pre-admission is required. For more information, call The Center for Clinical & Professional Development at 726-3111.	8
September 11 7:30–8:30am Patient Family Learning Center	**Internet Basics: Using the World Wide Web to Enhance Your Practice** This program is targeted toward clinicians who want to learn basic skills in accessing, searching and navigating the Internet. The goal is to teach clinicians to access quality on-line healthcare information to enhance clinical practice. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
Sept. 12, 8:00am–12:30pm September 14, (Exam) 8:00–9:30am Bigelow 4 Amphitheatre	**Transfusion Therapy Course (Lecture & Exam)** For ICU nurses only. Pre-registration is required. For information, call 6-3632; to register, call The Center for Clinical & Professional Development at 726-3111.	- - -
September 12 8:00am–2:30pm Training Department Charles River Plaza	**New Graduate Seminar I** This seminar assists new graduate nurses (with the guidance of their mentors) to transition into the role of professional nurse. Seminars focus of skill acquisition, organization and priority-setting, communication and conflict-management, caring practices, and ethical issues. For more information, call The Center for Clinical & Professional Development at 726-3111.	6.0 (contact hours for mentors only)
September 12 8:00am–4:00pm VBK6	**CVVH Core Program** This program is designed for ICU nurses and echmo-therapists, to provide a theoretical basis for practice using continuous venous-venous hemodialysis. Participants must pick up and complete a pre-reading packet prior to attending. Packets may be picked up in FND645. Pre-registration is required. To register, or for more information, call The Center for Clinical & Professional Development at 726-3111.	6.3
September 12 1:30–2:30pm Bigelow 4 Amphitheater	**OA/PCA/USA Connections** Continuing education session offered for patient care associates, operations associates, and unit service associates. This session is entitled, "Safe Care of Violent Patients." Pre-registration is not required. For more information, call The Center for Clinical & Professional Development at 726-3111.	- - -
September 13 8:00am–4:30pm Training Department Charles River Plaza	**Preceptor Development Program: Level I** Program is geared toward MGH staff nurses and advanced practice nurses who have served, or are interested in serving, as clinical preceptors for new graduates, experienced nurses, student nurses or international guests. Participants explore the roles of educator, role model, facilitator and clinical coach as well as partner in planning and guiding clinical experiences. For more information, or to register, call The Center for Clinical & Professional Development at 726-3111.	7

When/Where	Description	Contact Hours
September 13 1:30–2:30pm O'Keeffe Auditorium	**Nursing Grand Rounds** This presentation will focus on, "Breaking the Language Barrier: Accessing Patient Information in Languages other than English," presented by Martha Stone, coordinator of Reference Services, Treadwell Library. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
September 17 7:30–11:30am, 12:00–4:00pm VBK 401	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** Successful completion of this program re-certifies staff in AHA Basic Life Support. Priority will be given to staff required to have AHA BLS for their job. Others are encouraged to complete unit-based, age-specific mannequin demonstration to meet requirements. Participants must review the new AHA Health Care Provider Manual, which may be borrowed from the CCPD for a returnable $10 deposit. (Note: class has been extended to 4 hours due to changes in AHA requirements.) Pre-registration is required, as is proof of AHA Healthcare Provider certification within the last two years. For information, or to register, call The Center for Clinical & Professional Development at 726-3111.	- - -
September 17 (8:00–4:15) O'Keeffe Auditorium and September 19 8:00am–4:15pm Training Department Charles River Plaza	**Neuroscience Nursing Review 2001** This 2-day review is designed for experienced nurses who care for neuroscience patients or who are preparing for the neuroscience nursing examination. Participants my attend one or both days. Limited to 25. See Educational Offerings Calendar for fees. For more information, call The Center for Clinical & Professional Development at 726-3111.	TBA
September 18 8:00am–4:30pm VBK 601	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Program will provide a forum for staff to learn about the impact of culture in our lives and interactions with patients, families and co-workers. Topics include understanding and defining the importance of culture; the principles of cultural competency; understanding the dynamics of difference; the culture of Western bio-medicine; and the appropriate use of language services. A variety of interactive exercises will help to illustrate the concepts presented. For more information, call The Center for Clinical & Professional Development at 726-3111.	7.2
September 20 8:00am–4:30pm Training Department Charles River Plaza	**Operations Associate Preceptor Development Program** This new program is offered to operations associates to help them develop skills in precepting new OA staff. For more information, call The Center for Clinical & Professional Development at 726-3111.	---
September 20 8:00am–4:30pm Training Department Charles River Plaza	**Conversations at the End of Life** This program is designed to enhance nurses' ability to care for patients and families during this most difficult time. Topics will include: pain- and symptom-management, ethical issues, struggles and choices, patient-advocacy, and cultural considerations. For more information, call The Center for Clinical & Professional Development at 726-3111.	8.4
September 20 1:30–2:30pm O'Keeffe Auditorium	**Nursing Grand Rounds** This Nursing Grand Rounds will focus on research with a presentation by Anne Marie Barron. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
September 24 and September 27 8:00am–5:00pm Wellman Conference Room	**Advanced Cardiac Life Support (ACLS)—Provider Course** Provider course sponsored by MGH Department of Emergency Services. $120 for MGH/HMS-affiliated employees; $170 for all others. Registration information and applications are available in Founders 135, or by calling 726-3905. For course information, call Inez McGillivray at 724-4100.	16.8 for completing both days
September 25 and 26 8:00am–4:30pm VBK601	**BLS Instructor Program** A 2-day training program that prepares participants to teach CPR courses. Pre-requisite: current health-care provider card and commitment to teach at least 2 CPR courses per year. Pre-registration is required, and participants must pick up instructor textbooks and teaching assignment in the Center for Clinical & Professional Development (Founders 6) two weeks prior to course. For more information, or to register, call Roberta Raskin at 726-7572	13.2 for completing both days
September 25 and 26 7:30am–4:30pm Holiday Inn	**Pain Relief Champion Seminar(s)** This program provides an in-depth review of pain and pain-management with the goal of preparing participants to serve as resources for others. For more information, call The Center for Clinical & Professional Development at 726-3111.	TBA

MGH-Timilty Partnership seeks mentors

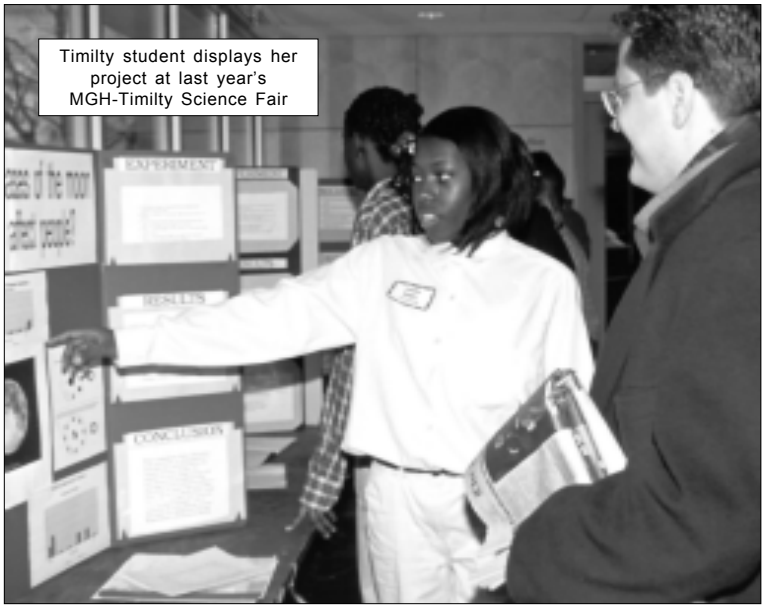
Few experiences are as rewarding as influencing a young person in a positive way. So when an opportunity to do so comes along, you really should take advantage of it!

The MGH-Timilty Partnership is currently seeking mentors to work with Timilty Middle School students to develop science projects for competition in the school's annual science fair. The Science Fair Mentoring Program is a great way for MGH professionals to share their knowledge and interest in science, and introduce students to the world of health care.

Mentors meet with students at MGH on designated Friday mornings, from October to January, to assist students with their science projects. Mentors may be paired with a student one-on-one, join other colleagues in mentoring a student, or mentor a group of students.

If you would like to become a mentor, please contact the MGH-Timilty Partnership Office at 4-3210.

For more information about the Science Fair Mentoring Program, or other volunteer opportunities available at the Timilty School through the Science Connection, please e-mail: timilty@ partners.org.



Timilty student displays her project at last year's MGH-Timilty Science Fair

New program rewards PCS employees who recruit or refer clinical staff for hire within Patient Care Services

- PCS Referral Program rewards PCS employees who refer individuals for hire into specific roles between now and September 29, 2001
- All current PCS employees are eligible (excluding directors, leadership and HR staff)
- $1,000 will be given to employees whose referrals are hired into PCS clinical positions of 20 hours per week or more

For more information,
contact Steve Taranto at 724-2567

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