

Caring

HEADLINES

November 21, 2002

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First annual Anthony Kirvilaitis Jr. Partnership in Caring Awards

A time to celebrate, a time to remember

It was one of those unsettling moments when that line between happiness and heartache got blurred. But when the mist cleared, we were reminded once again of what really makes MGH the world-class hospital it is today. People.

Tony Kirvilaitis, former training coordinator in The Center for Clinical & Professional Development, may not have been seen, but his presence was felt by all who attended the first annual presentation of the Anthony Kirvilaitis Jr. Partnership

in Caring Awards on Tuesday, November 5, 2002, in O'Keeffe Auditorium.

The standing-room-only celebration was attended by support staff, clinicians, members of the Kirvilaitis family,

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(L-r) are: Kirvilaitis Award recipients, Paul Culliton, operations associate on White 11; and Cristina Charles, unit service associate on Ellison 10; Kirvilaitis relatives, Ronald and Mary Gagnon; Tony's mom, Irene Kirvilaitis, Bruce Gentile; and Tony's sister, Maryann Roche.

MGH Patient Care Services
Working together to shape the future

PCS Clinical Recognition Program: recognizing clinicians at all levels of practice

In the past five years, we have learned a great deal about professional development and the importance of clinical recognition. We have come to a better understanding of, and appreciation for, the contributions of clinicians at all levels of practice, in all disciplines throughout Patient Care Services. And we have used that understanding to craft a meaningful clinical recognition program to formally recognize clinical staff for their expertise.

The program is framed around four levels of clinical practice:

- entry-level clinician
- clinician
- advanced clinician
- clinical scholar

Recognition at the first two levels is unit- or department-based and comes about as a result of a meeting between the clinician and his or her manager or director to assess the clinicians' current level of practice and set goals for continued professional development. Approximately 70–80% of all clinical staff practice at the clinician level.

Recognition at the advanced clinician and clinical scholar levels is voluntary and initiated by the clinician (after at least six months of employment at MGH). To seek recognition at the advanced-clinician or clinical-scholar levels, clinicians must first obtain the endorsement

of their managers or directors and then initiate a formal application for recognition. Part of the recognition process involves assembling a professional portfolio, which includes letters of support, a resume, and a clinical narrative that describes the clinician's current level of practice and demonstrates that the clinician meets the criteria for the level being sought.

The portfolio is submitted to a 12-member inter-disciplinary review board for consideration. Clinicians seeking recognition at these levels participate in an interview and an in-depth portfolio review with three members of the review board (one of whom is from the applicant's own discipline). Based on the interview and a review of the portfolio, the three-member panel makes a recommendation to the full review board, who determines by consensus whether or not the clinician should be recognized at the level being sought.

The review board notifies the clinician within three months of initiation of the application process.

As you know, we began accepting applications for advanced clinicians and clinical scholars several months



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

ago in our continuing journey to acknowledge and celebrate excellence in clinical practice. I'm very pleased to share with you the names of the first group of clinicians to be formally recognized as advanced clinicians and clinical scholars (see shaded box on this page). These clinicians have met the criteria for the highest levels of practice and we should be very proud of their accomplish-

ments. Please join me in congratulating our debut class of advanced clinicians and clinical scholars.

Update

I'm happy to announce that Annette Levitt, RN, nurse manager of White 8 and 10, will transition to a new role as clinical nurse in the Anticoagulation Management Unit. Annette will assume her new role in December.

Advanced clinicians and clinical scholars recognized on or before October 31, 2002.

Clinical Scholars

Neila Altobeli, RRT, Respiratory Therapy
Sharon Brackett, RN, Nursing (Ellison 4 SICU)
Pat English, RRT, Respiratory Therapy
Robert Goulet, RRT, Respiratory Therapy
Julie-Ann MacGrath, RN, Nursing (Bigelow 13)
Jennifer Sweet, RN, Nursing (Blake 14)

Advanced Clinicians

Debra Guthrie, RN, Nursing (IV Therapy)
Jane Harker, RN, Nursing (GI Unit)
Donna Miller, LICSW, Social Work (WACC037)
Wanda Ponte, RN, Nursing (SDSU)
Alice Rotfort, LICSW, Social Work (WACC037)
Michael Spiro, RN, Nursing (White 7)
Diane Thibault, RN, Nursing (Ellison 10)
Kathleen Tiberii, RN, Nursing (GI Unit)
Sandra White-Palladino, RN, Nursing (Ellison 16)

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.

Frequently asked questions: pediatric restraints

Our mission is to provide the highest quality patient care in an environment that is safe for all patients, families, visitors and employees. MGH is committed to maintaining the rights, dignity and well-being of all patients, which includes a high-quality Patient Observer Program.

This column, prepared by the Office of Quality & Safety, highlights some frequently asked question about our Patient Observer Program.

Question: What are some of the ways our new restraint policy extends to the pediatric setting?

Answer: The inpatient units of Mass-General Hospital for Children, like our

adult counterparts, have implemented new restraint guidelines in an attempt to minimize the use of physical restraints on hospitalized children. Typically, situations that require children to be restrained include: to protect them from injury; to prevent them from pulling out IV lines or interfering with the healing of a surgical incision.

Pediatric caregivers have attended educational sessions on, and have successfully implemented, new restraint guidelines. The use of siderails as a restraint has been an area of great interest. Many children, when they come to the hospital experience changes in their sleep patterns. Our current policy allows the use of siderails without a doctor's

order for children up to the age of six or for children who would normally use siderails to sleep at home. After numerous conversations with parents and children about the issue of siderails, we have instituted a program of individualized assessment to ensure each child's safety. We still use siderails when necessary, but we've found that many children over the age of six are fine with the use of top rails alone.

Pediatric care always presents us with special considerations, but we have done well in complying with new regulations and dramatically reducing the need for physical restraints by formally substituting the use of diversion tactics, relaxation techniques, and family intervention.

ICU Medication Safety Initiative

This month, you'll notice several changes in Provider Order Entry (POE), the Harvard II Pump Library, and the ICU Guidelines. In an effort to enhance safety and reduce medication errors, a team of clinicians from Nursing, Pharmacy, and Biomedical Engineering examined approximately 40 IV medications currently being used in ICUs. More than 325 changes were made to improve safety and reduce the risk of errors.

Every drug included in the Harvard II Pump Library was reviewed. Modifications were made to dosing and concentration levels where needed. These changes have been duplicated in POE and the ICU Guidelines. All changes were approved by the Critical Care Committee, the Pharmacy Clinical Practices Committee, the Drug Therapy Committee, and the Nursing Practice Committee. If you have any questions, please contact your critical care CNS, or pharmacist.

Educational Offerings and Event Calendar now available on-line

The Center for Clinical & Professional Development lists educational offerings on-line: <http://pcs.mgh.harvard.edu>
For more information or to register for any program, call the Center at 6-3111.

Call today!

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building

The MGH Blood Donor Center is open Monday through Friday 8:30am-4:30pm

Appointments are available for blood or platelet donations

Platelet Donations:
Monday, Tuesday, Friday 8:30am-3:00pm
Wednesday and Thursday 8:30am-5:00pm

Call the MGH Blood Donor Center to schedule an appointment 6-8177

Nursing Career Expo

Invite your friends and colleagues to learn more about nursing at MGH, including opportunities for staff nurses (experienced and new graduates), clinical nurse specialists, patient care associates, and surgical technologists.

Thursday, November 21, 2002
1:00-7:00pm
Walcott Conference Rooms

Tours of the hospital will include visits to: the Burn Unit, Cardiac Access, Endoscopy, Cardiac Arrhythmia Step-Down, the MICU, Cardiac Surgical ICU, Medical, The General Clinical Research Center, Cardiac Surgical Step-Down, Surgical Trauma, and the Transplant Unit.

"Advance Directives: True Life Stories," will be presented from 1:30-2:30pm

For more information, contact: Megan Brown (mcbrown@partners.org) at 726-5593 or fax: 726-6866.

Welcome to the operating room of the future

—submitted by Janice C. Plunkett, RN, team leader, General Surgery and Sandra Silvestri, RN, OR clinical nurse specialist

In recent years health care has undergone a transformation that has changed the way surgical procedures are performed. Nowhere is this more evident than in the new operating room that opened its doors on August 22, 2002. The two-year project to design and construct the 'operating room of the

future,' was a collaborative effort between the MGH departments of Nursing, Surgery, and Anesthesia, Partners HealthCare Systems, The Center for the Integration of Medicine and Innovative Technology (CIMIT), and other commercial partners.

Prior to the opening of the new operating room, a special committee was formed, and met

weekly, to discuss issues related to quality and how best to ensure continued, optimal patient care. The multidisciplinary committee formulated a new practice model for the operating room which is still being evaluated and improved.

Simulation labs were conducted to study the impact of new technology on patient care, clinical



practice, nursing workflow, and safety in the new OR environment. From the simulation labs the committee identified opportunities for improvement and implemented changes.

The new operating room is actually a self-contained operating suite that consists of a pre-operative room, an operating room, and a post-surgical transition room. The design of the new suite promotes positive patient flow and provides a more integrated perioperative experience for the patient.

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At left: Charlene O'Connor, RN, stands at the entrance to OR 49, the operating room of the future.

Above: Erin Pelletier, RN, demonstrates the computerized control station that controls all the electronic equipment in the new operating room.



Mike Nichols, RN,
prepares pre-op room

The physical proximity of the three rooms contributes to a more collaborative approach to patient care, allowing team members to be in constant communication. Team members can share knowledge about the patient from the moment the patient enters the pre-op room until he or she is discharged from the transi-

tion room. This has triggered new learning, new practices, and new ways of working together in the OR.

From the patients' perspective, there is greater continuity of care as the same caregivers stay with them throughout their entire surgical experience. The new model allows team members to check on

patients and evaluate their progress at every stage of their surgical progress.

Staffing the new operating suite are clinicians and surgical technologists from the Same Day Surgical Unit, the Main Operating Room, Anesthesia, and Surgery who have been specially trained to practice in the new setting. Each



Janice Plunkett, RN, retrieves supplies from
new computerized-inventory cabinet

team member brings a unique set of skills and experiences in pre-, intra-, and post-operative care.

Advancements in technology are creating new opportunities for education and specialization within the perioperative nursing field.

The ability to change and adapt fluidly has been a key factor in the success of the new operating suite. This prototype of the operating room of the future is intended to be a learning lab for the design of future operating rooms at MGH.



(L-r): Pelletier, David Berger, MD, Cristina Ferrone,
MD, and Tara McKenney, ST, perform surgical
procedure in new operating room.



McKenney sets up surgical instrument
table in front of new, flat plasma screen
on which members of the team can
view surgical procedures.

A day in the life of an OR nurse liaison

—by Gloria Moran, RN, OR senior staff nurse

My name is Gloria Moran. I am an operating room nurse. I usually work in the OR as a senior staff nurse on the orthopedic team. But twice a month I work as the nurse liaison between the OR and the Gray Family Waiting Area (GFWA). Sometimes, being the nurse liaison can be more challenging than working in the OR. As nurse liaison, I see approximately 100 cases during the course of a day. I monitor every room in the main OR to see how each patient is doing, or if changes, cancellations or delays have occurred. I go back and forth between the OR and the Gray Family Waiting Area, letting families and friends know how things are going so they don't worry.

And so my day begins. It's comforting to patients to know that a nurse will be talking with their family or friends and keeping them informed about their surgery. It's not uncommon for patients to be more concerned about the people waiting for them than about themselves. I always ask patients the name of the family member or friend who will be waiting for them. It may seem like a small thing, but when I arrive in the waiting area, it makes a

big difference. People smile when I say, "Hi, you must be Irene, or Mary, or Bob."

They're relieved to know I was with their loved one just moments ago. One patient actually sang a song for me about his wife. When I told her about it later in the waiting area, she laughed and asked if he had whistled, too. "He whistles a lot," she said. She felt better about her husband and how he was coping. She knew that I had met him and he was okay.

Typically, family members are only allowed in the recovery room with pediatric patients or in special circumstances when it's deemed necessary by the healthcare team. But recently because of a mis-communication, a family member expected to be able to see his wife in the recovery room. Mr. T's wife was having gynecological surgery and he was looking forward to being with her when she woke up in the recovery room.

When I met Mr. T he was already upset because he hadn't been able to go into the OR with his wife. He asked me what our policy was for visiting in the recovery room. I sat with him and explained that family members are not

usually allowed in the recovery room. My explanation included issues such as patient privacy, limited space, busy clinicians, optimal patient care, and infection control. He understood and accepted my explanation. But he was perturbed that there had somehow been a miscommunication. I offered my apologies to Mr. T and assured him I would do what I could to see that this kind of misunderstanding didn't happen again.

In follow-up, I went to the OR and spoke

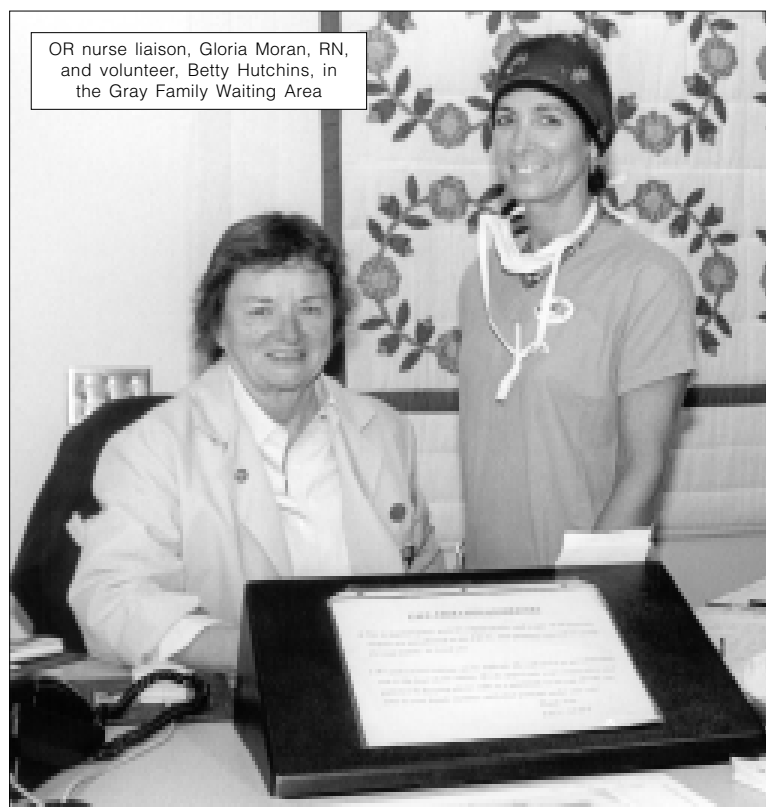
with one of the GYN nurses. I learned that Mrs. T's doctor was new to MGH and unfamiliar with our policy regarding the recovery room. I told her about my encounter with Mr. T and she assured me she would speak with him when he came out of surgery. The team approach worked effectively and we were able to achieve a positive outcome for all involved.

Mr. A arrived in the waiting area and wanted information on his girlfriend. English was not his primary language, but he said, "She was having an operation," and didn't know where she was. I called the Main OR desk to see if she had been added as

an emergency. No girlfriend there. I asked Mr. A if he knew what type of operation his girlfriend was having, and he said it had something to do with her brain.

This was a good clue: Neurosurgery. I called and got the phone number for Neuro-Radiology. I spoke with the secretary who said the patient wasn't there, but she thought she might be in the Embolization Lab. She connected me. The patient was indeed having an emergency embolization. I told Mr. A, and he was relieved to know where she was. He finally managed to sit down and relax, knowing she was in surgery and that the doctor would

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OR nurse liaison, Gloria Moran, RN, and volunteer, Betty Hutchins, in the Gray Family Waiting Area

The OR Nurse Liaison

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contact him as soon as there was news.

MGH serves many culturally diverse patients. In the Gray Family Waiting Area, I see family and friends from all over the world. I had recently returned from Vietnam, and by chance, there was a Vietnamese family waiting for their loved one, who was having a liver transplant. The mother had just arrived from Vietnam. I told her, through her son, about my trip to her homeland and the beauty I had seen there. A huge smile came over her face. I intuitively felt we made a connection. Each time I returned to the waiting area, I saw her and her family reaching out to me with their eyes. With a few words and short conversations, I was able to keep them informed and their minds at ease. The woman's son came through surgery very well. After all the beauty and kindness I had experienced in Vietnam, I was happy to be able to return a little here at MGH.

Sometimes my role as nurse liaison goes beyond the Gray Family Waiting Area. Today, a young boy was having a hemipelvectomy with reconstructive surgery. It is an extremely long and complicated procedure. The anesthesiologist had spoken with

the parents extensively before the surgery, but they would be unable to stay in the waiting area all day. So we worked out a plan to keep them informed by telephone. Every time I went to the OR, the surgeon would give me an update on the boy's condition, and I would call the parents. They would either be on Ellison 18 or at the Holiday Inn where they were staying. When I got my first update, I attempted to call the parents on Ellison 18 but they weren't there. I called the hotel, but there was no answer. I left a message along with my pager number. At about 1:00, a nurse on Ellison 18 paged me and said the boy's dad was up there. I decided to go up and meet with him. I was happy to be able to talk with him in person, not wanting to leave another message. They had already been through so much I wanted to do whatever I could to make this day less stressful for them. Later in the day I was able to tell him that the tumor had been removed and that reconstruction was underway. Dad was happy to know they were half-way through. The next call was to inform them that reconstruction was complete and the plastic surgery team was closing.

The Gray Family Waiting Area is staffed by a team of MGH volunteers. The volunteers and the nurse liaison work together to keep families comfortable and informed. Throughout the day, families come and go; it becomes increasingly challenging to remember names and faces and know where people are. Volunteers bring continuity to the process, helping the liaison keep track of family members. They alert me if certain families need a little extra time or care.

Frequently, fellow nurses from other hospitals are among the families waiting in the Gray Family Waiting Area. I've been told many times how important they think the nurse liaison role is, and that they plan to bring the idea back to their own institutions. To me, that's the greatest compliment, because it comes from another nurse. I know if I was ever in that situation, I'd want a nurse liaison there for me.

At the end of the day, when I throw my tattered, worn, and barely readable OR schedule in the trash, it is with a sigh of relief, but mostly, with a great feeling of satisfaction and achievement for having advocated for so many patients and families.

It is a privilege to be a nurse liaison.

Interfaith Thanksgiving Service

The MGH Chaplaincy is offering an Interfaith Service for Thanksgiving

Tuesday, November 26, 2002

12:15pm.

in the MGH Chapel

All are welcome. The service will be broadcast on MGH Channel 16.

Domestic Violence Vigil

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

Friday, December 6, 2002

12:15pm

in the MGH Chapel

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

A light pick-up lunch will be provided.

For more information, call the Chaplaincy at 6-2220

Pediatric Provider Order Entry

Implementation of the Pediatric Inpatient Provider Order Entry (POE), with on-site support from Information Systems, is occurring October 21–November 22, 2002.

On-site support is available 24 hours a day, 7 days a week.

A computer-based, self-learning tutorial is also available through the Start menu. Choose Partners Applications, Clinical References, CBT Courses, then MGH Order Entry CBT.

- Orders for pediatric patients receiving chemotherapy will remain on hard copy (until spring '03)
- Pediatric logic and order screens will be applied to all patients younger than 19 years old. If you have been using POE already, you may notice slight differences for these patients.

For more information, page the Provider Order Entry analyst on call via the Help Desk at 726-5085.

A Halloween to remember for three special little boys

Assalamu-Alaikum (Arabic for Peace be upon you) was the greeting I shared with my special patient every morning. She was a 30-year-old Middle Eastern woman who touched my heart for the eight months she received care at MGH for acute myeloid leukemia.

My name is Jill Nelson. I have provided oncology care for 13 years as a staff nurse, and recently as a nurse practitioner. Nursing is a career I chose as a young girl because of my desire to care for others. My first patients were my dolls, my siblings, and the family pet. It was during my first year as a staff nurse that I chose oncology as an interest and found my passion. Cancer is a disease that impacts every aspect of people's lives, and their family's lives, too. My goal is to assist every patient and family, as they go through this very stressful and vulnerable time, to maintain comfort, dignity, self-esteem, and their dreams.

I met Sabrah on a very busy Monday morning. In report I learned she was an Arabic woman with newly diagnosed leukemia, and that she was very ill, and very scared. I walked into her room and made a two-second assessment of the situa-

tion. She was a young woman lying in bed, her hair covered by a Hejab (a black scarf worn by Muslim women). She appeared tired and weak. On her bed were three young sleeping boys. In the corner was her very anxious husband, staring out the window at the foreign country that would hopefully cure his wife's illness.

I introduced myself to Sabrah, putting a hand on her shoulder. I pulled up a chair and listened to the story of how they had come to MGH. She spoke English beautifully. She had been feeling ill in her country of Abu Dhabi, very weak, and bruising easily. She was taken to the local hospital and within six hours was on a plane to Boston, a 16-hour flight. I told her and her husband that the next 48 hours would be filled with tests to confirm her diagnosis. She explained that doctors in Abu Dhabi had told her she had leukemia and needed to come to the United States for treatment. Her country made arrangements for her family to travel with her. At that point, her children woke up and needed to spend time with their parents, so I left.

The next couple of days, Sabrah and I spent a lot of time together, during treatments and

patient education. We started to form a strong bond. She shared with me that she had been married to Sultan for ten years and that it had been an arranged marriage. She was very happy with her husband, and her life at home. The three boys were the light of her life, ages: 3, 4, and 6. Sabrah and her husband were both employed in Abu Dhabi; she had been educated at the university and was now a teacher; and he worked for the government.

The International Office at MGH was a tremendous resource for Sabrah and her family, helping them find a place to live, providing contacts in the area, and most of all, offering friendly faces to whom they could speak in Arabic. I consulted with our Imam for education and guidance in caring for Sabrah and her family. I, along with the whole medical team, wanted to respect and understand her Muslim faith, while caring for her. I consulted a child life specialist to help us find activities for the three boys during long days at the hospital. Social Services also provided support and guidance.

A diagnosis of acute myeloid leukemia was confirmed, and treatment was initiated immedi-

ately. Sabrah tolerated chemotherapy fairly well. She became sick during the pancytopenic period, when her counts were at their lowest. She required multiple antibiotics and blood transfusions. The most incredible thing was no matter how sick she got, she always had a smile and a big hug for her boys. The boys had become friendly with the nursing staff. They knew where all the treats were kept on the unit and let us know when we were running low. My special time with the boys was showing them how to color in coloring books while teaching each other words in our respective languages. I have to admit, they learned English much quicker than I learned Arabic.

Nurses spent time with the boys showing them how to surf the Internet, something they had never done before. They learned how to play educational games,

and then taught each other. It wasn't uncommon to see the three boys run down the hall into their mom's room for a hug and then find their way to the nursing station for help on the computer.

Sabrah went into remission and after a month was able to leave the hospital to live with family in Boston. She enjoyed short day trips, meals at home and playing with the boys. Unfortunately, her leukemia returned, and this time with a vengeance. We tried numerous chemotherapy drugs, but nothing helped. Sabrah grew weaker and weaker. The spark in her jet black eyes grew dimmer. The boys sensed her illness. They saw their father crying, and praying more than the Muslim requirement of five times a day. The oldest boy, Ali, became quiet. The now five-year-old, Kareem, started acting out. And the three-year-old, Ahmed, would cry

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Jill Nelson, RN
oncology nurse practitioner

Exemplar (Jill Nelson)

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at night. I spent a lot of time with the children to assess their understanding of their mother's illness. The Imam advised Sabrah, Sultan and me on how best to discuss the seriousness of her illness. It was a gradual process, with a lot of support from her healthcare team. I went to the library and found a book about a mother who was sick and eventually died. Sabrah and I read the book to her children, (she translated). The boys cried and hugged their mother and father. I looked at this family in crisis and wanted to come up with something that would give them a little happiness.

It was fall and Halloween was coming. I was pretty sure these children had never heard of Halloween. I decided to dress them up in costumes and take them trick-or-treating. I called the International Office and the Imam to see if it would be appropriate to ask Sabrah and Sultan's permission for the boys to participate in an American Halloween tradition. They loved the idea. I asked Sabrah and Sultan, who had heard of Halloween. They got very excited and quickly translated the idea to the boys. I told them about the history of Halloween and its meaning.

I brought in some make-up to get them in the spirit. They lined up for face-painting. Sabrah was feeling a little better and was able to participate. She painted the boys' faces every day for the next week until Halloween. I put together three costumes: two clowns for the older boys, and a little mouse for Ahmed.

I arrived early at the hospital with a colleague who escorted us on our Halloween outing. When I went into Sabrah's room, you could feel the excitement. Everyone was laughing and smiling. The boys put their costumes and make-up on in another room to surprise their parents. They were so funny getting ready, laughing and dancing, things I hadn't seen them do in a long time. Sabrah and Sultan were thrilled with their children's excitement, and were the first to put candy in their sacks.

My colleague and I took the boys to the neighborhood where I grew up. We held hands and spent the next two hours trick-or-treating. They tried to run from house to house, but had difficulty managing their growing sacks. They were so proud of themselves for using English at every house, and saying 'Thank-you' loud and clear.

After our adventure, we brought the boys to McDonald's for that favorite American delicacy, a Happy Meal. Then it was back to the hospital. The boys jumped on Sabrah's bed to show her all the candy they'd received. They were so excited, they couldn't talk fast enough. Sabrah and Sultan thanked us for bringing happiness back to their family.

A few weeks later, Sabrah's health deteriorated again, only this time it was serious and required her to be moved to the Intensive Care Unit. She was too ill to recover. My special little boys were going to lose their mother. I spent time alone with them and Sabrah. She was intubated and unable to speak, so I told them

how much their mom loved them, and that they each had a special place in their hearts where she would always be. Then I asked Sultan to come into the room with us. I held each of the boys up to the bed so they could say goodbye, and in English, I love you. We all held hands while Sultan recited a Muslim prayer, and I read the Lord's Prayer. Sabrah passed away comfortably surrounded by her own family, and her American family.

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

Probably the biggest concern of hospitalized parents is the effect

their illness will have on their children. And this concern is magnified when patients are far from home, as was the case with Sabrah and Sultan. Jill went out of her way to bring some normalcy into the lives of these three boys, despite the tragic situation their family was facing. Jill consulted with child life specialists to develop age-appropriate activities for the children and contacted the Chaplaincy to ensure that she was being sensitive to, and knowledgeable about, their religious needs before asking the boys to go trick-or-treating. This is a wonderful story of exemplary care for a patient at the end of her life, and for her three young boys just beginning theirs.

Would you like to 'adopt' a family affected by domestic violence this holiday season?

The Diversity Steering Committee has received its list of families who will be participating in this year's holiday gift-giving event. If you and/or your group would like to adopt a family, please e-mail or call Beverley Cunningham, OC, at 4-6225. You will be given as much information about the family as possible without jeopardizing their anonymity (ages and genders of children, and a "wish list"). Please remember that these are "wish lists" and you're not expected to fulfill every wish.

On December 12, 2002, bring your wrapped gifts to the Main Corridor. Please label the gifts with the family's name (or number), the gender and age(s) of the family members, and the name of the health center with which they are affiliated. Words cannot describe the appreciation of the families who have been recipients of your generosity in the past. Thank-you for your interest and participation. Know that you are making a tremendous difference in the lives of some very special families!

**For more information, please call
Beverley Cunningham at 4-6225**

Muslim fasting: one of the pillars of Islam

—submitted by Firdosh Pathan, RPh, and
Lourdes Sanchez, manager, Interpreter Services

Many Muslim patients and staff began celebrating their holiest month of Ramadan on November 6th, this year. Ramadan (rama-DAH-n) is the ninth month of the Islamic lunar calendar. During this month, healthy Muslim adults fast from dawn until sunset. Fasting is one of the five pillars of Islam (which include: the declaration of faith, daily prayers, charity, and pilgrimage to Makkah in Saudi Arabia). The first revelation of the Muslim holy book, the “Quran,”

was revealed by Allah (God) through the Angel Gabriel to the Prophet, Muhammad, during Ramadan.

Over the years, the number of Muslim patients coming to MGH has increased due to referrals from the International Patient Center and communities in the area. Some Muslim patients come from countries such as Morocco, Iran, Ethiopia, Somalia, Eritrea, Lebanon, Saudi Arabia, Kuwait and the United Arab Emirates.

During Ramadan, Muslims abstain from

eating, drinking, smoking and conjugal relations from dawn to dusk. Ramadan lasts about 29 or 30 days depending on the cycle of the moon. Part of the fasting ritual includes avoiding anger and immoral behavior and showing compassion to others. Those who are sick, elderly, or travelling, and pregnant, nursing, or menstruating women are permitted to break the fast and make up the days later in the year if they're able. Muslims begin the practice of fasting at puberty, although many start earlier.

The Quran states that fasting is prescribed for Muslims ‘as it was prescribed for the people before them,’ so they may acquire self-control and God-consciousness. Muslims also fast to improve their health by eliminating impurities from the body, and as a way to acknowledge the plight of the poor, the hungry, and the sick. Ramadan is a month of spiritual consciousness and high social responsibility.

At the end of Ramadan, Muslims all over the world celebrate Eid-ul-Fitr, the festival of fast-breaking, which represents a spiritual victory of man over his appetites (desires and sensual urges). On this day, Muslims offer special prayers in congrega-

tion and thank God for His blessings and mercy. After prayers, Muslims greet each other with, “Eid Mubarak” (EED mu-BAH-rak), which means, “Happy Eid.” A celebration follows; children receive toys, candy and clothing; adults embark on charitable visits.

For the past few years, many in the MGH community have joined in the Muslim celebration of Eid-ul-Fitr. Toward the end of Ramadan, the MGH Muslim community and the PCS Diversity Steering Committee prepare a special dinner for Muslims and non-Muslims to share food, knowledge and conversation. And the tradition will continue this year.

Islam (is-LAHM) is a religion based on the teachings of the Prophet, Muhammad (mu-HAM-mad), who lived in Arabia 1,400 years ago. Followers of Islam (an Arabic word meaning, ‘submission or obedience to God’) are called Muslims (an Arabic word meaning ‘one who gives himself to God’). Muslims believe in One, Unique, Incomparable God, Allah (al-LAH). They believe in the Angels created by Him; in the prophets through whom His revelations were brought to mankind; in the Day of Judgement and individual accountability of actions; in God’s complete authority over human destiny and in

continued on next page



Deb Washington, RN, director of PCS Diversity (left), and members of the MGH Muslim community at one of the first Eid-ul-Fitr celebrations in November (Ramadan, the ninth month of the Islamic calendar) 2000.

Pediatric Bereavement Program: providing comfort and support after the loss of a child

—by Elyse Levin-Russman, LICSW, pediatric social worker

The Keffe Auditorium was the setting for the 11th Annual Pediatric, Neonatal, and Obstetric Bereavement Program, Sunday, November 3, 2002. The event brought parents, family members, friends, and staff together to honor and grieve for children who have died at MGH over the years. The program is coordinated by the Comfort and Support After Loss Committee, led by Fredda Zuckerman, LICSW, Obstetrics clinical social worker.

This year's event included presentations and words of support from Kathryn Beauchamp, RN, clinical

nurse specialist for the PICU; Alan Ezekowitz, MD, chief of Pediatrics; and Howard Weinstein, MD, chief of Pediatric Hematology and Oncology. Parents also participated in the program, sharing personal remembrances and stories.

Music was provided by the Wakefield Repertory Theatre Group and the St. Florence Choir. MGH chaplains, Ana Ruth Higbee-Barzola and Linda Knight, shared prayers in English and Spanish.

Families were invited to take part in the annual naming

ceremony, and were given flowers to plant in

memory of their children. Personalized fabric 'clouds' made by loved ones prior to the program will be assembled into a memorial quilt and displayed at MGH in the spring. While the death of a child is al-

ways difficult, this annual event provides an opportunity for families and caregivers to come together, share memories, and honor the precious lives of children lost too soon.



Comfort and Support After Loss Committee members (l-r) are: Ana Ruth Higbee-Barzola, chaplain; Linda Knight, pediatric chaplain; Fredda Zuckerman, OB social worker, coordinator, Comfort and Support After Loss Team; Brenda Miller, PICU nurse manager; Judy Patterson, conference coordinator; Kathryn Beauchamp, PICU clinical nurse specialist; and Bill Kneeland, staff nurse, Ellison 18.

Not pictured are: Heather Peach, child life specialist, Sharon Scott-Vernaglia, chief resident, Pediatrics; Elyse Levin Russman, oncology social worker; Eileen F. White, secretary, Social Services.

Muslim Fasting

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life after death. Muslims believe in a chain of prophets: Adam, Nooh (Noah), Ibrahim (Abraham), Isma'il (Ishmael), Iss-haq (Isaac), Yakoub (Jacob), Youssef (Joseph), Job, Moussa (Moses), Haroon (Aaron), Dawud (David), Solomon, Elias, Jonah, Yahia (John the Baptist), Issa (Jesus) to name a few.

Though revered by Muslims as the last of God's prophets, Muhammad is considered a human being and is not worshipped, but respected as a messenger of God. As a sign of respect, whenever the name of any Prophet is mentioned Muslims say "peace be upon him."

Many Muslims memorize the Quran and teach it to their children, believing that not one word of its 114 chapters has been changed over the centuries. The Quran is the source

of every Muslim's faith and practice. It deals with all the subjects concerning human life including wisdom, doctrine, worship, and law, but its basic theme is the relationship between God and the creatures. It provides guidelines for a just society, proper human conduct, and an equitable economic system.

Islam requires its followers to believe in one God, Allah, to believe in all his messengers and the books revealed to the messengers,

to believe in the angels and the day of judgment, to pay Zakat (2.5% of annual income in charity), to perform prayers (5 times a day), to fast in Ramadan, and perform Hajj (a religious trip to Mecca), if they can afford it, once in their lifetime.

Islam forbids Muslims from drinking alcohol, having sexual relationships outside of marriage, gaining unlawful income (by gambling or unethical behaviors such as lying, stealing and cheating).

Islam does not distinguish between Arab and non-Arab, black and white, or male and female. Islam motivates Muslims to do good deeds such as engaging in charity, being helpful, truthful and supportive of others who initiate good deeds. The Quran commands Muslims to respect their parents, especially when they are old. According to the Prophet, paradise is under the feet of mothers.

Kirvilaitis Awards

continued from front cover

and friends and family of award recipients, Paul Culliton, operations associate on White 11, and Cristina Charles, unit service associate on Ellison 10.

In her opening remarks, senior vice president for Patient Care, Jeanette Ives Erickson, RN, observed, "This is a hard time to be together. It's hard to be here without Tony. But I know if he was here today, he would want us to smile. This is an opportunity for us to celebrate, not only Tony's life, but the contributions of our support staff, who are the heart and soul of our hospital."

Ives Erickson acknowledged the Kirvilaitis family as, "the special people who brought Tony to us." She reflected on Tony's many contributions to MGH, the passion and compassion he brought to his role, and his commitment to our patients and families. "His words, his actions, everything he did said, 'Be good to people.' And he was."

Eileen Flaherty, RN, nurse manager, introduced Culliton, noting his exceptional rapport with staff and patients; his diligence and willingness to perform beyond what's called for in his job description; and his unique sense of humor, which is known and

appreciated throughout the unit. Flaherty shared one anecdote in which, due to a certain series of events, Culliton was forced to show up for work one morning in a tuxedo!

Culliton accepted the award, saying, "It's wonderful to have an award for support staff that honors Tony Kirvilaitis and the years of dedication and hard work he contributed to MGH. It is a privilege to be one of the first recipients of this award that bears his name." Culliton thanked his co-workers as, "the number one reason I'm standing before you today."

Nancy Dorris, operations coordinator, and Aileen Tubridy, RN, nurse manager of Ellison 10, introduced Cristina Charles. Said Dorris, "At the time of my first interview with Cristina, I knew I was speaking to someone special. Cristina takes pride in her job and in her unit. Frankly, Cristina doesn't think anything is outside her scope of responsibility. Her caring and compassion have no bounda-

ries. There's absolutely no doubt in my mind that Tony would be very pleased with this choice as a recipient for the first Anthony J. Kirvilaitis Jr. Awards."

Charles' comments were brief and heartfelt. Said Charles, "Tony, if you're standing here beside me, I'm giving you a big hug right now."

In closing, Ives Erickson unveiled the plaque on which the names of Charles, Culliton, and all future award recipients will be displayed.

Said Ives Erickson, "Two awards will be given every year to support staff who exemplify the values and characteristics that Tony lived by every day. This is a wonderful way for us to keep Tony's legacy alive, and to celebrate the invaluable contributions of our support staff."



(L-r): Tubridy, Dorris, and Ives Erickson congratulate Charles at award ceremony.



Culliton with fan-club members (l-r): Jesslyn Lemos, OA; Maura Hines, RN; Sara Kile, RN; and Karla Farrer, RN.

The Price is Right! comes to Bigelow 11

Cost analysis has never been so much fun! Thanks to the efforts of Bigelow 11 staff nurse, Melissa Roddie, RN, staff are gaining meaningful insight into the cost of providing care on their unit, learning how they can contribute to cost-containment efforts, and winning prizes for their participation. Such a deal!

Roddie, with the support of nurse manager, Eileen Flaherty, RN, and clinical nurse specialist, Kate Barba, RN, has crafted her own version of the TV game show, *The Price is Right!* Each week she posts a clinical scenario along with a list of items required to provide care in that scenario. Clinicians, OAs, and USAs have one week to guess the total cost of care and write their responses on an answer sheet in the staff lounge. The person

who comes closest to the total cost of items used, without going over, wins a gift certificate to Coffee Central.

Says Roddie, "It was meant to help raise awareness about healthcare costs and how we can use our resources wisely.

But in addition to being educational, I think staff are really having a lot of fun with it."

After 11 weeks, winners of the weekly *The Price is Right!* games will compete for a grand prize (TBA) in a much anticipated showcase showdown!



You have to play to win!

At left: Melissa Roddie, RN, staff nurse, Bigelow 11, helps co-worker, Jennifer Nadeau, RN, enter her response in the unit-based, "home" version of

The Price is Right! Above: Roddie presents prize to, Nejoua Elhirech, unit service associate and first winner of the game that gives contestants the opportunity to guess the cost of a different patient-care scenario each week.

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ELAD® on-call nursing team raises the bar on critical-care delivery

New technology, specialized training, and clinicians on the cutting edge of patient care are giving new hope to patients with serious, acute liver disease. A new support system called the Extracorporeal Liver Assist Device (ELAD®), made by VitaGen, enables potential regeneration of impaired or partial livers, or alternatively, supports patients biomechanically until a liver transplant can be

performed. This groundbreaking new technology was used at MGH for the first time on August 21, 2002, in the Blake 7 Medical ICU.

Because ELAD® technology requires specialized knowledge and training, VitaGen enlisted the participation of MGH nurses to become part of the ELAD® on-call therapy team. This team, trained by VitaGen experts, currently consists of 16 nurses from various

ICUs throughout the hospital (MICU, SICU, PACU) and one nurse from The Center for Clinical & Professional Development.

Team members are required to attend a mandatory four-hour training session each month to keep their skills honed and their knowledge current. The on-call team is responsible for providing coverage 24 hours a day, 7 days a week in 4- to 12-hour time slots, and for pro-

ELAD®-trained nurses:

Judy Dyer, RN, clinical coordinator
Rick DaSilva, RN, (MICU) nurse liaison
Jane Bryant, RN, (MICU) nurse liaison
Stacey Fabrizio, RN, (MICU)
Donna Saylor, RN, (MICU)
Barbara Sprole, RN, (MICU)
Judith McCurley, RN, (MICU)
Kathy Degenova, RN, (MICU)
Annette Brien, RN, (PACU)
Christine McCarthy, RN, (MICU)
Karen Griffin, RN, (SICU)
Brenda Whelan, RN, (SICU)
Anne Marie Malloy, RN, (SICU)
Jenn Albert, RN, (SICU)
Marica Vancini, RN, (Neuro ICU)
Lin-Ti Chang, RN, (CCPD)

viding ELAD® therapy to patients once they've been identified as appropriate candidates. The ELAD® on-call nursing team 'went live' in January, 2002.

ELAD® technology is currently in Phase II of the FDA approval process, which means it is still being tested for safety and efficiency of performance. The study coordinator at MGH is Judy Dyer, RN; Rick DaSilva, RN, and Jane Bryant, RN, are nurse liaisons; Winfred Williams, MD, is the primary investigator at MGH.

A simple explanation of how ELAD® works would be to say that blood is continuously drawn from the patient, separated into blood cells and plasma. The plasma is then circulated through the ELAD® device where detoxification occurs, essential

amino acids are metabolized, and needed proteins and clotting factors are produced. The treated plasma is then re-combined with the blood cells and returned to the patient.

The first and (at press time) only patient to receive ELAD® therapy at MGH presented from a community hospital with end-stage liver disease. His encephalopathy improved while receiving therapy, as did his hemodynamic and coagulopathy status. The patient received ELAD® therapy for two days before undergoing a successful liver transplant. He was discharged less than a month later able to ambulate with the assistance of a walker. Members of the ELAD® on-call nursing team were at his side during his entire pre-transplant hospitalization.

For more information about ELAD® contact the Medical ICU at 6-8048.



MICU nurses, Rick DaSilva, RN, and Stacey Fabrizio, RN, provide first-ever MGH ELAD® therapy to pre-liver-transplant patient.

Educational Offerings

November 21, 2002

When/Where	Description	Contact Hours
December 2 and 5 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
December 3 8:00am–4:30pm	Chemotherapy Consortium Core Program Wolff Auditorium, NEMC	TBA
December 5 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
December 5 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
December 6 8:00am–4:30pm	Wound and Skin Care: Beyond the Basics O’Keeffe Auditorium	TBA
December 9 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
December 9 8:00am–4:30pm	Coronary Syndrome Wellman Conference Room	TBA
December 11 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
December 11 8:00am–2:30pm	Mentor/New Graduate RN Development Seminar I Training Department, Charles River Plaza	6.0 (mentors only)
December 11 1:30–2:30pm	OA/PCA/USA- Connections “Safety & Self Care: Taking Care of Ourselves in Times of Stress.” Bigelow 4 Amphitheater	---
December 11 5:30–7:00pm	Advanced Practice Nurse Millennium Series O’Keeffe Auditorium	1.2
December 12 8:00am–2:00pm	CPR—American Heart Association BLS Certification VBK 601	---
December 12 1:00–2:30pm	The Joint Commission Satellite Network presents: “OSHA: Patient Safety and Healthcare Worker Injury-Reduction” Haber Conference Room	---
December 13 8:00am–4:30pm	Care of the Respiratory-Compromised Patient O’Keeffe Auditorium	7.8 (RNs) .6 (SLPs) certificate of attendance (OTs, PTs)
December 13 8:00am–4:30pm	Preceptor Development Program: Level I Training Department, Charles River Plaza	7
December 16 8:00am–2:00pm	CPR—American Heart Association BLS Certification VBK 601	---
December 17 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
December 19 10:00–11:30am	Social Services Grand Rounds “Examples of Short-Term Dynamic Psychotherapy: Treating Affect Phobias,” O’Keeffe Auditorium. For more information, call 724-9115.	CEUs for social workers only
December 19 8:00–11:15am	Intermediate Arrhythmias Haber Conference Room	3.9
December 19 12:15–4:30pm	Pacing : Advanced Concepts Haber Conference Room	5.1

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

Hand hygiene is focus of discussion in ESL classes

The Workplace Education Program, co-sponsored by MGH and the Jewish Vocational Service, provides English-language reading and writing classes to MGH employees for whom English is not

their primary language. In an effort to bring meaningful content into the classroom, the Workplace Education Planning and Evaluation Team decided to invite guest speakers to ESL classes to present information that is pertinent

in the workplace. On Monday, November 11, 2002, Paula Wright, RN, infection control practitioner, spoke to an intermediate ESL class about the importance of hand hygiene and proper disinfecting techniques.



Above: Guest speaker, Paula Wright, RN, CIC, infection control practitioner, talks to ESL class about the importance of good hand hygiene in preventing the spread of germs and bacteria. Wright encouraged the use of Cal-Stat for effective hand disinfecting. At left: ESL class members (l-r) Melvin Velasquez, Maria Pina, and Phanard Iclesias listen attentively.

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