

# Caring

October 18, 2001

## HEADLINES

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Welcome Home  
Mass General  
Disaster Response  
Team Members!

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**MGH** Patient Care Services  
Working together to shape the future

## Recent and upcoming events of note

On behalf of Patient Care Services and the entire MGH community, I would like to extend a heartfelt thanks to the members of the Disaster Medical Assistance Team who responded so courageously to our nation's call for help. Know that your colleagues who remained at MGH worried for your safety, prayed for your swift return, and wished they could have been there with you. As you will never forget your experiences in New York, we will not soon forget your sacrifice. We are so proud of you all.

With recent world events demanding so much of our attention, I'd like to take this opportunity to bring you up to date on some events that have happened here

at MGH that will impact our work within Patient Care Services. First, as you may be aware, the Volunteer Department, Medical Interpreters, Information Ambassadors and the LVC Retail Stores, all under the leadership of Pat Rowell, have joined Patient Care Services in order to better align these important services with our efforts to provide the highest quality patient care.

Last year, 1,117 volunteers contributed 163,572 hours to comfort, assist and improve the patient experience at MGH. Our growing team of interpreters provides an invaluable service, making care and treatment more accessible, reliable, and less intimidating for our international patients. And our information ambassadors

and retail stores (The General Store, the Flower Shop, and the Images Beauty Salon) help promote a patient- and staff-friendly environment every day. We welcome these departments to Patient Care Services, and look forward to working with them to better serve our patients.

Marcia Reissig, RN, has been appointed president of the Partners Home Care Program, and on September 10, 2001, Bonnie Glass, RN, former associate chief nurse, assumed the new role of vice president of Patient Services and chief nurse for this program. In this role, Bonnie will oversee the operations of four regional home care offices. Bonnie brings a vast amount of clinical knowledge and experience to this role; her vision and leadership will be invaluable as our home care program continues to expand.

I'm happy to report that we are well into our search for an associate chief nurse to lead our Women and Children, Community, and Mental Health Services. To date, more than 25 candidates have applied; many have already interviewed with Human Resources, Marianne Ditomassi, the executive director of my office, and/or me. We are taking great care to select



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

an individual who has the right qualifications as well as an appreciation of the complexities of this role in an academic medical center of this size. I will keep you informed as we move forward.

The Employee Referral Program, initiated over the summer, has yielded very rewarding results! Employee referrals were responsible for more than 30 new hires including 20 staff nurses, 6 patient care associates, 3 physical therapists, 2 respiratory therapists, 2 speech pathologists, and 1 physical therapy aide (and these numbers may be higher since press time). Many of these new employees have started work already, others are scheduled to begin in the coming weeks. Due to this remarkable success, the program has been extended through December 31st.

The Patient Care Services Leadership Retreat on September 26th,

once again, was a valuable day of work and reflection. Perhaps one of the most valuable sessions was our open forum discussion about the September 11th tragedies. Evelyn Bonander, director of Social Services; Deb Washington, director of Diversity; Mary Martha Thiel, director of the Chaplaincy; Judy Newell, interim associate chief nurse; and Mary Fran Hughes, nurse manager of the ED, facilitated a very candid discussion about the events, our feelings, our fears, and how best to support staff in the weeks and months ahead. This was such a constructive and empowering session that I'm planning to hold similar forums for PCS staff members in the future. We all need to talk about how our world has changed and how we've been affected.

Also at the retreat, we had an opportunity to dialogue with state rep-  
*continued on page 11*

### 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 December 31, 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 724-1567

## DMAT team members reflect on their experiences in New York City

Who ever would have thought that 'Ground Zero,' the military term used to describe the point of impact of a bomb or missile, would become part of our daily vocabulary? But so it has. That alone tells us things have changed.

No one realizes that more fully than members of Boston's Disaster Medical Assistance Team, who were deployed to New York City in the hours following the attacks. Specially trained MGH nurses, doctors, therapists and pharmacists staffed five clinics at Ground Zero, while other team members volunteered to work at severely over-burdened burn units in the city. All who stayed behind wished they could have gone, but took pride in knowing their MGH colleagues were answering the call.

All who were deployed agree: it was an experience that changed their lives.

*"Of all the disasters I've seen, this was the most devastating, both in terms of fatalities and the destructive effects of the explosion. The spirit of the rescuers, most of whom had lost friends or family, was unbelievable as we worked together at Ground Zero. I am grateful to my many colleagues at MGH who made it possible for us to assist New York in coping with this tragedy."*

—Sue Briggs, MD  
DMAT supervising medical officer

*"I was so impressed by the togetherness and focus of the New Yorkers. We unloaded trucks at two o'clock in the morning, in the pouring rain, a block from Ground Zero, and local paramedics, policemen, and civilians jumped in to help us."*

*"They lined the streets at Ground Zero clapping for us, waving flags, and shouting, 'Thank-you!'"*

*"The saddest moment for me was standing at Ground Zero, surrounded by highly skilled people and stockpiles of medical equipment, and realizing there were no survivors. Everyone had died."*

—Mary O'Brien, RN

Fire fighters' memorial statue, commissioned for fire station in Missouri, was at Kennedy Airport in New York on September 11th, en route to its final destination. Missouri fire fighters and the sculptor who crafted it subsequently donated the statue to the people of New York City.



*"When we arrived in the city, we worked through the night unloading equipment and setting up our clinic. By seven AM we started seeing patients continuously, twenty-four hours a day."*

*"As the perimeter of Ground Zero stabilized, we established four more medical stations, each one seeing up to a hundred patients in an eight-hour period."*

*"My first up-close view of the scene was at night. The emergency lighting created a surreal atmosphere. Standing there, I was humbled and overwhelmed by the immensity of the destruction."*

*"The image I will never forget occurred on the last night of our deployment. As I was returning to the main medical station, I saw about eight fire fighters silently, reverently carrying a basket stretcher. In it, was a body bag. They were bringing one of their own back home. It's an image I will never forget."*

—Tony Forgione, LPN

*"I've never seen such solidarity between people. Everybody mattered! It didn't matter who you were or what your title was; everyone stepped up and performed beyond all expectations"*

—Ron Gaudette, RPh  
pharmacist

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# Returning Heroes

*"I remember getting out of the car and seeing the smoke and the rubble in that eerie light around Ground Zero. I remember seeing hundreds of firemen coming down off that huge pile of debris, their faces filthy, their expressions so blank. I couldn't take my eyes off them. That's when it hit me..."*

—Marie LeBlanc, RN  
DMAT supervising nurse

*"When I first saw Ground Zero, I was heart-broken at the terrible loss... for all of us. I had to take a step back and remind myself that I was there to do a job. This wasn't the time for my own personal mourning—I was there for a reason. I was there to take care of people."*

—Peggy Hogan, RN

*"When I first saw the rubble, I felt like I was seeing a sacred place; you knew so many people had died there. It was so quiet. Except for the sound of machinery, there was an almost 'holy' silence."*

—Susan Diehl, RN



*"The leadership that Sue Briggs provided and the confidence she instilled in us were incredible. It was like... we knew we could do this because Sue knew we could do it! And Sue is never wrong!"*

—Ron Gaudette, RPh



(Photographs from Ground Zero included in this spread were taken by DMAT team member, Matthew Sholl, MD, of the Boston Medical Center Emergency Department)



Sue Briggs

*"I went with the second deployment. They specifically requested burn nurses. I knew my absence along with my four colleagues, would be a burden to my co-workers, but I knew the Bigelow 13 staff would pull together like they always do in times of crisis."*

*"I was sent to the Cornell Burn Center at New York Presbyterian Hospital. It was difficult to get the feel of a new hospital. Many of their treatment modalities were very different from what I was used to. I was very glad I had travelled with people I knew and trusted. We worked nine straight twelve-to-fourteen hour shifts. Several times, I thought of the Beatles song, 'I Get By with a Little Help from My Friends.'*

*"While we were in New York, I was struck by the out-pouring of the community. Cards with thoughts and prayers, most of them drawn by hand, covered the walls of the hospital. It was heartening to see messages from old and young alike, reaching out to the victims in the burn center."*

*"When I joined the DMAT team, I never expected to be called for anything of this magnitude. It was hard being away from my home and family. Now I realize the sacrifice our service men and women make all the time. I was proud to be able to help our nation at this time of need."*

—Sally Morton, RN

*"I went down with the second wave, so others on the team had already been working by the time we arrived. When I got there, all I could think of was, 'How can I do this? Am I good enough? Am I competent enough?'"*

*"You feel inadequate, but then you locate that confidence inside and you grab it and you just stay in that place. I remember squeezing Kristina's hand and saying, 'Don't worry. We're gonna do this. We're gonna be fine.'"*

*"We learned soon enough that it was okay to be scared. We were with great people. There was always someone there to support you. I always felt like I had a life preserver. Here I was at the site of one of our worst national disasters, and I never felt safer!"*

—Brenda Smith, RN



# Returning Heroes



*"We didn't want to let anyone down given the enormity of the tragedy. As it turned out... I don't think we ever encountered a situation we couldn't handle. You knew you could lean on any member of the team... whether you had known them for ten minutes, or worked with them for ten years."*

—Susan Diehl, RN

*"There was one policeman, you know, one of those real macho guys. They had to drag him into the tent against his will—he didn't want to leave the site. Once he allowed himself to sit, to step back from it all, he dissolved into tears... just sobbing uncontrollably."*

—Marie LeBlanc, RN

*"When the second wave arrived, Marie (LeBlanc) had... a little staff meeting in her room. She knew what we were about to see. She called us together and told us: 'I know what you're thinking. I know you're afraid. We were afraid, too. But you can do this. You have the skills. Just do what you always do. You'll be fine, I know you will...'*

*"And we were."*

—Peggy Hogan, RN



Brenda Smith at Ground Zero

*"At one point, I saw three firemen trying to get some sleep on makeshift chairs in the middle of all this debris. I finally convinced one of them to come lie down on a cot in the tent. Just before he fell asleep, he grabbed my hand. He slept with my hand in his, against his chest, for about twenty minutes. When he woke up, he looked at me and said, 'Thank-you. I just needed to hold a hand.'"*

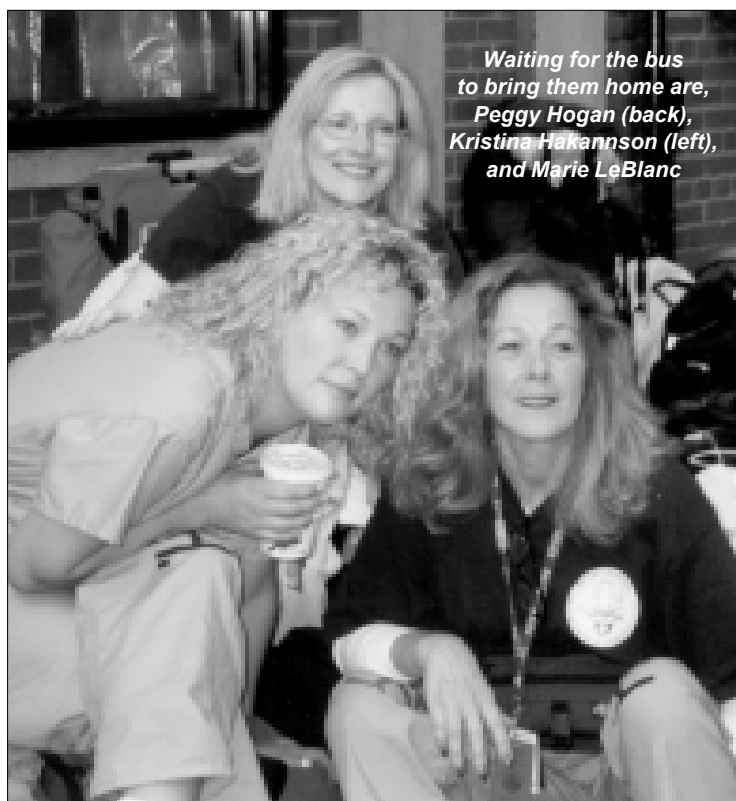
—Brenda Smith, RN

*"One of our clinics was set up inside a blown-out delicatessen. It was particularly surreal—it wasn't more than ten feet from the disaster site; we had our surgical supplies on shelves where eggs and cheese would have been, and there was a flickering neon 'Pizza' sign in the corner. It was just... unreal."*

—Marie LeBlanc, RN

**MGH DMAT Team Members**

Jen Albert, RN  
 Susan Briggs, MD  
 Erin Cox, RN  
 Frank Curtis, RN  
 Susan Diehl, RN  
 Cathy Drake, RN  
 Bob Droste, RN  
 Molly Finneseth, RN  
 Anthony Forgione, LPN  
 Ron Gaudette, RPh  
 Edward George, MD  
 Pam Griffin, RN  
 Kristina Hakannson, RN  
 Peggy Hogan, RN  
 Patrick Kadilac, RN  
 Marie LeBlanc, RN  
 David Lhowe, MD  
 Barbara Goll McGee, RN  
 Dawn Moore, RN  
 Sally Morton, RN  
 Mary O'Brien, RN  
 Vinny Riggi, RRT  
 Jay Schnitzer, MD  
 Robert Sheridan, MD  
 Brenda Smith, RN  
 Mike Spiro, RN  
 Barbara Walsh, RN



*Waiting for the bus to bring them home are, Peggy Hogan (back), Kristina Hakannson (left), and Marie LeBlanc*

*"It wasn't just people we treated. We provided emotional support to Gunner, one of the rescue dogs, while his handler was getting an eye wash. Gunner's eyes were so big and sad—he was starving for physical contact, so we gave him lots of TLC. He was so happy to lie at my feet and get a nice towel rub. He and his handler were working sixteen-hour shifts and not finding any survivors. It was emotionally draining for both of them.*

*"It really was an honor... a privilege... to go to New York. I don't think I've ever felt so united."*

*—Brenda Smith, RN*



Jeanette Ives Erickson, RN, senior vice president for Patient Care, welcomes returning DMAT team members



## Sometimes being an expert means looking beyond traditional expectations

I have been a pediatric physical therapist for the past 23 years, and I never stop learning from my patients. One patient especially comes to mind when I think about what I have learned recently. Ahmed is an 18-year-old boy, who arrived in the United States in December of last year. He came with his father and brother from the United Arab Emirates.

When I first met Ahmed, he was a quiet young man, severely involved with cerebral palsy. He did not speak English, and he made no attempt to communicate through the interpreter to express his thoughts.

Ahmed had come to Physical Therapy to be fitted for an electric wheel chair, a device that would give him independent mobility for the first time in his life. He was also scheduled to undergo surgery to lengthen the very tight muscles in his legs the following week. He had a rigid scoliosis (curvature of the spine) and severe contractures of his arms and legs. He had little voluntary movement in any extremity. He could roll by himself but needed maximum assistance to sit up. And he had never walked. We decid-

ed to defer ordering the wheel chair until after his surgery so we could reassess his sitting position after his hamstring was lengthened.

Several weeks went by, and I heard nothing of Ahmed. Finally, in late January, I received a call from his physician, Dr. David Zaleske, asking me to work with Ahmed in his post-operative recovery phase. When Ahmed, his father and brother arrived, accompanied by an interpreter, we began a long and painful rehabilitation process.

I examined Ahmed and found he had gained several degrees of range of motion in his knees, but was far from being able to fully extend them. We worked daily, Monday through Friday, trying to increase the motion he had gained during surgery. When he wasn't having physical therapy, his father performed exercises with him. He was fitted with a set of hip-knee-ankle orthotics with knee joints that would allow us to change the angle of his knee extension as he gained more range of motion.

In talking with Ahmed and his family in the initial post-operative visit, I learned that their goal in coming to the

United States was to stay until Ahmed was walking! I was stunned to hear this. I didn't quite know how to tell them that it was, in my opinion, an unrealistic goal. Here was a young man who could not sit by himself, who had never even stood up, and he expected to walk. Aside from his lack of motor control and balance reactions, his bones were extremely weak from never having supported his own weight. He had already sustained a fracture from bumping his foot. Standing would not only be very risky, we weren't anywhere near a bio-mechanical position that would allow him to stand.

I tried, as gently as I could, to explain through the interpreter, that I didn't think I could get Ahmed to a point where he would be able to walk. His father did not agree; in part because he had very little understanding of the true nature of Ahmed's cerebral palsy. He didn't seem to understand that there had been an injury to his brain, which prevented him from controlling his own movement. He thought that once Ahmed's legs were straight, he'd be fine.

For several weeks, five times a week, Ah-



Sue Riley, PT  
pediatric physical therapist

med, his father and brother came to PT for stretching exercises and to work on his sitting balance. I decided that I would work with the family to get Ahmed to as independent a level as possible, perhaps even get him to where we could do a stand-and-pivot transfer rather than a two-man lift. This, in itself would give Ahmed more independence than needing to be lifted in and out of his wheelchair.

Our treatments caused Ahmed significant pain, to which his father said, "It's okay. Go."

I tried to explain that I needed to listen to Ahmed's pain; that it was my guide for how hard to push him. But since Ahmed would not speak to me directly, and he wouldn't tell me through his father how much it hurt, I had to watch his face. I believe it was a matter of pride for Ahmed's father to bring Ahmed home, only if he could walk.

As hard as we worked, we could not make much more progress in his range of motion and he still lacked 60 degrees in one leg and 45 in the other. So, late in February, Ahmed returned to the operating room, where he underwent more surgery. When he came out of the operating room, his legs were straight! After a couple of weeks of recuperation, Ahmed returned to physical therapy with long leg casts. He would try to stand for the first time.

With the help of an aide, we lifted Ahmed to his feet between parallel bars. He stood there, looking at himself in the mirror with the biggest smile I have ever seen. His father and brother smiled, too, and they took pictures of Ahmed to send back home. Over the next several days, we worked on standing, teaching him how to use his hands to push up straight. We progressed to shifting his

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## Exemplar

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weight, something he couldn't do very well in any position, let alone standing. Then on to walking forward.

Ahmed did suffer one set back. Soon after he began standing, he arrived in PT one afternoon quieter than usual. When I tried to help him stand, he cried out in pain. When I deferred our treatment, he said, "I am very sorry, father. I am very sorry, Sue."

After speaking with Dr. Zaleske's office, we sent him for an x-ray, which confirmed a fracture through the rods in his right femur. He was taken back to the operating room where Dr. Zaleske inserted a stronger fixation device. A few weeks later, Ahmed returned with the same resolve to walk as before.

As Ahmed continued to progress, I saw a complete change in his personality. He interacted with me, frequently joking. He would arrive in the PT waiting room and ask for me, "Sue, please." Then he greeted me with, "Quickly!" He started telling me when he felt pain, and how far he wanted to walk. When we met to re-fit him for his wheelchair, it was he who asked for the interpreter so he could tell us exactly what he wanted. It was a far cry from the young man who hardly looked at me six months earlier.

In collaboration with Ahmed's occupational therapist and the brace shop, a walker was constructed, customized to fit Ahmed's upper extremity function. Once he received his walker, he was able to walk 15 feet with minimal to moderate assistance.

Following eight long months of intensive, often painful physical therapy, Ahmed returned home at the end of August. He could walk several feet with assistance, a goal I would not have ventured to set... let alone think we could achieve. The determination of Ahmed and his family (who left their lives in the United Arab Emirates for eight months) combined with the wonderful collaboration of our team, including the International Office, Orthotics, Occupational Therapy and Dr. Zaleske's office, made this possible.

While Ahmed's family's substantial resources facilitated his rehabilitation, it was his family's belief and hope that got him there. As a mentor of mine told me in my first year of practice, "When you stop learning... get out of the field." At the time I don't think I ever believed how *much* I could learn from my patients and their families, and how valuable those lessons would be.

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

When I finished this narrative I thought, what a wonderful, unexpected outcome for this family. Sue's skill and expertise allowed this family to achieve goals she herself didn't think possible. Given Ahmed's very limited range of motion, Sue worked with him, despite a language barrier, to improve his function and quality of life. Despite her own serious doubts about Ahmed's ability to progress, Sue worked tirelessly to ensure that he reached his fullest potential. And in so doing, she won his trust and friendship.

Imagine yourself in a foreign land, unable to speak the language, battling pain, and in the care of people you don't know. Wouldn't you want someone like Sue to be your physical therapist, and advocate?

Thank-you, Sue.

## Enhancing patient safety through teamwork solutions



### Leadership seminar features John J. Nance

**O**n September 28, 2001, the department of Radiology sponsored the seminar, "Enhancing patient safety through teamwork solutions," presented by, John J. Nance, veteran of the US Air Force and aviation analyst for ABC and *Good Morning America*. Nance, who has served on numerous patient safety committees, spoke to an audience of nurses, radiologists, radiologic technologists, and administrators about his experiences in aviation and how they relate to patient safety.

### 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

## Clinical Recognition Program

*The Fielding the Issues section of Caring Headlines is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions, or concerns presented by staff at various meetings and venues throughout the hospital.*

**Question:** What is the Clinical Recognition Program?

**Jeanette:** The PCS Clinical Recognition Program is designed to make clinical excellence at MGH visible and to celebrate all levels of clinical practice. The program will recognize and reward clinical expertise. And by articulating the attributes of clinical excellence, the program will serve as a foundation for professional development. Four principles guided the process for recognizing clinical practice:

- We recognize that the essential contribution clinicians make to clinical practice is the direct care they provide to patients and families, but we value contributions to clinical practice beyond direct patient care.
- We believe clinicians acquire knowledge and skill over time. Learning is achieved through experiences with patients, collaboration with colleagues and leaders, and formal education.
- We recognize the uniqueness of each discipline that contributes to the care and positive outcomes of patients. We recognize the need for each discipline to shape the

recognition model in ways that are flexible, dynamic and reflect the values and needs of the organization, their profession and the individual.

- We believe that clinician's contributions to the care of patients and families should be recognized and celebrated. This program will recognize individual performance, team contributions and organizational effectiveness.

**Question:** Where did the idea for a clinical recognition program come from?

**Jeanette:** Through open forums, staff meetings and The Staff Satisfaction Survey, clinicians throughout PCS expressed a desire for a program that recognizes and rewards clinical expertise.

**Question:** What is the program based on?

**Jeanette:** The theoretical framework of the program is skill acquisition, based on the work of Drs. Hubert and Stuart Dreyfus. This theory says that in the acquisition of skill, an individual moves from a reliance on rules and guidelines to intuitive decision making. This theory is the theoretical framework for several disciplines. The Professional Develop-

ment Committee also received consultation from two researchers: Laurie Hack, PT, PhD, from Temple University, shared her research on Expert Practice in Physical Therapy; and Benner Associates provided guidance with narrative-analysis and skill acquisition.

**Question:** How was the program developed?

**Jeanette:** Through careful review of more than 100 narratives written by clinicians within PCS, consultations with Richard and Patricia Benner, and discipline-specific focus groups, the committee was able to identify three themes of practice. They are: clinician-patient relationships; clinical knowledge and decision-making; and teamwork/collaboration.

From here, each discipline validated the levels and attributes of practice for each of these themes through focus groups and interviews with clinicians in their respective disciplines. This completed the work of the Professional Development Committee.

**Question:** What are the four levels of practice?

**Jeanette:** Entry-level, clinician-level, advanced clinician, and clinical scholar.

**Question:** How will the program be implemented?

**Jeanette:** A Clinical Recognition Steering Committee has been convened and charged with implementation of the program. This multidisciplinary group of clinicians and leadership divided into five groups to address key areas surrounding implementation.

*The Structure and Process group* will look at issues such as elements of the portfolio and composition of the review board. *The Clinician Education group* will address how more than 2,500 clinicians will learn about the program. *The Clinical Leadership group* will address how managers and directors can coach staff through the program. *The Clinical Resource group* will educate highly skilled clinicians so they can serve as resources to others. *The Marketing group* will look at creating ways to keep clinicians informed about the program. The work of all these groups will be reviewed by the Steering Committee, which will make recommendations to me for approval.

**Question:** Is the program mandatory?

**Jeanette:** Advancement to the advanced clinician or clinical scholar level is voluntary. Advancement to clinician level occurs at the unit or department level, and is managed by the unit manager or director.

**Question:** How will I know what level I should apply for?

**Jeanette:** The Clinician Education group is developing tools to assist clinicians in identifying their level of practice. After reviewing this material, clinicians should discuss with their managers or directors what level of practice they're considering applying for. Following this interaction, the clinician will prepare a portfolio to be submitted to a review board. The clinician will meet with the board, who will determine if the applicant meets the requirements for that level.

**Question:** What is included in the portfolio?

**Jeanette:** The Structure and Process group is completing their recommendation on what should be included in the portfolio. It is anticipated that it will include a resume, endorsement letter(s) from peers and colleagues, and a narrative. Clinicians applying for the advanced clinician or clinical scholar level will participate in an interview with members of the review board.

**Question:** How can I get more information on the program?

**Jeanette:** Articles will appear in *Caring Headlines*, and there will be a variety of forums and publications to keep you informed as we move forward. You can also consult with your manager or director.

## AMMP Scholarship and Recognition Luncheon

On Thursday, September 20, 2001, in the Wellman Conference Room, friends and members of the Association of Multi-Cultural Members of Partners (AMMP), came together to recognize distinguished employees (past and present) and present certificates to the 2001 AMMP scholarship recipients. AMMP chairperson, Ron Greene, RN, presided over the ceremony, infusing a welcome spirit of patriotism and solidarity.

Scholarships went to: Nedjey Cassamajor, Wanda Velasquez, Ingrid Beckles, Jacquelyn Flowers, Marina Marke, Dolores Kershaw, Ingrid John, and Cheryl Joseph. Certain members were singled out for special recognition, including: Maria Bloch, La-Dawn Hicks, Wanda Velasquez, Gilbert Arenaza, Jacquelyn Flowers, Cassandra Jones, Kathleen Hackett, Helen Witherpoon, Catherine Deely, and Jahanara Sachedina. Loretta Holliday was named Member of the Year. Henry Ryan, Patricia Beckles, Suzanne Culver, Kim Clarke, and Gaiel Thompson were also recognized.



AMMP chairperson, Ron Greene, presents award to Ingrid Beckles at 2001 Annual AMMP Scholarship and Recognition Luncheon.

### Jeanette Ives Erickson

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representative, Harriett Stanley, who chairs the Joint Committee on Health Care. It is so important that our representatives in the political arena understand the work that we do, the challenges we face, and the government support we need to be successful. This was a real opportunity to educate and influence our state policymakers.

Our break-out sessions continue to yield innovative ideas for strategies around retention and recruitment, diversity, marketing, collaborative governance, and our professional practice model. I will keep you informed as new ideas and initiatives are implemented.

On October 31, 2001, MGH and the MGPO will co-sponsor a hospital-wide Quality and Patient Safety Retreat to discuss strategies for developing enhanced working relationships among nurses, therapists, physicians, other caregivers, administrators and the newly established Office of Quality and Safety. Outcomes will be reported in a future issue of *Caring Headlines*.

You may have read in a recent issue of the *MGH Hotline* that Joan Sapir has taken over as vice president for Neurosciences and Pediatrics, and Jean Elrick, MD, is replacing Michael Jelinek, MD, as senior vice president for Admini-

stration. We look forward to working with both Joan and Jean as we cultivate new opportunities to collaborate.

#### Updates

Two additions to our PCS leadership team are: Priscilla Gazarian, RN, MS, the new clinical nurse specialist for Phillips House 20 and 22. Priscilla comes to us via intermediate and critical care units at Brigham and Women's Hospital and the Deaconess Hospital in Waltham.

Marian Jeffries, RN, MSN, NP, is the new clinical nurse specialist for the Ellison 19 Thoracic Surgery Unit. Marian has many years of thoracic nursing as well as nurse manager experience here at MGH.

Welcome, Marian and Priscilla.

### Pediatric Memorial Service

Dedicated to the families of children who have died in MGH pediatric, neonatal, pediatric intensive care, and labor and delivery units. The service is an opportunity for families, relatives, friends and MGH staff to come together to honor the children.

**November 4, 2001, at 2:00pm  
O'Keeffe Auditorium**

Ceremony includes readings by parents and family members, a naming ceremony, and a slide presentation. Memorial quilts will be displayed this year from November 2nd–November 5th.

### Domestic Violence Awareness Month

Programs begin promptly at noon in the Wellman Conference Room; (lunch is served at 11:45am)

**"Transforming Grief into Action"  
Thursday, October 18, 2001**

**"Domestic Violence in Lesbian, Bisexual Women and Transgendered Communities"**

**Thursday, October 25, 2001**

For more information, call Social Services at 726-2643

## The incredible power of being present

—by Ruth J. Bryan, RN, MSN, CCRN  
clinical nurse specialist

A clinical nurse specialist has many role responsibilities, including providing clinical expertise, implementing patient care initiatives, conducting research, providing staff- and patient-education, and being available for consultation. This narrative focuses on a patient situation that illustrates why I value being a clinical nurse specialist so much. One aspect of my practice that I truly love is being present and assisting in emergent situations; 'being there' with patients in crisis.

This past spring, I was consulted by a CNS colleague regarding a bedside bronchoscopy and conscious sedation (CS) on a unit that typically does not provide these procedures. Bronchoscopy is a procedure in which a tube (bronchoscope) is inserted via the nose to assess the lungs and anatomy associated with breathing. Conscious sedation is the clinical practice of providing medications (sedatives and analgesics) to relieve or minimize pain and discomfort associated with the procedure. Conscious sedation is often used in specialty procedure areas and intensive care unit settings.

As I spoke to the CNS and staff nurse on the unit, I quickly realized that this was an emergent situation; the patient was in a compromised state. According to hospital policy, conscious sedation was not to be performed on this unit, but moving this patient to a clinical site where conscious sedation could be performed was not in the patient's best interest at that moment in time.

I introduced myself to the patient, who was a 30-year-old woman from Rhode Island with recent onset of shortness of breath and a diagnosis of lung tumor. Her ability to breathe was becoming more difficult and her oxygen saturation was decreasing from 91% to 88% even with oxygen supplementation. As I spoke to her, I could sense her anxiety. I tried to relieve her stress by telling her who I was and how I was going to help her with this procedure. I explained to the staff nurse caring for her the importance of obtaining a small dose of an oral anti-anxiety medication to alleviate some of the patient's fear and anxiety before the physicians arrived to do the bronchoscopy. Working with

the staff nurse and CNS, I requested that specific equipment be readily available at the bedside. An additional oxygen flowmeter was necessary in the event we needed to manually ventilate this patient; a suction device for removal of secretions; and although a monitor was tracking her oxygen saturation, I also wanted her blood pressure monitored during the procedure.

In the meantime, I spoke quietly with the patient, asking if she had family at the hospital. She was able to communicate that her mother and sister were on their way from Rhode Island, but her husband was home sick with the flu and a temperature of 102°. She said her mother and sister were angry that her husband had chosen to stay at home. As she spoke, I could tell that this family conflict was adding to her anxiety and present health crisis.

I asked if she could put the issue of her family conflict aside and try to concentrate on herself. I reassured her that she was in good hands and that we would help her deal with her family issues after the procedure. She seemed to re-

lax a little after this conversation.

The respiratory therapist arrived with the bronchoscopy cart, and I introduced myself. Soon after, the physicians arrived. I learned that the patient had several mediastinal tumors; the concern was that one of the tumors had grown and might be encroaching on her lung or bronchus, interrupting air flow. If this was the case, she would be taken to the operating room for an emergent tumor debulking.

It was during this time that the primary physician (thoracic surgeon) explained to the patient how he was going to perform the bronchoscopy. As I had promised, I remained right there at her side throughout the procedure. I held her hand and maintained eye contact the entire time. I told her to keep looking at me. The physician administered local anesthetic to her neck in

the region of her vocal cords. It was imperative that she not move as the injection was being given; movement can cause the local anesthetic to be accidentally injected into a blood vessel, causing cardiovascular collapse or toxicity. The patient experienced a small amount of coughing at this time (her vocal cords were in spasm as a result of the local anesthetic) but it resolved quickly. Her oxygenation saturation ranged from 86% to 88% while she was receiving oxygen through the face mask. Because the mask needed to be removed during the bronchoscopy, I asked the respiratory therapist to set up a 100% blow-by tube of oxygen to provide some oxygenation to the patient during the procedure. My concern was that she wouldn't be able to tolerate much oxygen deprivation before suffering total respiratory collapse.

*continued on next page*



Ruth J. Bryan, RN, MSN, CCRN  
clinical nurse specialist

## Flu vaccination program begins November 1st

As direct care providers there are times when we question why patients choose not to comply with recommended care or treatments. We don't understand, because we know that the care or treatment being recommended would benefit the patient. It is a paradox. Yet, year after year, flu vaccination is recommended for healthcare workers across the country, and typically only 35% of all healthcare workers in America choose to be vaccinated against the flu.

Perhaps it's time to ask ourselves why we haven't been vaccinated. Flu vaccine is not active, and cannot actually cause flu. The only side effect that might be anticipated is soreness at the injection site.

Caregivers can easily pass the flu virus to others. The infectious period begins before actual symptoms appear and before most people realize they have the flu. Taking flu vaccine protects you, your patients, your co-workers, and your family. Vaccination of health care work-

—by Susan Loomis, RN  
Occupational Health Services

ers has been proven to reduce flu-related mortality among patients and minimize lost work days during the winter months.

Vaccine will be available beginning November 1, 2001, via the peer vaccination program on inpatient units and at MGH health centers. Vaccination will also be available at a booth in the Central Corridor November 1–7, from 7:00am–5:00pm. For more information, call MGH Occupational Health Services at 6-2217.

## Clinical Nurse Specialist

*continued from previous page*

I spoke to the patient and explained how the physician was preparing the bronchoscope for her exam. I reiterated what to expect, and again told her to concentrate on me, not the bronchoscope. She tolerated the initial insertion of the tube, but as it was advanced, she became tense. I had her focus on me, and I verbally guided her to slow down her breathing and concentrate solely on looking at me. I continually reinforced that she was doing a great job and that the procedure was going well and would be over shortly.

The procedure lasted about eight minutes, in which it was determined that her tumor was not restricting her airflow; her airway was reactive. She tolerated the procedure fairly well and required less oxygen after the bronchoscopy. She thanked

me profusely, saying she never would have been able to get through it without me. I was just grateful to have been able to help her so the procedure could be completed in a timely fashion.

After the procedure, I reviewed with the staff nurse what signs and symptoms he needed to watch for. Bronchodilators were to be administered every four hours. The CNS was very thankful for my collaboration in providing optimal care for this patient. It struck me that, what was 'no big deal' for me was a very concerning and problematic practice issue for the staff nurse and CNS because of their inexperience with bedside bronchoscopies. Though I appreciated their inexperience, it was the depth of their gratitude that really reminded me how

much I was able to support them in caring for this patient in an emergent situation.

This patient-focused process reinforced how valuable my assessment skills, bedside nursing practice, and clinical expertise and knowledge are as precious assets to patients, families, and caregivers across the various clinical settings. As experts, CNSs are able to connect very quickly with patients in a profound way to optimize their care and manage their needs. I am extremely proud to have been able to help this patient, and thankful that the CNS called for my consultation. She provided me with a valuable, "Ah-ha!" moment and reminded me how much I truly love patient care and how I profoundly impact both patients and nurses. It is this ability to be present in the moment and truly make a difference in people's lives that validates why nursing is so important to me.

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### Next Publication Date:

November 1, 2001



# — Educational

When/Where	Description	Contact Hours
November 1 1:30–2:30pm O’Keefe Auditorium	<b>Nursing Grand Rounds</b> This presentation will focus on, “Cultural Implications for Nursing Care at the End of Life,” presented by Carolyn Hayes, RN, nurse researcher, BWH. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
November 1 7:30–11:30am, 12:00–4:00pm VBK 401	<b>CPR—American Heart Association BLS Re-Certification for Healthcare Providers</b> 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.	---
November 1 and 2 7:30am–4:30pm Shriners Hospital Auditorium	<b>Pediatric Advanced Life Support (PALS) Provider Course</b> Limited to 45 people; registration is on a first-come, first-served basis. Fee: \$150 for Partners nurses, therapists, residents; \$225 for non-Partners nurses, therapists, residents; \$275 for physicians. For more information, call 726-8287. To register, call 726-3111.	TBA
November 2-3 8:30am–5:00pm O’Keefe Auditorium	<b>Negotiation Skills for Those not Born to the Table</b> 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. For more information, or to register, call The Center for Clinical & Professional Development at 726-3111.	TBA
November 5 8:00am–3:30pm Bigelow 13 Conference Room	<b>Management of the Burn Patient</b> This conference will assist nurses and therapist with the development of their practice related to the care of thermally injured patients. Topics will include the epidemiology and patho-physiology of burn injury; wound management; surgical treatment strategies; rehabilitation; psycho-social issues; and burn prevention. Registration is limited to 15. For more information, call The Center for Clinical & Professional Development at 726-3111.	6.9
November 5 8:00am–4:30pm O’Keefe Auditorium	<b>Managing Patients with Psychiatric Illness in the General Care Setting</b> With increasing frequency, patients with psychiatric and/or behavioral issues are being admitted to non-psychiatric units. This program targets general and critical-care staff who care for this challenging patient population. For more information, call The Center for Clinical & Professional Development at 726-3111.	7.8
November 6 7:30–8:30am Patient Family Learning Center	<b>Internet Basics: Using the World Wide Web to Enhance Your Practice</b> 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
November 7 8:00am–4:30pm VBK601	<b>Advanced Arrhythmia Interpretation Program</b> This program is designed for nurses who are competent in all aspects of arrhythmia interpretation, but wish to expand their knowledge in the areas of bundle branch blocks, and wide complex tachycardias among other topics. Pick up pre-reading packets from The Center for Clinical & Professional Development, FND645. Registration is required; call 726-3111.	7.8
November 8 8:00am–4:30pm Training Department Charles River Plaza	<b>Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other</b> 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

# Offerings —

When/Where	Description	Contact Hours
November 8 1:30–2:30pm O’Keeffe Auditorium	<b>Nursing Grand Rounds</b> This presentation will focus on, “Informed Consent in Cancer Clinical Trials,” presented by Steve Joffe, MD. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
November 9 8:00am–4:00pm VBK6	<b>CVVH Core Program</b> 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
November 12 8:00am–5:00pm O’Keeffe Auditorium November 19 8:00am–5:00pm Wellman Conference Room	<b>Advanced Cardiac Life Support (ACLS)—Provider Course</b> 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
November 13 7:30–11:30am, 12:00–4:00pm VBK 401	<b>CPR—American Heart Association BLS Re-Certification for Healthcare Providers</b> 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.	---
November 13 8:00am–12:00pm VBK 601	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> Limited to 25 people; registration is on a first-come, first-served basis. Fee: \$80 for Partners nurses, therapists, residents; \$110 for all others. For more information, call 726-8287. To register, call The Center for Clinical & Professional Development at 726-3111.	TBA
November 13 4:00–6:00pm Burr Conference Rooms	<b>Deb Wing Memorial Lecture</b> This annual lecture is given in memory of Deb Wing, an accomplished leader in neuroscience nursing at MGH. Topic will be announced at a later date. For more information, call The Center for Clinical & Professional Development at 726-3111.	TBA
November 14 8:00am–2:30pm Training Department Charles River Plaza	<b>New Graduate Nurse Development Seminar I</b> 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)
November 14 1:30–2:30pm Bigelow 4 Amphitheater	<b>OA/PCA/USA Connections</b> Continuing education session offered for patient care associates, operations associates, and unit service associates. This session is entitled, “Equipment: What You Need to Know.” Pre-registration is not required. For more information, call The Center for Clinical & Professional Development at 726-3111.	---
November 14 5:30–6:00pm networking 6:00–7:00pm presentation O’Keeffe Auditorium	<b>Advanced Practice Nurse Millennium Series</b> This new series provides an opportunity for advanced practice nurses from throughout MGH to network and attend clinical, management and professional development presentations for continuing education. This session will focus on, “Professional Connections,” presented by Ed Coakley RN, MEd, MA, MSN, Carol Camoso Markus, RN, MS, and Barbara Roberge RN, PhD. For more information, call The Center for Clinical & Professional Development at 726-3111.	---
November 15 10:00–11:30am O’Keeffe Auditorium	<b>Social Services Grand Rounds</b> “The Spiritual Dimension in Professional Practice,” presented by Thomas Yeomans, PhD, director of the Concord Institute. All staff are welcome. For more information, call 724-9115.	1.2 CEUs for social workers only
March 1 1:30–2:30pm O’Keeffe Auditorium	<b>Nursing Grand Rounds</b> This presentation will focus on, “Adverse Drug Reactions,” presented by Firdosh Pathan, RPh, and Colleen Collins, RPh. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2

## Clinical resource team and product standardization

—by Karen Miguel and Carmen Alvarez

Standardization is a fast-growing trend in healthcare facilities across America. In the Materials Management arena, a consultative approach to product standardization is proving to be an effective tool in improving quality of care while at the same time, reducing costs. Several of the nation's most influential health institutions are employing this consultative approach and reporting substantial rewards.

Our clinical resource team, comprised of clinical resource coordi-

nators, analysts and logistics coordinators, considers both clinical and financial data. This consultative approach does not dictate product choices; rather, it teaches a *process* that can be applied to any product line. Clinicians and staff of Materials Management, together with the clinical resource team, manage product changes and conversions, primarily driven by product safety, new technology, cost-saving opportunities, and contract expirations.

The basis of the approach is a carefully

crafted methodology known as, "the product management process." The clinical resource team approaches each project with an eight-step methodology. The steps are team-based, strive for continuous improvement, and are flexible to accommodate specific institutional needs. They include:

- identifying new product opportunities based on safety, new technology and cost savings
- Gathering data through research; contacting new and existing vendors

- Contacting preferred vendors
- Preliminary negotiations and projected savings
- Clinical trials and approval
- Final negotiations
- Implementation
- Monitoring success; evaluating results

The final phase of any project is evaluation, and this is done in intervals of 3, 6 and 12 months. Evaluation can occur in several ways, from evaluating financial savings to gauging user satisfaction and compliance.

Needle safety is an example of a project in which the product management process has been utilized. We developed a Sharps Injury Prevention Program, which offers safety pro-

duct alternatives and raises awareness around needle safety in the work environment.

We are always on the lookout for new ways to manage new challenges, knowing that clinical involvement and input from Materials Management are key to the success of any project.

The clinical resource team has begun to assess and prioritize hospital-wide versus corporate opportunities for utilization of time and resources.

While product decisions are always based primarily on clinical needs, standards, and quality considerations, the clinical resource team embraces a commitment to standardization opportunities and cost savings.

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## Caring

HEADLINES

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