

Caring

HEADLINES

April 17, 2003

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MGH nurses bring aid to Ecuador

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Andra Diephuis, RN, assesses child at makeshift clinic in Viente Ocho de Agosto, Ecuador.

MGH Patient Care Services
Working together to shape the future

JCAHO issues new patient safety goals

With concern growing for patient safety in hospitals and clinics across the country, the JCAHO has issued six new Patient Safety Goals for 2003. These goals apply to all JCAHO-accredited organizations, and effective January 1st of this year, all organizations seeking accreditation must be able to demonstrate how they are meeting these goals.

The JCAHO National Patient Safety Goals are:

- Goal 1:* Improve the accuracy of patient identification
- Goal 2:* Improve the effectiveness of communication among caregivers
- Goal 3:* Improve the safety of using high-alert medications

Goal 4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery

Goal 5: Improve the safety of using infusion pumps

Goal 6: Improve the effectiveness of clinical alarm systems

These goals encompass issues that are important to all of us and values that are embedded in our quality and safety initiatives. Many of our safety policies and practices have been in place for some time, others have been implemented more recently; all are geared toward protecting our patients and families while they are in our care. Because we will be asked to demonstrate our compliance with these new goals, teams have been convened throughout

the hospital to assess our readiness to do so and ensure that goals are being met in a timely and sustainable manner.

Some initiatives currently under way include efforts to improve patient identification and verification in the OR setting (Goal #1 and #4). Staff are developing and implementing new procedures to ensure positive identification of every patient and every surgical procedure. Checklists have been designed that engage the patient and the entire care team in identifying and verifying the surgical site and the procedure to be performed.

Steps have been taken to improve the safety of drug administration and the availability of high-risk medications (Goal #3). Many medications with high-concentrate electrolytes have been removed from patient care units and are now available from the Pharmacy upon request. Clinical leadership is working with Pharmacy to assess other drugs that may be made available on an 'as needed' basis. And we are currently reviewing the need to have so many different drug concentrations on hand. Reducing the number of concentrations available in the hospital would limit the possibility of drug-administration errors.



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

We are ahead of the curve in ensuring the safety of our infusion pumps (Goal #5). All infusion pumps that don't meet the new JCAHO goals were removed from service at MGH in 2000.

Biomedical Engineering is spearheading our efforts to examine the effectiveness of our clinical alarm systems (Goal #6); our policies related to effective communication among caregivers (Goal #2) are in line with JCAHO standards and we continue to monitor them.

I wanted you to be aware of the new JCAHO National Patient Safety Goals for 2003 and of our ongoing efforts to meet and exceed expectations. As always, patient safety is our highest priority.

Sad news

Once again, our hospital community was touched by tragedy with the deaths of Dr. Brian McGovern and Colleen Mitchell. Our thoughts and prayers go out to

their families at this very difficult time.

Whether or not we knew Dr. McGovern or Ms. Mitchell, we are all affected by this tragic event. I hope we can turn to one another for comfort, support, and reassurance as we cope with this enormous loss.

Our hospital is well known for the services and resources we provide to patients and families in times of crisis. Please know that these same resources are available to each and every one of you if you feel you need assistance in any way.

I know many of you knew or worked with Dr. McGovern and Ms. Mitchell, and this is particularly difficult for you. We all need to be honest and vigilant in assessing our own emotional needs and sensitive to the needs of our co-workers.

The Employee Assistance Program (6-6976) is available to assist all employees. Please don't hesitate to call.

Joint Commission Satellite Network Presentations

- May 1st: "Shared Visions—New Pathways: A new Approach to Joint Commission Accreditation"
- June 5th: "Staffing Effectiveness: Finding Long-Term Solutions"
- July 10th: "Medication Use: Preventing Errors"
- August 14th: "Emergency Management: Creating and Implementing an Effective Plan"
- September 18th: "Putting the Pieces Together: Self Assessment, Priority Focus Process, and Tracer Methodology"
- October 16th: "Realizing the Vision: Effective Leadership"
- November 13th: "Hospital-Wide Competency Assessment"
- December 18th: "Performance Improvement: Achieving Results"

For information about these sessions,
call 6-3111

Parking, transportation, and nursing documentation

Parking and Transportation

Question: I park at the Nashua Street lot and take the shuttle to MGH. The shuttle used to pull into the lot for boarding. Now it stops on Nashua Street. Where am I supposed to wait for the shuttle?

Jeanette: Prior to Monday, April 21, 2003, you should wait at the guard booth or on the sidewalk right outside the parking lot. Transportation has informed me that after 6:30am, the lot becomes too congested for the shuttle to maneuver safely inside the lot. Also, due to the construction on Nashua Street, there is no safe place on Nashua Street for the shuttle to stop for a prolonged period of time.

On April 1, 2003, Lisa Scannell, director of Transportation Services, met with the Staff Nurse Advisory Committee to propose an alternate boarding location. The proposed stop would be in the Spaulding Rehabilitation Hospital parking area, adjacent to the Nashua lot. The proposed stop is safer for passengers to board and more convenient for shuttle riders to wait. The new stop inside the Spaulding parking area will go into effect on April 21, 2003. Information will be distributed to all riders prior to implementation.

Question: I take the shuttle from the Nashua St. lot to MGH. It often takes more than 30 minutes to get to the hospital. Why is the route so long?

Jeanette: That route was put in place to accommodate the majority of employees parking in MGH area parking lots. At the Staff Nurse Advisory Committee meeting, Lisa Scannell discussed some other options that would decrease travel time and improve the quality of service. The committee agreed with the suggestions, and changes will be implemented on April 21, 2003.

Question: I take the shuttle in the evening to go to the Nashua Street lot. On numerous occasions, I've had to wait for the shuttle to arrive. Why is it so hard for the shuttle to stay on schedule?

Jeanette: Fleet Center activities combined with construction have made it increasingly difficult for shuttles to remain on schedule. Proposed schedule changes were discussed with the Staff Nurse Advisory Committee to ensure timely service and meet the needs of staff traveling to the Nashua lot in the evenings.

Information on all the above-mentioned shuttle changes will be communicated prior to April 21, 2003. If you have questions, please call the Transportation Office at 726-2250.

Question: I see Transportation employees working on Blossom Street. What are they doing?

Jeanette: Transportation assistants (TAs) are working at the main campus, on Blossom Street, and at the Charlestown Navy Yard, at Building 149, providing updated shuttle information to patients, visitors, and employees, and helping to keep shuttles running efficiently.

Shuttle schedules are accessible on the Partners website at www.partners.org, and are posted in the Gray and Jackson lobbies.

Nursing Documentation

Question: What is the time frame for a nursing assessment to be completed?

Jeanette: Every patient should have an admission assessment completed by a nurse at the time of admission to an inpatient care unit. Some patients are assessed in the Pre-Admission Testing Area (PATA) and arrive on the unit with a completed admission assessment.

Question: If a patient arrives on a unit with a completed assessment from the PATA, what is the responsibility of the nurse admitting the patient to the unit?

Jeanette: Nurses should review the assessment and check with the patient to see if anything

has changed since the assessment was conducted.

Question: What if the patient is unable to answer questions?

Jeanette: If a family member is present, they may assist with the completion of the form. If family is not available and the patient is unable to be interviewed, the nurse should write, 'Deferred,' and the reason why.

Question: What do I do with information I learn about the patient later in the hospitalization?

Jeanette: That information should be included in the progress note under the appropriate problem.

Question: After I've assessed my patient, in formulating the problem list, do I utilize nursing diagnosis?

Jeanette: Patient problems can be stated in medical diagnosis or nursing diagnosis. When nurses base decisions on nursing assessments, then nursing diagnoses should be used. Both nursing diagnoses and medical diagnoses are accepted methodologies.

Question: Where can I find the interventions that correspond with the patient problem list?

Jeanette: Nurses decide upon admission if it's appropriate to write interventions on the intervention sheet, use a pre-printed intervention sheet, or include the intervention with the progress notes as part of the

initial plan of care. In all cases, interventions should be dated, signed, and revised by the nurse.

Question: Where are outcomes listed in the medical record?

Jeanette: On the patient problem list.

Question: How do you know when outcomes are achieved/attained?

Jeanette: Information pertaining to attainment of outcomes should be reflected in the progress notes. When the outcome is achieved, the nurse indicates the resolution date on the patient problem list.

Question: Does each patient need to have a health care proxy/advance directive?

Jeanette: No. Each patient should be asked upon admission if he/she has completed a health care proxy. The patient's response and subsequent actions of the healthcare team to obtain the proxy should be documented on the health care proxy questionnaire.

Question: Why were desired outcomes put on the problem list?

Jeanette: To ensure that our care is not only individualized, but that specific goals are identified for each patient in relation to each problem identified.

Question: The problem list has been revised to include patient outcomes. What are the key points nurses need to consider when writing outcome statements?

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A memorable mission to Duran, Ecuador

—by Laura Taylor, RN, Andra Diephuis, RN,
and contributing authors, Annette Brien, RN, and Lisa O'Neill, RN

My name is Laura Taylor, and I am a nurse in the Medical Intensive Care Unit (MICU). About five years ago when I was a senior at Fairfield University, I went on a 10-day volunteer trip with a program called Rostro de Cristo, a Catholic volunteer program in Duran, Ecuador, that provides mission opportunities for students and young adults. The program also has a year-long component where volunteers work and live in Duran and function as mentors to other volunteers. During my 10-day trip, I was so inspired I decided to commit to a

year of service with the program when I graduated from college.

During my year in Ecuador, from 1998-1999, I lived in a community with five other volunteers. I primarily worked at a Hansen's Disease (Leprosy) Hospital and taught English to seventh graders. My experience was absolutely amazing. The people of Duran became my friends and extended family. My bond with them is something that will never leave me. I went to Ecuador knowing very little Spanish, and I was unfamiliar with the lifestyles of the country. I struggled every day with the

language and culture. I saw the devastating effects of poverty and wondered how my new friends endured such destitution. This is what inspired me to make a life-long commitment to service, social justice, and solidarity with the people of Ecuador. My goal was to continue to give back to the people and the community of Duran.

After my year in Ecuador, I often thought about going back to Duran on a medical mission. As an alumna of the volunteer program and a member of the council that advises the program, I asked permission to

bring a non-denominational group of medical personnel to Ecuador. The directors graciously agreed to sponsor a medical mission on a trial basis. My idea became a reality when, this past January, four MGH nurses, including myself, spent 11 days living and working in Duran.

I began the process of recruiting team members by talking about a medical mission to Ecuador with my co-workers. Word quickly spread, and three nurses volunteered to come with me. They were Andra Diephuis, Annette Brien, and Lisa O'Neill. Andra has worked at MGH for five years, first on the Bone Marrow Transplant Unit and currently in the Emergency Department. Annette has worked for MGH for seven years in the MICU and the PACU

and currently works on the Clinical Trials Unit. Lisa has worked at MGH for eight years, currently in the Cardiac Critical Care Unit.

The four of us started to meet monthly in September of 2002 to get acquainted with one another and plan for the mission. Our first focus was fundraising. Annette, who had experience raising money for oth-

er medical missions, coordinated a fundraising event at the Holiday Inn on Blossom Street. The event raised more than two thousand dollars. We each raised additional money and divided it equally among all of us to cover the cost of the trip (\$1,015 per person for flight, housing and food). We were very grateful to everyone who supported our efforts.

The next part of our plan involved making a list of the medical supplies we'd need for the mission and finding someone to donate them. We made a preliminary list of supplies based on an e-mail we received from a physician in Ecuador. With the help of her nurse manager, Maryfran Hughes, and Jim McCarthy, manager of supplies in the ED, Andra was able to facilitate the donation of much of what we needed. Two days before the trip we filled duffle bags full of medical supplies ready to be transported to Ecuador.

The last leg of the planning process was to decide on our goals for the trip. We weren't familiar with the health-care needs of the Duran community. Much of our discussion focused on how we would learn about the health care practices that existed in Duran. We made a plan to visit medical clinics once we arrived in Duran and to learn about

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(Photos provided by team)

Medical Mission to Ecuador

continued from previous page

the community by living there.

After the trip, as a group, we decided to write about our experience in Ecuador to raise awareness among other healthcare professionals about the culture and healthcare practices of a third world country. The following account was written by the four of us.

We arrived in Guayaquil, Ecuador, on January 11, 2003. Ecuador is located on the western coast of South America between Columbia and Peru. The country is about the size of Colorado. The population is about 13,000,000 with 70% of the population living in severe poverty. The average monthly salary for an Ecuadorian household is \$150 per month. The average cost

of a doctor's visit is \$2.00. Most of the people in Duran have little or no income and cannot afford a visit to the doctor.

From Guayaquil, we made our way to Duran, where we would live and provide medical care for the next 11 days. Duran is one of the poorest areas on the Southern coast of Ecuador, located about five miles west of Guayaquil. Contaminated water supplies and poor sanitation account for a large number of preventable illnesses in Duran. Minimal access to immunizations and follow-up treatment impacts the overall health status of the residents in this region. Although laws requiring immunization and monitoring of infectious disease exist, they are not strongly enforced.

Upon arrival in Duran, we quickly learned that the community was close-knit, friendly, and family-oriented. They quickly drew us in to their circle of camaraderie and friendship. Despite the poverty, the people of Duran never complained, always greeting us with a smile and a kiss. The community was poor but the people possessed a wealth of human strength and spirit.

We slept to the sound of people laughing, Spanish music, dogs barking and roosters crowing. For the first few days, our goal was to become familiar with both the culture and healthcare needs of the community. We toured different medical clinics, met nurses

and physicians, and mingled with the people of Duran. We came up with a plan for how to provide the community with our services.

Improvisation was a talent we learned quickly. In an area where resources were limited, we learned to improvise our

healthcare practices. As healthcare providers from a North American teaching hospital, this was one of the biggest challenges we encountered. At home, we're rarely forced to improvise treatment due to lack of resources. We

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Above: Annette Brien, RN (back), and Lisa O'Neill, RN, screen patients for hypertension and hyperglycemia at clinic in Duran.



At left: Laura Taylor, RN (center) teaches medical personnel how to use a nebulizer.

Opposite page: Andra Diephuis, RN, treats young boy and his sister in the community of Viente Ocho de Agosto.

Medical Mission to Ecuador

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learned there were no quick solutions and what we needed to provide was the essence of what nursing is all about: health promotion, education, and compassionate care to patients and their families.

We chose to work at three medical clinics serving families living in Duran. The clinics were in the poorest communities. Most families were unemployed. Some people, including children, made a living by selling candy and water on the streets of Guayaquil. Most families consisted of more than four members and often the entire family lived in one-room homes made of cana de azucar (sugar cane). There was no running water or sanitation; untreated water was delivered

to people's homes and stored in large, rusty, tin barrels.

Viente Ocho de Agosto (named for the day the town was formed, August 28th) was one of the towns where we worked. The people of Viente Ocho de Agosto built their community on a trash dump thinking they could make money by selling trash. Homes were literally built on the dumpsite. Of all the communities we visited, Viente Ocho made a lasting impression on all of us. The idea of living on a dump and making money by pilfering trash was one we all struggled with. It was the most challenging place to work because the poverty was so widespread and so much a part of their lifestyle.

Our work at the clinics and in the communities consisted of providing free medical care to the people of Duran. We advertised with posters and handouts that we would be available for free care. We saw patients in the clinics and in their homes. When we weren't working in the clinics we were walking around the community providing care. We treated patients independently with the help of translators and, when needed, we referred patients to Ecuadorian physicians. At times we worked alongside Ecuadorian physicians to learn more about the medical issues of the region and their modes of treatment.

Some common problems we saw were often associated with the environment. Parasites and intestinal worms were common because of the untreated drinking water.

We saw dermatological issues such as scabies, lice, and impetigo. There was a prevalence of respiratory problems due to air pollution, dust from unpaved roads, and heat. We had been told before we left home that a nebulizer was needed at one of the clinics. We were able to donate one and provide respiratory treatments as needed.

In addition to treating patients with medical problems, we provided advice on health promotion and helped educate both patients and medical personnel. We set up blood-pressure and blood-glucose screening systems. Though patients couldn't afford medication for hypertension or hyperglycemia, we spent time educating them about diet and nutrition and how that relates to blood pressure and blood glucose.

At the Hansen's Disease (Leprosy) Hospital in Guayaquil, we taught physicians and nurses how to use medical equipment that wasn't being used because no one knew how it worked.

In retrospect, we're pleased with what we were able to offer the people of Duran. And what they taught us is beyond words. By living and working with the people, we could see, hear, smell, and experience first-hand the issues they cope with every day. As nurses at MGH, we often see, up close and personal, patients and families enduring

much pain and suffering. The difference is, we have the resources to help patients and families cope with their pain and suffering. In Duran, resources are not as readily available and, often not available at all. This mission reminded us of how little others have and how fortunate we are to live in an abundant society. We came home with a new appreciation of our healthcare system and the resources we have on a daily basis.

We are grateful to have had the opportunity to go to Ecuador and work with the people of Duran. As a result of this medical mission, there is a prospect for future medical missions. Initial planning has already begun for a trip next year.

We would like to share a quote that we feel represents what we tried, and will continue to try, to accomplish in Duran.

"Go to the people. Live among them. Love them. Serve them. Plan with them. Start with what they know. Build on what they have. And when the best leaders leave, the people will say, 'We have done it ourselves' "

—Lao Tsu.

For more information about missions to Ecuador, contact: Laura Taylor, Andra Diephuis, Annette Brien, or Lisa O'Neill by e-mail.

Filing the Issues

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Jeanette: Nurses should:

- identify patient and/or family or significant other's goals to achieve an optimal level of wellness
- outcome statements are standards for measuring the effectiveness of the nursing care plan to address patient care needs
- outcome statements should be achievable and measurable in a

way that demonstrates either a change in the patient's health status or health maintenance in response to nursing care provided.

Question: How often should outcome statements or patient goals be re-evaluated?

Jeanette: If outcomes are not being met, nurses should re-assess the patient problem whenever needed and revise goal(s) and interventions.

Question: When re-assessing patient outcomes and goals, what are some questions to consider?

Jeanette: When re-assessing patient outcomes and goals, some of the things to consider include:

- Is the diagnosis or stated problem correct?
- Has the goal been mutually set (discussed with the patient and/or family)?
- Is there a need to allow more time to see if the plan of care will work?
- Do the goals and/or interventions need to be revised?

April is Occupational Therapy Month

You are a professional violinist, and the fingers on your left hand curl in spontaneously when you play. You broke your hip and you're unable put your socks on. You're concerned that your elderly parent may not be safe at home alone. Like they say, "Who you gonna call?"

Occupational Therapy. Occupational Therapy uses purposeful activities to help patients improve their ability to perform self-care and home, community, work, school, and leisure activities.

Occupational Therapy looks at how a disease or condition affects a person's ability to maintain their role in society (artist, mother, student, professional, etc.) Evalua-

tions include standardized and structured functional assessment tools. Specialized training in analyzing the multiple parts of a single activity help occupational therapists (OTs) enable people to return to their day-to-day activities despite their impairments.

OTs work with individuals of all ages. Therapeutic interventions are directed at developing, improving, sustaining or restoring daily-life skills. Treatment may include self-care and home-management training; fabrication of a variety of splints; prescription, fabrication and application of assistive and adaptive devices; functional tasks geared toward improving range of mo-

tion, strength, and dexterity; neuromuscular facilitation and inhibition techniques; cognitive re-training; visual/perceptual re-training; energy conservation techniques; ergonomic modifications, and caregiver training.

The MGH Occupational Therapy Department provides services on all inpatient units, in the outpatient setting, in hand clinics, and off-site at the Revere Health Center. The outpatient OT clinic is located in WACC127. The focus of services and programming is hand- and upper-extremity injuries, helping patients regain motion, strength, and functional ability. The clinic provides evaluations and treatment to neurological

and pediatric patients as well.

The inpatient OT service treats patients with a wide variety of diagnoses: orthopaedic, neurological, surgical, medical, burn, multiple trauma, cardiopulmonary, and oncology. OTs work in all ICUs, including the Burn Unit and the NICU. Inpatient OTs assess patients' ability to care for themselves at home following discharge. Some OTs are trained in AMPS (Assessment of Motor and Process Skills), a standardized evaluation tool

to assess a patient's ability to function in the community. One therapist has undergone training in A-ONE (Arnadotir OT-ADL Neurobehavioral Evaluation), a standardized assessment tool to simultaneously evaluate ADL performance and neurobehavioral deficits that interfere with task performance.

Please stop by the Occupational Therapy booth in the Main Corridor on April 30th and May 1st to learn more about the services that occupational therapists provide at MGH.



At left: occupational therapists, Elizabeth O'Farrell, OTR/L, and Dan Kerls, OTR/L, demonstrate technique for fitting patient with a hand splint to prevent contracture and improve function. At right: therapists, Nancy Kelly, OTR/L (back), and Maureen Sheridan, OTR/L, demonstrate methods for teaching patients how to use adaptive equipment for meal preparation.



Nurse cares for patient through 'last chapters' of her life

My name is Denyce Stanton, and I am a staff nurse on the White 9 Medical Unit. When I first met 'Jane,' she was awake, non-verbal, being fed through a G-tube, and unable to respond to commands or care for herself in any way. She was also beautiful. We all said she had a face like an angel. She was only 34, but as I cared for her, her body told me a different story. She had what looked like cigarette burns on her legs, arms, and shoulders; old slash marks on her wrists told of past suicide attempts. I wondered how her life had gotten so out of control.

Jane was diagnosed at age six with diabetes. The key to living with diabetes is maintaining good blood-sugar control. Because of the circumstances of her life, Jane was never able to maintain a safe blood-sugar level. Jane and her family lived in another state and were well known to that state's healthcare agencies. Through a combination of economic difficulties, mental-health problems, and an inability to allow others into their lives, her family got by. But Jane, with her serious medical condition, barely got by. Jane would call 911 to say she didn't feel right and have her blood sugar checked. Glucometers were given to her but soon lost or

broken. Her levels would soar to the 800s or fall to less than 20. To have such extreme fluctuations and refuse all but emergency care—this was a lucky woman. But as I cared for Jane that day, it looked like her luck had run out.

Jane came to White 9 following a stay in the ICU. She had been transferred to MGH from a community hospital with a blood-sugar level in the 800s and a questionable neurological process. She had stabilized for a time in the ICU, but within 24 hours her neurological condition deteriorated to, 'awake but not alert.'

I cared for Jane for three months. At first, I didn't see anything in her gaze, but in time her eyes began to follow me. Perhaps this wasn't the end of Jane's story after all, just another chapter. This young woman, who probably rarely had her hair shampooed or styled found herself the focus of the White 9, "Look Good, Feel Better" initiative. She was styled and pampered, and though she couldn't speak, her eyes and nodding head told us she loved every moment. With physical therapy, Jane was able to get out of bed and begin to ambulate down the hallway. She was even able to feed herself.

Jane lived with her parents and two children. The older child was born with severe handicaps;

the other child had a difficult relationship with Jane and was cared for by Jane's mother. Her family rarely visited, so we updated them on her progress by phone. Soon, Jane was accepted to a rehabilitation hospital where she would continue her recovery.

Sadly, a few days before she was to be transferred, Jane's blood sugar dropped precipitously to less than 20 and she began to exhibit signs of massive neurological assault. She stabilized, and we again hoped we were just writing another chapter in her saga. But unfortunately, that was not to be. Jane cried uncontrollably, and nothing we did seemed to comfort her. Her only independent movement was her left elbow. She became unstable hemodynamically and developed fevers from recurrent infections.

It became clear that Jane would not survive, and that she was suffering from the aggressive treatment. Her care team (nurses, physicians, social workers, Palliative Care, physical therapist, occupational therapist, and case manager) decided we needed to get her family together and make a decision about what Jane would want—aggressive treatment or comfort measures. Many unsuccessful attempts were made to contact the family. Finally, contact was made, and her moth-



Denyce Stanton, RN, staff nurse, White 9

er, sister, brother, and younger child came in to meet with the care team.

These meetings can be very challenging for everyone. The family had held out hope that Jane would pull through like she had so many times before. We had all hoped for that. But we were now watching Jane suffer with no chance for recovery. The family left the meeting unable to come to a decision. We understood. This was not easy. We asked them to think some more about what Jane would want.

I was surprised, several days later, to see Jane's entire family. I sensed something was different. During their previous visits they had seemed distant. Now they were crying. I felt they understood Jane's suffering and prognosis and were ready to say good-bye. Still, they left that night without changing her resuscitation status.

Several hours later, I received a call from Jane's mom. She was calling from a pay phone. "Call the priest and let her be at

rest," she said. We spoke for a few minutes and she talked with the physician. The priest came. We spoke about Jane for a while and then together went to her bedside and prayed for her to have peace. I cried for Jane, for her difficult life, her amazing courage, and for a mother having to bury her child. Jane died peacefully the next evening.

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

Denyce was present for Jane in exactly the right way, at every stage of Jane's illness. She offered hope; she provided comfort; and finally, she prayed for Jane to be able to rest in peace. Denyce looked beyond Jane's scars and saw a woman of strength and courage. When Jane's condition worsened she worked within the family dynamics to help them make the difficult decision to let Jane rest.

This is a beautiful story of wonderful bedside care that evolved into compassionate end-of-life care. Thank-you, Denyce.

Shattering the myths about organ and tissue donation

—by Sean Fitzpatrick, director of Public Education, NEOB

Approximately 17 people die every day awaiting life-saving organ transplants. They are among the 80,000 people nationwide on the national transplant waiting list.

The need for organs and tissues is increasing at a rapid rate, and the need far exceeds the supply. To raise awareness about the need for organ and tissue donation, the Federal government has designated April as National Organ and Tissue Donor Awareness Month.

Hospitals play an important part in alleviating the donor shortage. Hospitals are first to identify and refer potential organ donors. They provide a valuable service to their local communities by ensuring that families of all potential donors are given the opportunity to donate organs and tissues.

Anyone can become a potential organ and tissue donor. It only takes a few moments to discuss your wishes with your loved ones. Deciding to be a donor is just the first step. People need to share their wish to donate with their families.

For information on organ and tissue donation, call the New England Organ Bank at 800-446-6362 or visit their website: www.neob.org.

Organ and Tissue Donation Myths and Facts

Myth: I don't need to inform my family about my wish to donate because I signed a donor card and put a sticker on my license.

Fact: Your family and next of kin will be consulted before any organs or tissues are recovered. They will be asked to consent, and their wishes will be honored. Telling your family now of your wish to donate is the best way to ensure that your wishes are carried out.

Myth: If I donate, my body will be mutilated, I won't be able to have a normal funeral, and my family won't be able to see me to say good-bye.

Fact: Donated organs are removed surgically. Careful attention is made so that an open casket is still an option if that is the person's choice. You can still receive a traditional burial or cremation if you donate.

Myth: Doctors may let me die if they know I am an organ donor so they can transplant my organs to others.

Fact: The medical team treating you is separate from the transplant team, and every effort is made to save a person's life regardless of intent to donate.

Myth: Only wealthy or famous people receive transplants. I could never get one if I needed one.

Fact: Donor organs are matched to recipients based on blood and tissue type, geographic location, and medical urgency. Organ allocation is blind to wealth or social status. Factors such as race, gender, age, or celebrity status are not considered when determining who receives an organ.

Myth: It costs money to donate.

Fact: Organ and tissue donation is completely free. A donor's family is not charged for donation.

Myth: Donating organs and tissue is against my religion.

Fact: Most mainstream organized religions support donation. It is typically considered a generous act that is the individual's choice.

Myth: I'm too old to donate.

Fact: Strict age limits for organ and tissue donation no longer exist. Medical professionals decide which organs and/or tissues are suitable for transplantation. Age is not the determining factor; condition of the organ is.

Representatives from the New England Organ Bank staff educational booth in the Main Corridor during National Organ and Tissue Donor Awareness Month.



Forging friendships with our Cuban neighbors

—by Donna Perry, RN,
professional development coordinator

When Oswald (Oz) Mondejar, Human Resources manager, invited me to join a delegation bringing humanitarian aid to Cuba earlier this year, I had no idea what to expect. Little did I imagine that what awaited us was an extraordinary land and some of the most inspiring people I've ever met.

In February, Carmen Vega-Barachowitz, director of Speech-Language Pathology, Oz, and I were part of an 18-person delegation that went to Cuba in affiliation with an organization called ACCESO (Americans and Cubans build-

ing Community through Exchanges, Support and Outreach). ACCESO is a non-profit organization founded by Oz and state senator, Jarrett Barrios.

The delegation delivered approximately 5,000 books, including many donated by Treadwell Library and MGH staff. And MGH was instrumental in introducing ACCESO to vendors who donated much-needed medical equipment and supplies.

Despite an embargo on trade that has been in place for the past 40 years, and a severe economic crisis that has

impacted their country since the early 90s, Cubans have united in a way that both inspired and humbled me. They have developed an infrastructure of education, medicine, and social services. They face a staggering lack of material resources for these systems, including a shortage of food and medicine, but their solidarity shows a profound transcendence of the human spirit.

Throughout our visit we were shown incredible hospitality such as in the village of Bejucal, where we were treated to



Carmen Vega-Barachowitz presents Cuban student with stuffed animal in Cienfuegos, the sister city of Cambridge. The children had performed a play for the delegation in the town library.

a beautiful feast, music, dancing. It is humbling to accept food when you realize it's being shared by people who often go

hungry themselves. Our guide told us, "When visitors come, no matter where they are from, Cuban people try to give something, even when we have nothing."

The infrastructure of the Cuban medical system is a strong public health model. In smaller cities and towns there are local hospitals, called polyclinics, that triage patients. Critically ill patients are sent to larger hospitals in Havana. Each neighborhood has a nurse and physician responsible for providing 24-hour care. This system enables health care professionals to know their patients well and has facilitated a strong preventative, primary care model. The system is limited due to a lack of supplies, especially medications. Asthma medica-

continued on next page



Donna Perry, RN (seated), and another member of the ACCESO delegation at the Panama School for Children with Physical Limitations.

Forging Friendships

continued from previous page

tions, anti-hypertensives, and chemotherapy agents are the most critically needed. Shortly before our visit, we were asked if we could help a local historian whose breathing was severely impaired because he had no access to a steroid inhaler. The MGH pharmacy, was able to contact an outside drug representative and obtain a year's supply of the needed medication.

It is sobering to see people suffering from easily treatable conditions due to a lack of resources.

During our stay we visited medical facilities, libraries, schools, and social service organizations. At every stop we were filled with admiration at the way the Cuban people were able to transcend material limitations and achieve social progress. One example was our visit to the Panama School for Children with Physical Limitations. The children were radiant with joy, a testament to the good care they were receiving.

Friendship and solidarity were values that were echoed over and over by the people we met. A representative from the Cuban Council of Churches told us, "When we speak to people like you, we speak from our hearts. When you

return to the United States remember the great things about Cuba. Say, 'Let me tell you about the care the Cuban people showed us.'"

For more information about humanitarian outreach to Cuba, contact Oz Mondejar at 6-5741.



Vega-Barachowitz (left) Mondejar (center) and Perry (right) with physician and nurse of Bejucal Polyclinic

A friend in Cuba

by Carmen Vega-Barachowitz, SLP,
director, Speech-Language Pathology

I met Belkis at El Aljibe Restaurant. Oz had invited her to join us for dinner. They were old friends. All 18 delegates were there in addition to several Cuban family members of one of the delegation members. Belkis is a special education teacher. She teaches 9 deaf/blind students. She had been to Massachusetts as part of her training at Perkins School for the Blind.

Belkis and I spoke about her work and the challenges she faces. Teaching communication to deaf/blind individuals is a very specialized field and an art. She told me about one of her students. She had taught him to 'read' finger-spelling on his hand. He was young, I think she said he was 9 years old. She described him as bright and a fast learner. He had been identified as an excellent candidate for a cochlear implant. For the first time in Cuba, this procedure was going to be performed on deaf/blind children. Three children had been selected as potential candidates, all of whom were Belkis' students.

Castro had visited the school, and Belkis had been introduced to him as the person who would help the children learn to communicate after the procedure. Belkis was committed to doing the best for her students. She had tremendous passion for her work. She asked me what I knew about the rehabilitation of deaf/blind children after a cochlear implant. It is not my specialty, but I have access to information through high-speed technology and the Internet. We discussed potential sources of information, but none of them was available to her. Belkis' access is limited. She does not have e-mail. She gave me her friend's e-mail address, and I have become a window to resources for her, helping to increase her knowledge. We correspond in this way, and I now have a wonderful friend and colleague in Cuba.

Gesture of friendship; international coincidence

by Donna Perry, RN,
professional development coordinator

When I told my Boston College nursing professor, Sister Callista Roy, about my upcoming trip to Cuba, she recounted having met a nurse from Cuba at a Pan American nursing conference last year. The nurse had told Sister Roy about the difficulties they had obtaining nursing books in Cuba. Sister Roy remembered their conversation and asked if I would take a copy of her book to Cuba and deliver it to the nursing school. She gave me the latest edition of her textbook inscribed with a message to nursing colleagues in Cuba.

We tried to locate the nursing school in Havana, but after several unsuccessful attempts, we decided to try the Ministry of Health. Fortunately, there we met with the national director of Nursing, Ms. Escalona. We explained the purpose of our visit and presented her with the book. She recognized the title at once and invited us to sit down. With a heart-warming smile she said, "This is a very meaningful day. In spite of the difficulties between our governments, you have come to foster friendship. It is this spirit of humanity that is so important."

Ms. Escalona told us she had attended a conference last year where she had met Sister Callista Roy. She remembered telling Sister Roy that she had read some of her manuscripts but was unable to get copies of her book.

At that point we realized this was the same nursing leader who had inspired Sister Roy to give us the book to bring to Cuba! I couldn't believe we had found her! Sister Roy hadn't even known her name or where she worked in Cuba. This visit truly seemed meant to be.

An overview of magnet hospital certification

—submitted by the Magnet Steering Committee

*A*s you know, MGH is in the process of applying for magnet hospital recognition, the highest recognition offered by the American Nurses

Credentialing Center to organized nursing services in healthcare organizations. In January of this year, we submitted more than 2,000 pages of

written evidence documenting our readiness to seek this recognition. Following a review of our documentation, we were notified that a site

visit has been scheduled for June 10-12, 2003, to give us an opportunity to demonstrate and amplify what we have already submitted in writing. More than 170 staff nurses are currently serving as magnet champions to help prepare MGH staff for the visit. This is an exciting opportunity to

showcase the excellent care given at MGH and the wonderful team that makes that care possible.

Magnet Hospital Origins

National research conducted in the early 80s studied characteristics of hospitals that were able to withstand a significant nursing shortage at the

time. They identified the characteristics of those hospitals that were able to attract and retain qualified nurses. These hospitals were called magnet hospitals.

The New Magnet Hospital

In 1993, the American Nurse Credentialing Center, (ANCC) a subsidiary of the American Nurses Association, introduced a new certification process available to all hospitals and across all settings. Magnet Nursing Services Recognition, a coveted award, is the highest recognition the ANCC can award to organized nursing services. It speaks to the excellence of professional nursing in quality patient-care delivery and the support of an organization for its expert clinicians.

Ongoing research has shown
continued on next page

Magnet hospital certification: are we ready?

Administration

Magnet Hospitals

Participatory & supportive management style

Well prepared & qualified nurse executives

Decentralized organizational structure

'Adequate' nurse staffing

Deployment of clinical specialists

Flexible working schedules

Clinical career opportunities

MGH

Collaborative Governance comprised of 8 committees; implemented in 1997; more than 250 staff nurses and other clinicians participate each year.

Well-qualified nursing leadership team; 360° review for Nurse Leaders; Leadership Development Program to develop current and emerging leaders.

Nursing leadership (chief nurse, associate chief nurses, nurse managers). Unit clinical triad (nurse manager, clinical nurse specialist, operations coordinator).

Staffing to workload is facilitated by data generated by staff nurses; more than 20 years of acuity-measurement and analysis; resource-management determined for each unit by nursing leadership and staff.

More than 50 unit-based clinical nurse specialists; on-site consultation, professional development, practice and research.

Unit-based staffing, part-time and flexible staffing opportunities.

Clinical Recognition Program developed in response to request from staff nurses; recognizes excellence in clinical practice.

Professional Practice

Professional practice models of delivery of care

Professional autonomy and responsibility

Availability of specialist advice

Emphasis on teaching

Interdisciplinary, patient- and family-focused model of care matches needs of respective patient populations, models re-evaluated on an ongoing basis.

Annual Staff Perception Survey measures autonomy, control over practice and collaborative relationships with other disciplines; scores meet or exceed magnet levels.

Unit-based resources include a wealth of databases, texts, unit-based clinical nurse specialists; 21 nurses prepared at the doctoral level; conduct and utilize research; strong collaborations with academic nursing programs.

Preceptor and mentor-driven programs.

Professional Development

Planned orientation of staff

Emphasis on continuing education

Competency-based clinical ladders

Management development

Highly educated workforce

Role-specific orientation programs including new graduate and specialty orientations.

The Center for Clinical & Professional Development – numerous continuing education opportunities, reimbursement for continuing education.

Clinical Recognition Program

Leadership Development Program; Nurse Manager Academy (Hopkins)

Support for tuition-reimbursement, participation in continuing education and flexible scheduling.

Durant Fellowship in Refugee Medicine open to nurses and allied health professionals

The Thomas S. Durant Fellowship for Refugee Medicine was established by friends and colleagues of Dr. Durant shortly after his death in 2001. The fellowship honors Dr. Durant's memory and dedication to service by sponsoring healthcare professionals to follow in his footsteps serving refugee populations and victims of complex humanitarian disasters.

The first Thomas S. Durant Fellowship went to Kris Olson, MD, who is currently working on the Thai-Cambodian border

The Durant Fellowship Selection Committee

- Laurence Ronan, MD
- Mrs. Thomas Durant
- Jeanette Ives Erickson, RN
- Allison Rimm
- Susan Briggs, MD
- The children of Thomas Durant

in conjunction with The American Refugee Committee (one of two relief organizations through which Durant fellows are placed).

The Durant Fellowship is open to all healthcare providers, including nurses and allied health professionals who are interested in contributing to international relief efforts. The selection committee would like to encourage non-physician caregivers to apply to accentuate the broad humanitarian scope of the fellowship.

The fellowship offers:

- a stipend to cover expenses associated with the refugee service experience
- hands-on experience in the field administering medical care and support services to those in need

A minimum three-month commitment is required, but the fellowship is flexible in terms of accommodating the needs and

diverse availability of clinicians. Commitments may be for three-, six-, and nine-month time periods, or up to a full year.

Applicants for the Durant Fellowship must submit:

- a completed application
- a curriculum vitae
- a one-page essay explaining why you are interested in refugee care and what you hope to accomplish and learn from the experience
- two letters of recommendation

Final candidates will be interviewed by the Durant Fellowship Selection Committee (see shaded box). The one or two individuals selected will have an opportunity to meet with representatives from the relief organizations to ensure an appropriate 'fit' of talents and destination. Mentoring is available.

For more information, call Larry Ronan, MD, at 4-3874, or visit the fellowship website at: www.durantfellowship.org.

Magnet Update

continued from previous page

that the Magnet Recognition Program is a valid method of identifying hospitals that have an exemplary professional practice environment for nurses. The magnet designation provides consumers with valuable information in determining where to seek care. For experienced nurses, magnet certification is a guide to choosing where to work. More and more, nursing schools are informing their students about the advantages of working in the type of environment offered by magnet hospitals.

Characteristics of Magnet Hospitals

- Concern for the patient is paramount
- Nurses identify the hospital as a good place to practice nursing
- Nurses have autonomy and accountability over practice
- Nurses have control over nursing practice and their practice environment
- Supportive nurse manager/supervisor
- A reputation for quality nursing care as rated by patients.
- Increased retention of nurses.
- Low turnover

- Use of supplemental staff is virtually non-existent
- Nurses identify importance of working with other nurses who are clinically competent
- Staff are highly-educated
- Lower burnout
- Increased percentage of registered nurses in staffing mix
- More favorable ratio of nurses to patients
- Support for education
- Strong nurse-physician relationships and communication
- High degree of teamwork
- Your work has meaning, and you feel good about your work.

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senior vice president for Patient Care
and chief nurse

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CNS Research Task Force focuses on common patient problems

—submitted by clinical nurse specialists, Marion Phipps, RN, and Cynthia LaSala, RN

Advanced practice nurses are critical to the efforts of any hospital to redesign systems to provide effective, cost-efficient care. The role of the clinical nurse specialist (CNS) at MGH can be framed within Hamric and Spross's notion of spheres of influence. Each individual exerts his/her own influence within family, community, work, and social environments. At MGH, CNSs typically work within spheres that involve improving clinical practice through teaching, collaboration and consultation; understanding technology; product-evaluation, and recommending actions. CNSs promote staff development, facilitate change, and serve as role models for other staff. CNSs impact multidisciplinary systems through committee work and other initiatives that foster political and social change.

CNSs have a unique opportunity to affect practice and patient outcomes through direct patient-care activities, professional development, and staff mentoring. Over the years, CNSs at MGH have been involved in many collaborative initiatives to improve patient care and

change practice. Spross identified three components needed to promote successful collaboration. They include unity of purpose, or a common vision regarding organizational goals and philosophy; professional recognition of one another's skills and contributions; and effective communication.

In the fall of 2002, The Center for Clinical & Professional Development and a task force of CNSs came together to analyze the results of the "Staff Perception of the Professional Practice Environment Survey," completed in 2002. Results from the survey were made available to nursing staff throughout the hospital. One section of the survey identified high-frequency nursing problems as identified by staff, their ability to manage these problems, and adequacy of resources to assist in resolving them.

In recognition of the various domains of practice inherent in the CNS role, including expert clinician, educator, and researcher, Dorothy Jones, RN, nurse scientist, facilitated the development of the CNS Research Task Force to further evaluate the implications of patient

problems, CNS interventions to affect outcomes, and staff development needs for nurses throughout the hospital.

Membership in the group is open to all CNSs. To date, nine CNSs have joined. The purpose of the group is to:

- develop appropriate strategies that address identified needs of staff in the promotion of safe, quality, patient care
- support organizational goals of practice, education, and research
- identify approaches to increase the impact of the CNS and the promotion of organizational strategic initiatives
- identify linkages between high frequency patient problems, intervention strategies promoted by the CNS, and outcomes that impact staff and patients.

To initiate this process, The CNS Research Task Force first met to analyze common patient problems identified by nursing staff in the staff perceptions survey. The ten most frequent problems identified were pain, anxiety, immobility, infection, fear, con-



Clinical nurse specialists, Marion Phipps, RN (left), and Cynthia LaSala, RN

fusion, self-care deficit, incontinence, sleep disturbances, and family conflict. Nurses indicated they felt least prepared to address eating disorders, violence, substance abuse, decisional conflict, family conflict, and anger.

Individual CNSs within the group have begun to isolate specific problems identified by staff for the units they cover. In some settings, CNSs have initiated intervention strategies to address critical issues raised by staff. Future group meetings will continue to focus on evaluating other problems addressed by CNSs individually and collectively. It is hoped that data collected in the 2003 survey will report changes in the problems identified previously.

The CNS Research Task Force provides periodic updates to the larger CNS group of the its activities. It is the goal of the CNS Research Task Force to form link-

ages with the Nursing Research Committee, magnet hospital initiatives, and other pertinent service/organizational activities influencing patient care.

The task force meets monthly. Goals and activities for this year include ongoing discussion and examination of results, presentations at national meetings and Nursing Grand Rounds, publications, and a poster for Nurse Recognition Week.

Katie Brush, RN, and Ann Martin, RN, will present secondary data analysis of patient problems at the annual meeting of the National Association of Clinical Nurse Specialists.

Joan Gallagher, RN, and Dorothy Jones will present at the Eastern Nursing Research Society. It is anticipated that there will be more opportunities to publish and present the work of the task force as it continues to develop.

Educational Offerings

April 17, 2003

When/Where	Description	Contact Hours
April 25 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
April 28 and May 1, 5, 6, 12, 15 7:30am–4:30pm	ICU Consortium Critical Care in the New Millennium: Core Program Wellman Conference Room (except May 6th: Walcott Conference Room)	45.1 for completing all six days
April 28: 7:30am–4:30pm April 29: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: SEMC. Day 2: (VBK607)	14.4 for completing both days
April 29 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
May 1 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
May 1 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
May 1 1:00–2:30pm	The Joint Commission Satellite Network presents: “Patient Safety: Standard, Goals, Reducing Risk through FMEA.” Haber Conference Room	---
May 2 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
May 7 5:00–7:30pm	Managing the Menopause Patient in 2003: a Practical Approach O’Keeffe Auditorium	2.4
May 8 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
May 9 and 19 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
May 12 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
May 12 8:00am–4:30pm	Heart Failure: Management Strategies in the New Millennium O’Keeffe Auditorium	TBA
May 12 5:00–9:00pm	Congenital Heart Disease Haber Conference Room	4.5
May 14 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
March 14 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
May 15 8:00am–4:30pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
May 15 7:00–11:00am; and 12:00–4:00pm	Congenital Heart Disease Haber Conference Room	4.5
May 15 1:30–2:30pm	Nursing Grand Rounds “Ethical Dilemmas in Clinical Practice.” O’Keeffe Auditorium	1.2
May 15 10:00–11:30am	Social Services Grand Rounds “Treating the Clinical Triad: Eating Disorders, Sexual Abuse, and Substance Abuse.” For more information, call 724-9115.	CEUs for social workers only

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>.

Golden Pen Award recipients

The second round of Golden Pens have been awarded in the new program that acknowledges staff nurses for exemplary documentation.

The following staff nurses have received Golden Pens:

NICU: Kerstin Korpi and
Natasha Dominique
Ellison 7: Maureen Boyce and
Mary Lou Emmanuelle
Ellison 8: Nancy Aguilar
Ellison 11: Anne Coutinho,
Deb Periera, Ann Menna,
and Dolores Stewart
Ellison 12: Robert Marino and
Katie Belden
Ellison 14: Jennifer Roberts
Ellison 16: Kate Boyle, Ellen
Orthlieb, and Heather
Vallent
Ellison 17: Celine Mani and
Amanda Taylor
Ellison 18: Geraldine Gardner
and Tara Cirillo
Ellison 19: Bonnie Prall and
Stacey Fillis

Phillips 22: Denise Morelli, Ann
Geary, and Diane Heislein
Blake 6: Kelley Gramsdorf, Kathy
Roy, Sarah Shields, and
Kathy Evans
MICU: Kate Cosgrove
Dialysis Unit: Jennnifer Fennell
Blake 8: Lisa Torre, Nancy
Aguilar, and Deborah
Osborne
Blake 12: Meredith Pitz
RACU: Heather Parker, Judy
Tomasczuk, and Dawn
Crescetelli
PACU: Joan Lynch
Bigelow 11: Chantalle Alcante,
Elizabeth Shannon, Naomi
Njiru, Erin McLaughlin, Angela
Sewell, and Andrea Iannelli

Bigelow 14: Heather Mac-
Donald, Christine McKin-
non, Rebecca Johnston,
and Theodora Triantafilo-
poulos
White 6: Edy Colin
White 8: Denise Mondazzi,
Emily Schnapp, and Kate
Reynolds
White 10: Molly McCormick
and Erin
Murphy
White 11: Dan Sutton, Jean
Prieto, Maura Hines,
Elizabeth Browning, and
Wendy Rowland
White 12: Traci O'Leary and
Sue Morgan
SDSU: AnneMarie Reginato
and Cheryl A. Gomes

Once a month, one Golden Pen recipient is randomly selected from previous and current recipients to receive a \$50 American Express gift certificate. This month, the gift certificate went to Tyese Alrich of Bigelow 14.

Documentation change

Effective immediately, Physical and Occupational Therapy documentation (evaluations and progress notes) will be integrated into the main body of patients' medical records. This change was approved by the Clinical Policy and Records Committee and the Medical Policy Committee, and was implemented on all patient care units on Monday, April 7, 2003.

Therapy evaluation forms are now placed in the main progress section of patient records (PT: teal border; OT: pink border). PT and OT progress notes are included in the progress note section of the medical record under the respective discipline heading.

For more information, please contact Jane Evans at 4-0147, or Nancy Goode at 4-8579.

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