

Caring

HEADLINES

May 23, 2002

Nurse Week

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Special Issue

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Photos of MGH nurses throughout this issue of *Caring Headlines*



MGH Patient Care Services
Working together to shape the future

Sally Lai

White 8 staff nurse, Sally Lai, RN,
with patient, Nancy Ruggiero

MGH nurses have fun, fun, fun on the “Journey of a Lifetime!”

Part travelogue (Mt. Kilimanjaro), part *Entertainment Tonight* (video clips of *The West Wing*), and part game-show nostalgia (re-enactment of *The Family Feud*), senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson’s Nurse Week presentation was part tribute to the excellence of MGH nurses and part unabashed *fun!*

Teamwork was the order of the day, in word and deed. Following Ives Erickson’s presentation, nurses from the PACU and ED participated in a revival of the old TV game show, *The*

Family Feud, the likes of which you’re not likely to see again within the walls of MGH. Questions were designed to test participants’ knowledge of recognition, professional practice, communication and retention within the department of Nursing. The game spotlighted the need to work together as a team in order to succeed. And if laughter and applause were any indication, the demonstration was a roaring success!

Punctuated by photographs, slides, video clips and television newscasts, what follows is the text of Ives Erickson’s presentation, entitled, “MGH Nursing: the Journey of a Lifetime” (edited for space).

While this week is a formal celebration of the contributions nurses make, I would be remiss if I failed to mention that a lot has changed since our last Nurse Week celebration. The world has changed. The contributions we make have changed. Our practice has changed. And our patients have changed. Since September 11th, MGH nurses on our DMAT and IMSURT teams have applied their skills in a country they once hoped would never need them. These nurses were able to focus on their work at Ground Zero and at the Cornell Burn Unit in New York because of the support they got from you, their colleagues.

You did whatever it took to fill in the shifts left vacant by your peers. Our

Department nurses have teamed up with colleagues in the community creating systems to keep us safe. All MGH nurses are aware that we have fewer patients from around the world. And we have all learned that the lives of those we work with are precious. So today, I want to talk about teamwork.

It is the people of MGH that make this a world-class institution. It is because of you, individually and collectively, that being a nurse at MGH is the journey of a lifetime.

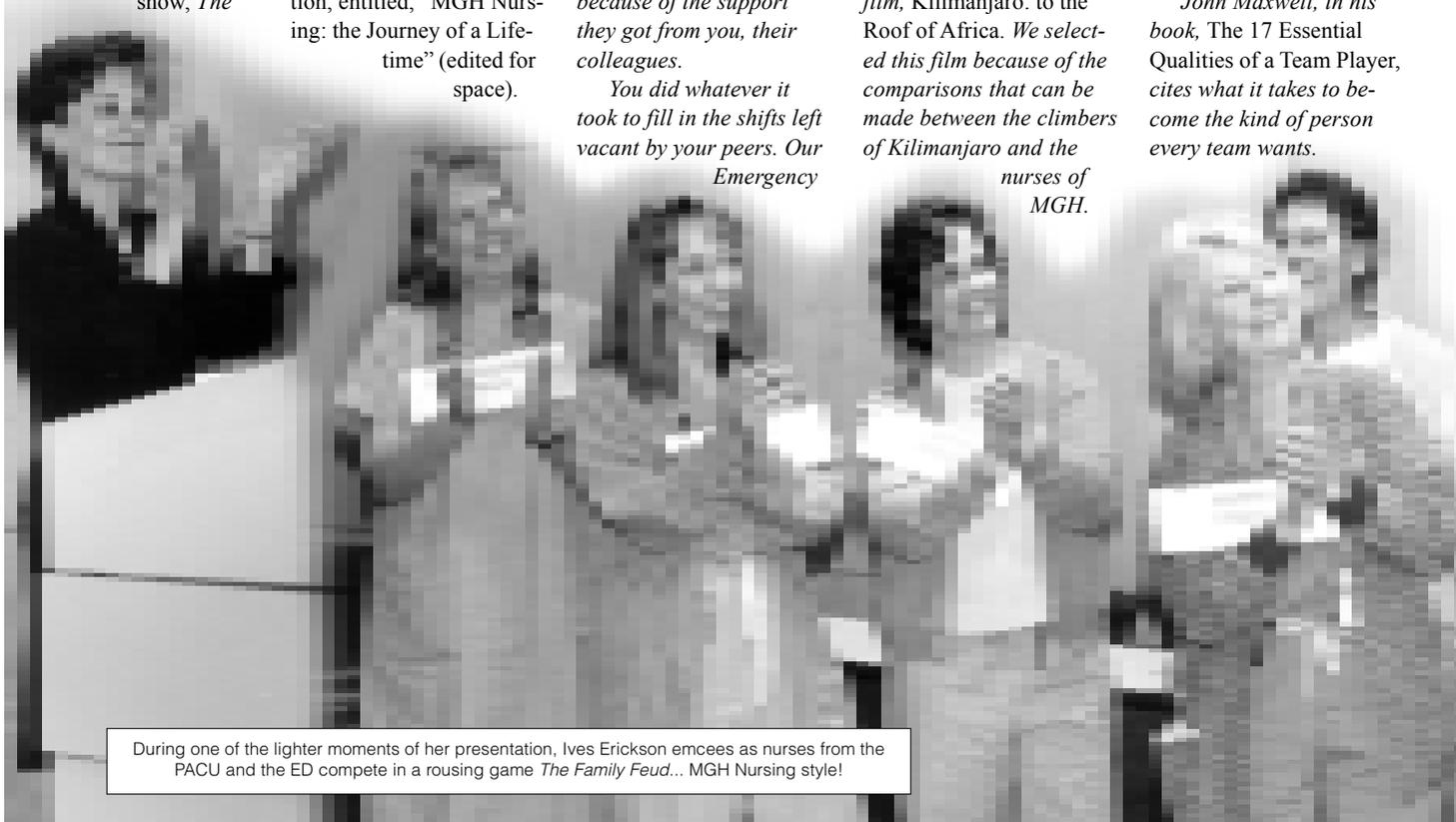
“Journey of a lifetime” is a phrase we borrowed from the Omni Theatre film, Kilimanjaro: to the Roof of Africa. We selected this film because of the comparisons that can be made between the climbers of Kilimanjaro and the nurses of MGH.

Like MGH, Kilimanjaro is a landmark of beauty and mystery, revered like no other. Kilimanjaro and MGH are extraordinary, spectacular, and quite unique. Kilimanjaro means, ‘mountain of greatness’ (note the M and the G).

Like climbing Kilimanjaro, the knowledge and skills required to be a nurse at MGH are varied and complex. Individuals may come to the mountain and to MGH, but it is a team that ensures the success and safety of the team members.

A team is a group of people with complementary skills, committed to a common purpose, goals, and approach for which they hold themselves accountable. You cannot build a great team without great team players.

John Maxwell, in his book, The 17 Essential Qualities of a Team Player, cites what it takes to become the kind of person every team wants.



During one of the lighter moments of her presentation, Ives Erickson emcees as nurses from the PACU and the ED compete in a rousing game *The Family Feud*... MGH Nursing style!

A great team player is:

- *adaptable*: willing to adapt to the team; does not expect the team to adapt to her
- *collaborative*: working together precedes winning together
- *committed*: there are no half-hearted champions
- *communicative*: many voices with a single heart
- *competent*: capable and highly qualified to do the job well
- *dependable*: the 'go-to' players
- *disciplined*: where there is a will, there is a win
- *enlarging*: adding value
- *enthusiastic*: your heart is the source of your energy
- *intentional*: working with purpose; making every action count
- *mission-conscious*: keeping the big picture in mind; continually looking for ways to help the team achieve its goal

- *relational*: building solid relationships with teammates
- *self-improving*: always trying to be the best you can be
- *selfless*: there's no 'I' in team.
- *solution-oriented*: having ideas about how to overcome obstacles
- *tenacious*: never, never, never quit

Every day we see the phenomenal outcomes of high-functioning teams at MGH. In our collaborative governance structure the essential characteristic is a team approach. Collaborative governance has become an important force at the MGH.

Our Clinical Recognition Program is the result of several teams (the Professional Development Committee; the Implementation Steering Committee; and the newly-formed review board) working together to pave the way for this new culture.

The Staff Nurse Advisory Committee provided invaluable input into the creation of the MGH Nursing Image Campaign. Their candor, creativity, and ability to articulate what it's like to be a nurse at MGH contributed to a campaign that will differentiate MGH nursing from the competition. Each ad in the campaign has the tagline: 'Simply the Best.'

I'd like to talk about the 7 essential skills of teamwork. These are the skills you would see if you observed a high-functioning team in action:

- *Listening*
- *Questioning*
- *Persuading*
- *Respecting*
- *Helping*
- *Sharing*
- *Participating*

And there is another important ingredient in any successful team. It is impeccable leadership.

An effective leader:

- engages people so it feels like all members contribute in a material way

- provides broad and equal support to his/her efforts, including equal access to influence his/her thinking
- adds value to others' decisions in a manner that makes them think, but allows them the final authority for the decision
- asks provocative questions and makes provocative suggestions that challenge the status quo to improve business performance and develop everyone's capabilities for the future.

There is a quote from The West Wing that I particularly like. It was said by Martin Sheen in his role as President while addressing his White House team. He said, "What will be the next thing that challenges us, that makes us go farther and work harder?"

As we continue on our "Journey of a Lifetime" as MGH nurses, I ask the same question of you.

What will be the next thing that challenges us? Together, there's nothing we cannot accomplish.

I'd like to end with this quote from Bill Clinton. And I want you all to substitute the words, 'chief nurse' where he says 'President,' because this is how I feel about all of you.

"Nothing the President does is possible without the talent, devotion, and hard work of the staff and the cabinet. I think it's very important that every President acknowledge, and the American people understand, that it takes teamwork; it's a group enterprise. The President needs to be responsible for the mistakes made on the big calls, but a lot of the really good things that happen day in and day out are because of the people who work here."

Thank-you, and Happy Nurse Week!



Using adverse events to enhance practice and improve systems

In the kick-off presentation of Nurse Recognition Week, Joan Fitzmaurice, RN, PhD, director of the Office of Quality & Safety, moderated a multi-disciplinary panel discussion designed to simulate the kind of investigative discourse that occurs when an incident report is filed following an adverse event.

Panelists representing Nursing, Respiratory

Care, Medicine, Risk Management, Biotechnology, and the Office of Patient Advocacy, were given a brief summary of a hypothetical adverse event that could occur in 'any hospital USA.' The session was unscripted; audience members were given a 'fly-on-the-wall' view of the investigative process as it unfolded among panelists.

The fictional incident presented to panelists was:

Patient X went for a diagnostic test as part of his work-up. He left the unit at approximately 8:30am. He had a trach tube to a mask; the cuff was inflated. Tube feeding had been turned off at 7:30am.

Patient X was in the waiting area when his wife witnessed him vomiting. He was suctioned, experienced extreme respiratory distress, and a code was called.

Following the reading of the incident, Fitzmaurice asked questions of panelists in an attempt to establish a more detailed understanding of the events that led to the code. Each question triggered more questions, and a much broader description of the incident was soon revealed. Discussion focused on precautions taken, documentation, communication, plan of care, medi-

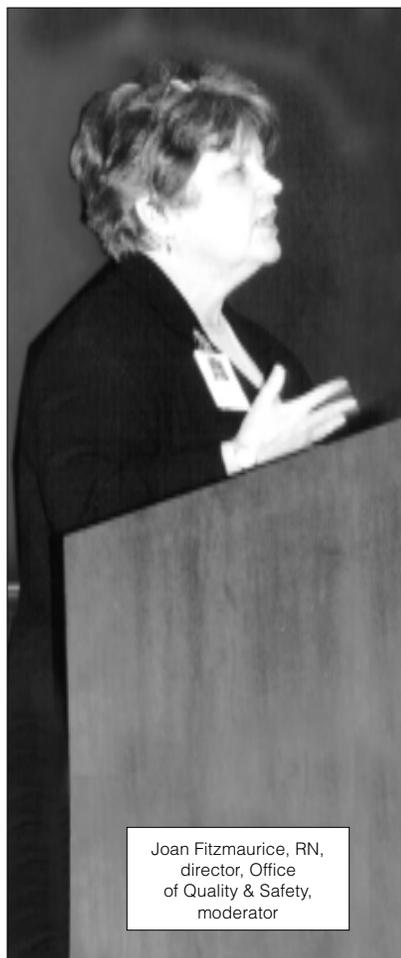
cal history, nursing assessment, level of experience of staff involved, technological concerns, policies and procedures, interventions, and much more.

The framework for analyzing and identifying contributing factors centered around:

- The care process
 - patient-assessment
 - plan of care
 - medication
- The caregivers
 - Human Resource issues
 - the human factor
 - the communication process (patient-family-staff)
- The environment
 - information management issues
 - equipment/technology
 - physical plant

Throughout the discussion, Fitzmaurice stressed that the purpose of the investigative process is not to assign blame, but to learn from the events, identify opportunities to improve systems, and implement strategies to reduce risk in the future. More often than not, said Fitzmaurice, adverse events are the result of multiple factors not the mistake of any one person. Frequently, incidents result from a breakdown in systems, indicating that a change in policy is called for.

Switching from 'any hospital USA' to MGH, Fitzmaurice said, "Staff need to know that this is a safe environment in which to explore these issues. Close examination of adverse events is essential to minimizing the risk of future events. And that can only be done effectively in a blame-free environment."



Joan Fitzmaurice, RN, director, Office of Quality & Safety, moderator

Patient X went for a diagnostic test as part of his work-up. He left the unit at approxi-



Panelists (l-r): Susan Sheridan, RN; Beth Nagle, RN; Patricia Wright, RN; Purris Williams, RRT; Cy Hopkins, MD; Diann Burnham, RN; Marilyn McMahon; and Ellen Kinnealey, RN (Honor Keegan, RN, not pictured, recorded panelists' comments)



Lucinda Afolabi

Staff nurse, Lucinda Afolabi, RN, with 11-month-old, Praneil Kumar, in the Pediatric Intensive Care Unit

Scientific

Collaborating to improve pain assessment: a multi-disciplinary thoracic oncology team implements JCAHO pain standards in ambulatory setting

Unit nurse leader, Barbara Cashavelly, RN, MSN, and nurse practitioner, Jennifer Tenhover, RN, MS, presented the results of their (and co-investigators: Karen Sommer, RN, MSN; and Joan Agretelis, RN, PhD) research study, entitled, "Collaborating to improve pain assessment: a multi-disciplinary thoracic oncology team implements JCAHO pain standards in ambulatory setting."

The purpose of the study was to determine if implementation of JCAHO pain standards would impact the average pain rating of patients in the ambulatory thoracic oncology setting.

They began by defining pain as, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." Since methods of assessing pain were not standardized across the practice setting, the research team saw this an opportunity to implement JCAHO pain standards and measure the results against a baseline pain-scale rating.

The research study asked two questions:

- What is the average pain rating for MGH outpatient thoracic oncology patients before implementation of JCAHO pain standards?

- Will the standardized assessment and recording of pain ratings in the patient record improve pain-rating scores?

The study consisted of two phases, each 11 weeks in duration. A key aspect of the study was the education and participation of medical assistants in obtaining pain-scale ratings from patients.

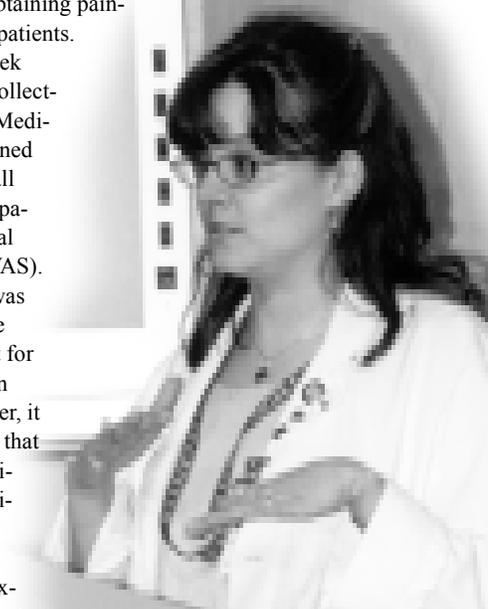
The first 11-week period was spent collecting baseline data. Medical assistants obtained pain ratings from all thoracic oncology patients using a Visual Analogue Scale (VAS). This information was not entered into the patient's chart (but for patients with a pain rating of 5 or greater, it was recommended that they tell their physician or nurse practitioner).

The second 11-week period was exactly the same except the JCAHO pain-standards were implemented as "the fifth vital sign," entered into the patient's chart, and recorded in a database.

Average pain scores from both phases were calculated and compared. The study showed that pain-management awareness was increased with identification of practice variations.



Barbara Cashavelly, RN,



Jennifer Tenhover, RN

Sessions

The use of respite care services by parents of children with chronic illness and disability

Nurse researcher, Nancy Terres, RN, PhD, of the Graduate Program in Nursing at the MGH Institute of Health Professions, presented the results of her research study, entitled, "The use of respite care services by parents of children with chronic illness and disability."

The study examined the use of respite-care services by parents of children with chronic illness and disability:

- by examining the factors that encourage or discourage the use of such services by this parent population
- by assessing the characteristics of parents' coping styles and family functioning to determine if these factors are related to whether or not they seek and/or use respite-care services

Terres defined respite care as, "a formal support service designed to give family members temporary, short-term relief from the care of a child with chronic illness or disability."

The study was exploratory, using a cross-section of eligible parents. Criteria were established to determine which families were eligible:

- The parent was the primary caregiver for a (chronically ill or disabled) child, aged 8 months to 20 years old
- The child was living in the parent's home on a full-time basis
- The child had been living in the home with the illness or disability for at least 6 months
- navigating around system obstacles
- finding strong advocacy within the system

Interviews were conducted by mail (questionnaires), by telephone, and in person. A booklet entitled, *Parent Survey on Respite Care* was sent to participating parents along with a cover letter (stamped return envelope, and pencil). A small stipend of \$25 was paid upon return of completed questionnaires.

Some reasons cited for not using respite care included:

- no knowledge of respite-care services
- making arrangements was a problem
- medical needs too complicated
- won't leave child with a stranger
- family doesn't qualify
- not enough money

Some families were able to obtain services by:

- developing personal relationships with their child's caregivers
- mobilizing community services

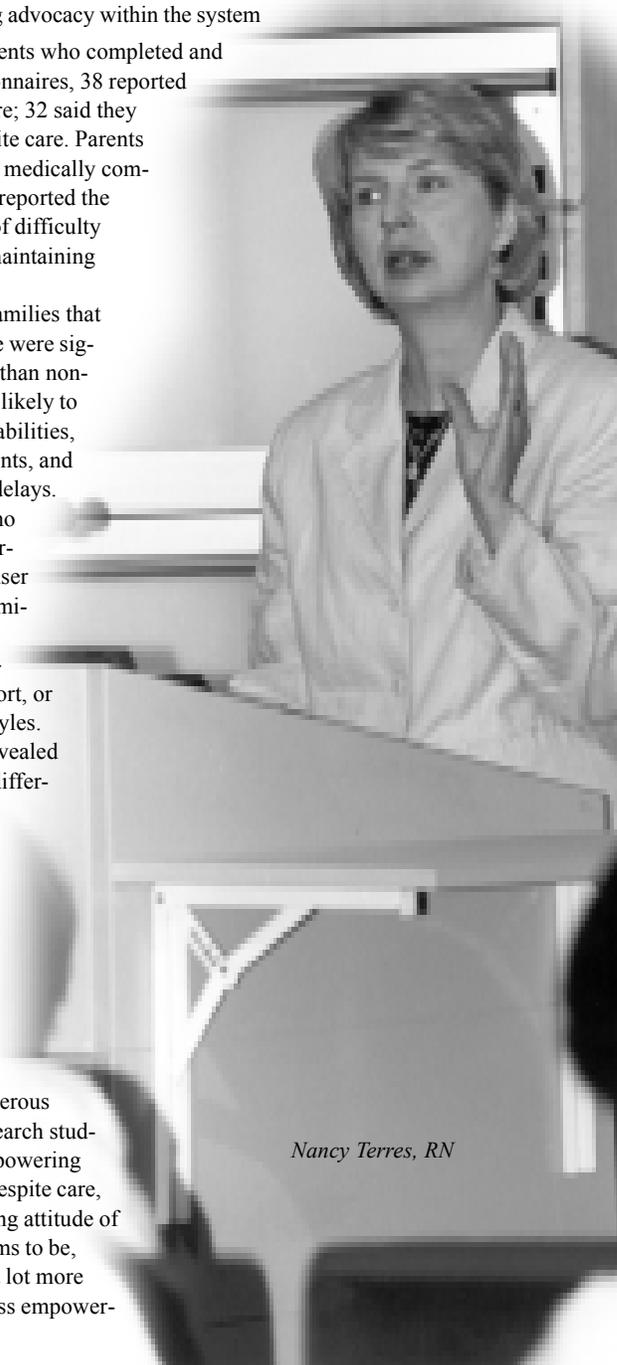
Of the 70 parents who completed and returned questionnaires, 38 reported using respite care; 32 said they did not use respite care. Parents of children with medically complex care needs reported the highest degree of difficulty obtaining and maintaining respite care.

Children in families that used respite care were significantly older than non-users, and more likely to have speech disabilities, visual impairments, and developmental delays.

There were no significant differences between user and non-user families in terms of family functioning, social support, or parent coping styles.

The study revealed no substantive differences/improvements in the availability of respite care since a previous survey conducted in Massachusetts nearly two decades ago.

Despite numerous surveys and research studies aimed at empowering families to use respite care, the overwhelming attitude of parents still seems to be, "We could use a lot more help and a lot less empowerment."



Nancy Terres, RN

May 23, 2002



Tara Tornabeni

Bigelow 11 staff nurse, Tara Tornabeni, RN,
with patient, Nidia Medina

Kathy Carr

Ellison 9 staff nurse, Kathy Carr, RN,
with patient, William Baker



Nursing addresses many facets of the human condition

My name is Ann Eastman. I have been a nurse for 27 years. I've had many different experiences with patients. When I look back, some of my experiences make me laugh, some make me cry, and some just make me shake my head and wonder. Each is unique and different. I had cared for patients who had lost loved ones while hospitalized before, but with Ms. Q, I was directly involved in conveying the news of the unexpected death of a loved one.

When I got report on Ms. Q on Sunday morning, I learned the basics about her hospitalization and our interventions so far. She was a middle-aged woman from the South who had needed a tracheal repair secondary to tracheal stenosis. This meant she would have a variety of needs. She would require close observation of her respiratory status, monitoring for tracheal edema, and encouragement to rest her voice and participate in pulmonary hygiene activities. I knew she would need encouragement to ambulate and 'get moving.' Pain could also be an issue since her chin (as is typical in this type of surgery) had been loosely sutured to her neck to keep her head in

a forward position to prevent strain on her tracheal anastomosis. This position can put a lot of tension on the muscles at the back of the neck and can be uncomfortable. She was also likely to have some pain at the incision line across her neck. I would need to assess her nutritional status and her swallowing capabilities. She would be advanced to a clear-liquid diet and would need supervision to be sure she could swallow with her head in this position. Further, we needed to discuss her history of diabetes and her medications (which included medications for neuropathic pain, diabetes, irritable bowel syndrome and depression). With all these issues in mind, I began to plan her care.

Then, to complicate matters even more, I was informed by the night staff that they'd just gotten word that Ms. Q's mother had passed away.

Beth, a friend of Ms. Q, had accompanied her to Boston and was staying at a hotel nearby. I felt it was too early in the morning to call Beth; I decided to wait until about 9:30. I also decided I wouldn't discuss the matter with Ms. Q until her friend could be with her. I was prepared to

revise this plan if too much time went by, or if I was unable to reach Beth.

Next, I spoke with the resident who would be speaking with Ms. Q's surgeon to be sure there were no medical reasons not to inform Ms. Q of her mother's death. The surgeon had no reservations about going ahead.

I went in to see each of my patients to check vital signs and give meds. When I met Ms. Q, she was very formal with me calling me, "Ma'am," despite introducing myself by my first name. She seemed a little stiff and distant. I wasn't feeling a comfortable relationship here, and I knew this could complicate things when it came time to give her the news of her mother's death.

I watched for visitors arriving on the unit, hoping to head off any company Ms. Q might have. But I became involved in an emergent situation elsewhere on the unit and didn't see Beth arrive. I knew asking her to step outside would be awkward, but I did so with apologies to Ms. Q.

I didn't know what Beth's relationship with Ms. Q was, or whether Beth had known Ms. Q's mother. So I had some trepidation about breaking the news to Beth. When I did tell her, she



Ann Eastman, RN
staff nurse, Bigelow 14

was shocked and saddened. She became teary-eyed. She said she had just talked to Ms. Q's mother the previous evening. Beth and Ms. Q had grown up together and Beth had known Ms. Q's mother nearly all her life. This was a personal loss for Beth, too. I now needed to comfort Beth and make some plan with her, despite her own sorrow, to tell Ms. Q.

First, I helped Beth call her hometown and get the details of what had occurred. I let her use our staff lounge so she could have some privacy and speak without distraction.

I returned to Ms. Q's room and began reviewing medications with her as we had planned. I felt uncomfortable doing this, wondering if it was appropriate at a time like this. But I felt that leaving her alone with her friend absent on a very thin explanation would feel like desertion. My plan was to let Beth get some information and

then have Ms. Q learn about her mother's death with her close friend and a caring nurse there to support her.

When we were done reviewing meds, I found Beth and we prepared to talk with Ms. Q. We spoke some words of comfort and encouragement to each other and joined Ms. Q in her room. With Beth sitting on her bed and me close by, Beth told her the news as gently as she could. Ms. Q looked totally unbelieving and then began to sob. My heart went out to her, even as the clinician in me worried about her making any sudden head or neck movements that might damage the repair.

Beth and I had also decided that a chaplain might be helpful. I had made arrangements for the Catholic chaplain to come. When he arrived, I briefed him quietly and he came in, prayed, and spent some time with both Beth and Ms. Q. I

continued on next page

Exemplar

continued from page 10

left to catch up on my other patients, whom my colleagues had been monitoring, to give me time to be with Ms. Q and Beth.

When I returned to the room, Ms. Q thanked me for my help. She said she had felt some awkwardness when her friend left so abruptly, even some irritation. But she said she understood now and was very grateful for what we had done. She told me about the plans and arrangements they were making. She told me a little about her mom, about how she and Beth grew up together, about their being sisters in their hearts.

Beth called her husband and made arrangements to stay in Boston a few more days. By this time, Ms. Q and I were on a first-name basis. I called her Abby. As it turned out, Abby's brother was on his way to Boston to see her. He was driving an RV and was bringing his dogs. He couldn't be reached on the road and so didn't know about his mother's death. I needed to find some information about parking an RV and boarding dogs. Why not? I contacted Social Services. They were very helpful; they referred me to a good resource for boarding dogs, and they suggested that Security could help with the parking question.

I, of course, had the usual physical care to provide for Abby as well. We followed up on my outlined plan of care, limiting some activities in deference to her mourning.

Later in the afternoon, Abby and I were alone. She said Beth had called her mother Saturday to let her know she had done well in surgery. She felt that had brought her mother some peace. She showed me a set of rosary beads. Her mother had suggested they exchange rosaries before she came in for her operation. It gave her a special connection to her mother, and I felt privileged to be included in that bit of intimacy.

While nursing may be made up of many little acts, for me it is utterly complex. Each thing that I did for Abby could be considered "simple." But taken all together, they made it possible for me to pro-

vide good basic care, and with the help of the team, care that addressed many facets of the human condition.

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

One of the great joys of nursing is having that opportunity to impact another person's life. Ann's sensitivity in supporting Ms. Q through the ordeal of learning about her mother's death while ensuring optimal post-operative care is truly exemplary. Ann's plan of care even extended to finding shelter for her patient's brother's dogs and a place to park an RV. Ann knows that nursing doesn't stop at the bedside.

Reading this narrative, I think we all felt that Ms. Q was in caring, capable hands.

Thank-you, Ann.

"Re-Configuring Clinical Teamwork for Safety and Effectiveness"

This session will be presented by the Concord Hospital Cardiac Surgery Team, which includes a registered nurse, a pharmacist, a physical therapist, a nurse practitioner, a surgeon, and a family member.

The presentation will be facilitated by Paul N. Uhlig, MD, MPA, associate professor, Dartmouth Medical School and medical director of the Cardiac Program at Concord Hospital in Concord, New Hampshire.

**June 6, 2002
5:00-6:00pm
O'Keefe Auditorium**

1.2 contact hours

For more information, call 726-3111

2002 Oncology Nursing Career Development Award

The Oncology Nursing Career Development Award recognizes professional staff nurses for meritorious practice.

Nominees must be MGH registered nurses functioning at the staff level in the inpatient or outpatient setting.

Nomination packets may be obtained from Joan Gallagher by calling: 6-2551.

All nominations should be received no later than May 24, 2002.

Call for Research Proposals!

Yvonne L. Munn Nursing Research Program

The Yvonne L. Munn Nursing Research Program supports research initiated by MGH nurses for the purpose of improving the care of patients and families.

Research proposals are now being accepted by The Center for Clinical & Professional Development, Founders House 636.

Applicants must be MGH clinical nurses.

Deadline for submissions is August 24, 2002

Proposals should be submitted to Brian French, Founders 636

For more information, call 724-7843

The Employee Assistance Program

presents

"Meditation for Stress-Reduction"

Presented by
Bruce Shackleton, EdD

Incorporating meditation into our daily lives can help reduce the level of stress we feel.

This seminar will outline the basics of meditation and provide an explanation of the cumulative and short-term benefits associated with meditation.

**At MGH on June 13, 2002
12:00-1:00pm
VBK 401**

For more information, call 726-6976



Kathy Moulaison
Perioperative nurses, Kathy Moulaison, RN, and Jaimie Lopes, RN,
confer in the OR
Jaimie Lopes

Nursing Research: improving patient care through clinical inquiry

Delivering the Research Day presentation, Barbara Wolfe, RN, PhD, director of the Research Collaborative at The Institute for Nursing Healthcare Leadership, spoke about using nursing research to expand our base of knowledge and improve our ability to provide quality patient care.

“Why research?” asked Wolfe as she showed a picture taken around the turn of the century. The picture showed a patient, wrapped in a bed sheet from head to toe, being doused with cold water by a healthcare provider. “To look for more humane and effective ways to care for our patients,” she said.

Wolfe went on to speak about how nursing research contributes to:

- increased knowledge
- improved practice
- an improved healthcare system

Evidence-based practice:

- is the application of knowledge and research
- is the scientific basis for clinical practice
- implies and recognizes clinical scholarship
- challenges traditional thinking and practices

Research is happening at the national level in a variety of venues, including The National Institute of Nursing Re-

search, the Institute of Aging, The Genome Project, biomedical imaging, complementary and alternative medicines, and in many other forums.

Wolfe noted that federal involvement in nursing research has come a long way since 1946. A brief summary of some of the national studies that have been conducted over the past few years include:

- Fall-prevention
- Post-operative pain management
- Alzheimer’s disease interventions
- A study to determine how we know when infants are in pain
- Incontinence in older patients
- Cardiovascular disease among the African American population
- Nausea related to chemotherapy

When we look at how research funding is allocated and which research institutes receive the most money, The National Institute of Nursing Research is close to the bottom; so there is much lobbying to be done in order to get the funding necessary to conduct valuable nursing research.

Wolfe noted that Boston is one of the ‘richest’ cities in terms of dollars allocated for medical research. MGH is the #1 recipient of medical research funding; and the

top 5 recipients are all in the greater Boston area.

Visibility continues to be an issue for nurse researchers. Conducting research is essential, but sharing the results of research studies with the healthcare community at large must also be a priority. Wolfe suggested that awards, clinical scholarships, speaking engagements and mentoring programs are all opportunities to share nursing research.

Under the heading of challenges facing nursing research, Wolfe included:

- securing funding
- recognizing good research findings
- evaluating the readiness for clinical application of research findings
- implementation and feasibility
- knowledge of how to conduct good research

Looking to the future, Wolfe foresees nursing research playing an important role in:

- confronting compelling health and illness challenges
- expanding the breadth and depth of science
- integrating research into healthcare practice and policies
- changing practice to meet the needs of patients and the healthcare environment

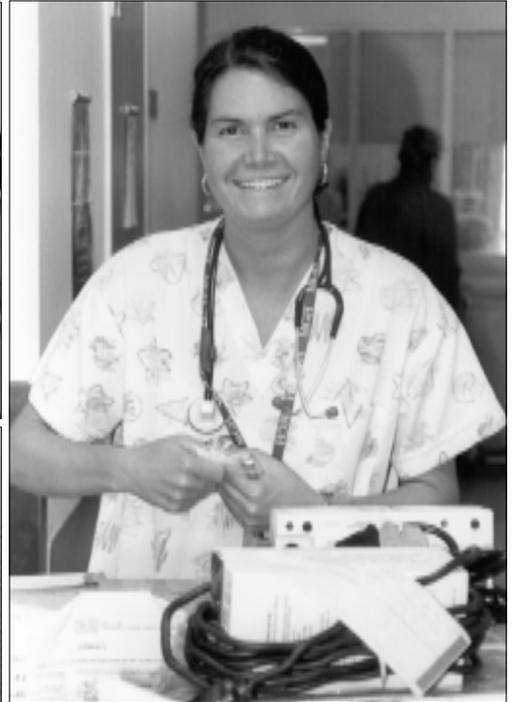


Barbara Wolfe, RN, director of Research Collaborative at The Institute for Nursing Healthcare Leadership

May 23, 2002



MIGH

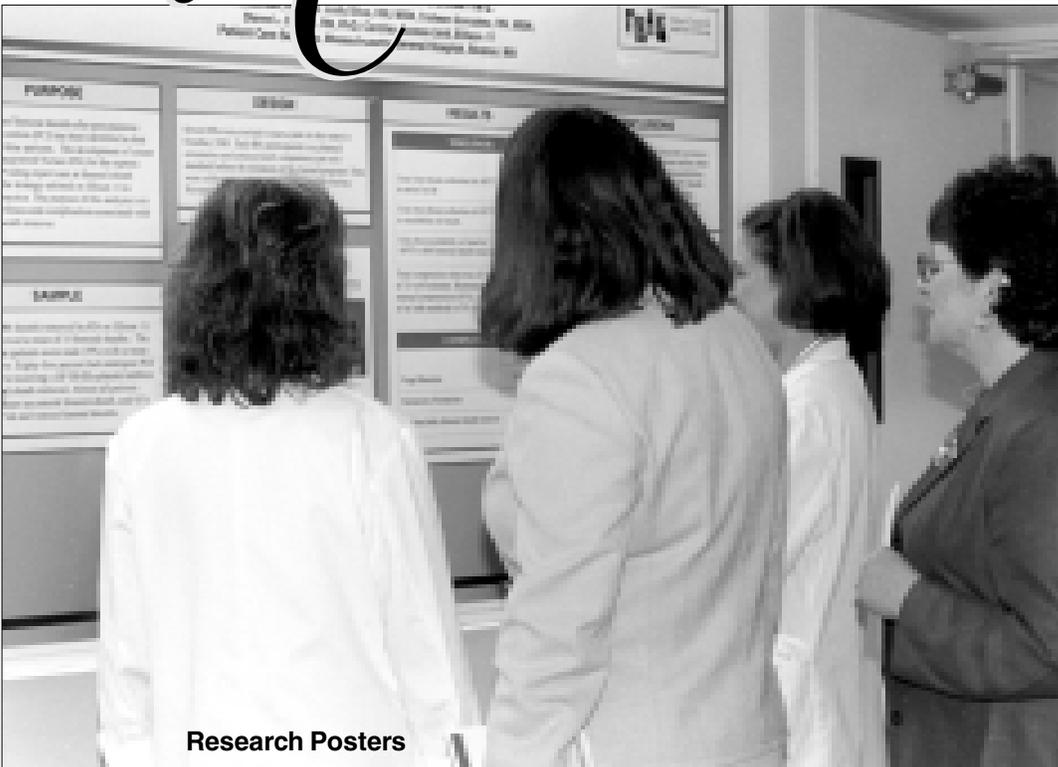


May 23, 2002

The Journey of a Lifetime!



Nurses



Research Posters



The Power of Nurses: as observed by the Massachusetts Commissioner of Public Health

The Commissioner of Public Health for the Commonwealth of Massachusetts and former MGH Hematology-Oncology fellow, Howard Koh, MD, MPH, gave an informative and entertaining presentation on, "The Power of Nurses," Tuesday, May 7, 2002.

Koh began by explaining that the department of Public Health is like a "merger" of medicine and politics. The goal is to bring the leaders from medicine and politics together to try to craft public policy in a way that helps all people in the Commonwealth fulfill their health potential.

In a presentation rich with personal anecdotes and professional revelations, Koh spoke on a myriad of topics:

- A broad description of the responsibilities of the department of Public Health includes oversight of the healing, treatment, cure and protection of the citizenry of the state, including prevention of injury and disease.
- The need for passionate and compassionate leaders in public health
- Nurses are involved in all aspects of, and issues related to, public health

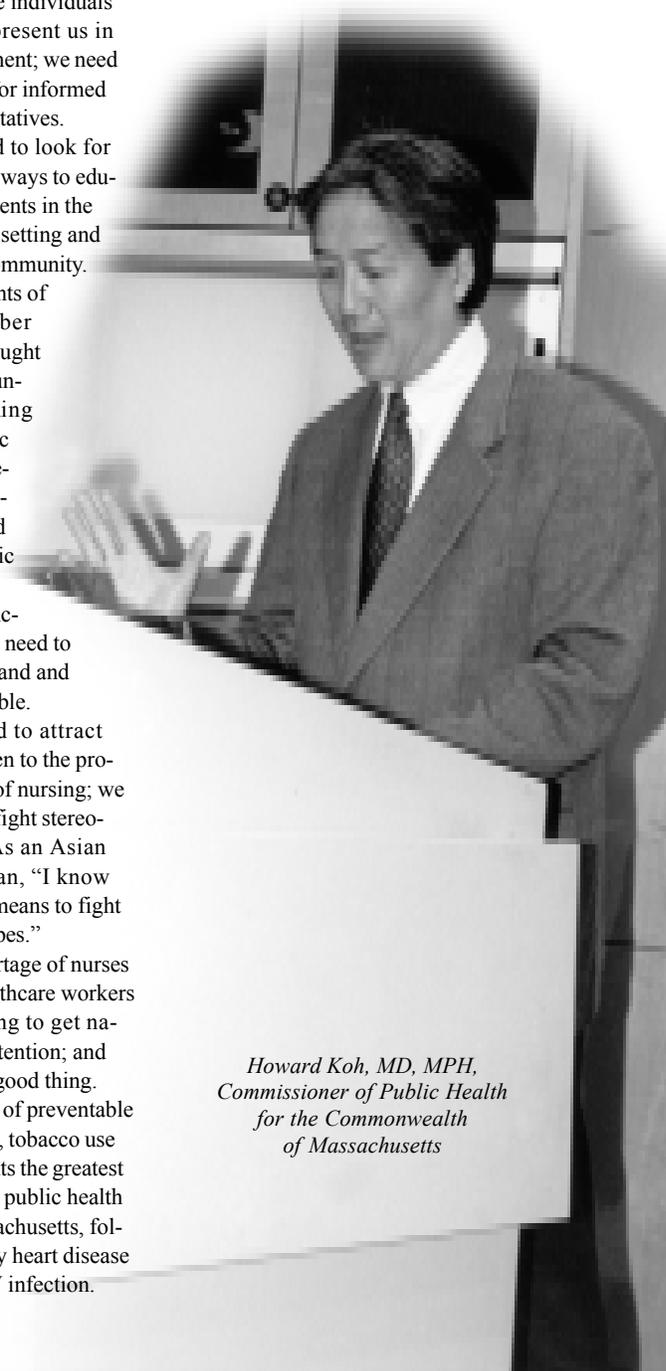
- Nurses are central to the delivery of patient care and should be central in delivering messages of prevention
- In these extraordinary times, we need to preserve our ability to maintain pride in what we do and ensure a stronger, better workforce for the future.
- When one emergency department is on divert it is a critical situation for the hospital; when all emergency departments in the city are on divert, that is a public health crisis. And ED nurses are on the front lines.
- With more and more patients needing to get into fewer and fewer EDs, this is a sign that our healthcare system is under siege. Nurses are key players in our efforts to succeed.
- When healthcare leaders across the state come together, we need to share best practices around retention and recruitment. This is an issue that demands our attention.
- We need to share our stories with the media, our friends, relatives, and most importantly, our legislators. We need to inform and ed-

ucate the individuals who represent us in government; we need to vote for informed representatives.

- We need to look for creative ways to educate patients in the hospital setting and in the community.
- The events of September 11th brought greater understanding of public health responsibilities and the public health infrastructure. We need to take a stand and stay visible.
- We need to attract more men to the profession of nursing; we need to fight stereotypes. As an Asian American, "I know what it means to fight stereotypes."
- The shortage of nurses and healthcare workers is starting to get national attention; and that's a good thing.
- In terms of preventable diseases, tobacco use represents the greatest threat to public health in Massachusetts, followed by heart disease and HIV infection.

- There is much work ahead as we try to reconcile these challenges to ensure a safe future for all citizens. Nurses play a pivotal role in all public health initiatives in these extraordinary times.

Koh ended with an a cappella serenade to all the nurses in the audience. In exceptionally good voice, he sang, "Did you know that you're my hero... You are the wind beneath my wings..."



*Howard Koh, MD, MPH,
Commissioner of Public Health
for the Commonwealth
of Massachusetts*

May 23, 2002



Robin MacDonald

Staff nurse, Robin MacDonald, RN, with patient, Paul Brennan,
in the Urgent Care Unit at the MGH Chelsea Health Center

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The role of reflective practice in advanced practice nursing

Private practice nurse practitioner, Hollie Noveletsky, RNC, PhD, opened her presentation, "The role of reflective practice in advanced practice nursing," with

a broad definition of reflection. Said Noveletsky, "Reflection allows clinicians to examine what they bring to an interaction and what others bring to an interaction

that either enhances or hinders their ability to connect. Reflection allows us to identify ideal practice so that we can work toward achieving it."

Noveletsky noted that there is a difference in the way novice and more experienced clinicians reflect. Where novice reflection tends to be more of a retroactive process, looking back on past interactions, expert nurses have the ability to reflect almost as events are occurring. It is the

difference, she said, of reflecting *on* practice, versus reflecting *in* practice.

Using Johns' Model of Reflective Practice, a framework for reflection crafted by British nurse, Christopher Johns, Noveletsky shared what Johns calls the eight framing lenses of reflective practice:

- Philosophical
- Role-related
- Theoretical
- Parallel pattern
- Problem identification
- Reality
- Temporal
- Framing the development of effectiveness

The framework is based on the belief that

knowing yourself is a prerequisite to caring for others. Within each of the perspectives, or framing lenses, there is a series of cues to help clinicians foster self-discovery and personal growth. The cues have to do with:

- Aesthetics
- Personal introspection
- Ethical considerations
- Empirical knowledge
- Reflectivity

Noveletsky spoke of a study conducted with two groups, one of which used a traditional method of sharing clinical information, discussing encounters and concerns, and keeping a journal of clinically-related issues. The other group engaged in a reflective sharing of clinical interactions and kept a journal using Johns' Model of Reflective Practice.

The study revealed that those who participated in the traditional group tended to focus on role-development, attainment of goals, and their journals were broad and general in nature. The reflective practice group focused on issues of context, values, relationships with patients, and their journals were more personal and introspective.

The reflective practice group was able to expand their insight into their own values and build on their experi-

ences. They reported a better sense of 'being known,' and a greater ability to connect with others.

Noveletsky stressed that reflective practice is an ongoing process of striving to achieve your 'ideal practice.' She cautioned clinicians not to use reflection as a means of finding fault with your current practice, but as a tool to become more aware of your strengths and weaknesses, to help you continually work toward the ideal.

Reflection *on* practice will start to become reflection *in* practice as you become more comfortable in self-reflection. Noveletsky suggested that reflection in practice is not a clinical tool that you pick up and put down as needed; it is a way of life that you carry with you wherever you go.

You may never reach your perception of 'ideal practice,' but you can continue to strive for it through reflective practice.

Noveletsky ended by sharing this observation of one of her students: "When we study, we learn what is ideal, what is optimal. In life, we sometimes fall short of the ideal. This semester reminded me that it is part of my contract with society and my profession to always strive for ideal practice. And if my practice is not ideal, then to figure out to the best of my ability, why not, and make an honest attempt to correct it."



Hollie Noveletsky, RN,
private practice geriatric
nurse practitioner

Educational Offerings

When/Where	Description	Contact Hours
May 28 1:00–3:00pm	Basic Cardiac Pacing VBK601	---
May 30 8:00am–4:30pm	Advanced Arrhythmia Interpretation Program Haber Conference Room	7.8
May 30 TBA	Wound and Skin Care: Common Problems, Common Products Training Department, Charles River Plaza	---
June 4 8:00am–4:30pm	Chemotherapy Consortium Core Program Wolff Auditorium, NEMC	TBA
June 6 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
June 6 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
June 6 5:00–6:00pm	Reconfiguring Clinical Teamwork for Safety and Effectiveness O’Keeffe Auditorium	1.2
June 12 1:30–2:30pm	OA/PCA/USA Connections “Working Together with Chaplaincy to Assist our Patients.” Bigelow 4 Amphitheater	---
June 12 8:00am–2:30pm	Mentor/New Graduate RN Development Seminar I Training Department, Charles River Plaza	6.0 (mentors only)
June 12 5:30–7:00pm	Advanced Practice Nurse Millennium Series O’Keeffe Auditorium	1.2
June 13 and 14 7:30am–4:30pm	Pediatric Advanced Life Support (PALS) Provider Course Shriners Hospital Auditorium	TBA
June 13 1:00–2:30pm	The Joint Commission Satellite Network presents: “Pain Management: Preemptive Strikes and Needs of Special Populations” Haber Conference Room	---
June 14 8:00–4:30pm	Advanced Concepts in Cardiac Nursing O’Keeffe Auditorium	---
June 17 8:00–4:00pm	Keeping Our Patients Safe Wellman Conference Room	---
June 19 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
June 19 8:00am–4:00pm	CVVH Core Program VBK601	6.3
June 20 10:00–11:30am	Social Services Grand Rounds “Helping Children Make Meaning of Illness and Hospitalization.” For more information, call 724-9115.	CEUs for social workers only
June 20 and 21 8:00am–5:00pm	Adult CCRN Course Review Shriners Burns Hospital	18 AACN contact hours (for both days)
June 20 8:00am–4:30pm	Preceptor Development Program: Level II Training Department, Charles River Plaza	7.8
June 20 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2

*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>*

May 23, 2002



Amy McCarthy

White 6 staff nurse, Amy McCarthy, RN, with patient, James Paquette, and his 'lucky duck' (affixed to phone)

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