

Caring

HEADLINES

July 4, 2002

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Summer 2002 Macaluso Awards

Excellence abounds at MGH. That was the message delivered by senior vice president for Patient Care, Jeanette Ives Erickson, RN, at the summer, 2002, Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards, held June 13, 2002,

in O'Keeffe Auditorium. Before introducing this year's recipients, Ives Erickson took a moment to acknowledge a change in the name of the award from 'expertise' in clinical practice, to 'excellence' in clinical practice. With the existence now of

the PCS Clinical Recognition Program and all that we have learned about the acquisition of knowledge and the evolution of clinical practice, a special review board recommended a shift in the

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Senior vice president for Patient Care, Jeanette Ives Erickson, RN (third from left), is flanked by Macaluso recipients (l-r): Sharon Brackett, RN; Marguerite Hamel-Nardozi, MSW; Mary Lou Kelleher, RN; Debra Smith, RN; and Kristin Parلمان, PT. Judith Lynch, RN (not pictured) was also a recipient.

MGH Patient Care Services
Working together to shape the future



Sharon Brackett, RN, BSN
staff nurse, Surgical Intensive Care Unit

About Sharon...

A graduate of the University of Rochester, Sharon has practiced at MGH her entire career. For the past ten years, she has been a staff nurse in the Ellison 4 Surgical Intensive Care Unit. Sharon has become an expert in the care of critically ill patients. She deftly manages the delicate titration of medications and the complex equipment that supports this critically ill population. In units like the SICU, clinicians help patients and families deal with difficult issues such as quality of life and end-of-life decisions every day. It's easy to see why Sharon was drawn to the work of the Optimum Care and Ethics in Clinical Practice committees. Her clinical knowledge, professional intuition, and compassion make her not only an excellent caregiver, but a clinician to whom others go for information and guidance. When a family in the SICU is struggling with the hardest decisions of their lives, they are fortunate to have Sharon beside them, helping them find peace.

Clinical Narrative

My name is Sharon Brackett, and I have been a nurse at MGH for 16 years, six on Baker 10/Ellison 7 and ten in the RICU/Ellison 4 SICU. In critical care nursing, accurate assessment skills, early interventions, intuition, and in-depth knowledge of the patient can make the difference and minimize or prevent complications. With increases in patient acuity, technology, and nursing responsibility, we have all had to acquire the ability to think critically in motion.

The best rewards in nursing are the bonds you form with patients and their families, understanding them as people within the context of their lives, and being able to advocate for their needs and goals. It can be difficult to accomplish this amid the hustle and bustle of tasks necessary to try to stabilize a criti-

cally ill patient. My 16 years of experience and development helped prepare me for a recent case, which tested my ability to do both at the same time.

I first took care of Melanie on New Year's Day. I came on at 7:00am and learned that I would be admitting a severely injured trauma patient within the hour. I began to assemble equipment, drug mixes, and blood warmers based on what little I knew about the patient. Melanie was in her 20s, had sustained many fractures which could not immediately be repaired due to her instability; she had a severe head injury with an intracranial monitor in place; and she'd had large blood volume requirement up until the surgery that removed her shattered spleen. She had been unstable in the operating room and was being brought to the unit following a stat head CT

due to high intracranial pressures.

On arrival to the unit Melanie was as sick as experience had told me to fear. Her heart rate was 140-160, her blood pressure on pressors and with blood transfusion was low at 80/40, and intracranial pressures were in the 40s. She was posturing, possibly seizing, and at immediate risk for cardiac arrest. It took several of us (physicians and nurses) 2 to 3 hours to get her somewhat stabilized. It took many changes and additions of medication, liters of fluid and blood, numerous ventilator changes, labs, and total sedation and paralysis of her muscles to get there.

During this time I was fielding multiple questions and having discussions with members of her numerous care teams. Though I was worried about her physiological care, I knew that somewhere there had to

be a distraught family who also needed care. The trauma nurse coordinator told me that Melanie's boyfriend, Dan, was in the waiting room. He had been with her at a party. They'd had a small argument, and she had left to go home. It was only after hours of searching that he learned about her accident.

I was worried about Dan, but knew it would be a while longer before I'd be able to let him in. I called the Emergency Department and requested the social worker on call. When she arrived, I asked a co-worker to watch Melanie, and we went out to meet Dan together. We introduced ourselves. He tearfully recalled the events of the night and explained that he had called her parents. They were flying in from out of state later in the day.

I briefly explained Melanie's condition and

assured him that I would let him see her as soon as possible. I returned to her bedside, comfortable that he was being taken care of and that the social worker would help contact his family for support.

When Dan was finally able to come in for the first time, I prepared him for what he would see. Melanie was very swollen and bruised. There were many tubes and lines. I told him Melanie would be unable to move or respond in any way due to the medications. But I told him he should talk to her anyway. I told him that if he wanted to hang photographs, we'd be glad to put them up in her room.

As we entered, I guided him to the left side of the bed where he had more room to get past the equipment, and I could comfort him while still being able to read the monitor and manage
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Narrative (Brackett)

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Melanie's constant instability. His quiet tears as he held her hand and spoke to her broke my heart. You couldn't help but shed tears with him. Her parents didn't come until long after my shift ended, but they were all in my thoughts that night.

In the next few days Melanie's condition waxed and waned. Her swings of instability were some of the worst I've seen. Her parents, soft-spoken, unobtrusive, and caring, like Dan would weep softly at the bedside, pulling at your heart. The pictures in her room showed a vibrant, smiling girl with the beauty of a model, very different from her appearance now.

While caring for Melanie, I was in the later stages of precepting a new nurse on our unit. She was up to the challenge of managing Melanie's care, but I knew she was sensitive to difficult cases. I knew getting her involved with these sweet people, whose daughter's outcome might not be good, would be difficult for her. But as a preceptor, I believe it's important to mentor staff, not only on physiological care, but on how to support patients and families through end-of-life care. It's important they know that you can find comfort and feel good at the end of the day because you helped a family find meaning and comfort from a tragic end.

We worked together to ensure that all teams regularly updated the family. We learned how Melanie and Dan had

met and lived together, how she loved watching collegiate sports, and how she had given up a job she loved after September 11th, because she worried it wasn't safe to fly. I walked my orientee and Melanie's parents through the neuro exam so we could all discuss and learn together what we saw and what it meant.

After several days, some things improved. We were able to decrease the sedation and stop the paralysis without high intracranial pressures, and she began to demonstrate single-limb withdrawal, a slight improvement. When I hugged her parents and Dan goodbye for the weekend, it was the first time there was a glimmer of hope.

My orientee was buoyed, but based on past experience, I cautioned her that things could change.

I returned on Tuesday to find that things had worsened; Melanie had required markedly increased doses of pressors to support her blood pressure; her lungs were worse; she had required massive amounts of sedation, including pentobarb coma because her intracranial pressures had gone higher than ever before.

Continued aggressive care and even resuscitation for someone this age is something many would not even question. But many things have changed during my 16 years of practice. There was a time when it was almost taboo to broach the subject of DNR status. Fortunately, today we respect patients' autonomy

and the inclusion of their goals in the plan of care, and this has led to the creation of the Limitation of Life-Sustaining Treatment Policy.

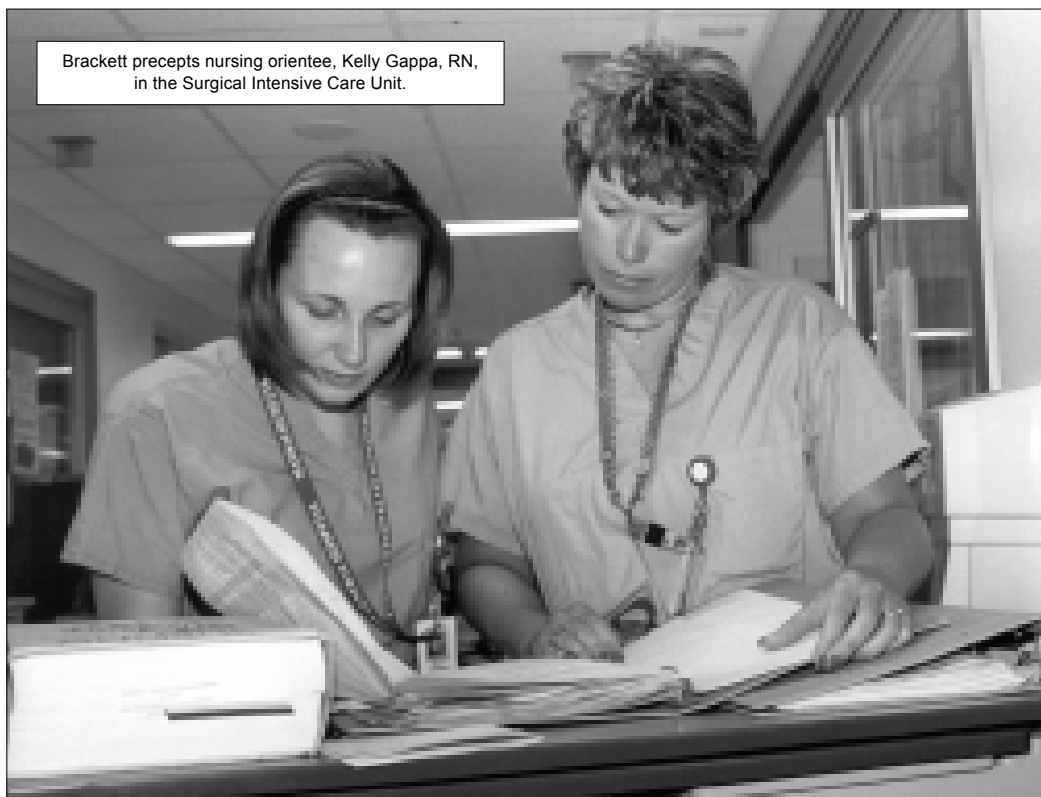
I felt we should meet as a team with Melanie's family. I brought up my thoughts in morning rounds with the multidisciplinary team. I suggested we meet (1) to prepare the family for how serious Melanie's head injury was, especially in light of the fact that her condition was continuing to worsen after a week; (2) to update them on all fronts; (3) to begin to prepare them for the fact that Melanie could die from this injury, and to discuss her goals for care and resuscitation status.

We met that afternoon in the conference room. Each service (Trauma, Rehab Medicine, Neur-

ology, Neurosurgery, and Anesthesia/Critical Care) addressed the issues that pertained to their specialty, including the fact that Melanie would require chronic care and would probably be unaware of those around her and would be unable to respond. Her parents seemed overwhelmed with all of the information. Then the attending physician asked me to speak because of my expertise in this area as a member of the Optimum Care Committee. It was such a gratifying feeling. I was used to being respected and called upon in this role as a consultant for the Optimum Care Committee, but not in my staff position. I have mentored staff on end-of-life care because of my involvement with the Optimum Care Commit-

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Brackett precepts nursing orientee, Kelly Gappa, RN, in the Surgical Intensive Care Unit.





Marguerite Hamel-Nardozzi, LICSW, MSW
clinical social worker

About Marguerite...

A graduate of Bridgewater State College, Marguerite received her MSW from Simmons College. She has practiced at MGH for five years, the last three years in the Cardiac Intensive Care and the Cardiac Surgical Intensive Care units. Any hospitalization brings with it tremendous stress and anxiety for patients and families. These emotions are heightened when a patient's condition requires admission to an ICU. As patients and families struggle to maintain hope and stave off fear, staff try to provide an environment where hope can flourish. Patients, family members and staff alike all turn to Marguerite for guidance and support. She's able to help them tap into their own inner resources. Her presence and ability to assess their needs help lessen the stress of hospitalization. Other clinicians seek her out to help them frame issues and develop interventions to assist their patients. Marguerite's knowledge, skill, and limitless patience are a comfort and a gift to patients, families and staff.

Clinical Narrative

My name is Marguerite Hamel-Nardozzi and I am a clinical social worker in the Ellison 9 CCU and Blake 8 CSICU. I have worked at MGH for the past 5 years. When introducing myself as a clinical social worker, often patients, and even staff, will ask, "What is it that you do?"

I believe one of the most valuable and challenging services I provide to my patients and their families as they face critical illness, is not so much what I "do" but my ability to "be with" them. By that I mean being fully present, witnessing with them as they bear the unbearable, tolerating the intense effect that accompanies tragic, painful loss and grief. Most times, there are things 'to do,' such as arranging family meetings with the medical team, consulting with colleagues in Chaplaincy,

Patient Advocacy and outside agencies, and providing physical comforts for the family. But the part of my job that is most challenging to me clinically and personally, is being fully present to people in pain, supporting, empathizing and guiding them as they face the ultimate pain of losing a loved one.

Mr. F was an 86-year-old man admitted to the Ellison 9 CCU from the intensive care unit of a local hospital. Mr. F was on an intra-aortic balloon pump, had been turned down for cardiac surgery, and was coming to MGH for a second opinion. Mr. F had been married for more than 60 years and had two sons and a daughter, Kerri. Kerri was her father's health care proxy and the family spokesperson.

On that first day, the whole family was present, and Mr. F's room was a hub of activity. But

for the next four weeks, the main scene in the room became Mr. F, ill, often unable to communicate, his daughter, Kerri, holding vigil by his side from morning until night.

Kerri was struggling to 'do the right thing' in advocating for and supporting her father, while reliving the experience of doing the same for her 16-year-old son, Mark, who had died of cancer 7 years before at MGH. My first encounter with Kerri was on that busy first day when I introduced myself to the family.

Kerri's first response was, "Oh, we don't need a social worker. I've done this all before," in a slightly dismissive tone.

Kerri impressed me as a person trying very hard to appear 'tough' and in command, but I could feel the anxiety and insecurity beneath the somewhat prickly exterior she presented. When a patient or family member presents with

that initial rejecting response, I have learned to respond in a way that respects their distancing yet leaves the door open. I usually reply that I want to know all the patients and families on the unit so they are aware of my availability should a need arise, and I let them know that I'll check in again.

As it turned out, the family called for my assistance later that day for help in obtaining a notary public and completing legal papers prior to Mr. F's intervention in the Cath Lab. As often happens, when receiving assistance with a specific question, Kerri saw me as a helpful ally. Now I could begin the real work of engaging her, slowly and carefully, building a relationship and assessing what she would need from me and the staff to assist her in coping with her father's critical-care stay. Mr. F was quickly deemed not a surgical

candidate. He was offered an intervention in the Cath Lab that might offer some hope for him to recover and return home. Kerri was told that if the intervention was not successful, the medical team agreed that nothing invasive or heroic should be attempted and that Mr. F's comfort and dignity would be of primary importance.

Kerri and her family had difficulty accepting this and voiced their desire for everything possible to be done. Based on Mr. F's medical condition and age, the medical team and caregivers saw a man probably at the end of his life. His family saw a man who had continued to work in his store, traveled, lived independently in the family home with his wife, and who had become ill suddenly. This family needed time and support as they went through the process of letting go,

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Narrative (Hamel-Nardozzi)

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grieving the anticipated loss of their spouse/father, and accepting the reality of his present medical state.

As she struggled with medical decisions, Kerri told me, "I want to live with memories, not regrets." She presented in a way that was very challenging for all of us. At times, she could be rude or condescending in her medical questions. She could be demanding and projected an air of entitlement. She was tall and imposing. One's natural reaction was to take a step back. And yet, as I conversed and listened to Kerri, trying to hear and understand her, I saw a very anxious woman, longing for connection and understanding for what she had endured in life and how it had affected her.

I quickly learned from Kerri that she was a breast cancer survivor, having endured surgery, chemotherapy and radiation while caring for her three young children a few years ago. She shared with me her fear of dying young and leaving her family while they still needed her. She had fought hard to remain strong for her children and husband. Then she learned her only son, 14 years old, also had cancer. Every decision along the way of Mr. F's care would reverberate within Kerri, evoking the feelings she had felt as she'd made daily decisions fighting for her son's life. She told me of her physical reaction each day as she entered MGH.

She would be filled with the sights and sounds of a bustling lobby and feel her heart begin to race. Each day, in varying ways, she relived the days, months and years of her son's illness and treatments. She recalled having to tell her son that he would lose his leg. "Can you imagine telling your fourteen-year-old boy that?" she asked.

The anger, pain and suffering of those days were superimposed on the present pain of making decisions about her father's care and facing the very possible outcome of losing him. My work with Kerri was to listen, empathize, validate her feelings, assist her in containing her anxiety and encourage

her self-care so that she could always return her focus to her father and his needs.

As I got to know Kerri, I was able to share some insights with the doctors and nurses caring for Mr. F. For example, Kerri's sometimes off-putting and demanding behavior really masked the anxiety and fear of a woman who had already endured multiple losses in life, including the ultimate loss of her child. While it had happened several years ago, it helped staff to realize that she was reliving this loss in a vivid way as she was here in the very place it had happened. I would check in with Mr. F's nurse each day, providing support and encouragement as she cared for Mr. F and in turn, Kerri. With this knowledge, nurses were responsive and open to

hearing about Kerri's inner turmoil and struggles and how it was playing out in her present interactions with them.

Kerri had often talked with me about the strong connection her father and son had shared. Three weeks into Mr. F's hospitalization I came to understand just how connected she meant. Kerri's son, Mark, had been born on Mr. and Mrs. F's wedding anniversary. Their 62nd anniversary, which would have been Mark's 23rd birthday, was fast approaching. The family had planned to come to the hospital to visit and acknowledge the wedding anniversary, and Kerri planned to visit the cemetery and bring a model motorcycle to her son's grave as she did on each birthday.

The celebration never took place as Mr. F took

a turn for the worse. The plan was to continue supportive care to Mr. F, giving him every chance to recover without any further invasive interventions. It was on that day that Kerri spoke of the day she had consented to a DNR order for her son and, "took him home to die."

She recalled his fearfulness about going to sleep, afraid he wouldn't wake up. "It's okay to sleep, I'll be here," she told him. And she recalled how he peacefully died in her arms. I told her how brave she had been and continued to be for her dad, here by his side.

It became apparent that MGH had done all they could for Mr. F, and while he continued to need intensive care, the unit at his local hospital could meet his present

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Hamel-Nardozzi (second from left), confers with Ellison 9 colleagues (l-r): Janel Dauphinais, RN; Sue Rogers, RN; and Lisa O'Neill, RN.



Mary Lou Kelleher, RN, MS
clinical nurse specialist

About Mary Lou...

A graduate of Lawrence Memorial Hospital School of Nursing, Mary Lou received her bachelor's and master's degrees from Regis College. She has practiced in a variety of roles throughout her career, including staff nurse, supervisor, manager, director, and now as pediatric clinical nurse specialist. When Mary Lou came to MGH in 1996, she was asked to do one thing—help put MGH Pediatrics on the map—and anyone who knows Mary Lou, knows she has done just that! Her bedside coaching and guidance, her collaboration with the multi-disciplinary team, the support she provides to families in crisis, her commitment to the philosophy and delivery of family-centered care have made her an indispensable member of our Pediatric team. For Mary Lou, there is no task too big or too small; no obstacle too great; no goal that cannot be achieved. For Mary Lou, there's no such thing as defeat. When you have a positive attitude, you have everything you need.

Clinical Narrative

My name is Mary Lou Kelleher and I am a pediatric clinical nurse specialist. I have been a nurse for more than 27 years and in that time I've seen my practice grow, develop, and expand. Writing this narrative is not an easy task. Describing one's practice, the core of what we do professionally as nurses, is not easy to put into words. Many people think of the word, practice, as a noun (a thing) as if it's something you can hold or touch. In reality, it's a verb (action), the combination of all our interventions, knowledge and compassion. It's what we call our work, the actions we take that people observe as 'caring.'

My practice is best described as an adverb (a word that enhances the action of a verb). In my role as clinical nurse specialist, I augment the practice of each clinical

staff nurse, assisting them to 'better define' their actions of caring. My role is to ensure that children and families receive the best possible care and that staff have the necessary tools to make this happen. My practice is wide and encompasses direct patient-care issues as well as larger programs and systems. I'd like to describe a typical day in the past month.

Every morning, our triad meets in the nurse manager's office for a cup of tea and a look at the anticipated challenges of the day. We discuss how we can assist one another and what staff may need from us. On this particular day, I was sharing with my manager and operations coordinator, my concerns for the staff of Ellison 17 who were facing the imminent death of Nathan, a little boy they had cared for over the past 6 months. My concerns arose from

the fact that the family had not been able to come to grips with a DNR order. Staff was having difficulty balancing the threat of perhaps having to provide invasive interventions for this child with their concern that Nathan have a comfortable death.

I brought up my plan to consult the Palliative Care Team for a supportive meeting for the nursing staff and any other members of the team. The triad agreed this would be a meaningful intervention. I arranged for the meeting to take place at 3:30pm so as many members of the team as possible could be present.

I make rounds daily in an effort to see as many patients and families as I can. On Ellison 18, I stop to see a family who comes 'regularly' to our hospital. Johnny has had multiple medical challenges from birth; he is now 12 years old. His mother is

his primary caregiver and is staying with him in the hospital.

When I enter the room Johnny's mom looks very tired and pale. I ask her how she's doing. She says, "Okay. His vomiting is slowing down; we're hoping to go home this afternoon." The phone rings and she engages in a conversation; I leave saying I'll return later, sensing that she needs to talk. I know from experience that when you ask a parent how she's doing and she answers in terms of her child, you need to get her to talk about the toll this is taking on her.

I scope out the unit for Johnny's social worker and have a conversation with her. We talk about the challenges of home care for Johnny and his mother's stress level. I speak with his primary nurse; she says Johnny's mother is having a hard time, she doesn't think she wants to go home. I explore why she

thinks this. She tells me that Johnny's mother has told her she's very tired and doesn't know how long she can keep doing this (caring for Johnny). I suggest a meeting with the nurse, the social worker, the case manager, the physician, Johnny's mother, and if possible, a representative from the home-care company to help support Johnny's mom and discuss plans for a successful discharge. I offer to be present; she asks me to attend.

I find out that the home-care agency won't be able to attend, but that Johnny is approved for 20 hours of nursing care a week. Unfortunately, they haven't been able to fill those nursing hours for the past three weeks. I give this information to Johnny's nurse, and we discuss how we can work with Johnny's mother to advocate for Johnny. I explain that if a company can't fill their nursing

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Narrative (Kelleher)

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hours within their own agency they are bound by law to sub-contract nurses from other agencies.

The meeting is set for 2:00 that afternoon. I rearrange my calendar to attend. 10:00am brings me back to Ellison 17 where Nathan's parents, physician, and nurse are discussing Nathan's DNR status. I sit in on the discussion. The parents are very upset, crying, looking to the physician and nurse to help them make the best decision for their child. The father asks, "What would you do if this was your son?" I see that Nathan's nurse is upset. I gently put my hand on her back so she knows that I'm there to support her as well as the family.

We explain to the family that having a DNR doesn't mean we're giving up hope. It means that we'll make the most of the time they have with Nathan, keep him as

comfortable as we can, so the remaining time can be happy time. More discussion takes place and with tears and hugs the parents agree to a plan of care and comfort for their son. When we leave the room I check with the nurse. She is at ease with the decision, but sad, as she loves this little boy. I give her time to talk and cry. I'm present for her so that she can continue to support Nathan and his family.

11:00am—Clinical Practice Management (CPM) Meeting. We discuss everything from medication issues to pediatric POE. I present the quarterly results of the Post Discharge Telephone Survey I've completed. I call 35-45% of the patients who have been discharged each month and ask them questions about the care they received. The results help guide our improvement initiatives and give us

positive as well as constructive feedback. As well as sharing this information with the CPM group, it is reviewed with staff and disseminated via e-mail.

I call Ellison 18 and ask them if Johnny's mother is there. I stop at Coffee Central, pick up two teas, and go up to visit her. I give one of the teas to Johnny's mother and I suggest we sit for a few minutes in the family lounge. I know she needs a break from the bedside. Quickly she reveals how tired she is, the stress of no 'respite' from Johnny's care, the financial burdens. I listen. When she pauses for a moment, I ask what keeps her going. "Johnny," she says. "I'm all he has."

I tell her she's a wonderful mother, and that she has every right to feel tired and frustrated—it doesn't mean she loves Johnny any less; it doesn't make her a bad mother. She looks at me for a moment, then quietly says, "Thank-you for saying that. Nobody ever

tells me I'm a good mother."

She tells me about the discharge meeting that afternoon. I let her know I will attend and tell her who else will be there. We discuss the importance of working together to ensure the best discharge plan for Johnny and her. I reinforce that she is Johnny's best advocate, she knows him better than anyone and she knows what they both need to be successful.

Quick stop by my office to check e-mail and make a few follow-up discharge phone calls (I try to do at least 5 a day). I find a delivery of 'give-a-ways' for the Children's Health Fair: CD holders with our logo. I show them to

staff. Everyone always gets very excited about plans for the annual fair. Our Children and Health-Care Week celebration helps build a sense of pride and spirit in who we are as pediatric caregivers.

While in my office, I'm visited by two staff nurses who make appointments for help with their narratives and portfolios for the Clinical Recognition Program. I've already met with both of them to assist in their process of deciding whether to apply.

The phone rings. It's a mother who got my name and number from our web site. She has questions about her child's learning needs at school. She describes a year of

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At left: Kelleher rounds with (l-r) child life specialists, Marilyn Gifford and Ellen Leonard, and staff nurse, Lori Appleman, RN; at right, Kelleher watches helicopter take off outside Ellison 17 with young friend, Laura Cheevers.





Judith Lynch, RN, BSN
staff nurse, Post Anesthesia Care Unit

About Judith...

A graduate of Northeastern University, Judy has practiced in the Post Anesthesia Care Unit (PACU) for the past 15 years. Patients recovering from surgery, wake in the PACU to Judy's kind eyes and reassuring smile. An experienced nurse, Judy's knowledge and skill allow her to anticipate patients' needs and intervene accordingly, always thinking three steps ahead. Nurses and physicians alike seek out her guidance and knowledge in caring for the most complex patients. They rely on her clear thinking, cool head, and vast experience. Judy understands it's not just the patient undergoing surgery, it's the whole family. She brings family members into the PACU at the earliest appropriate time so they can see their loved one and put their minds at ease. Many patients don't even remember their time in the PACU. But as they slowly recover, they're grateful for the vigilant attention and advocacy they received while in Judy's care.

Clinical Narrative

My name is Judy Lynch, and I'm a staff nurse in the Post Anesthesia Care Unit (PACU). It was a typical day in the PACU. Mrs. M had come to the PACU following a shoulder arthroscopy and surgical repair. At the age of 74, she seemed healthier than I did that day. She had walked to MGH from her waterfront apartment that morning for surgery and didn't understand the amazement I saw in such an endeavor. I thought to myself, I don't know if I could *normally* walk that far, let alone on the morning of my surgery... and by myself. I realized then that this very articulate and alert patient would benefit from knowing as much as possible about her care, the aspects of her recovery, and what to expect during her PACU experience.

As her PACU stay progressed, Mrs. M be-

gan having routine post-operative occurrences. She seemed somewhat restless and was moving about in the stretcher. She also kept asking how things had gone with her surgery. Mrs. M had received the medication known as Midazolam. This medication has the property of causing anterograde amnesia—meaning patients may not recall things. I explained all I could and asked how she felt; if she was nervous, had any pain, or was just uncomfortable all over. She told me she had shoulder pain for which I told her I could medicate her and this would help her feel better. She experienced pain relief but she also had some nausea, which you can get from parental narcotics. At that time I medicated her for the nausea and told her to try to take a little nap, all along reassuring her that she was being monitored and I would be looking after her.

She seemed to drift off for a short time and when she awoke she had renewed energy and vitality and was feeling better. She wanted to know how I knew she would feel better, and we talked about how I had learned from years of experience that sometimes the simplest things can help, like taking a nap or changing your position. I told her to try these things and we could re-evaluate if need be, but that we would work together to try to optimize her post-op care. All during this time I spoke directly and softly to Mrs. M so she knew I was going to try to help her. I think she felt comfortable to take a rest because I told her I'd be there watching over her and I would continue to monitor her.

At this point we began talking a little and this was when I found out just how observant and receptive Mrs. M had

been in her initial PACU admission. She asked me what my position was and wanted to know if I was in charge of the unit. I told her that I wasn't in charge, that I was a staff nurse, and that right now I was her nurse in the PACU.

Her questions persisted, and she even asked some of my peers if I was in charge. I wondered how she came to this idea and what I might have done to make her ask such a question. We talked for a few moments and Mrs. M said, "You seem to know what you're doing. But you're also aware of what's going on around you, and others are asking you questions and you seem to have the answers."

I soon realized that Mrs. M had heard me answer a number of questions from other staff, some I didn't even realize I had answered. She had also observed me assisting other nurses

with patient care. Jokingly, I told her I'd have my manager come over and talk with her. I felt strongly that Mrs. M realize my position was a staff nurse and that Kathy Cullen, my nurse manager, could have the opportunity to meet this wonderful, interesting woman.

We continued to chat for a short time and then another patient came to my assigned area in the unit. I excused myself from Mrs. M and told her I'd be nearby if she needed anything. After getting my other patient settled, I went back to check on Mrs. M and get her ready for transfer to the unit. When I called the unit for transfer, I learned that the room was not yet available, so Mrs. M would need to stay in the PACU a while longer.

I explained the reason for the delay to her. She was receptive to the fact that she would remain in

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Narrative (Lynch)

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the PACU until her room became available. She commented on how she felt relaxed and at ease knowing I was her nurse. Time seemed to pass at a snail's pace, and soon it was time for me to go to lunch. Mrs. M had been in the PACU for three hours and was well into her recovery—her vital signs were stable and her pain had improved. But her care didn't stop there. I continued to monitor her vital signs and keep her on the monitors in the PACU, knowing that had she been transferred already, she would have been removed from the monitors by now.

A colleague took over my assignment and I left the unit to take my lunch break. But before I left I had a last chat with Mrs. M and wished her luck in her recovery. I expected that her room would soon be ready, and she would probably be transferred before I returned.

Well, Mrs. M was still in slot 18 when I came back from lunch. When I went to see her she said, "I met your nurse manager and told her all about you." I thought to myself, I really wish you hadn't done that. I'm not comfortable with that type of attention and praise. I felt it necessary to reinforce to Mrs. M that I was a staff nurse, presently her nurse, and I had been doing this job for a number of years. With time, we all acquire knowledge and skills that may go beyond our scope of patient care and practice.

I thanked her for her comments and told her

that I had truly enjoyed caring for her today. At this point, I knew Mrs. M had had an impact on my day and the feelings I had about myself. My nurse manager did speak to me about what she had heard from Mrs. M, and once again I thought, I'm proud of my nursing practice and the effect it has on patients. She asked how I had made such an impression on Mrs. M. I told her I really wasn't sure; that I had explained everything I did during her PACU stay and that we had made a connection.

Our patients are not always as alert and inquisitive as Mrs. M and I felt good to know she was aware of everything

I was doing as her nurse. In the PACU, it's easy for us to become 'the forgotten part' of patients' hospital stays, but we provide all aspects of patient care at a time when they're in the most vulnerable stage of recovery from anesthesia and surgery.

Mrs. M eventually went to her room, and even though it was busier than when she first arrived, she still made sure my nurse manager and I knew what an impact I had had on her recovery. I finished my shift for the day and as I got ready to go home I thought, "What an observant and receptive woman I had taken care of that day." And I still think about Mrs. M and her persistence in seeking out my nurse manager to talk to her personally. I guess I look

at myself and the care I give patients a little closer each day. I am a patient advocate and have a varied number of skills that I use in my clinical practice including caring, comfort, and clinical knowledge.

I also see what Mrs. M observed when my peers were asking me questions. Being a resource can be a simple everyday gesture by answering a question or seeking out an answer to help others. I value being helpful to my peers and enjoy precepting new staff to the PACU. This narrative truly describes the valuable aspects of my caring practice and how I connected with this special woman. And not only did I connect with her, she made a big impression on me as well.

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

"I'm just doing my job." How often have we all said that? And then someone calls attention to the huge difference we made in his or her life. When Mrs. M asked Judy about her vigilance over the entire PACU, she was acknowledging Judy's ability to make her feel like she was the only patient in the room. Like most skilled clinicians, Judy's practice is based on experience, intuition, specialized knowledge, teamwork and compassion. Mrs. M was indeed fortunate to have Judy as her nurse. And so are we.

Thank-you, Judy.



Lynch spends time with patient, Eugene Coombs, as he recovers from surgery. With a smile like that, who wouldn't want to wake up in the PACU?



Kristin Parlman, PT, MS, NCS
inpatient neurological clinical physical
therapy specialist

About Kristin...

A graduate of Springfield College, Kristin received her master's degree in Science from Boston University. She is currently enrolled in the Doctor of Physical Therapy Transitional Program at the MGH Institute of Health Professions. Kristin is a clinical expert in acute-care, neurologic physical therapy. She has achieved the highest clinical recognition in her profession—she is a board-certified neurologic clinical specialist. Kristin's passion for her work and dedication to her patients is visible in every assessment and intervention she performs. She is a walking reservoir of knowledge and experience; but when she doesn't know something, she makes it her business to find answers and share them with her patients and families. She knows the limits that illness and injury impose on her patients, and she understands their frustration. She always finds creative ways for patients to increase their independence, empowering them to gain as much control as possible over their environment.

Clinical Narrative

My name is Kristin Parlman, and I have been a physical therapist at MGH for nearly ten years. For the past seven years, the focus of my practice has been treating patients with neurological impairments. I feel this narrative reflects the reasons I became interested in, and truly love, neurologic physical therapy.

David is a 24-year-old businessman from out of state. While in Boston on business, he began to experience lower-extremity weakness, numbness, and urinary retention. On admission, an MRI revealed a tumor involving his lower thoracic spinal cord and cauda equina. And additional work-up by the Neurology Service revealed another diagnosis: a potentially life-threatening chronic illness. It was felt that the tumor most likely reflected lymphoma.

On day two of his admission, Physical Therapy was consulted. His physical therapy examination revealed the anticipated impairments consistent with the site of his spinal cord tumor. All muscle groups presented with full strength except those innervated by the nerves at the L5 through S2 level, hip extensors 2/5, hamstrings 2-/5, bilateral ankle dorsiflexion and plantarflexion 1/5. Lack of light-touch sensation and pin prick also followed the same peripheral nerve pattern, extending throughout his buttocks, posterior thighs, and the lower portion of his legs and feet. Joint position sense was absent bilaterally in his ankles.

The combination of these impairments presented significant functional impairments for David, who was used to being very active, working hard, and traveling a great deal. David was now unable to stand with-

out the use of a walker and having the bed elevated to a height that made up for his weak hip extensors. When he walked, it required his constant concentration, looking at his feet and making them go in the direction he wanted them to. I remained quiet throughout my examination of his gait as any break in his concentration or lack of visual compensation resulted in loss of balance.

Unfortunately his sensation and motor impairments were so severe he was unable to elicit a balance reaction to stop his fall. In order to fully assess his balance reactions and safety during ambulation, I allowed him to get to a point where I needed to catch him and return him to standing. All this was not without significant physical effort for David. For a distance of just 100 feet, his heart rate increased from 90 to 130

and he reported significant fatigue. Also remarkable in David's presentation was his thin 6-foot frame that had deteriorated to 140 pounds, the result of a combination of medical problems. He demonstrated significant muscle wasting. Although David had denied any physical symptoms prior to the few days before admission, his presenting appearance told me otherwise. I knew that treating David would be complicated. I knew that David was denying much of what was happening to him and I needed to assess when he would be ready to accept the truth about his condition.

Initially, I focused treatment on improving his gait, introducing a strengthening and stationary-bike program, and education as it related to his spinal tumor. David never talked about his other medical issues, and many of his questions focused on his tumor

as if it were unrelated. I spoke to him honestly about my belief that as long as the tumor remained, strengthening exercises wouldn't 'cure' his weakness, but they would prevent future secondary effects of immobility and likely have some effect on muscles that were weak purely from immobility. The decision whether to radiate the tumor was still being discussed among neurologists and neuro-oncologists.

David followed through with a daily exercise program, which he reported made him feel like he was doing something other than waiting to get weaker. I provided David with foot orthoses to compensate for bilateral foot drop and improve his quality of gait. These, in combination with a standard walker, gave him independence in ambulating to the bathroom without assistance.

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Narrative (Parlman)

continued from previous page

Although he still presented as a risk for falls, his ability to ambulate outweighed the impact of spending much of the day in bed and the psychological impact of dependence for all mobility. We talked about this decision to have him walk more despite the risk of falling. He was willing to accept this risk although the risk was diminished with the use of his braces and walker.

During the first week, David began to talk more about his feelings of being overwhelmed. I asked him if he knew before he was admitted that something was wrong. David began to cry and

said he'd known other people who had ignored symptoms of illness and that he'd done the same thing. It was this conversation that triggered many discussions about the overall management of his health and future recommendations for physical therapy after discharge.

When I spoke with David and his family, I focused on the positive aspects: that David was now receiving proper medical care and that he now had the opportunity to show improvement in his health. We talked about the need for a multidisciplinary approach to manage his illness and

the need for good medical and psychosocial supports upon leaving MGH. I assured them that there were many resources and supports available to them.

David was an inpatient for approximately four weeks while he underwent radiation for the spinal cord tumor and continued daily physical therapy. A total of 14 treatments of radiation resulted in little change in the size of his tumor or significant change in his overall strength. It was still possible that future treatments would produce an effect. Despite little change in the size of his tumor, David progressed to ambulating with crutches and became able to rise from a standard-height chair.

His endurance had also improved as evidence of a much smaller heart-rate response to walking as well as subjective reports.

It was felt by the team that David could now be managed closer to home. Before discharge, I spent time educating David and his family about home-safety, functioning around the home, and continuing with his exercise program. I also phoned a physical therapy clinic in his home state and arranged for David to continue his care there.

It had been a long four weeks for David and he was looking forward to returning home with his parents. I know this is just the beginning of another chapter for him, and hopefully I've helped to prepare him.

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

This narrative gives us a wonderful opportunity to follow Kristin in her assessment and treatment of this medically and emotionally complex patient. She intuitively knew that David had been aware of his medical problems before admission, but she allowed him to reveal it to her in his own time. She was honest with him. She was there for him when he disclosed his illness to his family. And most of all, she gave him the full benefit of her expertise as a physical therapist.

This is a wonderful story of compassion, patience, understanding, and excellent clinical practice. Thank-you, Kristin.

Kristin Parlman, PT, and occupational therapist, Lori Loughlin, OTR/L, successfully help patient, George Cassell, transfer from bed to stretcher chair, where he can more easily perform activities of daily living.





Debra Smith, RN, BSN
staff nurse, Bulfinch Medical Group

About Debra...

A graduate of the Massachusetts General Hospital School of Nursing, Debra received her bachelor's degree in Science from Northeastern University. She has spent her entire professional career at MGH, as a staff nurse, manager, supervisor, and for the past four years, as a nurse in the outpatient clinic of the Bulfinch Medical Group. Debra's is the voice we all wish we could hear when we call our primary caregiver. A gifted and caring clinician, when Debra fields phone calls from patients, she hears not only what they say, but how they say it. She is constantly listening and assessing, using her highly developed sense of intuition. Debra is able to make critical decisions about a patient's care, sometimes without even seeing them. Whether on the phone or in the office, patients know they're in good hands when they feel the warmth and compassion of Debra's caring practice.

Clinical Narrative

My name is Debbie Smith and I have been a nurse at MGH for 27 years. I've spent the last 19 years in outpatient practices (IMA, Transplant) with the past 4 years as a member of the Bulfinch Medical Group, an extremely busy primary-care practice.

I work alongside four primary care physicians, three secretaries, and two medical assistants. As the one nurse, I have an average of 6 nursing visits per day, add-on and walk-in visits, the potential of being called in to assist 50 physician visits per day, and I triage approximately 90 phone calls per day. Unlike inpatient call lights, where nurses soon see and interact with patients, outpatient nurses often have to try and determine a patient's problem and the severity of the problem from just a voice on the other end of the phone.

I'd like to tell you about Millie, a 75-year-old woman who is followed in our practice. She has multiple, complex medical problems (CVA, hypertension, COPD, asthma, hypothyroidism, arthritis) and some psychological issues (mental retardation, paranoid schizophrenia, and depression). Millie lives with her only daughter and son, who both prefer not to be involved with her care unless absolutely necessary. Millie spends her weekdays at a senior day-care center. She claims to have only one friend with whom she goes to the Galleria every few weeks for a "day out."

Early on in my days with the BMG, I came to know Millie very quickly. She had a habit of calling in on our designated "emergency line" up to three times a day, and sometimes even more. She would leave repeated messages on the answer-

ing service evenings and weekends. Generally, Millie called on the emergency line to track down lab reports which we had already reviewed with her. She'd call on the emergency line to find out what the specialists had told us but weren't telling her, which was nothing different. She'd call on the emergency line complaining about her meds, meds she was no longer on, nor was she actually taking. Millie would call on the emergency line to talk about her daughter who wasn't her 'favorite.' Or Millie might call on the emergency line just to let us know she was feeling good.

When Millie called, she'd become quite excitable, get short of breath and then start either talking in a very loud nervous voice or cry. It would take me an extraordinary amount of time to calm her down before trying to

sort out why she was calling on the emergency line. Millie would incessantly say, "You're lying to me. I'm dying and you don't want to tell me." Or she'd say, "You want to get rid of me, give me to someone else, because I pester everyone all the time." It didn't take long to realize that Millie was quite anxious, emotionally labile, very lonely, and required lots of reassurance. She called so often that all the secretaries knew her number by heart.

But as calm and reassuring as I can be, I found that Millie had the ability to test everyone's patience. Millie's calls raised two concerns for me. My first thought was how to keep her off the emergency line unless it was an actual emergency; and secondly, how to decrease the sheer volume of phone calls without hurting her feelings or thinking we didn't like her.

I tried to gain Millie's trust by repeatedly reassuring her that I would always return her call, although I emphasized it would not always be immediately unless it were an emergency. I told her that it might be three hours later, but I would always call her back. Millie would constantly interrupt and agree, "I know, you always do call me back." It was important to stay on just one issue, as too many ideas confused Millie and made her very anxious. I knew Millie liked to feel that she was needed and that she could help someone else. I asked Millie whether she would do something to help me, and she readily agreed. "Of course, of course."

I came up with a plan that Millie could call into the office once a week (and she could pick the day), to check in with me. I explained very simply that if she were sick
continued on next page

Narrative (Smith)

continued from previous page

she could call more often. I told Millie that her physician, the secretaries and the answering service were going to be in our plan so that we could all help each other. Millie thought this was great and seemed quite happy that we were all so interested in her. She said she'd try. It took a while, as Millie kept reverting to her old behavior (calling numerous times daily) and then get upset that she had forgotten. But after one long year of 'constant reinforcement' we finally made it. Millie now called one day a week, on her chosen day, although she might still call three or four times on that day. It was a beginning, and it was important to reward Millie for this change. We (the entire staff) made a big deal of it. Millie even laughed one day when she said to me, "You really did tell everyone about our pact. The answering service mentioned to me last night how good I was doing."

We still had a ways to go, but it was a start. Although it took a year, it was one small step for Millie, but a giant leap for our practice.

Now that we had decreased the volume of calls, it was time to explain to Millie when to use the emergency line. Since Millie's calls were obviously not of an emergent nature, my main concern was that Millie would not be taken seriously if it ever was a true emergency that she was calling for.

Months later I invited Millie into my office on a

day when she was here to see her doctor (Millie always came two or three hours early for her appointments). I explained very simply to Millie why she shouldn't call the office and say it was an emergency unless it really was. I explained why that line needed to be left open for those patients who really did need my help quickly. Millie nodded constantly and seemed to understand.

When it was Millie's day to call, although she did call in on the emergency line, she would say, "Quickly" to the secretary, "it's not an emergency. Switch me to the other line." In keeping with my end of the bargain, I'd either take the call or call her back later in the day. Millie was quite proud of herself, as were we.

A few months later in the midst of a typical busy day, as I was seeing a patient in one room, while two other patients were waiting, I was asked by one of the MDs to transport a patient to the EW (with chest pain), while at the same time an outside EW was on the line wanting information. A secretary buzzed me to tell me Millie was on the line with an emergency. I admit, I immediately thought, "Oh no, not now, Millie."

As I was prioritizing everything coming my way and readying the patient to go to the EW, I took Millie's call and asked her if this was an emergency. She became quite anxious, started crying and screaming

"No, no, I'm sorry. I'll hang up." I asked her again why she was calling, and she replied, "I don't know." I asked if her breathing was worse, if she was more winded, did she have pain, or fever, was she feeling sick? And the response to each question was 'No.'

I spent a few minutes reassuring Millie and told her I'd call her back when I returned from transporting a patient to the EW. Leaving the EW,

and walking back to my office, I replayed our phone conversation in my mind. There was something 'different in her voice.' It left me with a nagging feeling that something wasn't right but I couldn't put my finger on it. When I spoke again with Millie, she had no specific complaint (breathing unchanged, sounded her usual winded self on the phone, no cough or fever) but something still wasn't settling well with me. I asked

Millie to come in to see me. This triggered an emotional outburst. "Now I know I'm dying. You're all lying to me. What's wrong?"

I calmly told Millie I couldn't sort out over the phone what was bothering her and that she obviously didn't feel right, and the only way to figure it out was to see her. It took about 10 minutes to calm Millie down and convince her to come in. I informed her physician

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Smith examines patient, Frances Soroco, in the outpatient clinic of the Bulfinch Medical Group.

Narrative (Brackett)

continued from page 3

tee and the Ethics in Clinical Practice Committee, but family meetings are usually presided over by physicians.

I explained that we were here as critical-care experts to guide them through the treatments that were appropriate and advise them on the risks and benefits. But they were here as experts on Melanie. We needed them to guide us through those recommendations by advising us about Melanie as a person and what she would want us to do if she could speak.

I let them know about the No Code Status and why they might consider this if her condition wor-

sened. I also mentioned that some patients in this situation might opt to discontinue aggressive treatment at this point because they couldn't accept that level of dependence/outcome. I stressed that they didn't need to decide right away, and that they should discuss it among themselves.

They thanked us all and looked relaxed that they knew all that they could about her injuries and prognosis. I talked with her mom and dad while Dan called his dad for support. We talked for a while. They talked about their sadness that their 'little girl was gone,' that she might never wake

up. They asked questions about withdrawal. We all hugged good-bye for the day.

Melanie stayed on our unit another three weeks or so. Her parents stayed, too. They were able to talk about how sad they were at her continued unresponsiveness, but they didn't want to give up hope. Melanie had been so vital and happy with life; they were able to voice that she would want every chance. She eventually stabilized to a point where she could come off drips. She was transferred to a unit and then to a facility closer to her home town. While our meeting didn't change the course we were on, it did open a dialogue that helped her parents cope with this

tragedy, and gave us the confidence that we were following a path Melanie would have wanted.

As years have passed, we are getting better at initiating and leading these discussions. Physicians and nurses working together in collaboration can lend important expertise and dimensions to this work.

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

Sharon's compassion and expertise are evident throughout this narrative. She anticipated and managed Melanie's fragile condition while seeing to the needs of Melanie's family as well. Sharon's

experience allowed her to anticipate Melanie's precarious condition and prepare her family for any setbacks. Even in the midst of this highly volatile situation, Sharon takes the time to teach her orientee about the complexity and nuances involved in caring for such an acutely ill patient.

Sharon was called upon to offer her expertise on end-of life care and withdrawal of treatment. She shared her knowledge in a sensitive and compassionate way, allowing Melanie's family to feel informed and empowered as they struggled to make difficult decisions.

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

Narrative (Hamel-Nardozzi)

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needs. His nurse and I discussed with the medical team the merits of transferring Mr. F closer to his home and friends and siblings who had been unable to see Mr. F while he was here. Also, Kerri would be closer to her home and her support network. We realized the likelihood that Mr. F would face the end of his life in an ICU, but we could try to make that ending as comfortable as possible for him and his family. To that end, after discussion and agreement among physicians and Mr. F's family, he was transferred.

A little more than a week later, I received a phone call from Kerri. She reported that her dad

had died peacefully after seeing his siblings, loyal employees, and close friends. Kerri told me of the beautiful funeral, attended by 500 people in the city her father had loved so much. She spoke of the eulogy her brother gave that captured the humor and essence of her father. There was a calmness and serenity in her voice I had never heard before as she told me of burying her father in a grave right across the path from her son, Mark. She said that after they buried her father, she walked across to Mark's grave and placed his birthday motorcycle on his grave. She told me that now her father and Mark were together and she felt comforted by

that. Kerri sent thanks to all who cared so lovingly for her father, and also for her.

By being present to Kerri, empathetically listening to and tolerating the intense feelings she was experiencing as she faced her father's death and re-worked the death of her son, I had helped her find some healing and comfort. She thanked me so much for "being with her through it all." I was eager to share this call with my colleagues in the CCU so they would know Mr. F died peacefully, surrounded by those he loved, and that his family was able to find meaning and comfort in his death. We had cared well for him and at the same time helped his daughter. She told me she now had, "wonderful memories, no regrets."

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

Marguerite understands that who we are is the result of the experiences we've had. When Marguerite learned about Kerri's past experiences, including the death of her son, she realized that Kerri was replaying that nightmare over and over. Marguerite shared her

perceptions with the medical team, which allowed them to understand her behavior in the context of the fear she was feeling.

Through Marguerite's subtle interventions, Kerri was able to open up and release her heavy emotional burden. With Marguerite's help, Kerri was, in fact, able to make meaningful memories instead of regrets.

What an enlightening look at caring practice. Thank-you, Marguerite.

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Narrative (Kelleher)

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turmoil for her third grader. I explain the evaluation process for a child with learning difficulties, and talk about her important role as advocate for her daughter. I give her the address and phone number of the Department of Education in Massachusetts so she can get a copy of the law (Chapter 766) and the Parent's Guide. I tell her to call me if she has difficulty accessing the evaluation system. She is grateful for the information.

The day is flying by. I stop and check on Nathan, his parents, and the team. All appear to be doing fine. A quick pat on the back to his nurse lets her know I'm there and that she is doing a wonderful job.

Up to Ellison 18: Johnny's discharge meeting. All are present and the meeting goes very smoothly. Johnny's mother is able to articulate her needs with some encouragement. The meeting ends with the case manager and Johnny's mother making a conference call to the home-care agency to discuss steps for getting the 20 hours they need. The social worker contacts DPH to activate involvement of the case manager. The resident physician calls Johnny's pediatrician to let him know what arrangements are being made.

The meeting ends and I'm back on Ellison 17, ten minutes late for the palliative care meeting I had arranged for staff. Nurses and child life specialists are already engaged in conversation.

Everyone shares their feelings, all hoping for a painless and comfortable death for Nathan. Nurses talk about how they'll support Nathan's parents, how they'll be culturally respectful, and the need to have the support of a chaplain for both the family and staff. We talk about what we can do to make every hour count and to make the remaining time Nathan's parents have with him as rich as possible. The meeting is very helpful, and staff thank me for facilitating it.

The operations associate receives a call that a patient sent home with hospice care six weeks ago is being re-admitted. His mother is no longer comfortable having him die at home. Staff on Ellison 17 have known this little boy for more than three years. They receive this message in disbelief. Multiple deaths are not a common occurrence on this unit. Coincidentally, many of the members of Nathan's team have also cared for this little boy. I pull the teams together for a meeting. We stand there for a moment in silence, then I say, "This is a special gift. We are privileged to be able to share in this precious time for both these little boys." I remind them that as nurses this is where their caring shines. It is during these difficult acts of love that they make the biggest difference in the lives of our children. They nod in understanding.

I return to my office; it's 5:30pm. I take a few

deep breaths knowing the next few days will not be easy. I look at the pictures of my healthy children and smile. Thank God for them. They are my balance.

A quick phone call to my nurse manager to fill her in on the day's events. Waiting at the elevator, I have a sense of accomplishment. The day was difficult, but I had made a difference.

My practice is definitely an adverb—enhancing the action of my staff, better defining their work. This is what I do. Make nursing more visible and support the caring action of nursing practice.

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

What a day! I'm exhausted. Mary Lou did a lovely job describing the many facets and challenges she encounters in a typical day as pediatric clinical nurse specialist. Unscheduled consults with members of her team, tending to the emotional needs of staff as well as patients, responding to clinical crises as they arise, assisting with administrative matters, providing support, en-

couragement, and solace when cherished patients die. I imagine Mary Lou's days are anything but typical.

What I see in this narrative is Mary Lou's unfaltering ability to persevere, to be present to all who seek her guidance, and to project a positive attitude even in the face of great pain and adversity. It's not a coincidence that this pediatric nurse leader possesses so many of these 'maternal' qualities.

This is a wonderful, informative look at exemplary nursing practice. Thank you, Mary Lou.

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.

Fellowships available for MGH Clinical Pastoral Education Program

With support from the Kenneth B. Schwartz Center and the MGH department of Nursing, fellowships are available for the winter, 2003, MGH Clinical Pastoral Education Program.

Five Schwartz fellowships are available to caregivers from disciplines other than Pastoral Care, including Medicine, Nursing, Social Services, and other disciplines. These fellowships are for clinicians who work directly with patients and families. Two fellowships are available to MGH registered nurses who are direct caregivers and have been practicing for a minimum of two years.

The winter Clinical Pastoral Education Program is a part-time program that starts on January 2 and runs through May 16, 2003. Group sessions are held each Monday from 9:00am–5:00pm; additional clinical hours are flexible and may be negotiated by fellows upon acceptance into the program.

For more information about these programs, call the MGH Chaplaincy at 6-2220. Applications are due by September 1, 2002.

Narrative (Smith)

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that I was bringing her in. As I anticipated her arrival, I continued to see scheduled patients, triaged phone calls and watched as a tremendous amount of work continued to pile up on my desk. Millie arrived one hour later throwing herself at the secretaries desk crying and talking so fast she couldn't be understood. I immediately evaluated her and found her to be dyspneic, with a temperature of 103, and an oxygen saturation of 94%. I transported her quickly upstairs to X-ray and her CXR revealed bilateral pneumonia. Millie was indeed quite sick.

The next hurdle was deciding whether to admit Millie or treat her

aggressively at home with daily visits to us and VNA services. We realized the easy decision would be to admit her into the hospital all the while with her screaming, "I can't go home. My daughter will be upset. I have to stay here. Please!" Yet her physician and I both knew that in her best interest, she would do better at home. We were afraid that she'd become dependent in the hospital and that her frail psychiatric balance would be totally disrupted. We proceeded to explain to Millie our decision to send her home on antibiotics, with visits to us daily and VNA visits in the evening. It took an inordinate amount of time repeating ourselves,

offering reassurance, and letting Millie know that if she didn't improve we'd admit her. Two hours later (yes, two hours later) Millie finally agreed to our plan and went home.

As I went back to the 'piles of work' awaiting me that day, I did know the time I had spent with Millie was very important. I returned calls to other patients who were not at all pleased by the delay. I kept the picture in my mind of who I had just helped and I kept my emotions in check. We saw Millie daily in the office with twice-a-day VNA visits on the weekend. She made very slow but steady improvement. Millie came in four weeks later looking great and when I commented on this and gave her a big hug, she burst into tears. "I'm not sad," she said.

"Very happy. But I just realized how sick I really was when I called you and you were there to take care of me. I just didn't know. I'm sorry."

I emphasized to Millie that she did the right thing telling the secretary that her call was an emergency. She may not have known why, but we all "clued" right in. She then presented me with a painting-number picture she had done on velvet at the senior day-care center. (Her physician would also soon receive one.) I now have both paintings displayed in my office in the 'gallery' as we now call it.

It's amazing that on a particularly frustrating day, I may chuckle or smile as I pass the pictures and remember, "I did make a difference." But the best part of all is seeing the pure pleasure on Millie's face as she seeks out my office for her visits to view her paintings and tell whomever might be walking by, the story behind them. That's when I know that all the time I spent working with Millie was truly worth it!

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

How many of us would have had the patience and staying power to work an entire year to achieve this kind of success? How many of us would even have presumed success was possible? Millie's behavior was a challenge. But Debra's commitment was not to be underestimated. Debra understood Millie. Debra understood Millie's need for attention and her desire to help people. She used Millie's strengths, ultimately, to help Millie help herself. Debra had no way of knowing that the groundwork she was establishing would one day save Millie's life. She did it because that's the kind of interest she takes in all her patients.

"Something didn't settle well with me." That's all Debra knew when she asked Millie to come in to see her. Sometimes that sixth sense is the strongest sense of all. Thank-you for sharing this inspiring narrative, Debra.



Educational Offerings and Event Calendar Now Available On-Line

The Center for Clinical & Professional Development is pleased to present the July-December, 2002 Educational Offerings Calendar on-line at

<http://pcs.mgh.harvard.edu>

To access the calendar, click on the link to CCPD Educational Offerings. View times, dates, locations, and descriptions of educational programs supported by the Center.

For information about Risk Management Foundation programs, visit their web site at:

<http://www.hrm.harvard.edu>

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

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

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Excellence in Clinical Practice Award (originally called 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, Excellence 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 a caring practice.

Macaluso understood the relationship of health, illness and disease. It was this under-

standing 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.

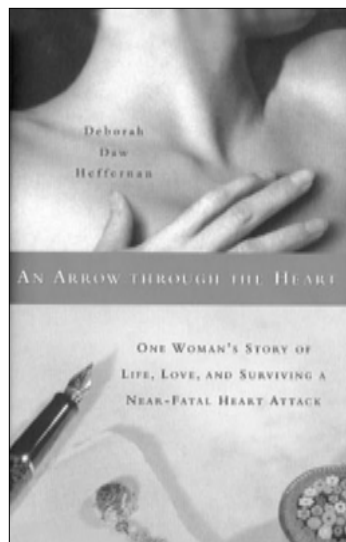
Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate expert practice throughout Patient Care Services. The Stephanie M. Macaluso, RN, Excellence 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, Excellence in Clinical Practice Award allows us to publicly re-commit ourselves to the highest standards of care we hold for our patients, and contribute to the on-going professional development of the clinicians within Patient Care Services.



An Arrow Through the Heart: an MGH Patient Shares Her Story

Author, Deborah Daw Heffernan and representatives from the cardiac surgical nursing staff will explore the MGH experience from the perspectives of the patient and the provider.

All clinicians are invited.

Thursday, July 18, 2002
1:30-2:30pm
O'Keefe Auditorium
Reception to follow

1.2 contact hours

For more information,
call 6-3111

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Jeanette Ives Erickson RN, MS,
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and chief nurse

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Macaluso Award Ceremony

continued from front cover

focus of the award from expertise to excellence.

In addition to the name change, a new element was added to the list of award criteria. As well as recognizing clinical practice that is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of entrepreneurial teamwork, the award now acknowledges practice that is also based on a foundation of leadership.

Guest speaker, Kate Walsh, senior vice president for Medical Services and the MGH Cancer Center, was asked to share her thoughts on the concept of 'excellence' in clinical practice.

Said Walsh, "In thinking about what I would say to this impressive gathering, I thought about something that may not always be evident to you as you go about your day-to-day work as busy caregivers. I thought about the message I would like to convey to you from your administrative colleagues. And what I want you to know is this: you matter. Stephanie (Macaluso) would be justifiably proud of you and your colleagues and the wonderful care you provide to our patients. I am enormously proud to work at MGH, and it's because of what you do every day. You matter."

Said Ives Erickson, "Every clinician has the opportunity to demonstrate excellence in practice at every stage of their professional development. And as you well know, excellence abounds at MGH. We're here today to celebrate six clinicians whose day-to-day practice makes us all proud to work at this hospital."

This year's recipients are: Sharon Brackett, RN; Marguerite Hamel-Nardozi, MSW; Mary Lou Kelleher, RN; Judith Lynch, RN; Kristin Parlman, PT; and Debra Smith, RN.

Ives Erickson read excerpts from nomination letters as she introduced each recipient. Introducing Brackett, she read from a letter written by Katie Brush, RN, which said: "Sharon is one of the finest clinicians I have ever worked with. Her practice is a model of critical-thinking skills, clinical reasoning and clinical judgment that are the hallmark of an expert critical-care nurse."

Director of Social Services, Evelyn Bonander, ACSW, wrote of Hamel-Nardozi: "Marguerite brings unique talents to the fast-paced, challenging ICU environment. Whether providing for family members' comfort... responding to difficult questions, or addressing issues of anger, sadness or grief,

Marguerite is present—listening, advocating, counseling, supporting."

Chief of Pediatrics, Ron Kleinman, MD, said of Kelleher: "In the twenty-five years I've been associated with MGH, I know of no one who has done more to advance the clinical practice of pediatrics than Mary Lou. Her strength is that she's a 'doer,' one hundred percent committed to family-centered care."

Director of Physical Therapy, Michael Sullivan, PT, said of Parlman: "Her passion for excellence in patient care is

one of her most infectious and engaging qualities. The reasoning and decision-making skills she brings to her own practice is extended to others as she probes for answers and facilitates their acquisition of knowledge and understanding."

Medical director of the Bulfinch Medical Group, Robert Hughes, MD, said of Smith: "I can honestly say that Debra is as excellent a nurse as I have ever worked with. She is a shining example of everything a nurse can be

to her patients, her co-workers, and physicians."

Lynch was unable to attend the award ceremony; her practice will be recognized at the December Macaluso award ceremony.

In closing, Ives Erickson thanked all the recipients and members of the Macaluso Review Board. "I know Stephanie is smiling on us today as we recognize these deserving clinicians," she said. "Excellence in patient care is alive and well at MGH."

Past and present Macaluso Award 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
Fredda Zuckerman, LICSW

June 15, 2000

Emily 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

June 13, 2002

Sharon Brackett, RN
Marguerite Hamel-Nardozi, LICSW
Mary Lou Kelleher, RN
Judith Lynch, RN
Kristin Parlman, PT
Debra Smith, RN

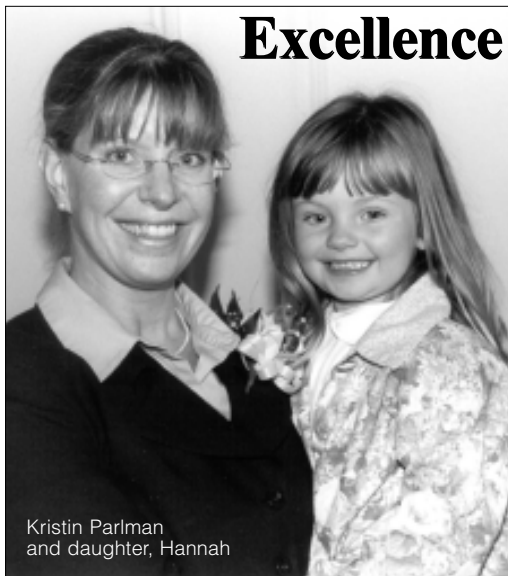
Educational Offerings

July 4, 2002

When/Where	Description	Contact Hours
July 10 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (contact hours for mentors only)
July 10 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
July 11, 12, 15, 16, 22, 23 7:30am–4:00pm	ICU Consortium Critical Care in the New Millennium: Core Program New England Baptist Hospital	45.1 for completing all six days
July 11 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
July 15 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
July 15: 7:30am–4:30pm July 16: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: Boston Medical Center. Day 2: (VBK607)	14.4 for completing both days
July 17 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
July 18 1:00–2:30pm	The Joint Commission Satellite Network presents: “Good Practice in Prevention: Ambulatory Care, Documentation Issues, Medical Staff Competence, and Patient Education.” Haber Conference Room	---
July 18 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
July 18 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
July 19 1:00–3:00pm	Pacing: Basic Concepts O’Keeffe Auditorium	---
July 24 8:00am–4:30pm	Caregiver Skills for the New Millennium Training Department, Charles River Plaza	7.2
July 24 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
August 1 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
August 1 7:30–11:30am, and 12:30–4:30pm	Pediatric Trauma—Part III Wellman Conference Room	---
August 1 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
August 6 8:00am–2:00pm	CPR—American Heart Association BLS Certification for Healthcare Providers VBK 601	---
August 8 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
August 14 8:00am–4:30pm	Preceptor Development Program: Level I Training Department, Charles River Plaza	7

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>

Excellence abounds at MGH!



Kristin Parلمان
and daughter, Hannah



Ives Erickson
and Hamel-Nardoizzi



Judy Lynch



Mary Lou Kelleher



Debra Smith and
Theresa Gallivan



Kate Walsh

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