

# Caring

HEADLINES

January 3, 2002

## Winter 2001 Macaluso Awards

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Just when you thought it couldn't get any better, any more inspiring, any more *powerful*, five clinicians with their collective wisdom, grace, and insight come together and shatter that misconception! That is what the

Stephanie M. Macaluso, RN, Expertise in Clinical Practice Awards have become—an exercise in shattering the limits of excellence.

The winter, 2001, Macaluso award recipients are: Clare Beck, RN; Anita Carew, RN; Robert Goulet, RRT; Kristen Jacobsen, SLP; and Thomas Lynch, RN. In a ceremony that delivered many memorable moments,

there was much laughter, more than a few tears, and an auditorium brimming with pride!

In a departure from past Macaluso award ceremonies, this year, senior vice president for Patient Care, Jeanette Ives Erickson, RN, invited a panel of representatives from Patient Care Services to dis-

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Senior vice president for Patient Care, Jeanette Ives Erickson, RN (center), with Macaluso recipients (l-r): Anita Carew, RN; Tom Lynch, RN; Kristen Jacobsen, SLP; Clare Beck, RN; and Robert Goulet, RRT

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



Clare Beck, RN, BSN,  
staff nurse, Surgical Intensive Care Unit

## About Clare...

*Clare is a graduate of the MGH School of Nursing; she received her BSN from the University of Massachusetts, and has been a critical-care nurse for 26 years. A valued preceptor and mentor, she understands the need to stay curious and relentless in the pursuit of excellence.*

*When the GRACU and RICU merged several years ago, Clare developed a thoracic surgery reference guide to assist staff who had not cared for this patient population before. She is deeply committed to quality and safety in the health-care setting. For the past ten years, Clare has coordinated the quality-improvement initiatives in the SICU. When collaborative governance was introduced, Clare became one of the first co-chairs of the Quality Committee. Her commitment and dedication to what is best for patients has been well demonstrated. She empowers clinicians with knowledge and information that heighten their awareness of opportunities to improve the care and outcomes for patients.*

## Clinical Narrative

*M*y name is Clare Beck, and I have been a staff nurse in the adult surgical intensive care units at MGH since 1980. I had many questions when I began my career in 1974 and was drawn to the intensive care environment in search of answers. Over the years, I have come to find that the questions themselves are the real draw.

I met Mrs. X on a Sunday morning. Her primary nurse was off for the weekend, and I was unfamiliar with her case. I had just finished orienting a new staff nurse and had not been 'on my own' for more than two months. Mrs. X was a middle-aged woman who had suffered a motor-vehicle collision. Her two school-aged

children had also been injured in the accident. Her 20-day ICU course included surgical repair of a hip fracture, placement of halo traction to stabilize a C-2 cervical fracture, embolization of a vertebral artery dissection, and aggressive management of a closed head injury and subarachnoid hemorrhage. The children had both been hospitalized for less serious injuries and had been discharged. The night nurse reported that the patient's husband had not called during the night and that a family visit was planned for my shift.

Before I entered the room, the questions began. *Have the children seen their mother since the accident?* No information was available about family visits. How-

ever, a Social Service note immediately after the accident stated that Mrs. X's son was 11 and her daughter was 7. I noted that the family lives in New Hampshire. I now anticipated the visit to occur between 11:00am and 2:00pm. *Should I call Mr. X to verify the visit?* Since even 'good-news' phone calls from the ICU are stressful, I decided not to disrupt the family's Sunday morning. *How is Mrs. X doing this morning?* My physical exam revealed a heavily sedated and confused patient who was able to follow simple commands and move all of her extremities. I re-oriented her to her surroundings and reassured her that she and her children were safe. I assessed her physical strength and found

her to be very weak after 20 days of bed rest. She had a normal heart rate and blood pressure, and she was receiving ventilatory support. She did not indicate that she was in pain, and she had no signs or symptoms of pain. *What does Mrs. X need?* My goals included maximizing her level of consciousness while providing pain relief and comfort, advancing her rehabilitation care, and reducing barriers to a positive family visit.

*Where do I begin?* I started by reducing the narcotic infusion dose. I hoped to decrease her somnolence and maintain comfort prior to the family visit. I consulted the orthopedic surgeon who agreed to advancing her physical activity. I organized and completed Mrs. X's 'routine' care

to avoid scheduling conflicts with the anticipated visit. At 11:00am I enlisted my colleague's help to lift Mrs. X into a cardiac chair. I removed the triadine bed from the room and replaced it with a standard hospital bed. The change would facilitate advancing Mrs. X's physical therapy. I positioned a bedside table in front of Mrs. X and placed pictures of her family within her view. I again re-oriented her to her surroundings and reminded her about her family's visit. At 11:20, her family arrived. I greeted them at the ICU entrance. I informed the family that Mrs. X was getting better and that the current plan was to reduce sedation and ventilatory support and advance physical therapy. *continued on next page*

## Narrative

*continued from page 2*

apy. I told Mr. X that if his wife responded to this plan, I expected her to be transferred from the SICU in several days and to be discharged to a rehabilitation facility within several weeks. I explained the support he and his wife would receive. Mr. X informed me that the children had seen their mother since the accident and were

not upset by the ICU environment.

*How is this family visit going?* Mr. X was surprised but happy to see his wife more awake and sitting in a chair. The children didn't seem frightened by the medical equipment. Because Mrs. X was sitting up, they could see past the halo bars. She was smiling at them. Mrs. X's son's face was at her eye level, and I provided a small step-stool to elevate her daughter to eye

level as well. The children visited for about 30 minutes relating stories about the accident and their hospitalizations. Mrs. X's son told her his sports activities were suspended; his arm was in a sling. Her daughter showed Mrs. X the stitches her doll, "Super Baby," received in the hospital. The family took a break for lunch.

*Can I do anything for these children?* I made a quick trip to the gift shop for red Tootsie

Pops and soccer and doll stickers. I told the children that their mother's recovery is helped by seeing that they are well and knowing they are going to school. I gave each child a small gift bag to acknowledge their assistance. After another brief visit the family returned to New Hampshire to prepare for the coming school week and next weekend's hospital visit. Mrs. X was transferred to a surgical unit on Wednesday, and she

was discharged to a rehabilitation facility close to her home 14 days later. I received a thank-you note from Mr. X on Friday. *How can someone whose life has been totally disrupted be so kind?*

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

Clare's narrative does what a good narrative should do: it allows us to eavesdrop on her critical-thinking skills as she cares for Mrs. X and her family. Before Clare even met Mrs. X, she was calculating the impact of her condition on the entire family. Clare knew how frightening the SICU environment would be for the family so she greeted them outside the unit and prepared them for what they would see. She was attentive to Mrs. X's immediate needs as well as her long-term rehabilitation needs. She was keenly aware of how this family was coping, and made them part of the healing process by telling the children how important it was for mom to be able to see them. She bought lollipops and stickers to return some normalcy to their lives.

This was just a brief glimpse into Clare's care of this family, but it was a very revealing glimpse. Thank-you, Clare.



Clare Beck, RN, conducts pre-operative teaching with Nancy Hilshey, the wife of a SICU patient, in preparation for an upcoming tracheostomy.



Anita Carew, RN,  
staff nurse, Newborn Intensive Care Unit

## About Anita...

*A graduate of Massachusetts Bay Community College, Anita has practiced at MGH for 28 years; 23 of those years have been in the Newborn Intensive Care Unit (NICU). Anita is a leader. In her role as neonatal-pediatric transport coordinator, she works with colleagues from all disciplines to ensure the highest level of care for our youngest patients. Anita expertly manages complex medical situations, never forgetting that the child is part of a family, and that all members of the family are affected by the child's illness. She knows the thoughts and fears that fill parents' minds as they worry about their child. With patience and guidance, Anita works with families, helping them to participate in their child's care—measuring medications, changing dressings, feeding, and so much more.*

*During a parent's worst nightmare, Anita is there, through all the highs and lows, encouraging, interpreting, and giving hope.*

## Clinical Narrative

*M*y name is Anita Carew and I am a nurse in the Newborn Intensive Care Unit (NICU). I've seen the look many times since I started in the NICU. It is sadness on the face of a new mom when she sees her baby on the ECMO (Extraorporeal Membrane Oxygenation) circuit, instead of in a bassinet. She imagines her baby at home, swaddled and safe with a mobile hanging above. She wonders how this could be happening to her, and questions if this is really her baby. She is very quiet, and I reach up to take her hand and have her touch her baby's face. Tears come to her eyes as she realizes how seriously ill her baby is, but despite all the equipment, she can touch her precious baby. I tell her to whisper to him and

tell him she is there. I tell her to sing softly to him so he'll know 'Mommy' is close by. She's afraid she'll disturb him or disconnect a piece of equipment. I assure her that *she* is what he needs, and that human touch is better than all our equipment and machines. She gives me a little smile and starts to whisper to her baby.

A mother who has a critically ill baby does not receive those calls congratulating her on the birth. She does not open presents, receive flowers and cards. All the calls are inquiring if the baby is okay and asking what went wrong. She wonders if she did something wrong and replays the pregnancy and delivery over and over in her mind. We become fast friends because I am the person telling her that

she can touch her baby. I am the person who can see the pain she is experiencing. I am the person who, over and over again, tells her she did nothing wrong. She asks my schedule; she wants to know when I will be here. This is a NICU primary nurse.

ECMO therapy is technology at its finest for sure, but overwhelming to a mother. It has saved many of 'our babies' from meconium aspiration, primary pulmonary hypertension, and diaphragmatic hernias. For this I am always grateful. But I am a mother first, and I always feel the pain of the mothers whose babies don't survive. They stand to the left of the bedside because they know the right side is forbidden. A line is drawn on the floor on their first visit so there

will be no accidental decannulation. Nurses and perfusionists are alert for anyone who comes near the circuit, and they are reminded to please stay on the left!

Lots of rules. Mom must be thinking, "This is my baby, not yours. I can do what I want." But she doesn't dare.

This is very fresh in

my mind because for the past two weeks I was on the primary team for a baby boy with persistent pulmonary hypertension. He also had Trisomy 21 (3 homologous chromosomes per cell instead of 2). How insignificant the Trisomy 21 diagnosis is when the baby is struggling for his life. We never

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Carew with Myriam Cyr  
after the ceremony

## Narrative

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even discussed it except to say that, fortunately, he didn't have a hole in his heart as other Trisomy 21 babies sometimes do. He did have duodenal atresia, which is associated with Trisomy 21, but that was not the problem at hand. The problem was whether or not we could reverse the pulmonary hypertension by using ECMO therapy to oxygenate his tiny body while his lungs healed. When the problem became even more complicated with fluid overload, we added more technology: CVVH (continuous venous-venous hemodialysis) to try to remove some of the edema. But he did not lose fluid. His days on ECMO grew into two weeks. We began to realize he might not survive. The circuit was removed and he lost his short battle to live in less than four days. His mother was grateful to us and wrote a heartfelt thank-you card. Once again, I feel her pain and the anger of losing her baby despite all our technology.

This is a NICU primary nurse.

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

In an environment so necessarily dependent on



In the NICU, Anita Carew, RN, holds 12-day-old, Rory Farris, just hours before he is discharged. Rory's proud parents wait eagerly to take their baby home!

technology and machines as the NICU is, Anita makes sure parents know that the human touch is still the best medicine. She is absolutely tenacious in ensuring that the parental bond is formed. A veteran NICU nurse and a true professional, Anita becomes a personal escort to parents, guiding them every step of the way, no matter where their journey takes them. Newborn babies are lucky to have Anita's knowledge, skill, and experience. Their parents are lucky to have her compassion, warmth, and understanding. And we're just plain lucky to have her!

Thank-you, Anita.

### Excerpts from Myriam Cyr's Comments

*I am the proud parent of a little boy whose presence here on Earth has much to do with the exceptional care given here at MGH, and in particular, by Anita Carew.*

*We arrived in the NICU very frightened, tired and confused. We had been warned that our 28-week-old son would be covered with wires and tubes. But our first sight of Gabriel was of the tiniest baby I had ever seen, sporting the cutest little blue hand-knitted hat complete with matching diaper and booties! The wires*

*had been artfully hidden in his blankets, and peering at us from the other side of his bed was the most reassuring face we had ever encountered. Her first words to us were, "Congratulations on the birth of the cutest boy ever born!" And within seconds, this amazing woman had normalized the most abnormal of situations. We had met Anita Carew.*

*When Anita would sense that I was panicking, she would say to me, "Don't worry. There's nothing that Gabriel can throw at us that we can't fix." And I believed it.*

*She welcomed my husband and me as part of the NICU team. She took the time to explain things to us. She taught me how to care for my son, how to remain calm; she valued our opinions; she was an advocate for Gabriel. And above all, she gave us faith.*

*We knew we were in one of the best hospitals in the world. Anita confirmed it for us. She bridged the gap between medicine and life—she nursed the whole person. She was our angel!*



Robert Goulet, RRT,  
respiratory therapist, Surgical Intensive Care Unit

## About Robert...

*Bob, a graduate of Northwestern University, has practiced at MGH for 17 years. With primary responsibilities in the Surgical Intensive Care Unit, Bob is no stranger to the Newborn Intensive Care and Pediatric Intensive Care Units. He is a member of the ECMO (extracorporeal membrane oxygenation) team, and is frequently called upon to share his expertise in the OR. It's not unusual to see Bob talking quietly with a family member, standing vigil at a bedside, or being consulted by colleagues over a particularly challenging case. He makes his practice seem effortless, going about his life-saving work with little fanfare, never one to seek the spotlight. Bob believes that patients get the best care when we all work together as a team, when we share ideas, help each other, and remember that the reason we're here is to care for the patient*

## Clinical Narrative

*M*y name is Bob Goulet, and I've been a respiratory therapist at MGH for 17 years. Let me relate a little of Diana's story.

During preparations for her cousin's wedding this 21-year-old, maid-of-honor-to-be lost control of her car, passed through a bridge guard rail, and came to rest completely submerged in a tidal basin 30 feet below. Within approximately ten minutes, a passerby extricated Diana from the automobile. She was revived by the rescuer and EMTs, but an airway could not be established at the scene. Notes describe her as combative, vomiting, and breathing agonally during transport to the hospital.

In the ED, Diana was immediately intubated, mechanically ventilated, and debris she had aspir-

ated in the brackish water was suctioned from her airways. The physical exam revealed only superficial injuries, but her temperature upon arrival was only 91°. A CT-scan indicated no head trauma, but found bilateral, dependent consolidation of the lungs. After a bronchoscopy to further clear her major airways, she was transported to the SICU.

In the SICU, temporary paralysis was induced to control shivering and enable her to be mechanically ventilated. An extensive bronchoscopy was then performed to continue clearing her airways. During the first evening in the ICU, she remained stable but continued to be ventilated with 100% oxygen and a high level (15cm H<sub>2</sub>O) of positive-end expiratory pressure (PEEP) to keep her from becoming

hypoxemic (insufficient oxygenation of the blood). She was able to follow simple commands and seemed to have suffered no obvious brain damage. Having survived an auto accident and near-drowning, it appeared she would recover.

For the next three days we continued to support Diana with the ventilator, waiting for her lung function to improve. A disturbing trend began to appear: her temperature spiked daily to 103°; her chest x-rays indicated bilateral diffuse infiltrates with dependent consolidation, and she continued to require high PEEP to prevent atelectasis, though we were able to decrease the inspired oxygen level to 45%. The descriptive diagnosis of acute respiratory distress syndrome (ARDS) was now being used to categorize her poor lung function.

Sputum cultures had grown *Shewanella putrefaciens*, an organism unusual to us, but common to briny water, and several varieties of *Pseudomonas*. Infectious Disease was consulted, and specific antibiotic recommendations were followed to counter the pneumonia.

On day five, an attempt was made to decrease the ventilator-end expiratory pressure from 15 to 12cm H<sub>2</sub>O, but she became hypoxemic, so the PEEP was returned to 15. By day six it had become difficult to do routine nursing care without causing her distress. Even turning her on her side caused her to become hypoxemic, from which she was slow to recover. Despite the ordeal, Diana continued to be an excellent patient, cooperating with her caregivers, communicat-

ing with her family and friends. Calm reassurances were repeatedly given to her and explanations of her care were made prior to any interventions. For someone so young and unfamiliar with critical health care, she appeared to be coping with the ICU environment and had become friendly with many of her caregivers.

Despite changes in her antibiotic coverage, fevers continued to spike to 103°, and her chest x-rays indicated increasingly severe ARDS. On ICU day eight, the team ordered a chest CT-scan to look for any specific area of infection that could be treated. By now Diana exhibited increased signs of respiratory distress. Despite having every spontaneous breath augmented by a significant level of mechanical

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## Narrative

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ical support, she had to work hard in tandem with the ventilator to expand lungs that were poorly compliant. During transport to the CT-scan, she was ventilated on 15 PEEP and 100% oxygen via Ambu bag. However, severe oxygenation problems were encountered as she was moved in the CT suite. An ICU physician was called to help, but after an additional 20 minutes of ventilation, her SpO<sub>2</sub> could only be brought up to the low 90s. She was

rushed back to the ICU, heavily sedated, and her ventilation fully controlled. Increased ventilatory pressures were necessary to achieve barely adequate tidal volumes. We had continually encountered problems with oxygenation, but now we were having trouble eliminating carbon dioxide from her blood, which was causing her to become increasingly acidemic.

The following day found Diana chemically paralyzed, near maximal ventilatory support, with a PaCO<sub>2</sub> near 100mmHg and pH around 7.10. That day, prone position-

ing was tried in an attempt to more favorably match her pulmonary blood flow with her alveolar ventilation. No improvement was noticed. A trial of inhaled nitric oxide was then ordered. This selective pulmonary vasodilatory gas was injected into the ventilator circuit in precisely controlled amounts. From there it was carried into her lungs where it could relax the constricted pulmonary blood vessels and, hopefully, improve the diffusion of oxygen into her blood. However, no significant beneficial effect was seen.

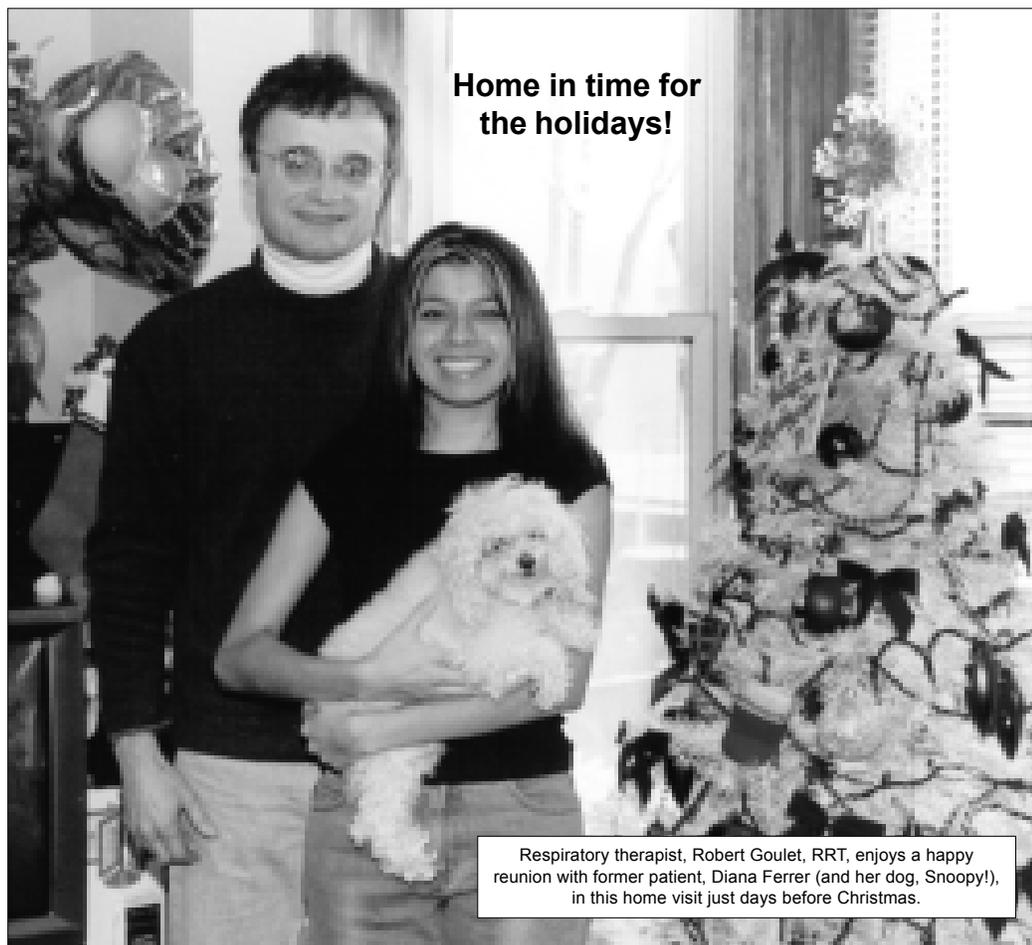
ICU day nine was the most anxious one for me. I knew that we were very near the point summed up by the phrase, 'maximal ventilatory support.' Functionally, Diana behaved as though the ARDS was still increasing in severity, yet we were near the limit of our ability to support her. The ICU attending physician and I began the day at the ventilator, where we attempted two additional maneuvers to improve her ventilation. Each maneuver briefly decreased her oxygenation, indicating we could not recruit any more functional lung tissue.

Discussion at rounds no longer revolved around improving her ventilation, it focused on preventing her from slipping further.

In a final effort to save her, Pediatric Surgery was consulted to see if they could place her on adult Extracorporeal Membrane Oxygenation (ECMO) support. The decision to offer this therapy had been delayed principally because it carried with it additional high risks and its efficacy on adults could not be predicted. ECMO has been used successfully on infants with specific lung problems since the early 80s, but its use on adults remains controversial.

By the evening of day nine, Diana's lungs were given a rest, being partially supported by the mechanical lung of the ECMO circuit. Pediatric surgeons had inserted large cannulas into her right jugular vein and left femoral vein. A portion of her blood supply was diverted at a flow of approximately 4 L/minute to the extracorporeal circuit, where a mechanical lung removed carbon dioxide from her blood and added oxygen. My assignment had changed from being a respiratory therapist in the ICU to being the therapist at Diana's bedside, responsible for monitoring and adjusting the extracorporeal support and mechanical ventilator. For the next two weeks, an ICU nurse

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### Home in time for the holidays!

Respiratory therapist, Robert Goulet, RRT, enjoys a happy reunion with former patient, Diana Ferrer (and her dog, Snoopy!), in this home visit just days before Christmas.



Kristen Jacobsen, CCC-SLP,  
speech-language pathologist

## About Kristen...

*A graduate of Saint Anselm College, Kristen received her MS in Speech-Language Pathology from the MGH Institute of Health Professions. Kristen works primarily with individuals, school-age through adult, who present with oral- and written-language deficits and/or cognitive impairments. Many of the children she treats are failing in school, having difficulty at home, and feeling a sense of increasing isolation. Kristen teaches patients and families the strategies and skills they need to successfully overcome their deficits. She advocates for patients with state and local government agencies to access needed resources. Often, by the time patients are referred to Kristen, they have exhausted their own reservoirs of patience, coping skills and hope. Kristen gives them back all of that and much more with her gentle guidance, insight, knowledge... and a smile that can break through any barrier.*

## Clinical Narrative

**M**y name is Kristen Jacobsen. During my nearly five years as a speech-language pathologist at MGH, I have had the privilege of working with many patients who come to the outpatient department seeking remediation for language and cognitive deficits acquired from an injury. Many of the patients I work with have sustained what is called a, 'mild head injury,' although the impact on their everyday lives and sense of self is anything but mild. Most of these patients bring to weekly therapy appointments a whirlwind of examples that they now have to face when trying to get from their door to my therapy door: they forgot their medications; they forgot to eat; they lost their keys; they became lost

leaving their neighborhood; and so I realize they have lost a part of themselves.

I often find myself sharing in their sadness for lost identities; yet feel grateful that they open their old, new, and feared future reflections of themselves with me. Together, with the combined efforts of family, employers, medical professionals and community services, we formulate a flexible plan that aims to reach their goal of an independent life from therapy. On a weekly basis, patients share the trials and errors they experience throughout the week, which reveal the full implications of the complex, high-level, cognitive and language deficits that can only be partially detected within the limited constraints of one-to-one communication in a small therapy

office. Patient and family feedback on the effectiveness of strategies learned in therapy for use in their daily lives can often help me to monitor and shape the plan as we move toward their goals. One afternoon two years ago, I walked with calm assurance out to the waiting room and introduced myself to a new patient, Mr. K, who taught me deeper meaning for the words teamwork, patience, perseverance and gratitude.

Mr. K is a 37-year-old police officer who sustained a mild traumatic brain injury during traffic duty when the side-view mirror of a large tractor-trailer traveling approximately 40 miles per hour, struck him to the ground. He lost consciousness briefly, sustained reduced hearing unilaterally from middle ear trauma, and a

neck and shoulder injury. He was hospitalized over night and released the following day. Head CT-scans reported negative for observable trauma. Mr. K returned home to his expecting wife and their two children, where he experienced symptoms of post-concussive syndrome, including headaches, blurry vision, and sleep deficits. Three months later, Mr. K was referred by his physician and neurologist to the MGH outpatient Speech-Language Pathology Department for cognitive therapy and job re-entry.

During our initial meeting, Mr. K initiated very little conversation and answered questions with terse, but polite, responses. During the interview and questionnaire, he reported no changes in listening, speaking, or daily-living skills that would indicate

potential attention and memory deficits. Contrary to most of my prior experiences, Mr. K did not provide cascading examples that reflected a new stranger within himself who could no longer track seemingly simple daily tasks without errors or exacerbation of headaches. Formal evaluation results revealed some attention- and information-processing problems that could significantly interfere with his communication efficacy during moderately paced, two-partner conversations in mildly distracting environments. Mr. K judged his performance as consistent with his pre-injury abilities. It was unclear to me if he was showing a lack of judgment and insight into his difficulties, which is commonly associated with head injury, or if, *continued on next page*

## Narrative

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perhaps, I had not gained his trust. He shared no hope for recovery, but indicated his only goal, “to be the first police officer in his state to return to work after an injury.” I spent some time outlining potential pathways to achieve that goal, in hopes of gaining his partnership and trust during this process. He agreed to attend therapy if it would help him return to work. After speaking with his physician and neurologist, it was decided that complete neuropsychological testing was needed to determine the full extent of difficulties and judgment, as well as job-related implications.

Mr. K commuted several hours to attend two-hour therapy sessions with me on a weekly basis. It was clear that “attending therapy” was defined by Mr. K as merely arriving to the department. He resisted engaging in tasks without extensive explanation about their purpose and relevance. I was able to surmise through our work in several sessions that Mr. K had fairly strong reasoning and problem-solving abilities, as well as fairly accurate self-rating abilities of his poor performance on attention and listening tasks. He showed improved performance when using strategies in therapy, yet he indicated that

he did not need to use the strategies in his daily life, and rating forms were rarely completed. Mr. K was reporting to me that the police chief was requesting a time line for returning to work. Yet, he would not agree to conversations about his difficulties between family members, the police chief and myself. Mr. K’s reports of experiencing no difficulties in the community were inconsistent with my clinical judgment and experiences, and I felt blind if I were to recommend him for work re-entry without his collaboration. However, I had not yet gained his trust. Although we shared the same goal, I found that my explanations of my

intentions and our necessary teamwork were dwarfed by his statement, “My speech-language pathologist stands in the way of my return to work.” I needed more than my prior protocols, professional experience and interpersonal-communication skills.

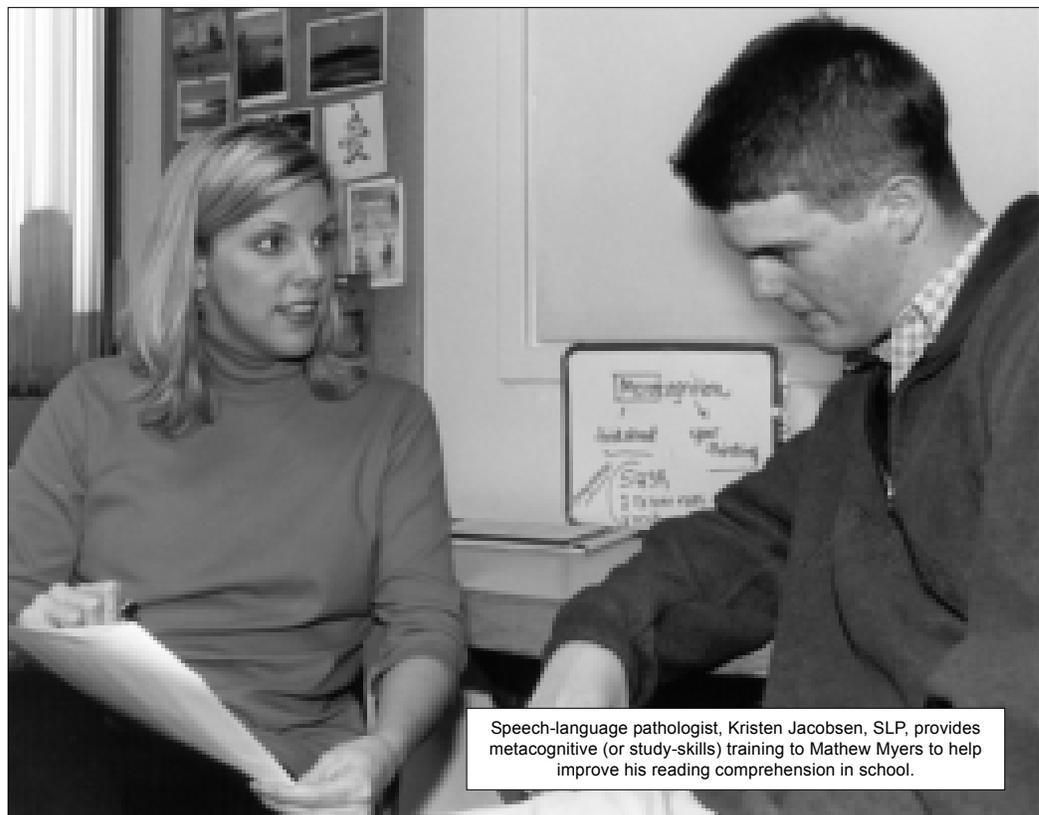
After some guidelines were clarified between Mr. K and myself, he agreed to have me conduct an on-site job-environment assessment to initiate, tentatively, the work re-entry process. Mr. K gave me a ‘tour’ so I could evaluate his work environment in a discreet manner that did not undermine his authority or trustworthiness among his colleagues. I was able to meet with the

police chief and discuss the job responsibilities during re-entry. He identified the 911 dispatching system as the first important task during re-entry. However, a new 911 computer system had been implemented during Mr. K’s medical leave. He would have to learn the new system. After watching dispatchers use this new, complex system, I felt the room spin slightly. I was concerned about Mr. K’s ability to carry out the dispatching task for an entire shift given his attention- and information-processing limitations. Fortunately, Mr. K shared my concern.

During our following sessions, Mr. K engaged in simulated 911 tasks

while employing attention and listening strategies. He actively participated in monitoring the effectiveness of his strategies and initiated new strategies to enhance his success. Mr. K began to share some of the changes he had experienced in his daily life since his injury. For example, he’d had to transfer all of the household financial responsibilities to his wife due to difficulties tracking the bills and money. His wife needed to work full-time now while he stayed at home to tend to two young children and an infant. Mr. K reported becoming overwhelmed with the children and related that tasks at home left him feeling worth-

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Speech-language pathologist, Kristen Jacobsen, SLP, provides metacognitive (or study-skills) training to Mathew Myers to help improve his reading comprehension in school.



Thomas Lynch, RN,  
staff nurse, Bigelow 11

## About Thomas...

*Tom received his BA in Philosophy from St. John's Seminary three years before receiving his AS in Nursing from Laboure College. In his 15-year nursing career, Tom has practiced in a number of settings, including: acute care, rehabilitation, and long-term care; and in many roles, such as: staff nurse, nurse manager, and supervisor.*

*But Tom found his passion caring for medical patients on Bigelow 11. Patients on general medical units present with every type of diagnosis and from all socio-economic classes and cultures. Tom is an excellent teacher and mentor. He is a role model and valued colleague. Physicians seek him out for his expert knowledge and nursing skill. He is a committed professional who always puts the needs of his patients first.*

*Even on a complex medical unit, Tom treats the whole patient: body, mind and spirit.*

## Clinical Narrative

**M**y name is Thomas Lynch and I am a nurse on Bigelow 11. Perhaps the primary reason I love general medical nursing is that one never knows what is going to happen next. We care for an infinite number of patients with an infinite number of problems, including patients with some unusual and uncommon diagnoses and complexities. We care for patients who have 'typical' types of problems, but these too have their own unique variations. For those open to the challenge, general medical nursing is its own specialty.

Mr. E is an 84-year old man who had been transferred to MGH from another hospital. He had had right and left radical neck dissections for metastatic cancer, and he'd had a laryngectomy. One

month later he had developed a subcutaneous fistula on the left side of his chest, which was treated by a resection and skin flap. He had also had a partial gastrectomy, tracheostomy, jejunostomy and a temporary salivary bypass. During the post-op period (at the referring hospital), Mr. E experienced sudden, severe substernal chest pain with supraventricular tachycardia. He was transferred to the Bigelow 11 Medical Unit to work up and rule out myocardial infarction. He arrived on our unit at about 4:00pm.

I first met Mr. E the following day. The nurse going off duty at 7:00am had had a rough night meeting Mr. E's needs and was almost apologetic passing him off to me. I reassured her that her report was fine, and it was, but it could never

have given me an accurate picture of what I found when I first saw Mr. E.

Mr. E was lying in bed with about as many attachments as I have ever seen on a general-care medical unit. He had a Salem-sump tube sutured to, and exiting, his right nostril connected to low-wall suction. In his left nostril was a salivary by-pass tube, also sutured in place. He had a tracheostomy air-line tube for O<sub>2</sub> mist. Coming off his chest were five cardiac monitoring leads, three hemovac drains from the left upper chest, and a jejunostomy tube. He had three recently stapled surgical incisions and a midline healed incision with Steri-Strips. In his left arm was a double lumen PICC catheter with Magnesium and PCA morphine attached to one port and blood

running through the other. Attached to a finger was an oxygen saturation probe. He had a Foley catheter draining. And finally, he had pneumoboots with their own tubing attached. All in all, he had some 15 tubes, lines and wires emanating from his body. To make the picture even worse, blood was oozing from several areas, including the hemovac site at the base of his neck, where the blood was trickling toward his tracheostomy. There was also a graft harvest site on Mr. E's left thigh that was bleeding. And I needed to place a second suction set-up for oral-tracheal suctioning. A less experienced person may have felt intimidated by this picture, but I had no doubt of my ability to meet Mr. E's personal, medical, and surgical needs.

Unfortunately, Mr. E was in one of the smaller rooms on the unit, and equipment was grouped around his bed in such a way that it was almost difficult to approach him. I stepped over and around some devices to get to him. I introduced myself to Mr. E, and he just sort of stared at me. Both the previous nurse and the medical resident had reported to me that Mr. E was deaf and unable to communicate. They felt he was confused and unable to be re-oriented at that time. Nevertheless, I began to tell Mr. E about my plan for him for the day, and explain the overall medical plan so far. Before I said much, he turned his head ever so slightly with a wide-eyed, "What are you saying?" look. It was then that I realized he had a hearing aid, and

*continued on next page*

## Narrative

*continued from page 10*

it was turned off. We resolved that problem quickly and at least he was able to understand what I was saying to him. Understanding *him* was still difficult as he barely moved his lips (and he had no voice as a result of his laryngectomy). He was too weak to use a pen and paper. But we made do fairly well for a while, with me talking to him and he gesturing to me.

I did a quick but thorough assessment of vital signs, comfort needs, and visual checks of all the tubes and wires. Mr. E was in pain. He needed assistance simply to hold the PCA control button, and he barely had the strength to press it. I taped the button to a tongue depressor so he could more easily grasp it. This allowed him to use the PCA more independently.

Once I was sure of his comfort, I decided to take control of the environment and do some 'interior decorating.' I completely rearranged equipment and lines, even hiding some stuff, so that on the one hand it was easy to get to Mr. E, and on the other hand, it made the environment less visibly threatening for him and his family when they visited. I expected that administering morning medications to Mr. E, taking care of his hygiene needs, and various other treatments



After changing his dressings and making him feel more comfortable, staff nurse, Tom Lynch, RN, brings a moment of levity to patient, Joseph Caracoglia

would take the better part of an hour. I had been assigned to three other patients that morning, so once I knew that Mr. E was comfortable and, for the moment, content, I attended to the needs of my other patients. Then I was able to dedicate more time to Mr. E.

I'm grateful that I work with a strong, professional nursing team on Bigelow 11. We often anticipate each other's needs and find help presenting itself, even before we look for it. My peers were more than ready to cover my other patients while I spent time with Mr. E.

While bathing and providing range-of-motion movement to Mr. E, I discovered that one reason he had been so stiff and uncomfortable was that he was afraid to move. The tubes sutured to his nose, the hemovac sutured to his chest, and the trach-tape across his neck made every slight movement excruciating. One of the first things I did was reposition and secure the tubes so they were more stable and less likely to pull on his sutures. That, coupled with enabling Mr. E to use the PCA more easily, soon brought him greater comfort. Later, I noticed he wasn't lying as stiffly and wasn't as afraid to

move. At times he actually did some active range-of-motion exercises himself.

Mr. E shared with me that one of the greatest sources of anxiety and fear for him, (in addition to being with a strange medical team in a strange environment after such a long history at the referring hospital), was his immediate fear that his comfort needs would not be met. I believe that my early and quick actions to assist his pain-control went a long way toward establishing a trusting therapeutic relationship between Mr. E and me, and through me, the rest of the staff.

As I finished bathing Mr. E, his wife, daughter and son-in-law came in. Naturally, they had much anxiety and many questions about his plan of care and how he was doing. In Mr. E's presence, I explained to them as I had earlier to Mr. E, that we were assessing his symptoms, monitoring his heart, giving him blood and following up on lab work, and I explained the purposes of all these measures. I reassured them that we were able to manage his immediate cardiac needs and current surgical interventions as well. I know that, like Mr. E, they were put at ease by my

*continued on page 13*

## Robert Goulet

*continued from page 7*

and an ECMO perfusionist, drawn from a subset of respiratory therapists, were assigned solely to Diana, operating under the direction of ICU physicians and pediatric surgeons.

Very soon after getting Diana onto ECMO we were able to decrease her blood carbon dioxide level and reduce the level of support provided by the mechanical ventilator. However, we still needed the ventilator to provide high levels of PEEP and oxygen. Our goal now was to maximize the contribution of ECMO and minimize the ventilator settings, which would give her lungs a better opportunity to heal. We had entered another phase of Diana's care, which carried risks of additional complications due to the extensive amount of equipment that was keeping her alive.

Diana's parents had been keeping a vigil at her bedside since her admission. One of them was always in the hospital. Their concern for Diana was heightened by the fact that they had lost a six-year-old daughter to illness before Diana was born. In the hours at the bedside, Diana's nurse and I offered what empathy we could, and provided explanations for questions they had. We tried provide comfort without giving them false hope. There was no way to know if Diana would survive.

Diana's lung function deteriorated further during her first two days on ECMO. It was at this stage that she probably would have succumbed to ARDS had we not been able to provide the extracorporeal support. However, by the third day of ECMO, her pulmonary status seemed to stabilize. For the next 11 days, she slowly regained lung function and we were able to reduce her

ECMO support. On ICU day 22, after being on ECMO for two weeks, the pediatric surgery team was able to remove ECMO support. Diana's lungs had improved enough so that we could support her with conventional mechanical ventilation, using a relatively low level of PEEP and 40% oxygen.

As I write this, Diana is still provided with a moderate amount of support from the mechanical ventilator. Her lungs are slowly improving, but they are in a post ARDS phase characterized by being poorly compliant and difficult to expand. She is very weak from a month of ICU care, a significant amount of which was spent while she was muscle-relaxed with chemicals that induced paralysis. Her weakness, combined with the rigidity of her lungs, continues to make it difficult for her to breathe on her own. But she continues to improve gradually and, hopefully, she'll be able to avoid further complications as she weans from the ventilator.

In addition to the physicians, nurses and therapists who function solely in the ICU, Diana continues to be seen by teams of others. Physical and occupational therapists assist her rehabilitation. Nutrition & Food Services help determine what she receives as she transitions from being fed intravenously to receiving food through a tube in her stomach.

Social Services continues to play an integral role in supporting her family. Once she is off the mechanical ventilator, Diana will spend time on a unit with different caregivers while she continues her rehabilitation. Eventually, we hope, she'll be able to walk out of MGH.

There is a special picnic that occurs nearly annually, sponsored by MGH Pediatric Surgery and organized by a collection of physicians, respiratory therapists, nurses and others at MGH. It looks no different than any other large family reunion, but it's held as a celebration for all the children and the few adults who've received ECMO therapy at MGH. It's impossible to sit on a picnic table amid the mayhem and pick out the former ECMO children from their friends or siblings who have never been seriously ill. There is one little girl who especially enjoys competing with me. Each year we head for the pool to see who can swim underwater the farthest. She's 14 years old now, and I don't have to let her beat me anymore. When she was three months old, her lungs were as diseased as Diana's, and she spent 34 days on ECMO while her family went through the same anguish that Diana's family is experiencing now. Hopefully, next summer, we'll see Diana and her family among these ECMO picnickers.

When people ask me why I've stayed at MGH for 17 years, I usually just let it go with, "Oh, it can be an interesting place to be a respiratory therapist." It's too complex to quickly summarize. I know it'll be a difficult place to leave when the time comes.

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

Diana's age and the circumstances surrounding her accident make this a very compelling narrative. But what is even more impressive is the tenacity, resourcefulness, and perseverance Bob showed in caring for this patient. He managed Diana's deteriorating and rapidly changing respiratory condition as if his own life hung in the balance. His intuitive understanding of the pathophysiology and technology drove the plan of care that ultimately led to the decision to place Diana on ECMO. Bob expertly managed this state-of-the-art technology while at the same time offering emotional support and compassion to Diana's family. Truly, Diana was fortunate to have been brought to MGH for her care. But perhaps the best thing that happened to her was that Bob Goulet became her respiratory therapist.

Thank-you Bob.

### The Employee Assistance Program

presents

#### "Single Parenting"

Presented by  
Ann Fishel, PhD, director,  
Adult Couples and Family Therapy

A growing number of women and men are raising children alone. This seminar will explore the challenges of daily life as a single parent and provide practical suggestions on how to succeed. Age-specific advice for parenting children at various stages of development will be provided.

**April 11, 2002**

**12:00–1:00pm**

**Wellman Conference Room**

For more information, call 726-6976.

## Thomas Lynch

*continued from page 11*

calm, knowledgeable and sensitive manner.

During the family's initial visit, the medical team made rounds and examined Mr. E. They took a brief opportunity to speak with and reassure the family. Unfortunately the team didn't immediately recognize how cognitively intact Mr. E was, and they tended to speak only to the family about his medical plan and what they thought Mr. E's wishes would be. The family members themselves were somewhat bewildered and anxious. They and Mr. E needed a strong, knowledgeable advocate: me. Out of earshot of the family, I informed the team that Mr. E was fully oriented and able to participate in decision-making.

We needed to find a way to communicate reliably with Mr. E. I had already paged a speech-language pathologist to see if a communication board would work for Mr. E. She met with me, reviewed his chart, and we decided that an alphabet board and a simple picture board would work for him. He was able to use these boards, and later, an electronic, artificial-voice device was provided. There was never much real dialogue with Mr. E. He was usually too fatigued to use these devices to communicate more than his im-

mediate comfort needs or to respond briefly to questions.

Mr. E's progress was somewhat confounded by his chronic renal failure. Mr. E was obviously a man with complex and tenuous medical and surgical issues that required many highly skilled, acute nursing intervention and much time. In collaborating with the medical team, I asked them to determine two critical decision points. First: In light of recent cardiac ischemia and elevated troponin, at what point do we transfer Mr. E to a more acute setting such as the step-down unit? And second: At what point would it be safe to return Mr. E to the referring hospital to complete his surgical care? The answers to these questions were related. It was felt that Mr. E's cardiac ischemia was at least partly related to the excessive oxygen demand created by his many surgical healing requirements and anemia (for which he was being transfused). It was decided that if after a sufficient monitoring, his EKG was stable, heart rate and blood pressure were well controlled, if he had no further symptoms of chest pain or ischemia, and if his troponins were trending down, then he would be able to be discharged back to the referring hospital. Conversely, instability in any of these areas would trigger consideration for transfer to a higher level of care.

Mr. E's medical and surgical problems were complex and unusual enough, in the experience of so many of my peer nurses, that I was able to do much teaching with them regarding his medical and surgical diagnoses and interventions, including management of his airway, surgical wounds and drains, comfort measures, and even how nurses can lead decision-making in medical management. I am conscious of the fact that in these teaching opportunities, as in every action I made with Mr. E, I was role-modeling fine professional nursing.

I cared for Mr. E for two days. On the second day, Mr. E met the criteria we had established for discharge back to his referring hospital. Again, I advocated for him with the medical staff regarding his continuing care and transfer. I prepared a referral and coordinated communication with the hospital. They were not

ready to receive him yet, so we monitored and cared for Mr. E for another day before he went back. I wasn't on duty when he left the next day. I regret not being able to say good-bye to him. He has a tough road ahead but a remarkable spirit to drive him. I'm proud that I was able to have a large influence in how quickly we identified and met Mr. E's immediate needs. I'm proud that I was able to establish a strong, albeit brief, therapeutic relationship with him so quickly, and in some ways more so, with his family. I know that my teaching and availability to them provided much comfort.

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

Put yourself in Mr. E's place: overwhelmed by illness, having endured multiple surgeries and

interventions, hearing-impaired, and completely at the mercy of a battery of machines. Tom walked into Mr. E's room and immediately took charge of the situation, technically, clinically, and compassionately. Driven by empathy and experience, Tom completely re-vamped Mr. E's environment to make it more functional, practical, patient-friendly and pain-free. He worked with other members of his team to develop a comprehensive plan for Mr. E, while at the same time sharing his knowledge and expertise with colleagues and less experienced clinicians to advance their practice and understanding.

Tom is a sensitive, caring, and confident nurse. We get the sense that the more complex and challenging the patient's needs are, the harder Tom pushes himself to excel. Mr. E is better off for his efforts. And so are we.

Thank-you, Tom.

### The Employee Assistance Program

presents

#### "Home-Buying"

Presented by

Robert Gray, senior mortgage originator, Harvard Credit Union

Buying a house or condominium for the first time can be an overwhelming experience. This seminar will give you an overview of the financial aspects of the purchasing process. An explanation of the steps necessary to secure a mortgage and obtain pre-qualification status will be discussed.

**March 14, 2002**

**12:00–1:00pm**

**Wellman Conference Room**

**March 7, 2002**

**12:00–1:00pm**

**8th floor—Conference Rooms A and B—Spaulding Rehab Hospital**

For more information, call 726-6976.

## Kristen Jacobsen

*continued from page 9*

less in the eyes of his family and himself. He revealed these feelings, as well as his fear that I wouldn't help him transition back to work if he admitted having problems. This was why he hadn't disclosed his difficulties at home during our initial sessions. Now he was able to talk openly about strategies that could improve his feeling of independence. He was able to demonstrate creative problem-solving strategies and monitor his use of these strategies at home so we could track his progress. He agreed to seek personal and family counseling, and communicate more freely among team members.

Finally, we were a team. Our team expanded to include Mr. K's family, the neurologist, the neuropsychologist, the counselor, an attorney, the chief of police, the town manager and me. We had open discussions for the

next year about possible job re-entry for Mr. K. Cognitive re-evaluations during therapy were consistently showing that Mr. K had made significant progress in his ability to process detailed information while listening and managing distractions and interruptions. He was able to multi-task in an organized, efficient manner. In fact, he was functioning consistently within above-average to superior ranges of cognitive abilities. Nearly two years after therapy started, the team agreed to a gradual job re-entry with partial responsibilities, part-time hours, and direct supervision under the police chief. Weekly reports completed by Mr. K, the police chief, and a colleague indicated that he exceeded all expectations for each job responsibility. Approximately three months after his discharge from therapy, I received a progress summary that indicated Mr. K was working at full capacity. There was also a note thanking me for 'being on his side.' I communi-

cated the same gratitude to Mr. K in return.

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

I don't think any of us can fully appreciate the personal, professional and emotional ramifications of sustaining a mild brain injury. Mr. K's injury robbed him of his job, his role in his family, and his hopes for the future. Kristen understood this. She knew that her interventions with Mr. K would be more than clinical—she had to gain his trust. Her visit to his workplace demonstrated her commitment to helping him re-enter the workforce and enabled him to share his fears, concerns, and the truth about his functional condition. This opened the door to a positive clinical relationship that allowed Mr. K to improve and flourish and actively participate in his own recovery.

What a happy and rewarding story. Thank-you, Kristen.

### Past and present Macaluso recipients

First award  
September 5, 1996

Stephanie Macaluso, RN

July 2, 1998

May Cadigan, RN  
Pat English, RRT  
Valerie Fullum, LICSW  
Sarah Rozehnal Ward, CCC/SLP

December 17, 1998

Maureen Beaulieu, RN  
Tessa Goldsmith, CCC/SLP  
Diana Grobman, RN  
Karen Lechner, LICSW  
Donna Slicis, RN

July 1, 1999

Rochelle Butler, LPN  
Alice Chaput, RN  
Diane Plante, PT  
Louise Sethmann, RN

January 6, 2000

Elizabeth Johnson, RN  
Sucheta Kamath, CCC/SLP  
Sandra McLaughlin, LICSW  
Freda Zuckerman, LICSW

June 15, 2000

Emilyn S. Bellavia, RN  
Mary Elizabeth McAuley, RN  
Diane McKenna-Yasek, RN  
Marica Wasenius Rie, PT

December 7, 2000

Gae Burchill, OTR/L  
Pamela DiMack, RN  
Claire Farrell, RN  
Marie Elena Gioiella, LICSW  
Irene Giorgetti, RN  
Lisa Sohl, RN  
Susan Thel, MSW

June 21, 2001

Neila Altobelli, RRT  
Constance Dahlin, RN  
Sylvia Gordon, LICSW  
Catherine O'Malley, RN

December 13, 2001

Clare Beck, RN  
Anita Carew, RN  
Robert Goulet, RRT  
Kristen Jacobsen, SLP  
Thomas Lynch, RN

### MGH Nursing Career Expo

The MGH Departments of Nursing and Human Resources invite staff nurses, CNSs, nurse managers, nurse practitioners, and new graduate nurses to come and discuss career opportunities with nurse managers, nurse educators and HR staff.

Staff nurse opportunities are available on a number of units, including critical-care units.

Two courses will be offered by The Center for Clinical & Professional Development:

**Mitral Valve Prolapse (MVP): A Case Study**  
presented by Lin-Ti Chang, RN  
12:30–1:30pm

**Chest Pain: Pulmonary Embolism vs. Angina**  
presented by Laura Sumner, RN  
2:00–3:00pm

1.2 contact hours for each course

**Sunday, January 13, 2002**  
**North and East Garden Dining Rooms**  
**12:00–4:00pm**

For more information, call 617-726-5593

### The Employee Assistance Program

presents

#### “Eldercare Planning”

Presented by  
Barbara Moscovitz, LICSW,  
MGH Senior Health

Eldercare planning can be a stressful process. There are many considerations, including decisions concerning living arrangements, access to community resources and choices that satisfy both the elderly relative and the family caregivers.

This program will define available resources, particularly around types of care and living options; and how family members can work together with elderly relatives to plan ahead to find the assistance that best suits everyone's needs.

**February 14, 2002**  
**12:00–1:00pm**  
**Wellman Conference Room**

For more information, call 726-6976.

## History and background of the Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Expertise in Clinical Practice Award. The purpose of the award is to recognize direct-care providers whose practice exemplifies the expert application of values put forth in our vision: practice which is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

The first recipient of the award, in 1996, was Stephanie M. Macaluso, RN, thoracic clinical nurse specialist. In honor of the high standards she set as an expert caregiver, the award is now known as the Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award.

Macaluso embodied the qualities and characteristics of an expert practitioner. She was known for her strong knowledge base, and intuitive skills. She knew when a clinical situation was changing even when common indicators remained unchanged. As an expert coach, she was one on whom peers relied and to whom physicians responded immediately because of her solid, proven track record of sound judgement.

Macaluso did not stand outside of a patient's realm of experience in her role as clinical teacher. Instead, she truly stood alongside patients conveying empathy and genuine concern. Macaluso's ability to be with patients in a way that acknowledged their shared humanity is

the basis of nursing as a caring practice.

Macaluso understood the relationship of health, illness and disease. It was this understanding that led her in her caring work to seek patients' stories. She knew that every illness had a story—relationships were disturbed, plans were thwarted, and symptoms became laden with meaning as to what else was going on in a patient's life.

Macaluso had the uncanny ability to put herself in touch with others and bring the encounter to an intimate level. It's hard to express how she made this contact with patients; maybe it was the way she approached them, the questions she asked, or the language she used. But somehow, they trusted that she knew what she was talking about. This trust and understanding allowed her to connect with patients and promote a sense of caring.

Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate expert practice throughout Pa-

tient Care Services. The Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award is now given twice a year. Registered nurses, occupational therapists, respiratory therapists, physical therapists, speech-language pathologists, social workers and chaplains who provide direct care are eligible for the award and may nominate co-workers whose practice exemplifies the standards described earlier.

Clinicians who are nominated submit a professional portfolio which is reviewed by a selection committee comprised of clinicians, administrators and MGH volunteers. To assist recipients in achieving both personal and professional development, recipients receive tuition and travel expenses to the professional development conference of their choice.

The Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award allows us to publicly re-commit ourselves to the high standard of care we hold for our patients, and contribute to the professional development of the clinicians within Patient Care Services.

### The Employee Assistance Program presents

#### "Estate Planning"

Presented by Jeffrey Bloom, Esq.

Seminar will provide an introduction to estate planning. Attorney, Jeffrey Bloom, will discuss the basic terms of estate planning, such as wills, power of attorney, guardianship, trust, probate, executors and administrators, and how elder care can coincide with estate planning, particularly around financing nursing home costs.

**Thursday, January 10, 2002**  
**12:00–1:00pm, Wellman Conference Room**  
For more information, call 726-6976.

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## Macaluso Award Ceremony

*continued from front cover*

Discuss the organizational impact of the Macaluso awards over the years. Panelists included: Theresa Gallivan, RN, associate chief nurse; Michael Sullivan, PT, director of Physical and Occupational Therapy; Liz Johnson, RN, staff nurse, Ellison 14; Marie Elena Gioiella, LICSW, clinical social worker; and Lillian Ananian, RN, nurse manager, Ellison 9.

Panelists reported a tangible sense of validation associated with receiving the Macaluso award. They commented that:

“The pride of receiving the award extends beyond the recipients to their colleagues and co-workers.”

“It is a reminder of the positive culture that exists at MGH.”

“It is reminder of the high standards set by Stephanie Macaluso, and an incentive to strive for excellence.”

And one panelist stressed, “Don’t be intimidated by the application process. Compiling a portfolio is an opportunity to reflect on, and better understand, your own practice. It is a powerful learning experience in its own right.”

Said Ives Erickson, “It’s important to begin to think about portfolio-development as we are about to embark on a new journey with the

implementation of our Clinical Recognition Program in just a few weeks.”

Ives Erickson presented each award individually, reading excerpts from each recipient’s portfolio and letters of nomination. Introducing Clare Beck, Ives Erickson read from a letter submitted by SICU nurse manager, Susan Tully, RN, who wrote: “Clare delivers meticulous, comprehensive care to her patients; her attention to detail has been instrumental in the recovery of countless patients. She is extremely considerate and thoughtful, and goes out of her way to do the little things that make people feel special. She constantly

challenges herself and those she works with to think differently about how they deliver care. She has taught me many valuable lessons.

“Clare represents the finest in nursing. She is an expert in the care of critically ill patients, and her tireless pursuit of excellence is extraordinary.”

Said Ives Erickson, “Clare is a nurse, a preceptor, a mentor, and an agent of change. And today, we add another descriptor to that list: Clare is a recipient of the Stephanie Macaluso Expertise in Clinical Practice Award.”

Another departure from past ceremonies came in the form of Miriam Cyr, the proud and happy mother of a newborn who was cared for in the NICU by Macaluso award recipient, Anita

Carew. In an emotional and heartfelt testimonial, Cyr shared some of the experiences she had with, “the woman whose dedication, knowledge, generosity, warmth and professionalism give new meaning to the word, nursing.” (See excerpts from Cyr’s comments on page 5.)

Reading from a letter submitted by one of Carew’s colleagues, Diana Grobman, RN, Ives Erickson said: “Anita is the ultimate teacher. As a clinician, she takes medically and socially complex patients and provides care that reflects her sensitivity and empathy. Anita gives one-hundred-and-fifty percent of herself to her families. She involves, teaches and empowers families to care for their children right from the beginning.

“Anita’s compassion for her patients extends beyond the NICU doors, as she attends baptisms and funerals at the families’ request...”

“Anita has made enormous contributions to our NICU. She meets and exceeds the values and traits of a candidate for the Stephanie Macaluso Expertise in Clinical Practice Award.”

In a curious stroke of chance, award recipient, Clare Beck, was one of those who supported respiratory therapist, Robert Goulet’s, nomination for the Macaluso award. Recounting Beck’s observations, Ives Erickson read: “Bob’s knowledge of respiratory care is truly astounding. He routinely identifies the individual needs of fragile patients and collaborates with the nurses

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Panelists (l-r): Lillian Ananian, RN, Michael Sullivan, PT, Liz Johnson, RN, Marie Elena Gioiella, LICSW, and Theresa Gallivan, RN, discuss organizational impact of The Stephanie Macaluso Expertise in Clinical Practice Awards.

# Educational Offerings

January 3, 2002

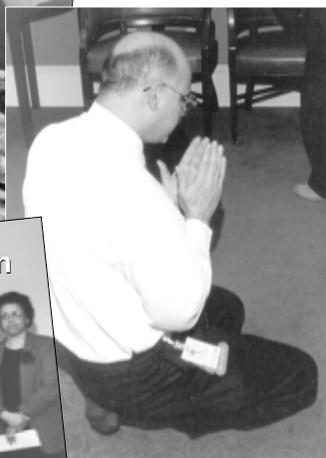
| When/Where  | Description  | Contact Hours                           |
|---|--|---|
| January 14—8:00am–5:00pm<br>January 24—8:00am–4:00pm        | <b>Advanced Cardiac Life Support (ACLS)—Provider Course</b><br>Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room  | 16.8<br>for completing both days        |
| January 14<br>8:00–10:00am, and<br>1:00–3:00pm              | <b>Management of Aggressive Behavior</b><br>Wellman Conference Room  | ---                                     |
| January 15<br>7:30–11:30am,<br>12:00–4:00pm                 | <b>CPR—American Heart Association BLS Re-Certification for Healthcare Providers</b><br>VBK 401                             | ---                                     |
| January 17<br>8:00am–4:00pm                                 | <b>CVVH Core Program</b><br>VBK6   | 6.3                                     |
| January 17<br>10:00–11:30am                                 | <b>Social Services Grand Rounds</b><br>“Caring for the Chronically Suicidal Patient.” O’Keeffe Auditorium                  | CEUs<br>for social workers only         |
| January 17<br>1:30–2:30pm                                   | <b>Nursing Grand Rounds</b><br>O’Keeffe Auditorium   | 1.2                                     |
| January 23<br>8:00am–2:30pm                                 | <b>New Graduate Nurse Development Seminar II</b><br>Training Department, Charles River Plaza                               | 5.4 (contact hours<br>for mentors only) |
| January 24<br>8:00am–4:30pm                                 | <b>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</b><br>Training Department, Charles River Plaza  | 8.1                                     |
| January 28: 7:30am–4:00pm<br>January 29: 7:30am–4:30pm      | <b>Intra-Aortic Balloon Pump Workshop</b><br>Day 1 at St. Elizabeth’s Medical Center; Day 2 at MGH (VBK6)                  | 14.4<br>for completing both days        |
| January 30<br>8:00am–12:00pm                                | <b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b><br>Wellman Conference Room                          | TBA                                     |
| January 31 and February 1<br>8:00am–4:30pm                  | <b>BLS Instructor Program</b><br>VBK601  | 13.2<br>for completing both days        |
| February 1<br>12:30–4:30pm                                  | <b>Pediatric Trauma—Part II</b><br>Wellman Conference Room   | TBA                                     |
| February 4, 5, 6, 11, 12, 13<br>7:30am–4:00pm               | <b>Critical Care in the New Millennium: Core Program</b><br>Locations vary. Call 6-3111 for information.                   | 45.1<br>for completing all six days     |
| February 4<br>8:00am–5:00pm<br>February 15<br>8:00am–4:00pm | <b>Advanced Cardiac Life Support (ACLS)—Provider Course</b><br>Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room. | 16.8<br>for completing both days        |
| February 5<br>8:00am–5:00pm                                 | <b>Chemotherapy Consortium</b><br>NEMC Wolff Auditorium  | TBA                                     |
| February 7<br>7:30–11:30am,<br>12:00–4:00pm                 | <b>CPR—American Heart Association BLS Re-Certification for Healthcare Providers</b><br>VBK 401                             | ---                                     |
| February 7<br>1:30–2:30pm                                   | <b>Nursing Grand Rounds</b><br>O’Keeffe Auditorium   | 1.2                                     |
| February 8<br>8:00–11:30am                                  | <b>Intermediate Arrhythmias</b><br>O’Keeffe Auditorium   | 3.9                                     |
| February 8<br>12:15–4:30pm                                  | <b>Pacing : Advanced Concepts</b><br>O’Keeffe Auditorium   | 5.1                                     |
| February 11<br>7:30am–4:00pm                                | <b>Diversity in Child Bearing</b><br>O’Keeffe Auditorium   | 5.1                                     |

For more information about any of the above-listed educational offerings, please call 726-3111.  
For information about Risk Management Foundation educational programs, please check the Internet at <http://www.hrm.harvard.edu>

# Peace on Earth...

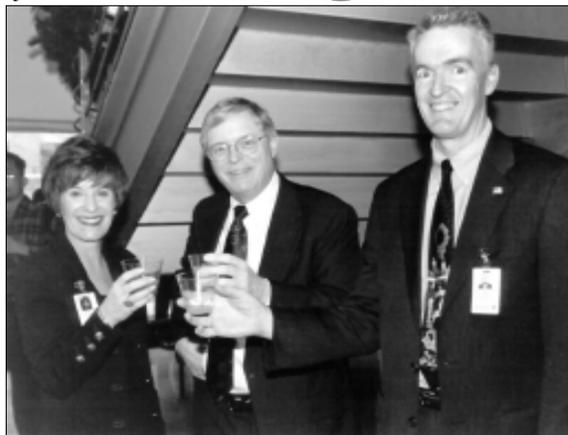


*Happy holidays from*





*Patient Care Services*



**Good will toward all.**



## Awards

*continued from page 16*

and physicians on the team to schedule treatments to support the patient's goals.

"Bob has excellent communication skills and tailors information to meet the needs of patients, families and colleagues... He always finds a way to give the best and safest care in a timely manner. He is very generous with his time, making his expertise accessible to all. Bob exemplifies expertise in clinical practice."

Speech-language pathologist, Kristen Jacobsen, SLP, was nominated by her director, Carmen Vega-Barachowitz, SLP. Ives Erickson shared some of Vega-Barach-

owitz's observations of Jacobsen's practice, including her: "impressively dynamic way of thinking about patients' problems;" her "total dedication and relentless effort;" her "powerful body of scientific insight;" and her "innovation, intellectual sophistication, creativity, technical agility, and inquisitiveness."

Vega-Barachowitz went on to write: "I frequently ask myself, 'How does she do it?' Kristen understands language and cognition and has developed a theoretical model that drives her interventions. But it is her absolute commitment to clinical practice, her passion for working with patients and families, her quest for expanded understanding, and her caring

and sincere devotion to the well-being of others that set her apart.

"I can assure you that Kristen possesses all the qualities and attributes that made Stephanie Macaluso such an extraordinary clinician. Kristen's practice is characterized by the values that we cherish and celebrate with this award."

Among many impressive letters supporting staff nurse, Tom Lynch's nomination, was one from Dr. Stephen Servoss of the department of Cardiology. Wrote Servoss: "Tom is one of the shining stars of MGH. We have shared a number of very sick patients, but one experience stands out in my mind."

In caring for an elderly male patient... "What had begun as an acute

abdomen or hypertensive urgency in many of our eyes, was, as Tom had suggested, severe bladder distention. Tom probably doesn't realize that I learned a great deal from him that evening. I saw the value of stepping back in a stressful situation to make a full assessment of an acute patient. I learned the degree of vigilance necessary to be an advocate for your patient. And I learned the value of always taking into account the patient's perspective of the near chaos that surrounds acute events in the hospital.

"Tom's compassion and reassurance toward the patient have stuck with me. There is no one I would rather have caring for me or my family than Tom Lynch."

Some recipients took the podium to say a few words of thanks; others didn't. Some recipients had known Stephanie Macaluso personally and took the opportunity to acknowledge her very real presence at this event. Others, who'd never met Stephanie but knew of her legacy, admitted to feeling humbled by receiving this award in her memory.

But all of the recipients, whether they spoke or not, made an indelible impression with their humility, their selfless acknowledgment of their colleagues and co-workers, and their steadfast insistence that what they do is 'all in a day's work.' If you didn't know better, you'd swear Stephanie reached down and hand-picked each one of them herself.

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# Caring

HEADLINES

FND125  
 MGH  
 55 Fruit Street  
 Boston, MA 02114-2696

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