

# Caring

August 7, 2003

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# Workplace Education Program celebrates 8 years of achievement

*(See page 4)*

Workplace Education Program student, Auzenda Goncalves, smiles proudly after finishing her reading at this year's Workplace Education Program graduation ceremony

**MGH** Patient Care Services  
Working together to shape the future

## An update on the 2003-2004 PCS strategic and operating plans

As you know, every year MGH and Patient Care Services (in separate but coordinated processes) review and revise our strategic plans to ensure we're positioned for success in the current economy and healthcare environment. This year, leadership from throughout Patient Care Services engaged in a comprehensive process to determine where our time, money, effort, and resources would be best spent.

We reviewed our vision, values, and guiding principles. We considered current trends, patient safety, and the underlying structure that supports patient care. We revisited our long-term strategic goals from past years. And based on all relevant considerations, we identified nine new areas of focus. Patient Care Services' strategic

goals for 2003-2004 are:

- We lead the industry in providing patient- and family-focused care.
- We partner with the community to better understand the healthcare needs of the diverse population of patients we serve and establish a shared vision of care and services.
- We are the healthcare industry leader for quality and safety.
- We develop and advance systems, technology and programs to promote individualized patient care and support those who provide care.
- We position nurses, therapists, social workers, medical interpreters, and chaplains within the hospital to have a strong voice in issues impacting patient care.

- We continuously create throughput systems and processes to drive the delivery of safe, efficient, timely, patient-centered care.
- We are the 'employer of choice' for all professions and support staff, and we value diversity in our workforce.

- We work to promote and support the institution in realizing financial growth.
- We provide excellent leadership and foster leadership growth opportunities.

Going hand-in-hand with our strategic plan are the key initiatives we'll be implementing to achieve our goals—the blueprint that will guide our decision-making—the operating plan.

The PCS operating plan is a framework to help us address the tactical issues necessary to achieve our strategic goals. Building on the 'Plan, Do, Check, Act' performance-measurement tool, our operating plan is four-pronged:

- Goals and organizational priorities
- Key initiatives
- Performance measures
- Improvement teams

To ensure that the initiatives are consistent with the needs of our patients and our workforce, feedback from the staff-perceptions survey,



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

patient-satisfaction data, and collaborative governance evaluations was used to craft the operating plan. Input from regulatory agencies and relevant developments within the hospital (such as: our new CEO, ethics initiatives, CPM initiatives, compliance programs, etc.) were taken into account.

Based on a careful review of all this information, key initiatives were developed specific to each strategic goal. For instance, relative to the goal: 'We continuously create throughput systems and processes to drive the delivery of safe, efficient, timely, patient-centered care,' we included the following key initiatives (this is only a partial list):

- Create auxiliary Emergency Department for less acute patients
- Develop a waiting-room plan
- Create a Rapid Admission Unit
- Increase transportation staff

- Open a new Physical Therapy space at the Revere Health Center
- Provide family members with temporary pagers and cell phones
- Establish wireless communication between caregivers

These are only a few of the initiatives that will be unfolding as we work to operationalize our strategic plan. As we continue to be vigilant in positioning MGH for success, your input, feedback, and participation will be key. The strategic planning process is an important tool in shaping the future for our patients, our staff, and the entire MGH community.

### Update

I'm happy to announce that Karen Hopcia, RN, has joined the leadership team of the GCRC as the new clinical nurse specialist. Karen is a doctoral student at the Harvard School of Public Health and, as a staff nurse, has participated in research at MGH for many years.

### Joint Commission Satellite Network Presentations

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

## Preparing for the JCAHO: some helpful reminders

*Question:* What is HEICS?

*Jeanette:* HEICS is the new system we've adopted to improve the hospital's command structure during a crisis. The system corresponds to systems used by other emergency-response agencies such as fire and police departments, and helps ensure consistency and open communication across settings in the event of an emergency.

*Question:* What is the hospital's new code identification system?

*Jeanette:* The new code identification system improves and simplifies the way employees identify emergency situations. In response to a

specific event, employees call 726-3333 and call Code Blue for cardiac arrest; Code Red for fire; or Code Disaster for an internal or external disaster. Having one number to call and the ability to quickly and concisely communicate what kind of help is needed, ensures that the appropriate response team is deployed in a timely manner. These same code calls are used in other institutions and agencies across the country.

*Question:* What is FMEA?

*Jeanette:* FMEA stands for Failure Mode and Effect Analysis. It is a risk-reduction system that improves processes through a systematic

analysis of each step to identify potential pitfalls, then redesigns them to eliminate or minimize their consequences.

*Question:* Why is FMEA important?

*Jeanette:* Most patient-safety reporting systems concentrate on analyzing adverse events. That means that an injury has already occurred by the time any learning takes place. FMEA allows proactive analysis of vulnerabilities *before* accidents occur, helping to keep injuries to an absolute minimum.

*Question:* What actions have we taken to help prevent hospital-acquired infections?

*Jeanette:* A hospital-wide hand-hygiene program is in place to reduce the number of hospital-acquired infections for patients and employees. As part of the program, a waterless hand disinfectant (CalStat) is used as the primary means of disinfecting hands *before and after* contact with patients.

Hand-washing is required whenever hands are visibly soiled or they have come in contact with blood or body fluids. This should be followed by disinfecting hands with CalStat.

Staff involved in patient care should not wear artificial nails and should maintain short, clean nails as part of good hand hygiene.

*Question:* What are some other environmental measures that help control the spread of infection?

*Jeanette:* In addition to good hand hygiene, there are a number of measures that should be taken every day to control infection:

- Strict adherence to isolation precautions is essential in preventing the spread of contamination to surfaces, supplies, and equipment
- All patient-care equipment should be appropriately cleaned and disinfected between patient use. Equipment and supplies should be stored appropriately
- Sterile items must be stored in an enclosed area to protect them

from environmental exposure that could compromise their sterility

- Cardboard shipping boxes are never to be used for storage in clean/sterile supply rooms. Cardboard boxes are often contaminated by organisms or insects
- Clean linen must be kept covered and protected from environmental contamination until ready for use by staff or patients
- All dirty linen should be treated as if it is contaminated; that means using the appropriate personal protective equipment (PPE) and avoiding contact with skin and clothing. Dirty linen should be placed directly into dirty-linen hampers, and dirty-linen hampers should not be used as work surfaces or storage areas
- Refrigerators should be labeled properly according to items stored inside. Temperatures should be monitored and refrigerators cleaned regularly
- Soiled materials should always be covered when being transported to the utility room
- Biohazardous waste should be appropriately separated from regular waste, kept covered, and properly identified with the biohazard symbol
- Only cleaning/disinfection solutions may be stored under sinks

### Call for nominations:

#### The Anthony Kirvilaitis Jr. Partnership in Caring Award

The Anthony Kirvilaitis Jr. Partnership in Caring Award recognizes non-clinical staff within the department of Nursing who exemplify the qualities that made Tony Kirvilaitis so valued in his role as training development specialist in the Center for Clinical & Professional Development. These qualities include *reliability, responsiveness, creativity, assurance, collaboration, and flexibility.*

The award is given to two individuals annually.

Operations associates, unit service associates, operating room assistants, unit assistants, patient care service coordinators, ED admitting assistants and patient care information associates are eligible for the reward.

Nominations are due by August 29, 2003.

Each recipient receives an award of \$1,500.00. Recipients will be recognized at a ceremony in November, and their names will be added to the plaque honoring all Anthony Kirvilaitis Jr. Partnership in Caring Award recipients.

For information about the nomination process, please contact Nancy DeCoste, training specialist, at 4-7841; or Carolyn Washington, operations coordinator, at 4-7275.

## Workplace Education Program celebrates achievement

If you haven't had a dose of good old-fashioned pride and inspiration lately, you should have attended the

graduation ceremony of the Workplace Education Program on Friday, July 11, 2003, because there was more than enough of both to go around! Spon-

sored by MGH and the Jewish Vocational Service, the Workplace Education Program offers a variety of classes to MGH employees who are learning English as a second language. Now in its eighth year, the program enrolled 110 students this year and received citywide recognition for its ongoing success.

Jean Elrick, MD, senior vice president for Operations, returned for her second year as graduation guest speaker. Said Elrick, "On behalf of the entire hospital, I want to congratulate you on this wonderful accomplishment. I know many of you had to overcome great challenges to

participate in this program—challenges like supporting extended families, working many jobs, going to school at night, and living far from campus. But what you're doing is important, and you should be commended. You show us other ways of thinking and speaking and eating. Your contributions to MGH are invaluable; you enrich us in ways I couldn't begin to describe. Know that we support you in your efforts to learn English, and we look forward to working with you for many more years."

Students from each of the ten classes came forward to read excerpts

from assignments they had done in class. Some students wrote about their native countries, some wrote about family members far away, others wrote about their experiences since coming to America and MGH. All showed great determination and appreciation for the opportunity to be part of the Workplace Education Program.

In addition to a wide range of English classes, the program added citizenship classes to its curriculum this year and expanded its guest-speaker series to include topics such as Cultural Sensitivity, Tuition Reimbursement, Hand Hygiene, Treadwell Library Services, Safety, and many other topics of interest to employees learning Eng-

*continued on next page*



Above left: student, Barnave Jourdain, reads an assignment he wrote in class during graduation ceremony.

At left: student, Francoise Loiseau (foreground), hugs instructor, Jane Ravid, after being congratulated by members of the ESL Planning and Evaluation Team (l-r): Mary McAdams, RN; Kathy Creedon, Nutrition & Food Services; Bill Banchiere, Environmental Services; Amy Jacobs, director of the Workplace Education Program; Carlyene Prince-Erickson, Human Resources; and Florentina Spinola, student representative.

## El-Shihibi receives U.S. citizenship

Nadia El-Shihibi is an MGH success story! A native of Morocco, El-Shihibi came to MGH in November of 1999 via France, where she met her future husband, a U.S. citizen of Libyan descent. She started her MGH employment with Environmental Services, and in August of 2000 she became a unit service associate on Bigelow 11. When El-Shihibi first came to the United States, she didn't speak any English. This year, within two days of each other, she graduated from the English Plus 1 class of the Workplace Education Program and officially became a United States citizen.

El-Shihibi (then Nadia Faiz) was featured on the cover of *Caring Headlines* in August, 2001,

accepting a certificate for completing an introductory English class.

Says El-Shihibi, "I have improved my English every year. I can read and write very well now. There are times when I have ideas and I can't express myself just right, but I am still learning."

El-Shihibi didn't tell anyone she was preparing to take the test to become a U.S. citizen. She wanted it to be a surprise. She went to the Federal office of Immigration and Naturalization and picked up a copy of the 40-page study guide. She knew there would be 97 questions on the test, but she didn't know *which* 97 questions, so she studied everything!

When El-Shihibi went in for her interview on June 17th, she was

nervous. But when the officer started asking her questions, she relaxed right away. She knew all the answers—Who's the President? Why are there 100 U.S. Senators? How many branches of the Federal Government are there? After completing her test, she was told immediately, "Congratulations! You are a citizen. You got 100%."

"I was so happy!" says El-Shihibi.

Jane Ravid, lead in-



Unit service associate, Nadia El-Shihibi displays her certificate of citizenship

## Workplace Education Program

*continued from previous page*

lish as a second language.

The Workplace Education Program is made possible through the hard work and dedication of many volunteers from many departments throughout the hospital including Nursing, Environmental Services, Food & Nutrition Services, Social Services, Police & Security, Hu-

man Resources, and many others.

In her closing comments, Carlyene Prince-Erickson, manager of Training and Workforce Development and emcee of the graduation ceremony, thanked the volunteers, the members of the Planning and Evaluation Committee, and Jeff Davis, senior vice president for Human

Resources, for their ongoing support of the program.

To the students, Prince-Erickson said, "Many of you have spoken eloquently about the lessons you've learned from us. You should know, we've learned a great deal from you, too."

For more information about the Workplace Education Program, call lead instructor, Jane Ravid, at 4-3976.

structor for the Workplace Education Program, has had El-Shihibi in many of her classes. Says Ravid, "I have seen such a change in Nadia. When she first started in the program, she spoke about her home in Morocco and her own culture and traditions. Now, she is interested in learning about other people's cultures and backgrounds. She's a wonderful, generous student, always bringing in books to share with classmates, helping them learn. Nadia is one of those students who helps people think in terms of bridging cultures."

Says Ruth Dempsey, RN, professional development coordinator and liaison to the USA group, "I consider Nadia to be a leader. She is always eager to participate. She's outgoing and respected by everyone, and because she is so willing to get involved herself, she inspires others to participate. And if you've ever met Nadia, you know she has a smile that lights up a room."

We congratulate El-Shihibi on her accomplishments and hope the light of that smile shines on MGH for many years to come.

## Respect and understanding at core of family-centered care on White 11

**M**y name is Karla Farrer, and I am a staff nurse on the White 11 Medical Unit.

"She's tough." That was the report I received on Mrs. A. Mrs. A wasn't the patient; her husband was. Mr. A had been admitted to White 11 from home hospice care with uncontrollable pain. He had been complaining of abdominal pain for several months, but his work-up had been negative. Frustrated, because he and his family knew something was wrong, they sought another opinion. It was then, tragically, Mr. A learned he had colon cancer. By the time the correct diagnosis was made, the cancer had metastasized, and he was dying.

Hearing this story, I understood fully why Mrs. A was so tough. The healthcare system had failed her husband. How could she trust us when she and her three children, ages 17-26 (my own age), were faced with losing their loved one.

I must admit I was nervous walking into Mr. A's room. I didn't want to upset them any more than they already were. I wanted them to know I was sympathetic to their situation, that I was there to ease Mr. A's pain and

help them in their grieving.

Nothing could have prepared me for how Mr. A looked. He was barely a skeleton of a man. Immediately, my heart went out to them. When I walked in, Mrs. A stood up quickly and positioned herself between Mr. A and me to stop me from getting close to him. I introduced myself and noticed how exhausted she looked. I knew what they had been through and how protective she was of him, so I was very aware of the importance of everything I said and did. I could see that Mr. A was comfortable in bed, so I didn't have to assess him immediately. That could wait until after I gained permission and perhaps some confidence from Mrs. A. I wanted her to feel she had some control over what was surely an uncontrollable situation. I told her I was there to help them both through this painful time and if there was anything they needed they shouldn't hesitate to call me.

I checked in on them several times an hour. I noticed how comfortable Mrs. A was in caring for her husband. It was obvious she was his primary caregiver at home, and she was confident in this role. I knew how important it was for her

to have this control, so I simply maintained my presence and availability to them. This worked. Over the course of the day, I was able to ease myself into helping them. I realized Mrs. A wasn't 'tough;' she was an extremely loving and devoted wife. I could feel her watching me as I cared for her husband, and I slowly felt her begin to relax as she realized I would care for her husband with respect and compassion. At the end of my shift, I realized we had taken a few tentative steps toward building a trusting relationship, but it would take time for her to truly trust me. I was happy I had a 12-hour shift ahead of me.

As I gave report to the next nurse, I focused on the strong bond Mr. and Mrs. A shared and all I had learned about them. I wanted everyone who entered their room to understand the reasons for Mrs. A's actions so we could support both of them.

The next day in report, the nurse told me Mr. A's pain had become an issue. I hurried to his room and found him in discomfort. I asked how the night had gone. Mr. A, who communicated by raising his finger, indicated he was uncom-



Karla Farrer, RN,  
staff nurse, White 11

fortable, and the look on Mrs. A's face showed her level of worry. I quickly left the room and called the Pain Service. They responded quickly. Mr. A was placed on a diala-did PCA. This allowed him to receive a continuous dose of pain medication and gave him the ability to self-activate a dose if his pain returned.

While I was able to address Mr. A's needs, I continued to work to find a way to care for Mrs. A. She kept a vigil at her husband's bedside; it seemed like she never slept or ate. I talked with her about this, but eating and sleeping obviously weren't priorities for her. I did notice that she loved coffee. In fact, the only time she left her husband's side was to go to Coffee Central. I was so touched one morning when she came back from Coffee Central with a cup of coffee for me. This was the beginning of a routine for us—every morning I would

get coffee and a muffin for her at Coffee Central, and when she went downstairs, she would return with a cup for me.

Those next few days were filled with family and friends visiting and sharing their grief. Mr. A would wake up occasionally and seek out his wife's face. In the few short days we had been together our relationship had gone from Mrs. A blocking my passage to her reaching out for my hand or us spontaneously hugging each other.

On the last day I cared for Mr. A, he was breathing irregularly. Nothing ever touched me so much as when Mrs. A said she hoped his suffering would end soon because she wanted me to be the nurse caring for him when it happened. As I write this, tears fill my eyes when I think about what a powerful and rewarding job I have.

I would never have thought that a statement

*continued on next page*

## JCAHO pain standards: assessing and documenting pain

—by Thomas E. Quinn, RN, project director,  
MGH Cares About Pain Relief

During the upcoming visit by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), surveyors will be looking for evidence of compliance with two new pain-related standards. Pain is also explicitly included in several pre-existing standards.

In this second article in our series on pain standards, we discuss a new standard in the “Patient Assessment” chapter of the JCAHO manual that states, “Pain is assessed in all patients.” This standard, clear and

unambiguous, raises awareness about the presence of pain across all populations and settings. We know that a patient’s report is the best indicator of pain, but a significant percentage of hospitalized patients, including infants and very ill patients, can’t tell us about their pain. In these cases, observing patient behaviors and collaborating with colleagues and families may provide important clues.

This standard:

- reiterates the requirement that pain screening be part of the

initial assessment of all patients

- requires a more thorough assessment when pain is identified in a patient
- requires either a plan of treatment for the pain or appropriate referral
- identifies critical elements of the required assessment: including pain intensity and quality (e.g., pain character, frequency, location, and duration)”
- requires that assessment be age-appropriate

- requires that the assessment be documented in a way that facilitates regular re-assessment and follow-up
- requires re-assessment appropriate to the patient’s situation

A key element here is documentation of the assessment “in a way that facilitates regular re-assessment and follow-up.” This requires consistency in the method of assessment, standardized language whenever possible, and placement of the documentation in a location easily accessible to all care-providers.

MGH has added intensity, the most basic pain parameter, to its standard vital-sign flow sheet, and specialty units that use a different flow sheet have also added a place to record pain intensity. Several tools are used throughout the hospital to describe pain intensity on a scale of 0–10. Pain screening is also part of the initial nursing assessment, and documentation on the Patient Problem List contributes to consistent re-assessment and follow-up. Comprehensive assessment and description of patients’ responses to therapy in the progress notes complete the documentation of pain assessment and management for most patients.

When documenting pain:

- If the patient is not experiencing pain, enter “0” (zero) in the pain-intensity column of the nursing assessment form and the vital-sign flow sheet; a blank is interpreted in the audit and by surveyors to mean, “Pain has not been assessed for this patient.”
- The flow sheet is intended to be a quick reference showing the presence of pain and the progress in treating it (by tracking the rise and fall in intensity). Progress notes contain more detail about the nature of the pain and its response to treatment.
- If a PRN analgesic (including a breakthrough med) is given, there should be a two-part note indicating the reason for giving the medication (including change in pain intensity) and the patient’s response to the intervention.
- Pain-related patient-education is reported on the patient teaching sheet.
- The plan for post-discharge pain management should always be recorded.

For more information, contact Tom Quinn at [painrelief@partners.org](mailto:painrelief@partners.org) or call 726-0746.

### Exemplar

*continued from page 6*

requesting me to be at the bedside for a patient’s death would impact me the way that it did. The whole time I cared for the family I thought endlessly about what else I could do to help them. I felt helpless that there was nothing more I could do. I left wishing I could work the next day.

The next morning on my way to a class, I stopped by the unit to give Mrs. A her coffee and muffin and say good morning. But the room was empty. Mr. A had died early that morning. I was sad and relieved

at the same time. Mr. A’s suffering was over, and it was time for the family to begin to heal. Several weeks later, I received a visit from a member of Mr. A’s family who brought me a gift and a card thanking me for my care of Mr. A.

I never did get to tell them how amazing and devoted I thought they all were. I don’t even know if they would have understood the impact they had on my career. I think often about them and how lucky I was to have cared for them all.

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

Karla’s narrative is a beautiful example of being present and available while allowing the patient’s story to unfold. Instinct told Karla to stop and observe before intervening. She took time to learn about this family. She knew it was important to tread delicately on Mrs. A’s sphere of control and slowly gain her trust. Karla’s vigilance, on all levels, is central to this narrative. She was intimately attuned to the needs of Mr. and Mrs. A. She advocated for Mrs. A with other members of the staff. She knew that sharing a cup of coffee with Mrs. A was more than just sharing a cup of coffee.

Thank-you, Karla,

### Educational Offerings available on-line

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

## Nursing for Tanya: a story of transformation

—by Steve Grondell, RN,  
staff nurse, Bigelow 11

I shuffled down the hallway toward her room doing a quick review in my head: ‘Jane’ was a young female patient, maybe 26 or 27 years old; she had had leukemia for half her life and had a bone-marrow transplant when she was 13. Her current diagnosis was bilateral pneumonia. Her lungs were weak. The respiratory system seemed to be the last to come on board after the bone-marrow transplant. I wasn’t an oncology nurse. I hiked up my scrubs as I entered her room.

Thinking back on that time, I had been a nurse for only a year and a half. Not really a new grad, but I felt like one. Nursing was hard for me. I was in meetings with my nurse manager every week. I ran patients with my clinical nurse specialist every day. I was task-oriented, and nurses who started after me seemed to be advancing faster than I was. I was told I was where I should be on the nursing track. But I didn’t think I’d ever get ahead in this job. I didn’t even know if nursing was the right career choice for me.

\* \* \* \* \*

The decision was made to put this young woman on comfort measures. Her name is Tanya.

Tanya looks at me with a great smile when I walk into her room.

“Hi, Steven,” I hear through her oxygen mask.

Tanya isn’t my patient. She’s my friend. And we aren’t at MGH anymore; we’re at another hospital. I rushed there after my shift at MGH. I arrive just in time for the morphine to go up. She’s pretty good about not making a big deal of it, and so, neither do I. We chat for a bit and have a few laughs that only she and I can share.

Then, after an awkward silence, through tears, she says, “I’m sorry...”

Tanya and I met in nursing school. She was that annoying little girl with the constant cough. The cough you resented after hearing it over and over and over during lecture. She sat right in front of me every day for two years straight. As time went by, I stopped noticing the cough, and we became friends. I learned about her leukemia, and her cough, and how her lungs were constricted from the transplant, but how well she was doing.

She explained that her mom was a nurse, and all she wanted to do was be a nurse, too.

I was becoming a nurse because... I didn’t know why. It just seemed like a good idea at the time. I liked helping people.

Tanya was very limited physically, so I made myself available to help with the heavy work, to be there for moral support and the shoulder to cry on when she felt overwhelmed by it all. I was calm, cool, and collected all during nursing school; always ready to lend that hand or shoulder if needed. After all, nursing school was easy for me. I was president of the class. Tanya was secretary.

Tanya cried often because school was hard for her, and it was what she wanted most in life. She was a realist and knew she would never be able to have children, perhaps never even get married. She wouldn’t be able to dance like she once did. She knew her life wouldn’t be long. But she wanted to help people, the way she herself had been helped during her illness.

My remedy for her tears was laughter. We laughed often and we laughed hard. We laughed until we cried again — coming full circle. But the tears of anxiety were gone, and we were ready for another day.

Years later, Tanya is at the end of her life. There is so little time left, perhaps only days or hours before



Steve Grondell, RN,  
staff nurse, Bigelow 11

she’s gone. Here I was doing what Tanya always wanted to do—I was a nurse. But was I the kind of nurse I was for Tanya when we were in school? Was I the kind of nurse Tanya always wanted to be?

No, I wasn’t.

Tanya had said she was sorry. But I was the one who was sorry; sorry for wasting her dream.

At Tanya’s wake, the song she loved most played over and over: *I Hope You Dance*. That song is how Tanya lived her life. And now, because of her, it’s how I

live mine. After a few days off for her funeral, I went back to nursing with a new attitude and new desire.

Now, another year and a half later, nursing is my career and not only do I love it, I’m good at it. I’m senior staff on my unit, I participate in collaborative governance, and I was a magnet champion. I am a preceptor and mentor to other new grads, and in my opinion, I *am* the kind of nurse I was for Tanya.

I am the kind of nurse Tanya always wanted to be.

### Get REAL!

Have you ever thought about the impact MGH has on the environment?

Have you ever wanted to do something about it?

Now’s your chance.

REAL (Raising Environmental Awareness League) is a newly formed environmental group at MGH seeking new members.

For more information, e-mail: [peaceout@quik.com](mailto:peaceout@quik.com) or [rhorr@partners.org](mailto:rhorr@partners.org)



## Nurses and social workers promoting family care

On Thursday, July 10, 2003, members of the MGH Family Care Program staffed an educational booth outside the Eat Street Café to raise awareness about the services of the Family Care Program and to raffle off a doll house, a fitting symbol of the importance of family life.

The Family Care Program places elderly or disabled individuals who are unable to live on their own in stable home situations where they can receive appropriate care for their individual needs. Nurses and social workers supervise the care program for each client and orient host families to the client's needs. Staff of the Family Care Program visit homes regularly and maintain close relationships with host families to ensure continuity and support.

Clients of the Family Care

Program may be frail due to advanced years, have chronic medical conditions, suffer from mental illness, or have some form of memory impairment. Families and clients are carefully matched to optimize success. Most families report a great sense of reward and satisfaction at being able to make such a profound difference in someone's life.

Clients benefit from being in a nurturing environment; being able to maintain old relationships while developing new ones; knowing their care is supervised by a licensed social worker and registered nurse; and just being part of a family unit.

The program is currently seeking vol-

unteer families. If you know someone who would be interested in opening their home to a person in need, please contact the MGH Family Care Program. For more information about the Family Care Program, call MGH Social Services at 724-0759.



Operating room nurse, Maureen Daly, RN, was the lucky winner of the Laura Ashley doll house!



Staffing the Family Care Program educational booth are (l-r): Joan Monahan, Barbara Olson, Mary Connolly, and Alice Rotfort.

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- Reading Language Disorders  
Carolyn Horn, MED
- Respiratory Care  
Ed Burns, RRT
- Social Services  
Ellen Forman, LICSW
- Speech-Language Pathology  
Carmen Vega-Barachowitz, MS, SLP
- Volunteer, Medical Interpreter, Ambassador  
and LVC Retail Services  
Pat Rowell

### Distribution

Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

### Submission of Articles

Written contributions should be submitted directly to Susan Sabia as far in advance as possible.

*Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746.

### Next Publication Date:

August 21, 2003



## Davis receives Jeanette Ives Erickson Award for Invaluable Contributions to Resident Life



Elizabeth Davis, RN, staff nurse, MGH Obstetrics & Gynecology Service

Elizabeth Davis, RN, staff nurse in the MGH Obstetrics & Gynecology Service was honored with this year's Jeanette Ives Erickson Award for Invaluable Contributions to Resident Life and Teaching on the Vincent Memorial OB & GYN Service. The award, named for senior vice president for Patient Care, Jeanette Ives Erickson, RN, was presented to Davis at this year's resident and fellow grad-

uation ceremony on June 20, 2003.

Davis was chosen from among approximately 40 nurses by the residents she helped train during their four-year learning experience at MGH.

Says Hye-Chun Lee, MD, "I'm so glad Betty received this well-deserved and long-overdue award recognizing her commitment to patients and medicine. She is the familiar face I often see first thing in the morning and last thing at night

before leaving the clinic. Her unlimited patience, long hours, and follow-up care make her the 'glue' of the Vincent Gynecology Clinic."

Because MGH and Brigham and Women's Hospital share an integrated residency program, many residents move back and forth between MGH and BWH. Davis was also this year's recipient of the Ella Adams Memorial Award for contributions to resident life and teaching at BWH.

## RN Satisfaction with Medication System Survey

The Pharmacy Nursing Performance Improvement Committee (PNPIC) will be conducting the 4th annual RN Satisfaction With Medication System Survey this month.

Questionnaires will be distributed to all patient care units.

The responses of approximately 500 staff nurses each year have informed and directed the committee's improvement efforts. Please take the time to make your voice heard and contribute to the continuing development of the drug-delivery system.

## Substance abuse and withdrawal in the acute-care setting

**September 22, 2003  
8:00am-4:30pm  
O'Keefe Auditorium**

Program will include information on the new **Alcohol Withdrawal Clinical Pathway**

- 8:00 An overview of addiction and screening process (Michael Bierer, MD)
- 9:45 Alcohol Withdrawal Pathway and medical management of ETOH and opiate withdrawal (Ted Stern, MD, and Greg Friccione, MD)
- 11:15 Nursing management and assessment (Psychiatric CNS Consultation Team)
- 1:30 Management of the geriatric patient (Cornelia Cremens, MD)
- 2:15 Stages of Change (Martha Kane, PhD)
- 3:15 Discussion, questions and answers, case studies

This program will help clinicians develop skills in assessing and caring for adult patients withdrawing from drugs and alcohol in the acute-care setting.

All clinicians are welcome.

For more information or to register, call The Center for Clinical & Professional Development at 726-3111.

Contact hours will be awarded to nurses

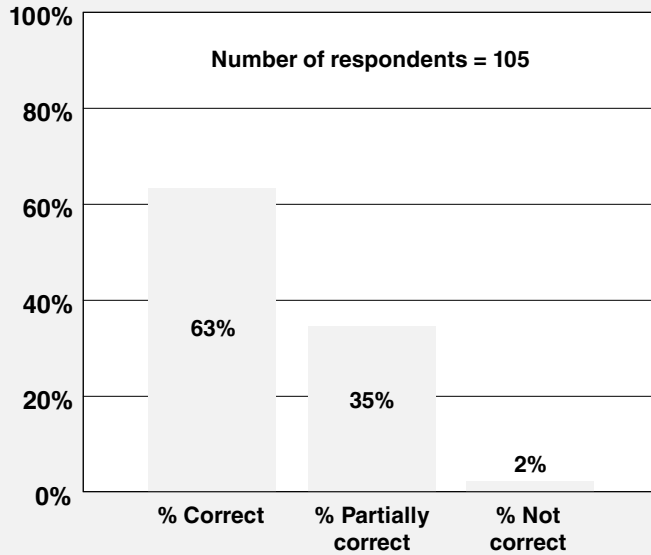
# Educational Offerings

August 7, 2003

When/Where	Description	Contact Hours
August 19 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
August 19 8:00am–4:00pm	<b>Intermediate Respiratory Care</b> Bigelow 9 Conference Room	TBA
August 21 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
August 21 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2
August 27 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
September 2 8:00am–4:30pm	<b>Chemotherapy Consortium Core Program</b> Wolf Auditorium, NEMC	TBA
September 4 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
September 4 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Issues related to Disaster Mental Health.” O’Keeffe Auditorium	1.2
September 8, 9, 15, 16, 22, 23 7:30am–4:00pm	<b>Greater Boston ICU Consortium CORE Program</b> SEMC	44.8 for completing all six days
September 8 8:00–4:30pm	<b>Cancer Nursing Concepts: Building Blocks of Practice</b> O’Keeffe Auditorium	TBA
September 10 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
September 10 1:30–2:30pm	<b>OA/PCA/USA Connections</b> “Preventing Violence in the Workplace.” Bigelow 4 Amphitheater	---
September 11 8:00am–4:30pm	<b>Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other</b> Training Department, Charles River Plaza	7.2
September 12 and 18 8:00am–5:00pm	<b>Advanced Cardiac Life Support (ACLS)—Provider Course</b> Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
September 15 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
September 15 and 16 8:00–4:15pm	<b>Neuroscience Nursing Review</b> Day 1: O’Keeffe Auditorium. Day 2: Walcott Conference Room	---
September 16 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
September 16 8:00am–4:00pm	<b>Intermediate Respiratory Care</b> Bigelow 9 Conference Room	TBA
September 17 8:00am–3:00pm	<b>Management of the Burn Patient</b> Bigelow 13 Conference Room	6.9
September 17 1:30–2:30pm	<b>USA Educational Series</b> “Work-Related Injuries.” Bigelow 4 Amphitheater	---
September 18 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Organ and Tissue Donation.” O’Keeffe Auditorium	1.2

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>.

### Environment of Care Monthly Staff Survey Results



### Environment of Care Survey Question

**Function:** Clean-linen storage

**Question:** What are some standards and guidelines for the storage of clean linen?

**Answer:**

- Clean linen should be stored in an appropriate location and should be covered. Covers on linen-supply carts should remain pulled down; they must be maintained and kept clean. The bottom shelf of each cart has a splash guard to protect supplies during floor cleaning. All linen-exchange carts and supplemental orders should be covered when transported. Clean linen and soiled linen are stored in separate holding areas at all times.
- Linen bags are deposited in the laundry chute in holding rooms, not stored in public hallways. If any linen is torn or damaged, it should be separated and returned to Materials Management.
- All materials to be incinerated should be bagged separately in red biohazard bags.



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