

Caring

HEADLINES

December 5, 2002

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Medical Nursing Wants You!

Can you tell which one of these nurses is actually a recruitment poster?

(Need help? Turn to page 10)



Medical nurses staffing the Medical Nursing educational booth are (back row l-r): Nancy Holland, RN; Nancy Walsh, RN; Denise Ajewski, RN; Tracey Dimaggio, RN; Gayle Peterson, RN; Kathy DeGenova, RN; and Melissa Roddie, RN. (Front row): Maura Hines, RN; Keri Ross, RN; and Karen Murphy, RN.

MGH Patient Care Services
Working together to shape the future

MGH a leader in emergency preparedness:

Since well before the events of September 11, 2001, MGH has been a leader in disaster planning and emergency preparedness, working closely with local, state, and federal agencies to ensure a coordinated and efficient response. Since September 11th, hospitals across the country, including MGH, are re-evaluating and modifying their disaster-response plans to be more accessible and manageable in the event of an actual emergency.

The MGH Emergency Management Committee has taken several steps to ensure the hospital's readiness for any type of internal

or external disaster. One of those steps was the hiring of full-time emergency-preparedness staff person, Julia Gabaldon, who has been serving in this position since June. Gabaldon meets with senior management, department heads, and key committees to maintain an ongoing dialogue about, and make recommendations on improvements to, our disaster response strategies.

We have recently adopted a new emergency command structure, called the Hospital Emergency Incident Command System (HEICS). HEICS is an emergency management system originally developed in

California that has been used successfully by many hospitals across the country. It is a flexible, reliable, efficient system that activates only those positions required for a given crisis or disaster. The system is based on a clearly delineated chain of command; a pre-prioritized list of responses appropriate for the event; a common language to facilitate communication with internal and external agencies; accountability of participants; and a documentation component to be used for systems improvement and to assist in cost recovery. The HEICS emergency management system

helps minimize the level of chaos and confusion that usually accompany a large-scale medical emergency and optimize our opportunity to respond in an efficient, coordinated manner. To date, approximately 200 MGH employees have been trained in the HEICS management system.

MaryFran Hughes, RN, nurse manager in the ED, has been very involved in our disaster planning efforts, both within the hospital and as our representative on outside committees. MaryFran chairs The Conference of Boston Teaching Hospitals Disaster Subcommittee, which is comprised of representatives from the Boston hospitals, The Boston Emergency Management Agency, The Boston Fire Department, and Boston EMS. The group meets monthly to discuss issues, plan drills, and evaluate our readiness to respond.

Obviously, many of our preparations are centered around bioterrorism, chemical, and nuclear events. MGH is actively involved with The Boston Public Health Council Bioterrorism Surveillance Task Force, which has instituted a monitoring system of hospital em-

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



During disaster drill, November 8, 2002, team members (l-r): Erica Dee, RN, ED nurse practitioner; Chris Cabral, MD, emergency medicine resident; Pierre Borczuk, MD, ED attending physician; Michelle LaRue, ED PCA; and Maureen Beaulieu, RN, ED staff nurse, triage patient at the entrance to the Emergency Department.

Staff perceptions survey, cultural celebrations,

Question: For the past 5 years, the information from The Staff Perceptions of the Professional Practice Environment Survey has been an important method of informing you about clinicians' level of satisfaction with the professional practice environment. I heard that the survey won't be conducted in 2003. Is that true?

Jeanette: The Staff Perceptions of the Professional Practice Environment Survey will be conducted in 2003, but it will be postponed for approximately six months. Let me tell you why.

Six years ago when I was appointed senior vice president for Patient Care, I worked with the leadership of Patient Care Services to develop a vision statement and strategic plan outlining what we wanted to achieve. Today, I can honestly say that, together, we have made considerable progress in improving the profes-

sional practice environment for clinicians.

I've spent much time reflecting on what we have achieved and what we need to do to ensure that MGH remains a supportive and professional environment for clinicians.

Our vision is unchanged. But we have achieved our six original strategic goals (see shaded box). It's time to revisit our strategic plan.

In October, I led a strategic planning retreat with the Patient Care Services Executive Committee. Peter Slavin, MD, chairman and CEO of the MGPO and president-designate of MGH, joined us for part of the day. We reviewed data from the Staff Perceptions of the Professional Practice Environment Survey and patient-satisfaction data. We had in-depth discussions about what we want our future to look like.

By the end of the second day, we had iden-

tified our strategic direction for the coming year. How does this relate to the Staff Perceptions of the Professional Practice Environment Survey?

As you know, the survey measures eight organizational characteristics important to clinicians (autonomy, control over practice, relationships with physicians, teamwork, communication, conflict-management, internal work motivation, cultural sensitivity) and it

gives me insight into how we're doing in meeting our strategic goals.

Since our strategic goals are changing, it's important that we spend time communicating and implementing these goals before we ask for your input on how well we're doing.

Question: When will we learn more about the strategic initiatives?

Jeanette: We are in the process of synthesizing the outcomes of our retreat. I look forward to sharing our new strategic direction with you in the coming months and hearing your feedback and suggestions.

Question: I notice a lot of different cultural celebrations when I walk through the Main Corridor of the hospital. Can you tell me how decisions are made about which events are celebrated?

Jeanette: The PCS Diversity Steering Committee coordinates a number of events to acknowledge celebrations that are held nationally each year, such as St. Patrick's Day, Black History Month, Latino Heritage Week, etc. In 2003, with the help of many interested employees, we will be celebrating Disabilities Awareness Month (November), Asian American Awareness Month (April), and Women's History Month (March) as well. If you're interested in joining a task force to help plan or coordinate special cultural events, or if you would like to contribute an idea, please contact Deborah Washington, RN, director of Diversity at 724-7469.

Our 2002 Strategic Goals

Goal #1 Enhance communication to promote employees' understanding of organizational imperatives and their involvement in clinical decisions affecting their practice.

Goal #2 Promote a professional practice model that is responsive to essential requirements of patients, staff, and the organization.

Goal #3 Assure appropriate allocation of resources and equitable, competitive salaries.

Goal #4 Position nurses, therapists, social workers and chaplains to have a strong voice in issues affecting patient care outcomes.

Goal #5 Provide quality patient care within a cost-effective delivery system.

Goal #6 Foster diversity of staff and create culturally-competent care strategies supporting the local and international patients we serve.

Jeanette Ives Erickson

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ergency departments to help identify the onset of a bioterrorist event and alert infection-control teams.

The Conference of Boston Teaching Hospitals Disaster Subcommittee, working collab-

oratively, has identified minimum guidelines for preparedness to chemical hazards, and is currently designing training programs for clinical and non-clinical staff.

On November 8th, MGH participated in a

citywide drill to test our response to a crisis involving a 'dirty bomb' (an explosive with radioactive material). Our disaster response team did an outstanding job, and independent evaluators gave us high grades on our performance.

For more than 20 years, MGH has been a leader in disaster planning in this city. In that

time, we have learned many lessons and formed strong relationships with public-health and public-safety agencies. No one can predict or anticipate a medical disaster. But I agree with MaryFran, a knowledgeable and informed nurse leader, who said recently, "The relationships we've formed and the level of sophistica-

tion we've achieved around disaster planning will be our greatest strength in the event of an emergency. I'm comforted knowing that I'm surrounded by so many individuals who are committed to the safety of our hospital and our community."

I think we can all find comfort in that knowledge.

Managing Patients' Complaints: a look at the work of the Office of Patient Advocacy

On Thursday, November 14, 2002, Sally Millar, RN, director of the Office of Patient Advocacy, presented, "Managing Patients' Complaints," at a meeting of the Association of Multicultural Members of Partners (AMMP). Millar set the stage for her presentation by giving an overview of some key trends that have emerged over the past few years. Patient census and acuity have risen significantly; average employee workload is greater; and the average length of stay has decreased dramatically. "All of these factors," said Millar, "have an impact on the work of the Office of Patient Advocacy."

Before sharing specific (anonymous) case studies, Millar explained that the purpose of the Office of Patient Advocacy (OPPA) is to serve as liaison between patients and the organization as patients share their expressions of commendation or concern to ensure that moral, ethical, operational, and patient-care standards are upheld.

The day-to-day work and interactions of the OPPA staff bring value to the hospital

beyond the resolution of individual complaints and concerns. Said Millar, the work of OPPA provides added value in the form of:

- Providing objective representation in a neutral, non-threatening manner on issues brought to the office by patients, families, visitors, and/or staff.
- Providing guidance to patients, families, visitors, and/or staff on patient rights and responsibilities, and organizational ethics.
- Building versatile mechanisms for effecting change when it is needed based on input from our customers.
- Establishing formal support strategies that empower staff to manage commendations and/or concerns on the unit level.

Some assumptions that guide the work of OPPA are that:

- People want to be heard
- People want to know that we care
- People want us to do the right thing (for them)
- People want to make sure that if something negative happened to them, it doesn't happen to someone else

- People want to feel important

OPPA offers some guidelines for addressing patient concerns. These guidelines can be useful for staff in all settings:

- Acknowledge the patient's issue
- Reply promptly
- If it is appropriate, apologize for the experience
- Determine what resolution the patient is seeking
- Conduct an investigation (report event to the Patient Care Assessment Committee and/or the Service Quality Assurance Committee, if it is appropriate)
- Follow up with the patient regarding the results of the investigation.

Millar explained that issues brought to the Office of Patient Advocacy range in severity from serious to mun-

dane, but all issues need to be addressed with care and respect. Millar suggests:

- Listening and empathizing with the person
- Apologizing, when appropriate. Even saying something like, "I'm sorry you had this experience," can go a long way toward reducing bad feelings.
- Finding a solution, and involving the person in achieving that solution
- Doing something special to restore a positive relationship.
- Thanking the person

- Following up when the resolution is achieved (if it is not immediate)

"What is clear from the feedback we receive in the Office of Patient Advocacy," said Millar, "is that our clinicians go to great lengths to provide quality, problem-free care to all our patients."

For more information on managing patient complaints, please call the Office of Patient Advocacy at 726-3370.

For more information about AMMP or to inquire about membership, please send e-mails to: phsampp@partners.org.



Sally Millar, RN, director of the Office of Patient Advocacy, presents at recent meeting of the Association of Multicultural Members of Partners (AMMP).

Changing our perceptions of individuals with disabilities

Accompanied by their service dogs, Keela and Homer, speakers, Barbara Ceconi, president of Access Umbrella, and Kurt Kuss, educational trainer, presented, "How We Perceive Individuals with Disabilities," at Nursing Grand Rounds on Thursday, November 14, 2002. Both blind, Ceconi and Kuss talked about the subtle prejudices that exist toward people with disabilities, and how we need to be proactive in changing our perspective both

out in the world and in the workplace.

"Most people aren't completely comfortable interacting with disabled individuals," said Kuss. "It doesn't make us bad people. It just means we need to be proactive in adopting a different way of thinking about things." To demonstrate, Kuss engaged participants in an interactive game of 'Us-and-Them.'

Holding up little toy figures, Kuss created a make-believe scenario for each toy person and asked audience mem-

bers to label them 'Us' or 'Them.' He described people who were deaf, blind, mentally ill, or paraplegic. Each time, audience members said, 'Them.' Then he amended the descriptions, making them family members, best friends, or temporarily disabled by an injury. Instantly, they became one of 'Us.'

"Nothing about them changed," said Kuss, "except our perception of them."

This is an important lesson to learn as we embark on our own journeys to 'change our per-

ceptions of individuals with disabilities.'

Some other salient points of Kuss and Ceconi's presentation included:

- Remember that a person with a disability is a person first!
- Treat every individual with courtesy and respect.
- Use common sense in your interactions with disabled people; but if you don't know something... ask!
- If you ask a question, listen to the answer and take it to heart.
- Be aware of the language you use. Such phrases as 'wheelchair bound' can seem prejudicial.
- Remember that there

are ranges of disability within every disability (levels of deafness, degrees of mobility, etc.)

- Know what accommodations your patients with disabilities may need (help getting changed, help giving a urine sample, help reading and signing forms).
- When caring for a blind person, describe sights, procedures, activities, etc. Include colors and sizes in your descriptions in case the patient may need to relay the descriptions to someone at home.
- Know what resources are available in the hospital to assist individuals with disabilities.
- Give people options. Let the individual who has the disability decide what's best for him or her (elevator vs. stairs; wheelchair; physical assistance; etc.)
- If a disability is still new, remember that there is a time of grief/mourning as the person comes to grips with his or her loss of independence.

The December 5th Nursing Grand Rounds will address "Hiring Individuals with Disabilities." Rounds are held on the first and third Thursdays of the month at 1:30pm in O'Keeffe Auditorium. For more information, call The Center for Clinical & Professional Development at 6-3111.



Kurt Kuss and Barbara Ceconi talk about the "Us-Them" syndrome during recent Nursing Grand Rounds that dealt with, "How We Perceive Individuals with Disabilities."

Psychiatric CNS Consultation Service

—by Robin Lipkis-Orlando, RN,
nurse manager, Blake 11 Psychiatric Unit

In an effort to improve access to psychiatric care for patients on medical units, to improve the experience of clinicians caring for patients with psychiatric and behavioral issues, and to enhance medical and psychiatric bed capacity, a new pilot program has been introduced on five units in the hospital. The Psychiatric Clinical Nurse Specialist Consultation Service pilot program began in June of 2002. Units participating in the pilot are: Bigelow 11, and White 8,

9, 10, and 11.

To meet the goals of the program, four psychiatric clinical nurse specialists are working staggered hours, including weekends, to respond to referrals from staff. Referrals can be made to request a mental status assessment, a safety assessment, to help clinicians develop and implement behavioral contracts with patients, to help educate staff about psychological care to medically ill patients, or to assist teams in making decisions that facilitate patient transi-

tions. Any clinician who encounters a patient whose reactions, responses, or behaviors challenge their skill beyond their level of comfort may call for a psychiatric nursing consultation.

The CNSs participating in the pilot are Barbara Guire, RN; Jenny Repper-Delisi, RN; Mary Lussier-Cushing, RN; and Monique Mitchell, RN. Each CNS brings a unique perspective from previous positions at MGH and/or other institutions. Each brings a

wealth of psychiatric nursing experience to this new role.

The success of the Psychiatric Clinical Nurse Specialist Consultation Service will depend on strong collaborative practice with unit-based CNSs, nurse managers, the multidisciplinary teams on each medical unit, and the department of Psychiatry consult service. Already, there have been a number of patient-care conferences to discuss managing patients in restraints, patients in withdrawal from alcohol or other substances, patients with end-of-life issues, and patients with behavioral problems. Working directly with staff nurses on each unit,

psychiatric CNSs have helped develop treatment plans that incorporate psychological and behavioral interventions and support the complexity of care that staff provide 24 hours a day, 7 days a week.

The psychiatric CNS's involvement in assessing and treating patients with profound medical illness and concomitant psychiatric illness allows patients to remain on medication with additional psychiatric support, or if medically stable, allows for discussions with case managers and other members of the treatment team about options for transfer to a psychiatric setting. This coordinated care model enhances our ability to provide patients with the most appropriate care in the most appropriate place.

Feedback about The Psychiatric Clinical Nurse Specialist Consultation Service pilot program has been very positive, including comments such as, "Your expert assessment and assistance not only supported our patients, but supported those of us striving to provide quality nursing care," and, "You are an accepted group among our staff. Staff always takes the initiative to call."

This is how partnerships in caring are created. For more information, call 4-9110.



Nurse manager, Robin Lipkis-Orlando, RN (second from right), with members of The Psychiatric Clinical Nurse Specialist Consultation Service pilot program (l-r): Monique Mitchell, RN; Jenny Repper-Delisi, RN; Barbara Guire, RN; and Mary Lussier-Cushing, RN.

Nurses and house staff working together to improve patient care

Every June a new group of residents comes to MGH to continue their education. This is when their education moves beyond books and labs to the day-to-day accountability of actually caring for patients. Working alongside these residents and fellows are members of the interdisciplinary healthcare team. But perhaps no group works more closely with new house staff than nurses.

Together, nurses and house staff work to ensure the best possible outcomes for patients and families. They chal-

lenge, teach, and support one another from the moment new house staff arrive, always driving each other to be and do better. But even considering the amount of time that nurses and residents spend together, gaps can exist in their understanding of one another's practice.

In an effort to close that gap, Theresa Gallivan, RN, associate chief nurse, and Hasan Bazari, MD, director of the Residency Training Program, came up with an idea to bring these two groups closer together.

Based on the belief that communication is the key to understanding, a monthly lunch meeting was established where nurses and residents come together to address issues that impact patient care and collaborative practice.

Since the fall of 1999, a group of staff nurses and nurse managers from the general medical units, and house staff have met every month to discuss general and specific issues affecting their daily practice. The group has discussed and resolved

issues such as:

- nurses and physicians rounding together to ensure coordinated development of the patient's plan of care and to prevent nurses from having to page physicians out of rounds later
- methods of ensuring timely and appropriate blood draws
- the development of orientation materials for house staff and nurses
- having photographs of nursing staff on the units to help house staff in identifying unfamiliar faces.

Says Jeremy Abramson, MD, "House staff-nursing relationships are of paramount importance in being able to provide the finest medical care to our patients. The ability of nurses

and residents to maintain open communication is also an important factor in nurse and house-staff satisfaction. These meetings allow us to raise issues and resolve them early."

Amy Sozanski, RN, staff nurse on White 8, says, "The committee promotes communication and collaboration. Both groups gain a greater understanding of each other's issues and concerns."

Meetings are held on the fourth Thursday of every month from 12–12:30 in the Bigelow 10 Conference Room. Meetings are open to medical house staff and general medical nurses. For more information, please contact Mary Ellin Smith, RN, at 4-5801.



At a recent lunch meeting, are (l-r): Michelle Ciaramaglia, RN; Andrea Kelley, RN; Keith Perlberg, RN; Jeremy Abramson, MD; Eran Zacks, MD; and Andrew Yee, MD.

New graduate nurse cares for dying patient

My name is Maura Neville, and I am a staff nurse on the White 11 Medical Unit. As a new graduate nurse, I was hired by MGH to work on a Urology Unit, but shortly after I started, the unit was changed to General Medicine. When the announcement came that the unit would be changing, many nurses had to decide whether to move to the new Urology service or remain on White 11 and practice in general medicine. Many of the nurses I worked with had been urology nurses throughout their entire careers. Some did decide to explore other specialties within the hospital, and some chose to stay. I was one of the nurses who stayed.

After the change to general medicine, I was apprehensive about the patients I would be encountering on our unit. Would I be able to care for this patient population? At times it was overwhelming to think about managing patients with multiple and varied medical problems and complex psychosocial issues. But it was a challenge I was up for.

About a month after the transition, I was assigned to care for Mr. T, an elderly patient with multi-system failure who was expected to die that day. As I received report on Mr. T, I wasn't able to absorb any more information other than the fact that he was actively dying. I felt uncomfortable and afraid of what it would be like to care

for a patient in the last moments of his life.

When I went in to assess Mr. T, his breathing was shallow and labored. When I put my hand on his chest, I could feel fluid rumble in his lungs. His eyes were closed and he didn't respond when I spoke his name. However, when I touched his wrist to take his pulse, he reached for my hand. Mr. T continued to hold my hand as if to say, "Please don't leave me alone."

It being my first time caring for a dying patient, I asked the clinical nurse specialist (CNS) for guidance. I felt like I should be doing something more to change the situation and help Mr. T. As a nurse, it was difficult for me to switch from working toward making a patient well to not intervening when someone is so close to death. The CNS came into Mr. T's room and assured me that I was, in fact, doing the right thing. Just being with the patient and letting him know that he wasn't alone was the best thing I could do. Eventually, Mr. T's breathing became slower and each breath seemed as though it would be his last. I stood next to Mr. T, leaned over his bed, and began talking quietly to him. I also



Maura Neville, RN,
staff nurse, White 11

began to cry. After Mr. T died, I stood in his room in awe of what I had just experienced. I had never witnessed such an incredible moment before.

Performing post-mortem care is a humbling task. It made me realize how important it is to care for someone after they've died the same way you would if they were alive. It reinforced for me that being a nurse is not limited to performing activities that contribute to health, it's also helping someone to have a peaceful death.

It has been eight months since White 11 became a medical unit, and my experience with Mr. T has been one of many that have challenged me. Caring for Mr. T was demanding emotionally, but the experience taught me a lot. I am no longer wary of caring for dying patients. I consider it an honor.

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

In this narrative, Maura shares a paradigm moment in her career. What she is describing is the power of *presence*. When Maura first met Mr. T, she worried she had nothing to offer him—no intervention to heal him, no magic pill. With the guidance of her CNS, Maura realized she did have something to give: her presence. She held Mr. T's hand, cried with him, comforted him, and stayed with him.

Maura's description of post-mortem care is important. The respect and dignity with which we care for a person after he dies is part of our contract to deliver the highest quality, compassionate care. I'm sure Maura will reflect on this experience often throughout her career.

Thank-you, Maura

Call for Portfolios PCS Clinical Recognition Program

The Patient Care Services Clinical Recognition Program is now accepting portfolios for advanced clinicians and clinical scholars. Portfolios may be submitted at any time; determinations will be made within three months of submission.

Refer to the <http://pcs.mgh.harvard.edu/> website for more details and application materials, or speak with your manager or director.

Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6.

For more information, call 6-3111.

‘Simple acts of nursing’ bring comfort and support

*M*y name is Karen Ward and I have been an oncology nurse for four years. I have worked on the Ellison 14 Oncology-Bone Marrow Transplant Unit, and for the past 18 months on the Bigelow 12 Infusion Unit. As an oncology nurse on Bigelow 12, I not only manage patients’ medical needs, but I strive to connect with them on an emotional level as well. It was during my time on Bigelow 12 that I had the pleasure of meeting Mary and Tom.

Mary was my first primary patient in the outpatient setting. I met her and Tom for the first time in January of 2001. She was a 68-year-old woman with endometrial cancer. She was in clinic for her first cycle of chemotherapy with carboplatin/taxol/adriamycin. I’ll never forget walking into her room and seeing her. She was wearing a vibrantly colored sweater and her hair and make-up were *just so*. She had the most beautiful eyes that looked so serene. She smiled with her eyes. I couldn’t help thinking: “How could this be my patient? She doesn’t even look sick.”

As I introduced myself, I saw that peaceful look in her eyes turn to

fear. When I asked, “How are you? Are you okay?” she understandably began to cry. I spent some time with her and Tom teaching her about her chemotherapy and potential side-effects; her antiemetic regimen; and what her typical visits with me would be like. Mary showed such strength, but through her tears, I also saw a fragile woman.

For the next four months, I saw Mary and Tom every three weeks for Mary’s chemotherapy. It was during these four months that I really got to know her and the simple things that meant so much to her. She spoke proudly of her three children, Kathy, Steven, and Liz; her grandchildren; how she and Tom met. She shared stories about the four years they had lived in Hong Kong, her love of singing, and even her taste for Thai food. These conversations and a sharing of feelings helped our relationship develop. Our relationship became more than illness and treatment.

After Mary’s first four cycles of chemotherapy, she began weekly carboplatin and radiation therapy. She did well with this, but after only a few months, she began to have headaches and had a seizure at

home. Her cancer had spread to her brain. Her oncologist confirmed this with me. When he gave me the news, I cried. I knew this meant that Mary’s prognosis was poor. The relationship we had formed was much more than patient/nurse, but it wasn’t until this moment that I fully understood that. I thought: “How could I have let this happen? What was I thinking? Or *was* I thinking?” The simple answer was yes, I knew what getting into this relationship could mean. As an oncology nurse, I’m sometimes afraid to get too close to my patients. I know I won’t have this kind of emotional connection with all my patients, but every once in while you meet someone and can’t help but let them into your life. That was Mary, and by extension, Tom and their family.

In addition to continuing Mary’s treatment, I knew we had to make the time she had left quality time. She began whole brain radiation therapy and more chemotherapy. This was very taxing on her body, and she was beginning to have more symptoms: intractable nausea and vomiting, headaches, and some memory loss. Even with all of these side-effects, Mary kept



Karen Ward, RN,
staff nurse, Bigelow 12

a positive outlook. She tried to keep life as ‘normal’ as possible. After a long day of radiation and chemotherapy, she still found the energy to visit with her daughter, Liz, and granddaughter, Katie, for what she referred to as her, ‘Katie fix.’ As time moved on, Mary’s cancer continued to progress to her adrenal glands, lungs, and bones. She continued to fight with all she had. Her doctor, social worker, and I continued to support her through all her decisions, keeping her best interests in mind. We had two meetings with Mary and Tom about the things they wanted to do before she died. We asked the difficult questions, like: Were there things she needed to say or share with her children before she was unable to speak? Mary and Tom were both very receptive to these discussions, but still wanted to pursue any treatment that held hope.

By December of 2001, Mary’s symptoms worsened. She became increasingly difficult to care for at home, and Tom became more concerned for her safety. With their consent, we set them up with a VNA bridge program. We chose a bridge program because it would provide care for Mary at home and when the time came that she needed hospice, the same agency would be able to continue her care. After meeting with the VNA nurse at home, Mary came into clinic and told me she didn’t want the bridge program. She felt it was too much, having someone associated with her illness at home with her all day. Between physical therapy and the VNA nurse, by afternoon, she was exhausted and felt she hadn’t accomplished anything. She also felt she wasn’t ready for hospice. I spent a lot of time with her and Tom explaining that although

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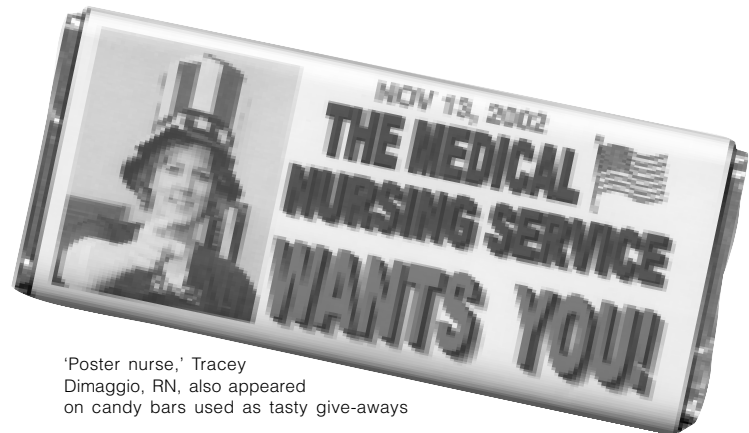
Celebrating medical nursing at MGH

When you're proud of what you do; when you're good at what you do; and when you want everybody to know it, it's time for a celebration! That was the motivation of the Medical Nurse Group in planning a special day to showcase their work and accomplishments.

The Medical Nurse Group is comprised of staff nurses from each of the general medical units (Bigelow 11, Ellison 16, Blake 7, Phillips 20, Phillips 21, White 8, White 9, White

10, and White 11) and the Medical Intensive Care Unit (MICU).

Members of the Medical Nurse Group wanted to do something to promote the image of medical nursing, to educate MGH employees and the public about the role of medical nurses, and to more clearly define medical nursing as a nursing specialty. Toward that end, the group decided to designate a special day to showcase the many aspects of medical nursing at MGH. That day was Wednesday, November 13, 2002.



'Poster nurse,' Tracey Dimaggio, RN, also appeared on candy bars used as tasty give-aways

The Medical Nurse Group staffed an educational table in the Main Corridor and displayed posters reflective of their work and the complex field in which they practice.

Some of the posters focused on:

- Statistics on medical nursing at MGH
- Unit-specific highlights of past year's accomplishments
- Collaboration between units
- Medical nurse development programs (including the New Graduate-Mentor Program, etc.)
- A history of nursing at MGH
- Patient education (including handouts on common diagnoses such as hypertension and diabetes)
- Reflections of medical

nursing practice through clinical narratives

Medical nurses work in general medical units and in the Medical Intensive Care Unit. They care for some of the sickest patients in the hospital, and often for patients who suffer from multiple, complex medical problems.

Says Kate Barba, RN, medical clinical nurse specialist, "Medical nursing is one of the most rewarding professions a person can choose, and we just wanted to get the word out. The event was a huge success; hundreds of employees and visitors stopped by. I think we reached a lot of people."

For more information about medical nursing at MGH, call Kate Barba, RN, clinical nurse specialist, at 6-2754 or Adele Keelley, RN, nurse manager, at 6-2594.



A passer-by stops by the Medical Nursing educational booth and poster display in the Main Lobby on November 13, 2002.

Precepting surgical technologists

On October 19, 2002, the Massachusetts State Assembly of the Association of Surgical Technologists (AST) held its annual meeting at Mercy Hospital in Springfield. MGH surgical technologist, Ted Todd, CST, interim orientation coordinator in the Main OR, and Jayne MacPherson, CST, clinical director of the Surgical Technologist Program at Bunker Hill Community College, spoke about the importance of precepting surgical technologists. Todd and MacPherson are both active in the AST—MacPherson serves as vice-president and editor of the AST newsletter, *A Stitch in Time*; Todd is AST secretary.

Todd and MacPherson's presentation addressed the principles of precepting surgical

—by Ted Todd, CST, surgical technologist and interim orientation coordinator in the Main OR

technologists, including students in their clinical rotations, new graduates, and newly hired surgical technologists. MacPherson

Many students embarking on a new career in Surgical Technology come from diverse backgrounds. The OR set-

The goal of the program is to nurture versatile, productive, satisfied practitioners who've had broad-based exposure to the multifaceted aspects of an exceedingly complex, high-tech environment.

son described the experience of students at the clinical site and the working relationships that exist between the clinical director of the college, and the coordinator, preceptors, and support staff at the hospital. Accurate, ongoing, consistent communication is crucial.

Support is another key factor in the success of the program.

ting is new and strange to them; the tasks can seem overwhelming. It is essential that preceptors and support staff are not only knowledgeable, but patient, sensitive, supportive, and consistent.

Todd followed with: "Up and Running: Precepting with a Purpose." Todd focused on the new graduate-newly hired surgical technolo-

gists, their training and orientation. He described the newly evolving orientation program currently being implemented for new graduate surgical technologists and registered nurses in the OR. The program, called the Novice Block Program, is based on the adult-learning theory put forth by Patricia Benner, RN, in her book, *Novice to Expert*. Benner describes performance at the novice, intermediate, and expert levels.

The Novice Block Program in the OR is built on this theory that takes into consideration the different stages of learning and skill-acquisition of new graduates. The year-long program focuses on novice capabilities and supports practitioners as they develop their service-specific skills to the intermediate and expert levels. The goal of the program is to nurture versatile, productive,

satisfied practitioners who've had broad-based exposure to the multifaceted aspects of an exceedingly complex, high-tech environment.

One of the advantages of the Novice Block Program is its potential for recruitment and retention. When students first hear about the program, they like the idea that they will experience a high degree of independence while enjoying the support and guidance of the precepting team.

The Novice Block Program is a work in progress, constantly changing to meet the needs of new students and new hires. But Todd, his fellow coordinators, the clinical staff, clinical nurse specialists, and nurse managers are confident the program is working.

For more information about The Novice Block Program, e-mail Ted Todd at etodd@partners.org.

No Home for the Holidays: Ethical Issues in the Care of Homeless Persons

Sponsored by the MGH Ethics Task Force

Moderator: Susan Warchal, RN, BS,
chair of the MGH Emergency Department Ethics Committee

Panel Members:

Linda Kane, MSW, social worker, Emergency Department
Caroline Melia, RN, MS, advance practice nurse, St. Francis House
James O'Connell, MD, Boston Health Care for the Homeless

**Friday, December 13, 2002
12:00–1:00pm**

Sweet Room, Gray-Bigelow 4

Bring a lunch. Beverages, chips and dessert will be provided

For more information, call 6-3111.

Domestic Violence Vigil

The MGH Chaplaincy, HAVEN, The Employee Assistance Program, and Police & Security invite you to attend the Annual Domestic Violence Vigil.

**Friday, December 6, 2002
12:15pm
in the MGH Chapel**

Please come to remember those who have died as a result of domestic violence, and to commit ourselves to creating a community where all people are safe.

A light pick-up lunch will be provided.

For more information, call the Chaplaincy at 6-2220

New role: clinical nurse specialist in ethics

—by Ellen M. Robinson RN, PhD
clinical nurse specialist, CCPD

A new role has been created in The Center for Clinical and Professional Development: clinical nurse specialist in ethics. The role promises to provide great opportunities for clinicians in Patient Care Services to enhance their knowledge, comfort, and skill in identifying and analyzing issues that trouble them as they go about the business of providing care to patients and families. I assumed this new role in September, and hope to be able to bring a more programmatic approach to our work around ethical issues, focus on new strategies to support practice, and tap into the resources of the CCPD to develop new programs and integrate this work into existing programs as appropriate.

Healthcare ethics can be defined as a discipline that provides clinicians with the theoretical background and tools necessary to help identify ethical issues in practice, usually as they relate to specific patient cases. An understanding of theories and analytical strategies gives us a 'language' that lends clarity to our discussions of ethical issues. Once this understanding

is achieved, clinicians, patients, and families can begin to explore alternatives to ensure the patient's well-being. In health care, this process is best accomplished through inter-disciplinary participation. Each discipline has a unique philosophical perspective and knowledge base essential to a holistic approach to the patient's medical condition and the impact of that condition on his or her life.

In today's world, ethical questions have become commonplace. Technological advances in science and medicine have produced a plethora of treatment options for individuals at every stage of life. For many, these options are both life-saving and life-giving, and carry the added gift of enhanced quality of life. For others, this may not be the case.

Decisions about how best to use technology to enhance the physical, psycho-social, and spiritual lives of patients and families are complex. Often the answers are not readily apparent. Healthcare ethics assists clinicians, patients, families, and researchers to achieve more rationality in determining the appropriateness of various technologies for

each individual situation. When applied in an inter-disciplinary model, each profession contributes a philosophical perspective, which when shared, often results in a synergy of strategies that are creative, sound, and provide untold benefit in the individual patient-family situation.

As a clinical nurse specialist in ethics, my goals are to develop new approaches to learning, contribute to staff's awareness regarding ethics resources, and help staff feel comfortable identifying and facilitating alternatives spurred by ethical issues in their practice. Currently at MGH, opportunities exist for clinicians to enhance their knowledge of clinical ethics through events and seminars coordinated by the Ethics Task Force, the Ethics in Clinical Practice Committee, or unit-based ethics rounds. Some clinicians have developed expertise in ethics as a result of their involvement with these groups, or through participation in the MGH Optimum Care Committee, the Pediatric Bioethics Committee and other groups.

Through continued efforts in education,

consultation and committee work, the focus of my work will be to assist clinicians to integrate ethical sensitivity and decision-making into their daily practice. This will be manifested through an increased comfort in representing their concerns about patients' cases at the inter-disciplinary table. Clinicians, particularly nurses, can become more confident in, and trusting of, their ethical sensitivity. Often, when a clinician experiences a sense of moral distress, it is a signal for the need for inter-disciplinary review. Sometimes, perceived ethical problems can be resolved through team and family meetings. Others might require more sophisticated consultation to identify ethical issues and alternatives. A coordinated approach to ethics education from the CCPD will be a first step in moving toward this staff-oriented goal.

Today, ethics is part of everyday clinical practice. Knowledge of theories and approaches to ethical analysis is accessible and understandable and should be part of every healthcare professional's clinical preparation.

Consider the work of the PCS Ethics in Clinical Practice Committee where clinicians of all disciplines have had the opportunity to learn, discuss, and collaborate on projects that have enlightened thinking and integrated ethics into practice throughout the institution. Contributions to policy-development and education are but a few of the achievements of this committee. In the role of clinical nurse specialist in ethics, I will strive to assist staff in building their clinical skills in ethics, which ultimately will better serve the patients and families in our care. I look forward to this journey with all of you.



Ellen Robinson, RN
clinical nurse specialist

Ellison 16 PCAs receive Excellence in Action Award

Peter Slavin, MD, chairman and CEO of the MGPO and president-designate of MGH, paid a special visit to Ellison 16 on Thursday, November 21, 2002, to present an Excellence in Action Award to the unit's team of patient care associates.

Co-nominated by Norma Gerton, RN, nurse manager, and Alan Goostray, clinical service coordinator for Perioperative Nursing, the team was recognized for their commitment to quality patient care, their support and pre-

ceptoring of new employees, and for the part they play in creating an atmosphere of collegiality on the unit. Said Slavin, "I want to recognize the patient care associates of Ellison Sixteen for their abounding energy and for the important contributions they make to patient care on a daily basis. You go that extra mile to ensure that our patients' experience at MGH is a positive one."

The Excellence in Action Award program began in January, 2001, as a collaborative

project between the MGH Service Improvement Program and Human Resources. Awards are given monthly by Slavin and Britain Nicholson, MD, chief medical officer.

Says Mary Cunningham, coordinator of the program, "Employees in all roles and positions who demonstrate the highest caliber of care and service are eligible for the award. This recognition helps make the contributions of staff at all levels visible."

For more information, call 4-1004.



Peter Slavin, MD, chairman and CEO of the MGPO and president-designate of MGH with (l-r): Lillian Kahn; Jennifer Lunetta; Norma Gerton, RN, nurse manager; Emmanuella Valcimond; Foos Sheikahmed; Toni-Ann Pedi; Theresa Gallivan, RN, associate chief nurse; and Carola Benjamen.
PCAs not pictured: Blossom Beckford, Elsa Powell, Pedro Torres, and Viviane Wade.

Educational Offerings and Event Calendar now available on-line

The Center for Clinical & Professional Development lists educational offerings at:
<http://pcs.mgh.harvard.edu>

For more information or to register for any program, call the Center at 6-3111.

Chaplaincy offers Buddhist meditation sittings

The MGH Chaplaincy offers monthly Buddhist meditation sittings in the Chapel on the third Thursday of every month, from 2:00-2:30pm.

For more information, call 6-2220

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For more information, call: 617-724-1746.

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December 19, 2002



Exemplar (Karen Ward)

continued from page 9

this program had hospice attached to it, it didn't mean we were giving up on her; she would still come in to clinic to see me for chemotherapy. I spent the rest of the afternoon reinstating her VNA bridge program. I made sure all her visits with PT and nursing were scheduled together in the morning so she was able to have some time to do the things she wanted during the day. After having time to think about what had happened, I realized how frightened she was becoming of dying.

All the hard work, team meetings, and asking the difficult questions paid off. During one of her next visits to the clinic, Mary told me how she had been talking to her children and Tom about things she might not have, had we not had our meeting. She shared that she had given a piece of jewelry to one of her daughters, a piece she wanted her to have after she was gone. Mary was taking slow steps toward finalizing important things in her life, but keeping in mind that she was not giving up. I had such a great feeling of accomplishment after hearing about the things she was doing. I thought to myself: What would she or Tom have done had we not discussed these

important issues? Would they have been as prepared?

Mary was hospitalized not long after this. It was during this last hospitalization that I began to see that fragile woman again. We had one last family meeting where we told Mary there was no chemotherapy or radiation therapy that would stop her cancer now. She understood what this meant. Her main concern was her husband. I recall her turning to Tom with sad eyes and saying, "I'll be okay, but what about you?" I was amazed at the timing of her comment. At a time when you'd think she would only be concerned with her own pain and suffering, she was still giving to others. Her concern for her husband was no surprise to me. They had a wonderful bond of love and friendship, and their understanding of each other went beyond words. As a newlywed myself, I admired the enduring sense of love and commitment they still had so many years into their relationship.

Because of the support of her medical team and her family, Mary was coming to terms with her own death. We had allowed her the time to do this. By the end of the meet-

ing we had learned of Mary and Tom's wish for her to be at home with their family. On her last day in the hospital, I spent some quality time alone with Mary. We expressed our feelings for each other. It was a very difficult moment for both of us. I think, in our minds we both thought we probably wouldn't see each other again. As I got up to leave, she said, "The next time I'm here, I promise I'll come and visit you." And I believe she has kept her promise to me. It was a warm feeling I had leaving her that day. I knew that because of the hard work of her medical team, she was able to comfortably go home and spend her last few days with the people she loved. Mary died a few days later at home, surrounded by her family.

I attended Mary's wake the following Sunday. As I approached the family, I was overwhelmed with feelings. Other nurses may be able to relate to this experience. I was introduced to many people and many others just approached me. They were all "so happy to finally meet me" and "had heard so much about me." Though I only knew a small number of them, I felt as if they all knew me. I was received with such warmth. I thought attending this wake was a simple, respectful act, but it was obviously more than

that for Mary's friends and family.

I continue to keep in touch with Tom and Liz. When I spend time with them, I think of how it was because of Mary that I was able to meet this amazing family, and I wish she could be here. I know how much she would love to be with us, and in some ways, I think she is. Tom and Liz frequently thank me for all I do for them, but I often have to stop and thank them for what they've given me. Their friendship is very special. Patients and families don't realize that although we give something to them, they give so much in return. I feel privileged to have cared for Mary and her family, and to have shared this experience with them. It's not easy for me to describe how my relationship with Mary and her family impacted me both as an individual and as a nurse. I try to bring some of the lessons I learned from her into my daily practice. It was Mary and her family that brought me to appreciate what a pivotal role we play in the care of our patients. A month before our final good-bye, Mary and Tom gave me a beautiful pin for Christmas. It's from one of Mary's favorite places. I wear the pin every day at work. When I look at it, I think of them. I think that what we may perceive as simple acts of

nursing are much more than that to our patients. Thank you, Mary.

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

Every day at MGH clinicians are intimately involved in the lives of their patients and families. Many clinicians worry that they might become too involved and lose their professional objectivity. As I read this narrative, I thought about an article written by Patricia Benner recently on, "Creating Compassionate Institutions that Foster Agency and Respect" (*American Journal of Critical Care*, March, 2002). In it, Benner talks about the role of the "compassionate stranger." The compassionate stranger is one "who responds to the tragedy of others out of compassion and solidarity with the tragedies inherent in the human condition."

Karen worked with Mary and her family to help them come to grips with Mary's impending death and maximize the time they had left together. She asked the 'tough questions' and accompanied them on this journey despite her own very real pain at the loss of this remarkable woman.

This is a wonderful narrative. Thank-you, Karen.

Educational Offerings

December 5, 2002

When/Where	Description	Contact Hours
December 16 8:00am–2:00pm	CPR—American Heart Association BLS Certification VBK 601	---
December 17 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
December 19 10:00–11:30am	Social Services Grand Rounds “Examples of Short-Term Dynamic Psychotherapy: Treating Affective Phobias,” O’Keeffe Auditorium. For more information, call 724-9115.	CEUs for social workers only
December 19 8:00–11:15am	Intermediate Arrhythmias Haber Conference Room	3.9
December 19 12:15–4:30pm	Pacing : Advanced Concepts Haber Conference Room	5.1
December 19 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
January 2 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
January 2 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
January 6, 7, 13, 14, 21, 22 7:30am–4:00pm	ICU Consortium Critical Care in the New Millennium: Core Program TBA	45.1 for completing all six days
January 6 and 23 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
January 8 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
January 8 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
January 9 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
January 14 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
January 16 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
January 16 10:00–11:30am	Social Services Grand Rounds “The Treatment of ADHD in Adults.” For more information, call 724-9115.	CEUs for social workers only
January 22 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
January 24 8:00am–4:00pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
January 24 8:00am–4:30pm	Psychological Complications of Pregnancy and Postpartum Shriners Auditorium	TBA

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111. For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

OB Family Education Program

On Tuesday mornings at 10:00am the hallway begins to fill with strollers and the sound of babies cooing. The Mommy and Me Group is about to begin. This post-partum

support group, part of the OB Family Education Program, started in March, 2002, and has been a wonderful addition to the OB services

—by Lori Pugsley, RN,
OB Family Education coordinator

provided at MGH. Once a week, a group of new and veteran mothers meets to share the joys and challenges of caring for infants, toddlers,

and even older children. The forum offers first-time mothers an opportunity to ask questions, seek support, share stories, and see that they're not alone in struggling to meet the challenges of caring for a new baby.

Mothers bring their babies to group meetings, some as young as a week old. Mothers are often surprised at how demanding caring for a new baby can be. Hearing other mothers talk about their frustrations, sleepless nights, new discoveries, advice, and parenting strategies is a comfort during this time of great adjustment. Mothers are able to watch each other's children grow and change from week to week while they themselves learn and become more confident in their own parenting skills. Says one mother, "I look forward to Mommy and

Me meetings every week."

To celebrate the success of the program, the group had a special picnic by the Charles on a beautiful day in September. Eleven mothers and babies participated in the celebration. For one mother it was the first time out of the house since giving birth. For others it was a chance to celebrate their first summer as a parent.

The journey into motherhood is challenging. The nurturing and encouragement provided by the Mommy and Me support group helps mothers feel confident along the way. Many mothers have developed friendships and support networks outside the group.

For more information about the OB Family Education Program, call 726-4312.

Members of the Mommy and Me support group enjoy a picnic on the Charles.



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