March 7, 2002

Caring HEADLINES

Inaugural class of new graduate critical care nurses

Inside:

—by Scott Ciesielski, RN, clinical educator

February 14, 2002, marked the graduation of the inaugural class of the New Graduate Critical Care Nurse Program. The program, a collaborative offering of Patient Care Services and the MGH Institute of Health Professions (IHP), is one strategy to help curb the impact of the anticipated nursing shortage, particularly in the area of critical care.

The New Graduate Critical Care Nurse Program is an intensive, six-month, continuing education program designed to give new graduate registered nurses extended knowledge in critical care. The program includes both theory and practice. Participants receive classroom instruction at the IHP and unit-based, precepted clinical experience here at MGH. Seven critical care units participated in the first offering, including: the Bigelow 13 Burn Unit, the

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Inaugural class (seated, l-r): Shannon Fraser, RN; Nicole Roy, RN; Jennifer Johnson, RN; Heidi Simpson, RN; Jackie Baty, RN; Ericka Rogasky, RN; (standing): Megan Mooney, RN; Samantha Sacks, RN; Jennifer Schnarr, RN; and Nancy Masciarelli, RN. Not pictured: Erin Fitzpatrick, RN; Kathleen Neville, RN; and Bridget Scanlon, RN.

(Photo by Abram Bekker)

MGH Patient Care Services

Working together to shape the future

In the debate over arbitrary staffing ratios, we must be the voice of reason

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

At a time when many states in the country are enacting legislation to establish arbitrary staffing ratios for hospitals, it is imperative that everyone, healthcare professionals and lay people alike, understand the issues driving these efforts.

Our industry and our nation are bracing for an unprecedented shortage of healthcare workers in the near future, most notably, a shortage of nurses. At the same time, patients today are sicker, requiring a level of care that is far more complex and demanding than at any time before in our history. Add to that the fact that insurers are mandating significant cost cuts, and it's clear that every caregiver's focus must be on providing quality health care.

The solution to this problem is *not* arbitrarily legislating staffing ratios. Implementing 'cookie-cutter' ratios is like relying on an umbrella for every weather condition. You're fine if it rains. But what if it snows? What if there's a hurricane, a tornado, or monsoon? Wouldn't it be better to tailor your protection to fit the conditions? This is exactly the logic we must use in crafting a solution to our staffing challenges. No matter what the external pressures may be, it is absolutely essential that we be able to provide the right clinician to the right patient at the right time. Every time.

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In Massachusetts and in other states across the country, there are a number of bills under consideration aimed at alleviating the shortages anticipated in the coming years. Bills that promote mentoring programs, recruitment and retention strategies, and knowledge-based infrastructures should be supported. Bills that promote 'one-size-fits-all' staffing solutions should be eschewed as short-sighted. These bills offer quick fixes that, in the long run, will not solve the problem. While staffing ratios may be an attempt to force under-staffed institutions to provide more adequate staffing, they don't address the underlying issues. Moreover, ratios that are introduced as 'minimum,' are often interpreted as 'maximum' once the law is passed.

At MGH we are fortunate to have an informed and responsible leadership team that values patient care and patient safety above all. Since 1985, we have had a patient classification system in place that gives us detailed, accurate, meaningful information about our inpatient population on a daily basis (updated as patients are admitted). We measure patient volume, not by 'head count,' but with individualized information about patient needs, variations in care requirements, variations in patients' condition over time, and acuity. That means we look at all patients and their nursing needs. We measure patient volume in a way that gives us precise information about the resources needed to provide the best possible care for our patients. This is an effective tool that helps us quantify our work load and measure our staffing needs in a strategically significant way.

The method we use at MGH, and the method we advocate for the rest of the country, is to base staffing decisions on patient need not on arbitrary, pre-mandated staffing ratios.

Perhaps the best way to approach staffing questions is to ask yourself, 'What is the ultimate goal?' If your answer is safe, high-quality patient care then clearly,

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About staffing ratios...

- With staffing ratios we run the risk of replacing critical nursing judgement and assessment with fixed numbers.
- All patients are not the same. Care needs vary from patient to patient, and for the same patient over time. Nurses must have the flexibility to staff accordingly.
- All nurses are not the same. At times when experientially younger nurses are working, more staff might be needed. At times when more experienced nurses are working, fewer staff might be needed.
- Because of shortened lengths of stays and the need to admit patients for short-term observation, census and acuity can change from shift-to-shift, and from hour-to-hour. Flexibility is required to staff according to patient need, not number.
- Once established, mandated minimum staffing ratios often become maximum staffing limits.
- Other mandated practices have failed because they neglected to take into account the individual needs of each patient (mandated 24-hour OB deliveries, mastectomies, etc.)

Patient Safety Awareness

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

Question: Will MGH be doing anything to observe National Patient Safety Awareness Week?

Jeanette: National Patient Safety Awareness Week, March 10–16, 2002, is an opportunity to promote education and communication about patient safety, and form partnerships between patients and caregivers to improve safety. MGH will have an information booth in the Main Corridor on Tuesday, March 12, and Thursday, March 14, from 11:30am–1:30pm. Pamphlets will be available on medication safety, how to communicate with health care providers, and how to become a more informed healthcare consumer. Educational materials will also be available in the Blum Patient-Family Learning Center.

Question: Is it true that we have a blame-free policy for reporting adverse events?

Jeanette: Yes. The purpose of reporting adverse events is to give us a way to look at systems and processes and identify ways to improve safety and reduce risk. The intention is not to point a finger or blame an individual. Everyone is encouraged to fill out an incident report for any occurrence that is inconsistent with our quality-of-care standards or the routine operations of the hospital.

A report should be filed whenever there is an injury or potential injury to a patient, visitor, or staff member. Any condition that might be hazardous should be reported. Our policy on reporting adverse events can be found in the Clinical Policy and Procedure Manual.

Question: There are a lot of sophisticated products and equipment used in providing care today. How do we minimize the risks associated with this equipment?

Jeanette: Don't ever use products or equipment you are unfamiliar with. If something unusual happens during use of any equipment, do not attempt to troubleshoot beyond your level of capability. Seek more expert advice, such as a clinical specialist, or call Biomedical Engineering. If you think it's appropriate, remove the equipment from unit. It is best not to alter or adjust equipment until it has had a chance to be fully evaluated.

Always clearly mark the device or piece of equipment 'Out of Service,' and communicate the nature of the problem to the appropriate person. Important information can be gained by sequestering equipment in exactly the same state as when the problem was first noticed.

Question: How can clinicians contribute to patient safety?

Jeanette: Clinicians contribute to patient safety every time they advocate for their patients. In any patient situation where there is uncertainty or discomfort, or if something just doesn't feel right, it's important to speak up and take advantage of the many resources available, including more experienced clinicians, clinical specialists, nurse managers and supervisors.

Jeanette Ives Erickson

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legislated staffing ratios are not the solution.

Each of us who works in health care knows the danger inherent in making sweeping generalizations. No generalization is more dangerous than assuming that one hospital is like another, one patient is like another, or one clinician is like another.

As the debate about staffing ratios continues, we, who are most knowledgeable about patient care, must be the voice of reason. We provide an indispensable service, and we must prevail in deciding how that service is delivered.

Updates

I'm pleased to announce that Grace Good, ACNP, is joining General Medicine's Team 4 Medical Access Unit as a nurse practitioner. In her new role she will work closely with clinicians in all disciplines to ensure continuity of care for this medically complex patient population.

SICU staff nurse, Rob Bergman, RN, has accepted a position as clinical nursing supervisor. Rob will assume his new responsibilities beginning March 8, 2002.

Dale Raucci, RN, MSN, joins our team as the first nurse practitioner for the Hemodialysis Unit. Dale is experienced in acute and chronic hemodialysis and peritoneal care. She will officially assume her new responsibilities later this month.

Karen Rose, who has worked as a temporary recruiter for the past three months, is joining the PCS Human Resources team as a full-time recruiter for OAs, USAs, and entry-level support staff.

Christina Vasilou will provide HR support to a variety of departments within PCS including Volunteer and Interpreter Services, PCA recruitment, and other responsibilities.

Welcome all.

Diversity in Childbearing

—by Patricia M. Connors,RNC, MS, WHNP, perinatal clinical nurse specialist

On Monday, February 11, 2002, in O'Keeffe Auditorium, the Diversity in Childbearing Conference was held to help raise awareness about the many different cultural beliefs and practices surrounding childbearing. With increased understanding, clinicians are better able to integrate meaningful sociocultural aspects of care to achieve the highest quality maternal-child health care.

The conference, coordinated by Germaine Lambergs, RNC, IBLC, and Patricia Connors, RNC, MS, WHNP, provided a wealth of information on various religions, values, languages, and childbearing practices employed around the world. Presenters included:

- Ruth Amadi-Nwogu, RN, (African)
- Stella Chan-Flynn, CNM, (Asian)
- Marisol Alverez, RN, (Hispanic)
- Joan Lovett, RN, (Irish)
- Bonnie Godas, (Jewish)
- Kim Deltano, CNM, Maureen Carrigan, RN, and Jo Costantino, (Alternative Families)
- Ayfer Candeger, (Muslim)

Throughout the day, it became clear that despite many different perspectives, there were also a number of shared beliefs and values across cultures. In African, Asian, Hispanic, Jewish and Muslim communities, for instance, male-dominant extended families are common, and grandparents are respected for their longevity and wisdom. Amadi-Nwogu observed that when women have babies in Africa, the whole village celebrates. With the immigration of these groups to the west, a level of family support has been lost; this is something caregivers need to be aware of.

Deltano, Carrigan and Costantino shared their experiences raising children in a family with two mothers. They stressed that they have the same concerns for their children as traditional families. They juggle child care, financial issues and the everyday demands that go with child-rearing just like the rest of society. On occasion, they've had to deal with the pressures of prejudice and intolerance, which has added another level of difficulty to their parenting efforts.

Alverez spoke about being 'primed' since she was a little girl to prepare for motherhood. Her Bolivian grandmother would strap dolls to her back so she could be like her mother carrying her siblings. Caring for her younger brothers was routine.

Chan-Flynn talked about the use of herbs and herbal remedies by some cultures, especially the Chinese, to aid healing. In both the African and Chinese cultures, men are not allowed to participate during labor and delivery. Some Chinese believe the labor support person must have the same astrological sign as the patient.

> We all live under the same sky, but we don't all have the same horizon.
> —Konrad Adenauer

Lovett described socialized medicine as it exists in Ireland and showed a humorous Irish film to entertain participants.

Godas spoke about the influence of religion on childbearing, especially in the Jewish faith. After describing different Jewish sects, she explained what is expected of pregnant women within each sect. She explained that the health of the woman takes precedence over Jewish law. In the event a woman may have emotional difficulty at not being able to adhere to a religious fast or have to do some type of physical activity on the Sabbath, the Rabbi should be consulted to put the woman's mind at ease. Muslim women prefer female caregivers and keep themselves covered when a man enters the room.

There was discussion about the nutritional value of various ethnic foods and the significance of hot versus cold food.

Different backgrounds can influence whether a person is stoic or freely expresses discomfort. Many Chinese are perceived as stoic while Hispanics tend to be very expressive. Domestic violence exists in all cultures but is handled differently in some countries. In Africa, the abused party returns home, and family members confront the abuser. It is not considered a legal issue. Chan-Flynn showed a moving film addressing domestic violence in a Chinese community.

Kate Chalmers, RNC, WHNP, gave a dynamic presentation on the practice of female circumcision (mutilation). Chalmers is a women's health nurse practitioner who became interested in the topic when the daughter of a friend accompanied a college classmate to Africa. The 19-year-old African girl was a student and had agreed to this 'right of passage' to protect her family's honor. Chalmers' showed a Pultizer Prize winning slide presentation that captured both the physical and emotional results of this ritual. The

continued on next page

(Photo by Bonnie Godas)

Patricia Connors at Diversity in Childbearing Conference

Critical Care RN Program

continued from front cover

(Photo by Abram Bekker)

Ives Erickson, at graduation ceremony, wears replica of shawl worn by Florence Nightingale, whom she called, "a social activist, a visionary, and one of the most remarkable women of the nineteenth century."

Blake 8 Cardiac Surgical Intensive Care Unit, the Blake 7 Medical Intensive Care Unit, the Blake 12 Neuroscience Intensive Care Unit, the Ellison 3 Pediatric Intensive Care Unit, the Ellison 4 Surgical Intensive Care Unit, and the Ellison 9 Coronary Care Unit. The program had a 100% success rate with all participants successfully practicing on their respective units.

Graduation was held at the Holiday Inn on Blossom Street. Jeanette Ives Erickson, RN, senior vice president for Patient Care, opened the ceremony by welcoming the honorees, preceptors, staff, and leadership of the IHP, MGH, and North Shore Medical Center (who had two new graduate nurses in the program). Said Ives Erickson, "Like Florence Nightingale, you [graduates] are our newest trail-blazers. You are the future of nursing, and I know our profession is in good hands."

Heidi Simpson, RN, PICU, spoke on behalf of the new graduates. She called the program, "a challenging and rewarding experience and a great opportunity." She thanked program coordinators, Scott Ciesielski, RN, and Laura Mylott, RN, and unit leadership and preceptors for their support throughout the program.

Barbara Sprole, RN, Medical Intensive Care Unit, spoke on behalf of the preceptors. "This was an incredible learning experience for preceptors as well as new graduates," said Sprole. "There was always great support from everyone involved."

Carol Picard, RN, associate director for the Graduate Nursing Program at IHP, and Mylott, shared their experiences in helping to craft the program.

Ives Erickson presented new graduates with certificates of completion and a copy of Nightingale's *Notes On Nursing*. Preceptors were also given certificates of completion, a tuition voucher for the IHP, and a small gift.

The second New Graduate Critical Care Nurse Program began February 26, 2002. The summer program will begin on August 19, 2002. For more information or to apply, call Scott Ciesielski, RN, clinical educator in The Center for Clinical & Professional Development, at 726-3111.

Save the Date!

Patient Safety Awareness Week
March 11-15, 2002

Look for details on your unit

Call for Nominations!

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

Nominations are now being accepted for the June, 2002, Stephanie Macaluso, RN, Excellence in Clinical Practice Award.

Deadline for nominations is April 5, 2002.

Registered nurses, occupational therapists, physical therapists, respiratory therapists, speech-language pathologists, social workers and chaplains are eligible.

Recipients will be announced during the first week of June.

Award is $1,500 to be used toward an educational offering of the recipient's choosing.

For more information or assistance with the nomination process, call Mary Ellin Smith, RN, professional development coordinator, at 4-5801.

Diversity in Childbearing

continued from previous page

special nursing and medical considerations needed by a circumcised woman during labor and delivery were also addressed. Although female circumcision is rare among our patient population, we do need to be aware of the special care required to support a positive birthing experience for circumcised women.

Different cultural beliefs exist around breast-feeding. Lambergs stressed the importance of being sensitive to each woman's background in helping to facilitate nursing. For example: knocking before entering a room, to ensure privacy for women who may want to remain covered. Lambergs mentioned that the use of formula in some countries is considered a status symbol.

The conference focused primarily on providing a better understanding of our patients' cultural backgrounds. But perhaps a collateral benefit was instilling a greater appreciation of our colleagues who may have been educated in a different cultural setting. It is important that we hold onto our diverse perspectives, so that the many different customs and beliefs that make childbearing so personal and unique are preserved.

Evidence-based practice instills confidence, hope in Bigelow 14 patient

Tyese Maggio, RN, staff nurse (left), and Virginia Capasso, RN, PhD, clinical nurse specialist

We are Tyese Maggio and Virginia Capasso, staff nurse and clinical nurse specialist (respectively) on Bigelow 14. This is an account of our care of Mr. B, a 45-year-old Russian American man with severe peripheral vascular disease. Mr. B had undergone a left above-the-knee amputation years ago in Russia. Much later, after relocating to the United States, his disease progressed to his right lower extremity requiring lower extremity bypass surgery. After discharge, he was readmitted to the Vascular Surgery Unit with an infection of the wound and dehiscence (opening) of his incision. Needless to say, Mr. B was extremely anxious, as were his caregivers, to save his remaining leg.

Mr. B's wound was extensive, exposing muscle tissue and the prosthetic graft that surgeons had placed. The wound bed was substantially covered with devitalized necrotic and sloughing tissue. But Mr. B had come to the right place. Nurses and physicians on our unit have extensive experience with diverse and unconventional treatment modalities for wound care. His healthcare team went to work right away to collaborate on the best possible treatment of this wound, with the goal of saving his leg.

When standard saline wet-to-dry dressings failed, our nursing staff realized the need for a more aggressive treatment. We needed to hasten the wound-healing process and ensure wound closure to save the graft and Mr. B's leg. We suggested a less conventional treatment for Mr. B. We had had experience using a product called VAC dressing. VAC is a vacuum-operated device that attaches to a sponge dressing in a wound that is covered with Tegaderm to create a seal. It is used to evacuate debris, essentially debriding the wound and hastening granulation tissue-growth to close the wound.

We began by ordering the equipment. Two types of sponge dressings are available. One is more traditional and aggressive, one is more gentle, preventing bleeding and adherence to the wound bed. We knew Mr. B's graft was tenuous, but the need to speed closure over the graft was more important at the time. Plus, the device allows the vacuum pressure to be adjusted, so we opted for the traditional sponge with a low vacuum setting.

The next step was to measure the wound so that we could measure the effectiveness of the treatment every time the dressing was changed. Typically, the VAC is changed three times a week (Monday, Wednesday, and Friday, or Tuesday, Thursday, and Saturday) and, of course, more frequently in the event of occlusions or leaks.

Through our practice-based clinical experience with the VAC, we had developed a protocol for this dressing:

1) Irrigate the wound in a way that allows for pressurized irrigation to help remove any loose sloughing debris.
2) Dry the wound perimeter with sterile gauze to prevent maceration of the wound edge.
3) Paint the wound perimeter with a special barrier film to protect the healthy tissue.
4) Place a piece of Duoderm close to the perimeter of the wound to cushion the tubing and prevent any pressure ulcers at the wound edge.
5) Cut the sponge so that it will completely fill the wound bed and place it inside the wound.
6) Cover the sponge with occlusive adhesive, creating a complete and tight seal. Pinch the adhesive around the tubing to prevent pressure on the Duoderm.

Using this protocol, Mr. B's wound was cleaned and dressed. The procedure can seem tedious and complicated to nurses with little VAC experience, or to a patient who is relying on you to save his limb. Mr. B watched in awe as we dressed his wound. The look in his eyes told us he was frightened. The whole experience was overwhelming for him, but he soon learned that with practice and experience, this treatment could save his leg.

Within two days, (second dressing change), the VAC had already debrided some of the devitalized tissue and granulation had begun over the graft. Each time we changed the dressing, less slough was apparent and more granulation had occurred. The size of the wound also decreased each time. The graft had finally been covered with new tissue, and we could now proceed with more aggressive treatment by increasing the vacuum pressure gradually to its maximum setting.

The treatment was working and Mr. B had become very hopeful. He began to advocate strongly for himself. Every Monday, Wednesday, and Friday he would call the nurses' station at 8:00am sharp letting us know that this was the day his dressing needed to be changed. He also became very active in his own wound care. He would sit up in bed watching our technique, offering suggestions on how to cut the sponge, and telling us where to place the duoderm, tubing, and adhesive. Eventually, Mr. B actually donned gloves and assisted us in changing his dressings. This helped him feel more involved in his care, more confident in us and in the treatment itself.

After two weeks of the VAC treatment, Mr. B's

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Greene receives Black Rose Award

Ron Greene, RN, case manager and chair of the Association of Multi-cultural Members of Partners (AMMP), was one of five Boston-area residents to be chosen as a recipient for this year's Black Rose Award, an honor bestowed each year by the Kappa Nu chapter of the Sigma Gamma Rho sorority of Northeastern University.

Ron Greene, RN, case manager

According to Kappa Nu's description of the award, a Black Rose is a black man who displays sincere, dedicated interest, and commitment to uplifting his people. A Black Rose shares his knowledge and serves as a positive role model for young African Americans in the community, thereby planting the seeds for others to develop into Black Roses of the future.

The recognition ceremony was held on Thursday, February 21, 2002, at Northeastern University. Patient Care Services congratulates Ron for this well-deserved honor.

New name, new criterion for Macaluso Award

The Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award recognizes direct-care providers whose practice exemplifies our values and vision. Since 1996, 37 clinicians have received the award and 86 others have been nominated.

This award has taught us much about practice that is *caring, innovative, guided by knowledge, built on a spirit of inquiry and based on a foundation of leadership and entrepreneurial teamwork.* It is from this knowledge that two changes are being introduced beginning with the June, 2002, presentation of the award.

Effective immediately, the award will be called, The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award. With the introduction of the Clinical Recognition Program it is important to remain clear about the intention of the Macaluso award. Stephanie's commitment to excellence has been a guiding principle in all decisions concerning the award. The new name allows us to continue to celebrate excellence at all levels of practice.

The other change is the addition of leadership as a criterion for the award. Leadership has been continuously reflected in the portfolios of past recipients and nominees. Leadership occurs when clinicians are positive role models, willingly share knowledge with others, collaborate effectively with other disciplines and influence practice on other units, in other departments and other disciplines. More information about these changes will be available on your unit.

Nominations are now being accepted for the June, 2002, Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award. For more information, call Mary Ellin Smith, RN, at 724-5801.

Exemplar

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wound was two-thirds full of healthy new granulation tissue. Treatment needed to continue, but Mr. B was no longer in need of acute hospital care; he was out of immediate danger. We began a search for a skilled nursing facility where he could continue his VAC treatment, but soon learned that very few skilled-nursing or rehab-nursing staff have experience with VAC dressings. And Mr. B's insurance didn't cover treatment in his home by visiting nurses.

It was decided that Mr. B would stay at MGH for VAC wound care until his wound closed. Within one more week, the wound bed was completely filled with granulation. Mr. B was discharged home on once-a-day Panafil dressing changes performed by visiting nurses. As of this writing, there have been no reports of complications.

Mr. B's story is a prime example of how practice-based clinical knowledge can change someone's life. I remember the look of fear in Mr. B's eyes during his first week at MGH. By the end of the second week he was relieved; he knew we were succeeding in saving his leg and his actions and words showed it. Whenever we completed a dressing change he would smile and give us a 'thumbs-up.' It still makes me smile when I remember him saying in his thick Russian accent, "Thank-you very much."

We thank Mr. B and patients like him who give us the opportunity to expand our clinical knowledge through practice.

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

This is a wonderful example of evidenced-based practice and critical thinking. The knowledge and experience of these two clinicians told them that standard treatments would not save Mr. B's leg. They advocated for the use of VAC dressings, and the team supported them. They weighed the benefits of different sponges based on Mr. B's specific needs. And in the midst of all this technology, they were able to give a frightened patient reassurance and hope.

I think it's a testament to Tyese and Ginger's presence and quality of care that Mr. B not only looked forward to his dressing changes, but put on gloves and participated in his own care! What a terrific story of teamwork and knowledge-based practice.

Thank-you, Ginger and Tyese.

Same Day Surgery Unit participates in hands-on arthroscopy simulation lab

—by Patricia Lynch, RN, BSN, orthopaedic team leader, SDSU

On Thursday, February 14, 2002, approximately 25 nurses and scrub technicians from the Same Day Surgery Unit (SDSU) attended an educational seminar in the Arthroscopic Simulation Lab in Ruth Sleeper Hall. The seminar was offered by Dr. Dinesh Patel to help educate staff and provide hands-on experience with arthroscopic instrumentation.

Patel began with a brief review of knee anatomy and went over key clinical-evaluation and diagnostic aspects of knee injuries. Four stations were available for SDSU staff to simulate the use of instrumentation and experience the hand-eye coordination necessary to perform precise arthroscopic procedures. Staff fully appreciated the difficulty involved in achieving the level of hand-eye coordination and manipulation of instrumentation necessary to effectively 'scope' a knee.

An added level of difficulty, as well as an element of fun, was introduced when heart-shaped tags were 'planted' in the knee joints so participants could simulate loose-body retrieval techniques.

(Photos by Paul Batista)

Above and at left: nurses and scrub technicians from the Same Day Surgery Unit simulate arthroscopic techniques under the direction of Dr. Dinesh Patel.

Call for Nominations!

The Susan and Arthur Durante Award for Exemplary Care And Service with Cancer Patients

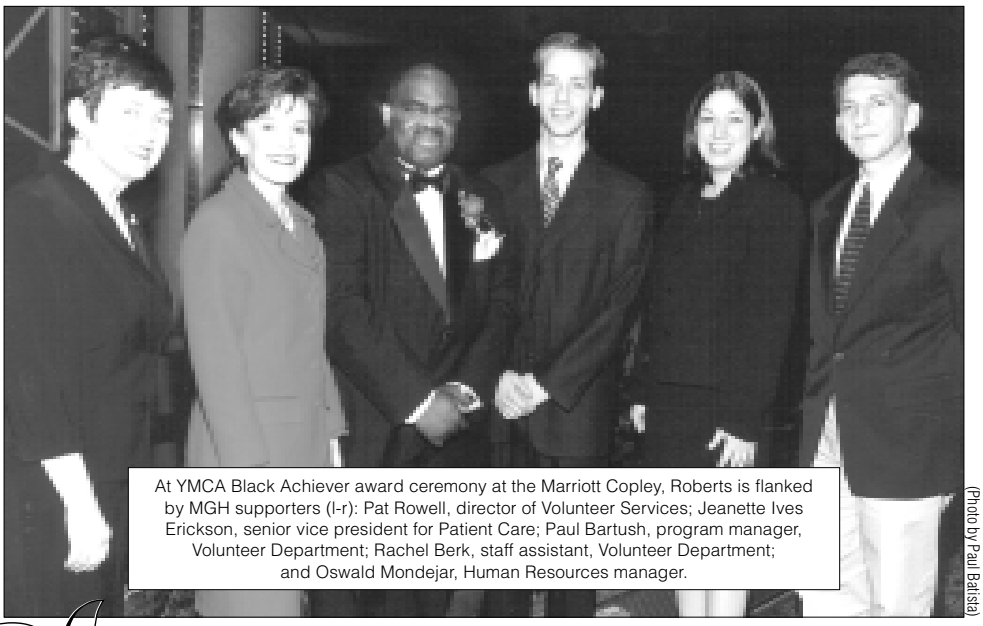
The MGH Cancer Center is now accepting nominations for the 2002 Susan and Arthur Durante Award for Exemplary Care and Service with Cancer Patients. The award recognizes clinical caregivers and support staff whose work with cancer patients reflects compassion, caring, exemplary performance, and outstanding work.

Recipients receive $1,000 each.

Deadline for nominations is Friday, March 15, 2002

For more information, please contact Joelle Reed at 6-2689.

Roberts named 2002 YMCA Black Achiever



At YMCA Black Achiever award ceremony at the Marriott Copley, Roberts is flanked by MGH supporters (l-r): Pat Rowell, director of Volunteer Services; Jeanette Ives Erickson, senior vice president for Patient Care; Paul Bartush, program manager, Volunteer Department; Rachel Berk, staff assistant, Volunteer Department; and Oswald Mondejar, Human Resources manager.

(Photo by Paul Batista)

Sam Roberts, coordinator for MGH Volunteer Services, was named one of this year's Outstanding Black Achievers, a prestigious award given each year by the YMCA. Roberts was honored at a special celebration held on January 31, 2002, at the Marriott Copley Place.

The Black Achievers Program was created to recognize African American professionals in the Greater Boston area who have contributed significantly in the workplace, and who are committed to mentoring and nurturing young people in the community.

Roberts was nominated by three colleagues: Pat Rowell, director of Volunteer Services, Paul Bartush, program manager, Volunteer Department; and Rachel Berk, staff assistant, Volunteer Department. In their letter of nomination for Roberts, they wrote: "Sam has been known as a team player throughout his 26-year employment at MGH. He is known for his willingness to jump in at a moment's notice, to lend a hand regardless of what needs to be done. He is fully invested in everything he does, at work as well as in the community."

Roberts interviews, orients, and coordinates the assignments of approximately 1,200 volunteers at MGH. He also leads the MGH bicycle team that supports many local and national charities.

Upon hearing of Roberts' recognition, Rowell expressed her pride, saying, "Sam has always put our patients first. It's wonderful to see him recognized in this important way. He is a kind and caring person, and we're lucky to have him in our department."

Nursing Green!

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NERBNA celebrates National Black Nurses Day at MGH

On Tuesday, February 19, 2002, the New England Regional Black Nurses Association (NERBNA) held its annual meeting and award ceremony at MGH, honoring three of the area's most eloquent, gracious, and accomplished nurses: E. Lorraine Baugh, RN; Patricia Beckles, RN; and Joanne Prince, RN.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, and senior vice president for Human Resources, Jeff Davis, were both on hand to offer congratulations and welcome NERBNA to MGH. Said Ives Erickson, "If we can spark an interest in nursing in one young minority person, we will have succeeded. I hope you'll return to MGH again and again, and let us support you in this important work."

NERBNA board member, Sebra Barcuis, RN, presented an historical perspective of black nurses and their contributions to nursing in America and around the world. Barcuis mentioned such notable black nurses as Harriet Tubman, Sojourner Truth, Susie King Taylor, and the first black registered nurse, Mary Eliza Mahoney. Her presentation included one of the evening's honorees and founder of NERBNA, E. Lorraine Baugh.

One of many common traits shared by the three honorees is that they're all 'retired,' and all still working tirelessly making a difference in the lives of patients and in their communities. In their acceptance speeches, each woman spoke from the heart about her commitment to nursing.

Said Baugh, "I'm delighted to see so many 'firsts' for black nurses. I look forward to many more firsts in the coming years."

Prince commented on the importance of providing culturally competent care, saying, "I'm so pleased to see so much attention focused on the needs of all patients. You young nurses, you keep on keepin' on!"

And in typical fashion, Beckles ended on a high note, saying, "If there's a young person within the sound of my voice who's thinking about becoming a nurse, *come see me*! I'll give you such encouragement. There is nothing more rewarding than being a nurse!"

(This photo by Paul Batista)

Clockwise from left: Award recipients, Patricia Beckles, RN, Joanne Prince, RN, and E. Lorraine Baugh, RN, listen during historical presentation; Beckles addresses gathering after accepting award as Ron Greene, RN, NERBNA president, looks on; Greene pins PCS director of Diversity, Deborah Washington, RN, in recognition of being the first NERBNA nurse to hold the position of director of Diversity.

When/Where	Description	Contact Hours
March 18 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
March 21 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
March 21 8:00am–4:30pm	**Operations Associate Preceptor Development Program** Training Department, Charles River Plaza	---
March 21 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
March 22 8:00am–4:30pm	**Taking Care of the Cardiac Patient: Knowing the Basics** O'Keeffe Auditorium	TBA
March 25, 27, 28 (Note: days not consecutive) and April 1, 2, 3 7:30am–4:00pm	**ICU Consortium Critical Care in the New Millennium: Core Program** Mount Auburn Hospital	45.1 for completing all six days
March 25 8:00–11:00am and 12:00–3:00pm	**Care for Patients at the End of Life: Clinical & Ethical Considerations** Wellman Conference Room	4.5
March 26 1:00–3:00pm	**Basic Cardiac Pacing** VBK601	TBA
March 27 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
March 27 8:00am–4:00pm	**CVVH Core Program** VBK601	6.3
April 1 and April 8 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
April 4 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
April 4 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
April 5 8:00am–4:30pm	**Nursing: a Clinical Update (MGH School of Nursing Alumnae Homecoming Program)** O'Keeffe Auditorium	TBA
April 9 9:00am–4:30pm	**Management of the Burn Patient** Bigelow 13 Conference Room	6.9
April 10 1:30–2:30pm	**OA/PCA/USA Connections** "Handling Difficult Patient Situations." Bigelow 4 Amphitheater	- - -
April 10 5:30–7:00pm	**Advanced Practice Nurse Millennium Series** O'Keeffe Auditorium	1.2
April 10 8:00am–2:30pm	**Mentor/New Graduate RN Development Seminar I** Training Department, Charles River Plaza	6.0 (mentors only)
April 11 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2

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

Golden Rule alive and well on Phillips 20

Phillips 20 nurse manager, Keith Perleberg, RN, and operations coordinator, Beverley Cunningham (seated, left), with unit service associates (l-r): Ange Joseph, Nancy Edwards, and Dina Flores (seated).

Nurse manager, Keith Perleberg, RN, recalls, "When I first started as nurse manager on Phillips twenty, Bev Cunningham, our operations coordinator, told me we had three very special unit service associates. And it wasn't long before I saw for myself what a delightful, kind, responsible team they are." Perleberg is talking about unit service associates, Nancy Edwards, Ange Joseph, and Dina Flores.

Says Cunningham, "Keith and I wanted to do something to show our appreciation for the contributions these three woman make to our unit every day. They add such richness to the lives of our patients, visitors and staff."

Perleberg and Cunningham started having 'appreciation lunches' every six weeks or so. They would order food from various local restaurants and the five of them would sit and have lunch together. Says Perleberg, "It was our way of saying thank-you for their hard work and the incredible, unique spirit they bring to the unit."

So it came as a complete surprise one morning when Edwards, Joseph and Flores announced that they had ordered lunch for the entire staff of Phillips 20 to show *their* appreciation for the 'home' they've found on this unit.

Says Joseph, "We wanted to do something special because our managers are so nice, so understanding, and so willing to get involved."

Edwards agrees. "Having lunch with Keith and Bev every month made us feel special. We wanted to do something nice for them in return."

It sounds like Phillips House 20 is a pretty nice place to work.

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