February 6, 2003

# Caring HEADLINES

# IMSuRT team deployed after super-typhoon, Pongsona, devastates Guam

On December 8, 2002, super-typhoon, Pongsona, ravaged the Pacific island of Guam, a United States territory located approximately 3,700 miles southwest of Hawaii. With sustained winds of 150mph and wind gusts exceeding 180mph, Pongsona leveled homes, destroyed roadways, and severely damaged Guam Memorial Hospital, the island's primary source of medical aid and only civilian hospital. On December 9th, President Bush declared Guam a federal disaster area, calling for the deployment of medical-assistance teams to help with rescue and recovery operations. MGH nurses, doctors, therapists, and others who volunteer with the International Medical-Surgical Response Team (IMSuRT) were called to action.

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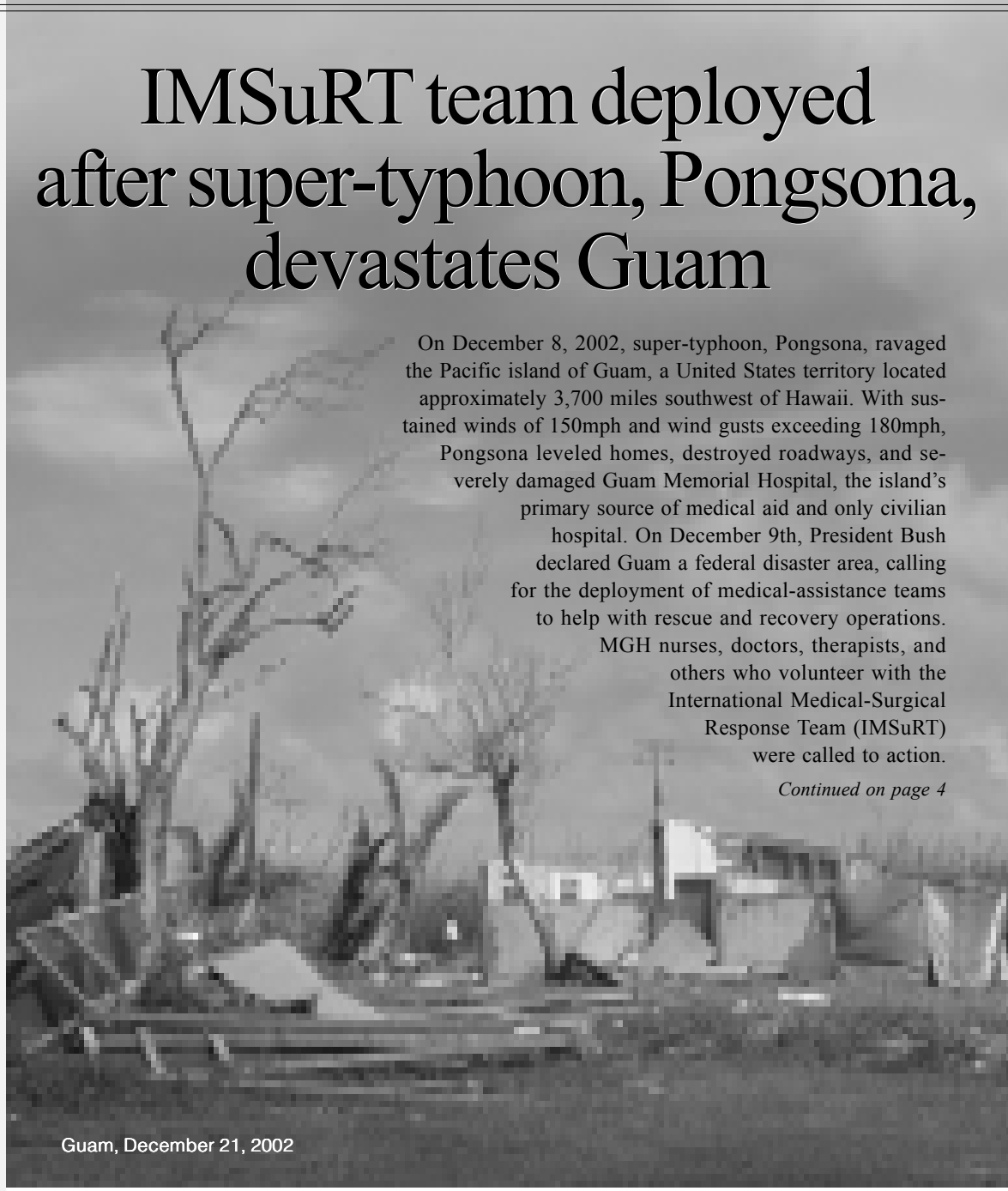

Guam, December 21, 2002

## Inside:



**MGH** Patient Care Services

Working together to shape the future

# Managing workplace violence

*An interview with Bonnie Michelman, director of MGH Police & Security*

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

*Jeanette*: Bonnie, MGH is a safe place to work. Why is it important to talk about workplace violence?

*Bonnie*: MGH is a very safe place to work. But in every work place, in every industry, in every geographical location, there is always a potential for violence. The more prepared our employees are to manage and prevent potentially threatening situations, the better it is for everyone.

*Jeanette*: What exactly are we talking about when we say, 'workplace violence?'

*Bonnie*: There's a wide range of behaviors and situations that fall under the heading of, 'workplace violence.' We could be talking about threats of physical harm, intimidation, stalking, domestic violence, unwelcome e-mails, harassment, cyber-crime, patients having psychotic episodes, the scenarios are endless. Workplace violence is any situation in which an employee feels unsafe.

We find that most potentially volatile situations stem from three basic areas: disgruntled employees; patients and/or family members who may be upset; and random acts of violence that aren't necessarily attributable to any identifiable source.

We're fortunate to have an extremely well-trained and proactive staff in the department of Police & Security. Because of our ability to defuse potentially dangerous situations, we've been able to keep serious violent incidents to an absolute minimum.

*Jeanette*: If an employee feels threatened or finds him/herself in a potentially harmful situation, what should he/she do?

*Bonnie*: Anyone who feels threatened in any way should inform their manager and call Police & Security immediately (726-2121).

I can't stress strongly enough the importance of contacting us early. The sooner we know about a potential threat to an employee's safety, the more options we have to de-escalate the situation.

I always tell people to listen to that little voice inside them; a person's instincts are usually right. You may be reacting to a look, or a nuance of behavior, or any one of a number of non-verbal cues. Listen to those warnings, and make that call.

I also want to advise people not to try to handle difficult situations on their own. This is a hospital; most employees are clinicians or support staff or administrators who aren't trained to handle criminal or potentially violent situations. I certainly wouldn't dream of trying to perform surgery or operate a ventilator—that's not my area of expertise. Employees need to let us handle these matters. This is what we're trained to do.

*Jeanette*: Do MGH Police & Security staff members have the same authority as public police officers?

*Bonnie*: Most members of Police & Security are trained and licensed as state special police officers, which gives us the same authority as public police officers on

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## Workplace violence warning signs

- Romantic obsession
- Chemical dependence (alcohol or drug)
- Depression
  - One in seven depressed people will commit an act of violence against themselves or others
- Pathological blaming of others
- Elevated frustration with the environment
- Interest or obsession with weapons
- Personality disorders
  - Unusual changes in normal behavior
  - Inflexible, impaired, or unhealthy behavior
  - Rigid, won't listen to reason
  - Dramatic shifts from calm to aggressive

## What can you do to prevent workplace violence?

- Report all suspicious behavior
- Take *all* threats seriously
- Inform Police & Security about any problems outside of work that could result in workplace violence
- Trust your instincts, and be aware of your surroundings
- Be professional with co-workers, patients, and visitors
- Contact Police & Security for consultation or assistance at 726-2121.

# The Service Recovery Program

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

*Question*: I've heard people talk about The Service Recovery Program." What is that?

*Jeanette*: The Service Recovery Program began as a pilot program to be used in certain instances when customer service breaks down despite our best efforts. In certain circumstances, in addition to apologizing and addressing the immediate needs of the patient, staff can provide a tangible offering as a demonstration of our desire to rectify the situation.

*Question*: What kind of service breakdowns qualify for this kind of service-recovery gesture?

*Jeanette*: Examples include a patient who has waited an unusually long time to see a clinician, or a family member who was unable to see a patient prior to a procedure because of an oversight by staff. We're talking about occurrences that aren't directly related to a patient's clinical outcome but are nonetheless important and dissatisfying to the patient or family.

*Question*: What recourse do staff have in such cases?

*Jeanette*: As part of The Service Recovery Program, staff might send flowers, or give a gift certificate to Coffee Central, the Eat Street Café, or the parking garage to patients or family members. Though the monetary significance is small, the gesture acknowledges a breakdown in our customer service efforts and lets patients know we care and want to rectify the situation.

*Question*: Where does funding for the program come from?

*Jeanette*: The program is funded through the Service Improvement Program and is part of our ongoing effort to improve the service we provide to patients and families.

*Question*: Can any unit take part in this program?

*Jeanette*: Soon The Service Recovery Program will be implemented hospital-wide. Currently, the 12 inpatient units that participated in the pilot have access to the program's funding, and five more units will be added this month. Further expansion of the program to inpatient and outpatient areas is planned for the future.

*Question*: How can I find out if The Service Recovery Program has been implemented on my unit?

*Jeanette*: Check with your nurse manager or director to find out if the program has been, or is scheduled to be, implemented in your area. If no plans are in place, let your manager or director know if staff in your area are interested in participating in the program.

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## Jeanette Ives Erickson

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MGH grounds. We do have the authority to make arrests on MGH property.

*Jeanette*: Can you give us an idea of what an employee can expect if they call Police & Security for assistance?

*Bonnie*: Every situation is different, so every response is different. Our response is necessarily geared to the nature and severity of each individual threat or situation.

Some of the things we would do might include:

- conducting a complete assessment of the situation, including an evaluation of the employee's safety both here at MGH and at home
- asking a lot of questions to get a thorough understanding of the situation (including many questions the employee may not have considered or thought to be relevant)
- imposing limitations on individuals, such as restricted visiting hours, or required escorts
- making changes to an employee's work site to ensure they have adequate protection
- talking with suspects to let them know their actions or behavior is unacceptable
- escorting employees to and from their cars when they come and go from work
- tracing phone calls
- conducting intensive background checks on potential suspects
- meeting with local law-enforcement

I want people to know that our services extend to every employee of the hospital whether they're here at MGH, at home, or anywhere else they may feel threatened.

And our services are free and confidential.

*Jeanette*: How can employees learn more about recognizing and managing potentially dangerous situations?

*Bonnie*: The department of Police & Security offers a number of programs for employees and managers. One of the best is, "Management of Aggressive Behavior," which is available to staff upon request. We also offer customized in-service training geared to specific patient populations. For information about training call (724-3030).

I and members of my staff are available to attend staff meetings. Knowledgeable staff of Police & Security come to units and talk about potential vulnerabilities, how to identify signs of aggressive behavior, and what to do about it. This is a great opportunity, not just for staff to learn about workplace violence, but for us to learn about the unique needs and considerations of each unit.

*Jeanette*: Thank-you, Bonnie, this is very helpful.

*Bonnie*: My pleasure. Please let staff know they can reach me at 6-7979; John Daley, the manager of our Investigative Unit, at 4-3036; or John Driscoll, assistant director of Police & Security at 4-3032.

# MGH clinicians working with the International Medical-Surgical Response Team deployed to Guam

The following photographs and e-mail correspondences received from members of the International Medical-Surgical Response Team (IMSuRT) working in Guam in the days following super-typhoon, Pongsona, provide a glimpse into the conditions they endured and the services they provided in response to this disaster that virtually crippled the island.

*From Sue Briggs, MD, IMSuRT chief commanding officer*
*December 13, 2002*

Team has landed and started to work. Critical care, emergency ward and respiratory assets working at both hospitals.

Few nurses working at emergency clinics on both ends of island.

Help appreciated. Military medical teams have just arrived and will begin working in next 24 hours. Thanks for your support.

Susan

*From Jacky Nally, team leader (not deployed)*
*December 14, 2002*

Just heard from our folks in Guam.

Pay phones working, no other phones working, e-mail down, no cell-phone service, all are doing well. 15 members working at Guam Memorial Hospital. Local staff very glad they are there.

Other team members are working to set up second clinic to help elevate travel for locals in need of health care. First clinic operational and going well. Clinic sites are on north and south sides of island.

Weather warm, mid 80s, rainy on and off. Housing in a hotel, sanitary conditions good at this site.

Jacky

*From Sue Briggs, MD, IMSuRT chief commanding officer*
*December 14, 2002*

Word from Washington is they're "eating our team up." They're so happy to see nurses and others with skills they can use in the hospital right away.

We can be proud of MGH once again.

Susan

*From Mike Bailin, MD, anesthesiologist*
*December 14, 2002*

It is 5:10pm on Saturday the 14th. We are 15 hours ahead of you.

Until today, our group had been in two hotels. The food and water were not approved. No one got ill as far as I know.

Having everyone in one place now is good.

The hospital is in reasonable condition. Telemetry and the Pedi unit have collapsed walls.

We're seeing a steady stream of people: telemetry, acute, kids, 18-month-olds with chicken pox, bradydcardia, CVA, MI, chest pain, kidney infections; some trouble filling meds at local pharmacies. They are using the ER to manage and care for 'boarders,' for lack of telemetry. ER is seeing 100 patients a day.

Mike

*From Jacky Nally, team leader (not deployed)*
*December 15, 2002*

Just received an update from Guam

Everyone doing well. 15 team members working varied shifts in Guam Memorial Hospital. ICU has re-opened. Our team members are working not only their shifts but sharing their wealth of knowledge and clinical skills with the local nurses.

25-bed military field hospital now on-site outside Guam Memorial. Should be fully operational soon. Right now they have 4 beds and are receiving patients.

Thanks to all who have supported our team's deployment. Great job.

Jacky

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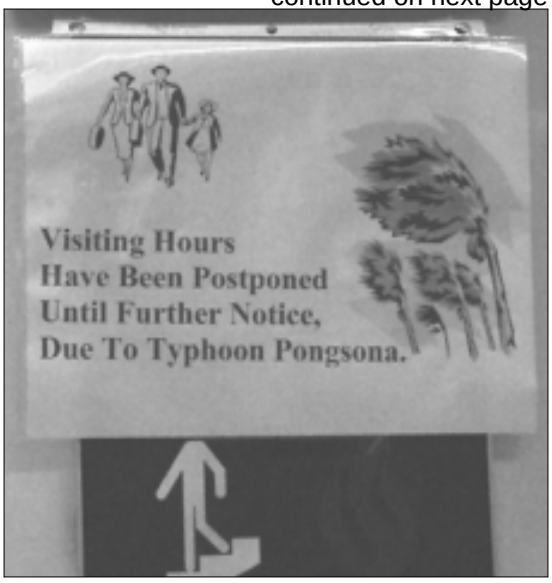
DMAT team member and physician assistant, Deb Doherty (from another Boston hospital), ministers to young child at the DMAT clinic in Agat.



*From Robert Goulet, RRT, respiratory therapist (written upon his return)*

Once at Guam Memorial, we could see how poorly staffed and overworked their Respiratory Department was. Their Respiratory Therapy Department consisted of approximately 18 staff with a core of registered therapists and others who had learned on the job. They had been working long shifts since the storm, then going home to damaged houses with no water or electricity.

Three respiratory therapists, Dave Kissin (from Maine Medical Center in Portland), Mel Honda (from the Hawaii DMAT team), and I, immediately began working night shifts.

Staff at Guam Memorial were incredibly gracious. I was amazed at the hospitality they extended considering the difficult circumstances they were enduring. Whenever I started to feel tired, I just thought of what they were going through, and that put things in perspective.

All the respiratory therapists helped care for patients in the ICU, the Neonatal ICU and pediatric areas, on units, and in the Emergency Room where we saw patients with a wide variety of medical problems.

Though the typhoon devastated much of the island, fortunately, there were not a lot of serious injuries to the islanders themselves. Patients were so grateful for our services, and our host coworkers were so appreciative, we actually managed to have some fun while we were there.

Robert

*From Barbara McGee, RN, staff nurse (written upon her return)*

I worked as a supervisory clinical nurse specialist with the Ohio DMAT team. We worked to organize and operate a clinic in the southern town of Agat. At first, the team, along with approximately 50 tons of equipment, was deployed to a school-bus parking lot. But our location was changed to a senior citizen center near the local police station in the thought that people would be more likely to find their way to this location. This turned out to be a good idea as local transportation was severely limited due to a shortage of gasoline and impassable roads due to the storm.

We cleaned the building and set up treatment, suturing, and pharmacy stations. We saw approximately 70-90 patients per day, many who had sustained minor injuries while cleaning up after the storm and needed wound care and tetanus vaccines.

We saw many cases of upper respiratory infection in the elderly and pediatric populations, and had two critical transports to GMH for chest pain. Our pharmacy filled more than 1,000 prescriptions for medications that had been lost, destroyed, or improperly stored.

Barbara

**Clinicans deployed to Guam**

Michael Bailin, MD
Geoff Bartlett, communications
Robert Boomhower, security
Allen Bouchard, RN
Kathryn Brush, RN
Lin-Ti Chang, RN
Joseph Conlon, communications
Deb Doherty, physician assistant
Catherine Drake, RN
Robert Droste, RN
Robert Goulet, RRT
Robert Holst, paramedic
Patrick Kadilak, RN
David Kissin, RRT
Barbara McGee, RN
Jacquelyn Riley, RN
Joseph Roche, RN
Maryalyce Romano, RN
Michael Spiro, RN
John Twomey, RN
Brenda Whalen, RN

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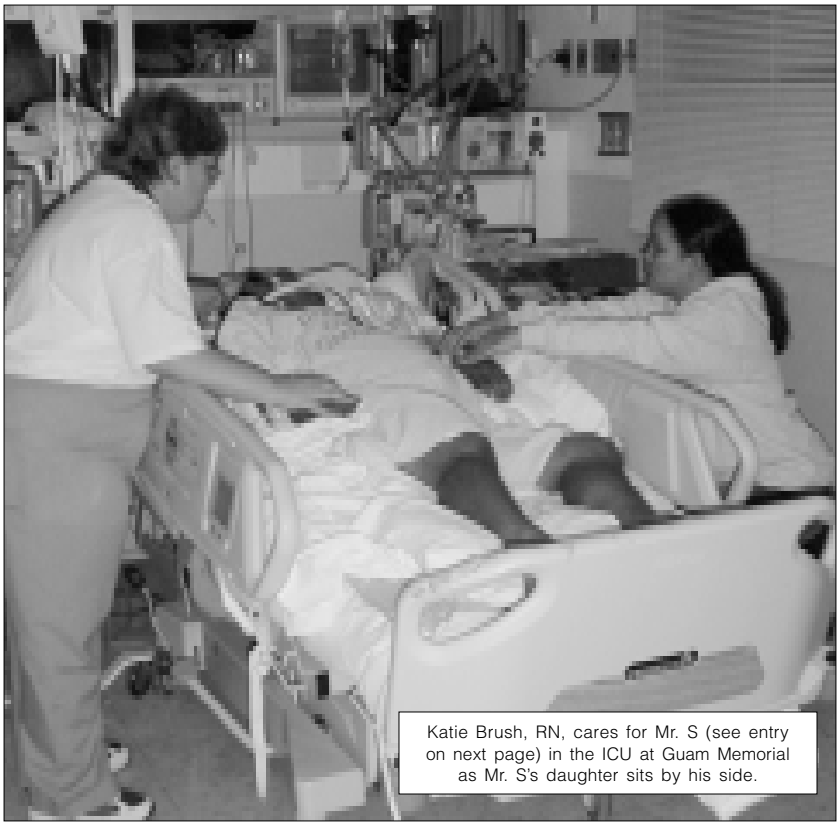
Maryalyce Romano, RN, of Ellison 7, and Mike Spiro, RN, of White 7, in the ED at Guam Memorial Hospital



Katie Brush, RN, cares for Mr. S (see entry on next page) in the ICU at Guam Memorial as Mr. S's daughter sits by his side.

## Guam

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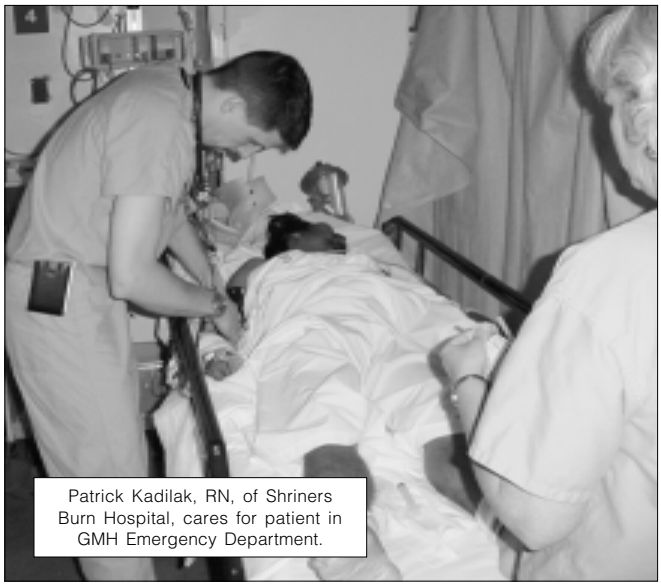
*From Katie Brush, RN, clinical nurse specialist (written upon her return)*

Our mission was to provide much-needed relief to the staff of Guam Memorial. Injuries had been sustained not only during the storm, but also during clean-up and survival efforts after the storm. People were living in makeshift homes without water, fresh food, electricity, or gasoline. Many patients were admitted with lacerations, infections, bug bites, and exacerbations of chronic conditions (such as hypertensive crisis, myocardial infarctions, dialysis crisis, and untreated diabetes mellitus).

Our arrival enabled the staff of Guam Memorial to take their first days off since the typhoon hit. With the loss of their Telemetry Unit, patients requiring monitoring were in the ICU and ED, as they were the only remaining units that had monitoring capability. During our stay, the GMH ICU achieved its highest census ever.

We were challenged by a critical lack of supplies, equipment, and medications. But perhaps the most challenging issue was the continuous loss of power and communication, impeding contact with physicians for much-needed orders.

Our presence during this crisis had significant impact on staff and patients alike. The unfortunate story of Mr. S is one example of the difference we made. Mr. S was a 41-year-old man who awoke at 5:00am with chest and abdominal pain. He came to GMH, was evaluated, diagnosed, and treated in the ED. It was determined that he had a thoracoabdominal aortic aneurysm dissection. We were able to stabilize Mr. S for the next two days, during which time his daughter arrived from England. We got to know his family, stories about him and the Chamorro culture (the native culture of Guam) and we helped his family accept Mr. S's impending death. I can honestly say that our guidance and support contributed to Mr. S being able to survive long enough to see his daughter before he died.



Patrick Kadilak, RN, of Shriners Burn Hospital, cares for patient in GMH Emergency Department.

There were many challenges and opportunities for the staff who worked in the ED. Under these seriously strained conditions, it was necessary to restructure the triage system to identify patients who really needed telemetry and oxygen. Although we were in a traditional healthcare setting, the rules of disaster triage applied. Our limited resources had to be allocated to patients who had the best chance of survival, and supportive care given to those whose chances were limited. This was a moral and ethical mind-shift for our staff who are accustomed to unlimited resources and solutions to patient-care dilemmas.

Some of our team members were used to augment other DMAT teams who were deployed from

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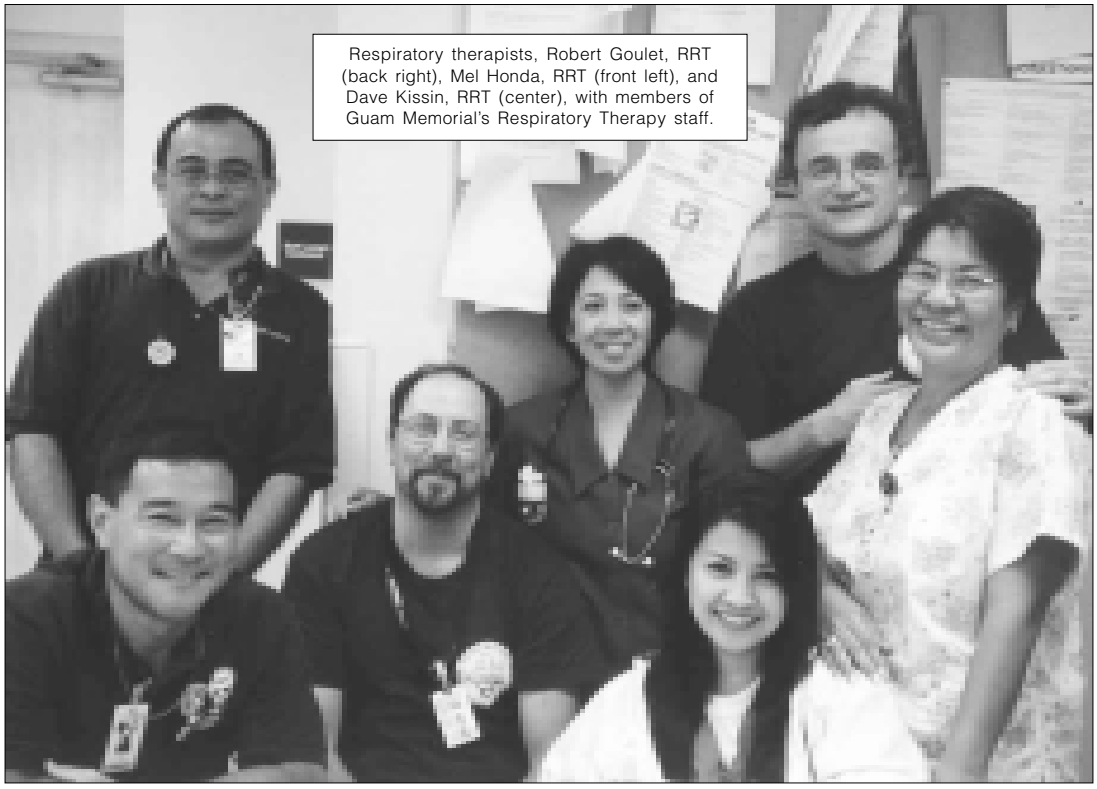

Respiratory therapists, Robert Goulet, RRT (back right), Mel Honda, RRT (front left), and Dave Kissin, RRT (center), with members of Guam Memorial's Respiratory Therapy staff.

Ohio and California. Those teams were charged with setting up clinics on the north and south ends of the island. The clinics were set up near bus routes to allow patients with no gas to access care. This also helped decompress the overwhelmed GMH as the clinics could assess, diagnose, and treat patients who didn't require acute care.

One DMAT team set up a clinic in a more remote area, in the village of Agat. Agat, a less populated and more economically challenged area, had need for care closer to home. Many of the patients seen at the Agat clinic had never been seen by a physician before and used the clinic as their first opportunity to access much-needed care.

Super-typhoon, Pongsona, hit just before the holidays. IMSuRT team members left their friends and families to respond to this disaster in our global community. This could not have happened without the unfaltering support of so many people, including our employers and co-workers who took on additional burdens, which allowed us to respond to this crisis.

Thank-you all, Katie

*From Aurelio Solidum, RN, nurse manager of the ICU at Guam Memorial Hospital*
*January 10, 2003*

Things have started to settle down a little bit here on our quaint little island of Guam. Many of us still don't have power and/or water, but progress is slowly being made. Now that we've all had some time to breathe and relax somewhat, we find that our thoughts go out to the wonderful group of people who helped us during our crisis, during our time of need. Katie, Lin-Ti, Bob, Pat, Joe, Bob, Dave, and all the others known fondly to us as 'the DMATS.'

Words cannot begin to describe how grateful we are for the helping hand you provided during our hectic post-typhoon recovery period. You all demonstrated such professionalism and wonderful, endearing personalities, which none of us will ever forget. Although your time here was brief, we all felt like you were part of our GMH family. We embrace you as such and memories of your presence will not fade in our hearts and minds.

One of our patients took some pictures of some of us together and as soon as I can figure out how to use this computer, I will send them to you!

Once again, thank-you for assisting us when you did. You were God-sent and truly a blessing for the employees of GMH and our little island community.

Hope to hear from you soon! Solidum

This was the only time the IMSuRT team was able to be together as a group. On their last night in Guam, with 85°+ temperatures and 100% humidity, the team donned their tropical attire for an impromptu holiday celebration.

# Blake 2 nurse learns life lessons from dying patient

Julie Conlin, RN
staff nurse, Blake 2 Infusion Unit

My I was introduced to Dr. R, a 34-year-old man, while in orientation as a nurse on the Blake 2 Infusion Unit. Dr. R had recently been diagnosed with colon cancer and at the time of presentation, it had already metastasized to his liver. I didn't know it at the time, but I was to learn so much from this patient.

Dr. R was new to the United States. He had recently arrived with his wife from Belgium via his native Haiti to start a fellowship at a local hospital. His wife, who was three months pregnant with their first child, also worked in health care. Dr. R was very tall and graceful. He had a smile you could see a mile away. It was hard not to like him straight-away. But those were his outward, more obvious attributes. It was the other stuff that taught me so much; made me question so much; and still has me questioning, reading, and wondering.

Dr. R, in both personal and professional ways, was a challenge to me. When I first met him, he had already failed his first line of treatment, and been approved for Oxaliplatin, a phase 11 clinical trial for metastatic colon cancer. Oxaliplatin has many challenging side effects, but Dr. R said little about his symptoms and appeared to sail easily through his treatments. During his every-other-week appointments, we discussed his lab work, his symptoms, future plans for treatment, and his appointment schedule. But it was an effort to get him to discuss his disease. He was usually very matter-of-fact when discussing things related to his colon cancer. He often said, "It's not one of my favorite subjects." But he humored me for the first minutes of our meetings and answered my many questions so I could document them in his medical record. Then we would spend the rest of the time talking about everything but his disease.

I learned where he was from, what his life in Haiti had been like. I learned the occupations of his parents and siblings. He told me why he had chosen Medicine. Eventually, I learned where he and his wife first met. I was privy to know the gender of his yet-to-be-born son. And he asked many questions of me. "What are you doing this weekend Miss Julie? Where will you spend Christmas? How is your family?"

At first, I was uncomfortable with our conversations. I would continuously try to steer the conversation back to him, to how he was living with his disease. But he would cut me off every time. He was never rude or obvious about it. But seconds later I invariably found myself telling him my weekend plans. In his gracious and delicate way, he swayed the conversation so that we were *not* talking about him.

But I was determined to talk about *him*. I thought it was my job to get him to open up about his fears and concerns. But every effort of mine was met with a smile, a 'Thank-you,' and a statement of it being, 'God's will.' As Dr. R's health declined, I tried even harder to get him to talk. I met with other members of his healthcare team to discuss what I thought was Dr. R's 'denial' about his health. I consulted colleagues. And I continuously tried to get him to talk about his impending death. And he calmly, almost serenely, told me it was God's will for him to be "right where he was."

It was during his final hospitalization that I finally stopped forcing my own expectations on him. He told me he would "be okay no matter what happened." And I finally realized that he really would be okay. It was at this point that I knew I was getting far more from my relationship with Dr. R than he was getting from me. It is only now that I fully realize Dr. R was not in denial at all. He was living out his faith in God. He was accepting his future, his place in God's often mysterious will. I do not try to fool myself and think he didn't have fears. He worried about his wife. He was so sad for his son, who was then one year old. He wanted to see his parents one last time. And those are only the fears he voiced. I imagine there were many more. But Dr. R had a strength and sense of calm that came directly from his faith in God

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# Celebrating the legacy of Dr. Martin Luther King, Jr.

Georgia Congressman and civil rights activist, John Lewis, was the featured speaker at this year's Partner's event honoring the memory Dr. Martin Luther King, Jr., on January 24, 2003, in O'Keeffe Auditorium. Lewis' remarks recalled his turbulent young adulthood when he rode with the Freedom Riders, participated in the Selma civil rights march now known as Bloody Sunday, and was shepherded by Dr. King in his development as an activist and humanitarian.

(Photos by Paul Batista)

**Above:** Congressman John Lewis with Pat Beckles, RN, at reception following event; **At left:** members of the Paul Robeson Institute for Positive Self-Development recite poem; **Below:** MGH president, Peter Slavin, MD, presents Lewis with gift ("The Faces of MGH").

The event included a poetry reading by four members of the Paul Robeson Institute for Positive Self-Development, and a piano offering by Yegue Badigue, a student from the Perkins School for the Blind.

It was a day of sobering recollections, joyous celebration, and hope for a peaceful, united future. At a time when the world is facing great uncertainty, it was a day that brought people together in a spirit of brotherhood. Congressman Lewis' friend, Dr. Martin Luther King, Jr., would have been proud.

## Exemplar

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and His ultimate goodness.

It was while taking care of Dr. R that I began to question my own 'faith.' Would I derive the same courage and calmness from my God? And who was my God? Where did I fit in with His plan? I was raised Catholic. I was baptized. I made first communion and confirmation. I went to church every Sunday. The typical stuff. That was the religion and faith of my youth. I don't know yet if it is the religion and faith of my adulthood. I am on a journey of discovery, and I have Dr. R to thank for putting me on that journey.

May my journey last a lifetime.

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

What a wonderful narrative. We can all learn something from Dr. R and his journey. Certainly, this is a story about the power of faith and spirituality. But it's also a story about the importance of listening to our patients, understanding their needs, and letting their values and beliefs guide the care we provide.

Julie deserves so much credit for recognizing the depth of Dr. R's faith and not trying to replace or override his beliefs with her own. This is culturally competent care at its most poignant.

Thank-you, Julie.

# Staff nurses 'champion' Magnet preparation

*—submitted by the Magnet Steering Committee*

This is a new, short-term column in *Caring Headlines* that will run throughout phase II of our Magnet hospital preparations. Future columns will keep you apprised of our progress and include a series of questions and answers to help inform staff about a number of topics in preparation for the Magnet site visit in the spring.

As many of you know, we have enlisted the aid of 174 nurses to act as Magnet champions to help prepare unit-based staff for the upcoming visit. Now that our written evidence has been submitted, the role of Magnet champions becomes all important. Magnet champions attended a special half-day training program to learn how to effectively share and disseminate information to unit co-workers and other members of the healthcare team. When the Magnet appraisers make their site visit, they'll speak with employees from all settings and disciplines to get a sense of our interdisciplinary professional practice model and clinical work environment. Staff's understanding of the process and appreciation of the importance of Magnet certification is key.

### A Magnetic Personality

Following are the 14 Magnet Standards used to determine what hospitals meet Magnet-hospital eligibility requirements. How prepared do you think we are?

- Quality of nursing leadership: are they strong, knowledgeable advocates for staff?
- Organizational Structure: is it decentralized, with strong representation for nurses?
- Management style: do leaders invite participation and feedback?
- Personnel policies and programs: are salaries competitive? Is staff offered flexible schedules?
- Professional models of care: are nurses given responsibility and authority?
- Quality of care: is it an organizational priority?
- Quality of improvement: are nurses involved?
- Consultation and resources: are there adequate human resources?
- Autonomy: are nurses allowed independent judgement?
- Community and the hospital: is there a strong presence in the community?
- Nurses as teachers: are nurses permitted, and expected, to incorporate teaching in all aspects of practice?
- Image of nursing: is the work of nurses characterized as essential by other members of the healthcare team?
- Interdisciplinary relationships: is a sense of mutual respect exhibited among all disciplines?
- Professional development: is significant emphasis placed on inservice education, continuing education and career development?

Adapted from *Modern Healthcare*, December 16, 2002

As a first step, we have summarized the 14 Magnet Standards into one brief overview for quick reference. (See shaded box titled "A Magnetic Personality.") Copies of these standards are available on every unit.

Every week the Magnet Steering Committee will provide Magnet champions with information relevant to our preparations. This information will be shared with staff in a number of ways, including staff meetings, informal conversations, and in writing. Please take the time to listen, learn and interact with the Magnet champion on your unit. Your feedback, questions, and input are important as we move forward in the application process.

Copies of the written evidence we submitted to the American Nurses Credentialing Center are available in a number of locations throughout the hospital. We encourage you to review these materials at your convenience. They contain a wealth of information about our work, our professional practice model, the environment in which we provide care, and much more. Binders containing our written evidence can be found in the following locations:

- The Center for Clinical & Professional Development
- Bigelow 10 Management Support Office
- The Gray-Bigelow 015 Conference Room
- Founders 134 (Kim Chelf's office)
- Founders 108 (Theresa Gallivan and Jackie Sommerville's office)
- Gray-Bigelow 424 (Dawn Tenney's office)
- Bulfinch 230 (Jeanette Ives Erickson's office)

With the help of our Magnet champions and the support and enthusiasm of all clinicians and support staff, Magnet hospital certification is only a few short months away.

**Frequently asked Magnet questions**

*Question*: What is a Magnet hospital?

*Answer*: In the early 80s, there was a serious nursing shortage in the United States. Some hospitals were better able to attract and retain nurses during the shortage than others. The American Nurses Association commissioned a qualitative national research study to better understand the characteristics of hospitals that thrived despite the shortage. They identified a consistent set of characteristics in the hospitals that thrived.

The term 'Magnet' hospital was chosen to describe those hospitals because they were able to 'attract' and retain a staff of qualified nurses to provide quality care.

In 1993, the American Nurse Credentialing

*continued on next page*

## Magnet Update

*continued from page 10*

Center, (ANCC) a subsidiary of the American Nurses Association, introduced a certification process for hospitals to become recognized as Magnet hospitals. The Magnet Nursing Services Recognition is the highest level of recognition awarded by the ANCC.

*Question*: Why would a hospital want to apply for this recognition?

*Answer*: Research has shown that Magnet hospitals create and promote a practice environment that positively affects morale and the quality of care. This helps retain experienced nurses, and is an effective way to recruit new nurses. We are on the verge of a nursing shortage that is predicted to be worse than any in recent years. Being able to attract and retain qualified nurses is a key element in supporting the mission of the hospital to provide outstanding patient care.

*Question*: Why does MGH want to apply for this recognition?

*Answer*: Magnet hospital recognition is more than a plaque on the wall. The process of applying for this recognition will strengthen our institution, position us to face the current shortage, ensure our reputation as the employer of choice, and enhance our reputation as a leader in quality care.

*Question*: How many Magnet Hospitals are there?

*Answer*: At the present time, there are 65 Magnet hospitals in the United States; none in Massachusetts.

*Question*: How does a hospital apply for Magnet hospital recognition?

*Answer*: The first step in the application process is to join the National Center for Nursing Quality (NCNQ). We did this in April of 2002.

Next we began submitting quarterly data to the National Database for Nursing Quality Indicators (NDNQI). This data profiles our nursing staff and provides measures of patient care related to quality nursing, such as pressure ulcers and slips and falls.

In July, 2002, we applied to the ANCC for Magnet recognition. On January 9, 2003, we submitted 2,305 pages of written evidence that describe our practice environment. The ANCC is currently reviewing this information along with two appraisers who will conduct a site visit at MGH in a few months.

Only about 70% of all applicants receive Magnet hospital certification.

# Ode to a Magnet Hospital

*—by Marianne Ditomassi, RN,*
*co-chair of the Magnet Steering Committee*

'Twas just another good idea
that Jeanette Ives Erickson had,
To pursue Magnet Recognition—it's not just a passing fad,
It's the American Nurse Credentialling Center's most coveted prize,
And MGH Nursing wants to try it on for size.

We conducted a lit search and benchmarked with those who are Magnet already,
Through the Staff Perception Survey, our staff told us we're ready.
We hired a consultant to help us chart our course,
She told us the Magnet process is transforming—a powerful force.

A Steering Committee was convened and led by Dito and Lori,
Their job was to work with others to tell MGH Nursing's story.
The Committee was impeccably staffed by Ed and Lauren,
Who found the work anything but boring.

Four workgroups were formed and the real work began,
Day in and day out did the meetings span,
The Professional Practice group chaired by Jackie and Marie,
Focused on practice, documentation, and nursing's philosophy.

Trish and Keith led the Professional Development team,
Capturing cultural competence, research, and the latest educational routines.
The Knowledge Management group chaired by Sally and Dawn Tenney,
Measured nurse-sensitive indicators and cost-analyses correct to the penny.

Theresa and Judy led the Interdisciplinary Team,
And didn't miss a collaborative effort, it would seem.
Eight weeks later, the groups handed in the fruits of their labor,
Created through collecting information from their MGH neighbors.

Now onto the Writer's Group, the evidence went,
Ninety-five criteria, not quite ready to be sent.
Here's where Chris, Ellen, Nancy, Julie and Mel,
Put into one voice, what we do well.

Then it was time for formatting, to number the pages,
There were moments, it seemed to Negui, it took ages.
Then Jess saved the files on carefully-prepared disks,
And off to the printer they were whisked.

On January 9th, the evidence was mailed,
But, our Magnet status has yet to be sealed.
Onto phase two—the site visit —we need to prepare,
But our 174 Magnet Champions will surely get us there.

Debra and Brian have worked with staff with the aim,
To create a program filled with presentations, talking papers, and even a game.
Nurse Managers and Clinical Nurse Specialists are also keys to success,
As leaders, coaches, and sharing with staff what we do best.

Well that is as far as the story now goes,
It's time to cross our fingers and our toes,
In addition to a well-deserved rest,
We're looking forward to hearing we're a Magnet Hospital—'Simply the Best.'

(Individuals referenced in the poem include: Marianne Ditomassi, Lori Carson, Ed Coakley, Lauren Holm, Jackie Somerville, Marie LeBlanc, Trish Gibbons, Keith Perleberg, Sally Millar, Dawn Tenney, Theresa Gallivan, Judy Newell, Chris Graf, Ellen Fitzgerald, Nancy McCarthy, Julie Goldman, Mel Heike, Negui Gomez, Jess Beaham, Debra Burke, and Brian French.)

# Ellison 19 nurse feels true spirit of Thanksgiving

*—by Carol Upham, RN, staff nurse, Ellison 19*

It was busy, as usual, on Ellison 19. We were preparing to discharge as many patients as possible to be home for the holiday. What a beautiful Thanksgiving this would be, I thought, as I glanced out the window at the snowstorm in progress. Six to eight inches would fall before the day was over. It was my holiday to work so my husband, John, was in charge of cooking and cleaning. I was excited.

An overhead page to the phone caught my attention and brought me back into focus. It was a call from John's employer. "Your husband has had a grand-mal seizure, he's unconscious, and en route to the local hospital."

It couldn't be. He's so healthy. He's a runner. Why hadn't I been more attentive to his occasional complaints of light-headedness? Why had I blamed it on allergies? It must be a brain tumor, I thought. I felt paralyzed and alone.

With sudden awareness, I realized that Jay, our operations associate, was pushing a chair beneath me as I desperately listened to the caller and tried to write down directions to the hospital. Within seconds my colleagues were at my side. Helina, our nurse practitioner, was already on the phone arranging the fastest route to the hospital. Bonnie, our resource nurse, quickly reassigned her duties and mine as she insisted on accompanying me to the hospital. Marie, our patient care associate, handed me all the change in her wallet. "Take it," she said, "You'll need it for phone calls."

En route to the hospital by train, our clinical specialist, Marian, called Bonnie's cell phone to say that John had called and was alert, orientated, and waiting for me. I sighed with relief as it seemed like a great weight had been lifted from me.

We arrived at the Emergency Room (ER) in record time considering the storm, the train ride, and the taxi. I hugged Bonnie and said good-bye, thinking she would want to leave, but she insisted on staying until she saw that John and I were okay. It was then that I became aware of a 'code blue' in progress in this small ER. Maybe it was our MGH scrubs that allowed us to walk right in, but I felt I had to be in there.

I quickly spotted John in a cubicle across the room being closely monitored. He waved and looked happy to see me. Bonnie and I again embraced and she returned to MGH by train to finish her shift.

The ER doctor informed me that they had already evaluated the results of an emergent CT of John's head and had ruled out a brain tumor. They said it was safe for him to travel so I transferred him to MGH, where his primary care physician, Dr. Snow, was waiting for us. John was admitted to Ellison 16 and immediately sent off for an MRI. Tracy and Amy, John's nurses on Ellison 16, made his first admission to a hospital a very positive experience. They were caring and professional and at the same time created a very supportive environment for me. I went home that night relieved that John was in the best of hands.

I will be forever grateful to my fellow staff at MGH and I remain so proud to be part of the nursing staff on Ellison 19. I have worked at MGH for 35 years, participated in many emergency situations, cared for thousands of patients and families in crisis. I always thought my experience would somehow prepare me for this kind of event. It didn't. It did, however, make me realize how often I have been there for patients by just "doing my job." It didn't feel special doing those things for my patients. But now, more than ever, I realize how valuable good nursing support can be.


Carol Upham, RN (4th from right), with Ellison 19 co-workers (l-r): Mireia Grima-Cervantes, RN; Roger Snow, MD; Bonnie Prall, RN; Halina Slowik, NP; Marian Jeffries, NP; Marie Philiossaint, PCA; and Jay Emmons, OA.

# Professional Achievements



## Cardiac nurses publish

"The Identification of Malnutrition in Heart Failure Patients," by Diane Carroll, RN; Carol Homeyer, RN; Sandra Nicol, RN; and Colleen Zamagni, RN, was published in the *European Journal of Cardiovascular Nursing,* in June 2002.

## Carroll presents in 2003

Diane Carroll, RN, will present a paper in New Haven, Connecticut, in March, at a meeting of the Eastern Nursing Research Society. Carroll will present two posters at the National Teaching Institute of the AACN in May, in San Antonio, Texas.

## Hopcia accepted to Harvard doctoral program

Karen Hopcia, RN, has been accepted to the Harvard School of Public Health doctoral program in Occupational Health. Hopcia received an award from the NIOSH to cover tuition and a stipend.

## Nurses receive certification

The following nurses from the Main Operating Room have received certification as operating room nurses from the Association of Perioperative Nurses (AORN):
Janice Brouillard, RN, CNOR
Michelle Johnson, RN, CNOR
Dianne McElvery, RN, CNOR
Debra Tassinari, RN, CNOR

Linda Lundblad, RN, ONC, received her certification as an orthopaedic nurse from the Association of Orthopaedic Nurses.

## Sweezey earns 25th consecutive certification

Kathleen Sweezey, RN, a member of the float team for Ellison 8 and the CSICU, has earned her 25th consecutive certification as a CCRN.

## Kinnealey receives Janssen Elder Care Award

Ellen Kinnealey, RN, received The National Patient Safety Foundation's Janssen Elder Care Award for her paper, "Infusion Pumps with 'Drug Libraries' at the Point of Care: a Solution for Safer Drug Delivery." Kinnealey will be recognized at the 5th annual NPSF Patient Safety Congress in March, in Washington, DC. Her paper, along with the other finalists', is available on-line at: www.npsf.org

## Posters and manuscript accepted

Diane Carroll, RN; Glenys Hamilton, RN; and Barbara Kenney, RN, published their article, "Changes in the Health Status, Psychological Distress and Quality of Life in Implanted Cardioverter Defibrillator Recipients Between Six Months and One Year After Implantation," in the *European Journal of Cardiovascular Nursing*.

Carroll, Hamilton and Brian McGovern, MD, presented the poster, "Quality of Life in Implanted Cardioverter Defibrillator Recipients: the Impact of Device Shock," at the American Heart Association Scientific Session in Chicago, in November, 2002.

Carroll, Sally Rankin, RN; Patricia Winder, RN; Elizabeth Hiltunen, RN; Michelle Rait, MA; and Alice Butzlaff, RN, presented their poster, "Relationship Provision for Unpartnered Elders: an Intervention to Enhance Cardiac Recovery," at the Gerontology Society of America Scientific Session in Boston, in November, 2002.

## Capasso presents on wound healing

Ginger Capasso, RN, presented, "Wound Healing in a Prospective Payment System," at the Society for Vascular Nursing in Orlando, Florida, in April, 2002.

She presented, "New Approaches to Peripheral Vascular Disease," at the Nurse Practitioner Associated for Continuing Education (NPACE) conference in Falmouth, in July, 2002.

Capasso also presented, "Current Wound Therapy," at the *Nursing Spectrum*'s Career Expo in Dedham, in September, 2002.

## Office of Patient Advocacy recognized in *Advance for Nurses*

Staff of the MGH Office of Patient Advocacy (Sally Millar, RN, director; Sheryl Katzanek; Diann Burnham, RN; Steve Reardon; and Anita Galloway) were spotlighted in the September 30, 2002, issue of *Advance for Nurses*, in an article entitled, "Advocating for Patients: Nurses are Leading the Way at Massachusetts General Hospital."

## Carroll receives research grant

Diane Carroll, RN, has been awarded the 2002 Medtronics Physio-Control AACN Small Project Grant for her research proposal, "Quality of Life in Patients at Three and Four Years After Insertion of an Implantable Cardioverter Defibrillator (co-investigator, Glenys Hamilton, RN).



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**Next Publication Date:**
February 20, 2003

# Excellence in Action Award goes to staff of Phillips 20

At a small ceremony on Phillips House 20 on Tuesday, January 14, 2003, Peter Slavin, MD, president of MGH, presented an Excellence in Action Award to the staff of Phillips 20. This recognition came about as the result of a letter written by patient advocate, Sheryl Katzanek, expressing the sentiments of patient, Neil Cronin. The letter eloquently captures the level of care and service that make the Phillips 20 staff deserving recipients of this award. Katzanek wrote:

Dr. Slavin:

Recently, I had the pleasure of speaking with a patient who wished to extol the virtues of the staff that have so aptly cared for him over the past several years. I would like to take the opportunity to share his comments with you.

Mr. Neil Cronin is a 42-year-old gentleman who sustained serious injury following a diving accident at age 18, leaving him quadriplegic. He has been admitted to MGH over the years for management of medical problems related to his immobility. By his own account, Mr. Cronin reported more than 800 inpatient days on Phillips 20 over the past five years. Quite simply, Mr. Cronin credits the staff of Phillips 20 for saving his life. When asked if there were any individuals in particular he wished to single out, Mr. Cronin declined, for fear he would leave someone out. He said the entire staff—from nurses, to operations associates, to PCAs—has been wonderful. He feels that staff have become part of his family and together, they have lived through life's trials and tribulations. He commented, "Love comes in strange ways. I love these nurses."

In terms of staff's clinical expertise, Mr. Cronin informed me that he has the utmost confidence in their ability to "do the right thing." He described how, on two occasions, staff literally saved his life with their quick recognition and treatment of life-threatening complications. He added that staff is so attuned to his needs that often, they recognize required treatment, movement, or therapy even before he does.

It is evident though, that staff of Phillips 20 have delivered more than exquisite clinical care. Mr. Cronin says he has never felt the need to avail himself of any psychopharmacological assistance because "the staff of Phillips 20 *are* my antidepressants." From buying birthday cards for Mr. Cronin's mother to writing cheerful, little notes on his water pitcher, staff have truly demonstrated that good health care is more than just good medical care.

These comments are only a small portion of the sentiments Mr. Cronin shared with me, and I'm certain I have not adequately captured the depth of appreciation that Mr. Cronin feels for the entire staff of Phillips 20.

I will, however, conclude with the same sentence that Mr. Cronin used to end our conversation. He said, "Whoever thought of the word 'sweetheart' was thinking of Phillips House Twenty."

For all this and more, I am pleased and proud to nominate the staff of Phillips 20 for an Excellence in Action award.

Sheryl Katzanek,
patient advocate

Phillips 20 nurse manager, Keith Perleberg, RN, with Cronin's primary nurse, Nancy Walsh, RN.

Patient, Neil Cronin (center front) and MGH president, Peter Slavin, MD, (center back) surrounded by Phillips House 20 staff at Excellence in Action award ceremony.

| When/Where | Description | Contact Hours |
|---|---|---|
| February 19<br>1:30–2:30pm | **USA Educational Series**<br>Bigelow 4 Amphitheater | - - - |
| February 20<br>1:30–2:30pm | **Nursing Grand Rounds**<br>O'Keeffe Auditorium | 1.2 |
| February 20<br>10:00–11:30am | **Social Services Grand Rounds**<br>"Children from Families with Alcoholism and Substance Abuse." For more information, call 724-9115. | CEUs<br>for social workers only |
| February 21 (Day 1)<br>8:00–4:30pm | **End-of-Life Nursing Education Program**<br>O'Keeffe Auditorium | TBA |
| February 26<br>8:00–4:30pm | **Workforce Dynamics: Skills for Success**<br>Training Department, Charles River Plaza | TBA |
| February 26<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar II**<br>Training Department, Charles River Plaza | 5.4 (for mentors only) |
| February 26, 27, March 3, 4, 10, and 11<br>7:30am–4:00pm | **ICU Consortium Critical Care in the New Millennium: Core Program**<br>BWH | 45.1<br>for completing all six days |
| February 27<br>8:00am–12:00pm (Adult)<br>10:00am–2:00pm (Pediatric) | **CPR—Age-Specific Mannequin Demonstration of BLS Skills**<br>VBK 401 (No BLS card given) | - - - |
| February 27<br>7:30–11:30am; and 12:30–4:30pm | **Pediatric Trauma Update**<br>Wellman Conference Room | - - - |
| February 27<br>7:00am–12:00pm | **CVVH Core Program**<br>VBK 601 | 6.3 |
| February 27<br>1:00–2:30pm | **Conflict Management for OAs and PCAs**<br>VBK 601 | - - - |
| February 28<br>8:00–4:30pm | **Cancer Nursing Update 2003**<br>O'Keeffe Auditorium | TBA |
| March 4<br>8:00am–4:30pm | **Chemotherapy Consortium Core Program**<br>Wolff Auditorium, NEMC | TBA |
| March 6<br>7:30–11:00am,<br>12:00–3:30pm | **CPR—American Heart Association BLS Re-Certification**<br>VBK 401 | - - - |
| March 6<br>1:30–2:30pm | **Nursing Grand Rounds**<br>O'Keeffe Auditorium | 1.2 |
| March 6<br>1:30–2:30pm | **Shared Vision–New Pathways: A New Approach to Joint Commission Accreditation**<br>Haber Conference Room | - - - |
| March 7 (Day 1)<br>8:00–4:00pm | **CCRN Review Day**<br>O'Keeffe Auditorium | TBA |
| March 12<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar I**<br>Training Department, Charles River Plaza | 6.0<br>(for mentors only) |
| March 12<br>1:30–2:30pm | **OA/PCA/USA Connections**<br>Bigelow 4 Amphitheater | - - - |
| March 13<br>8:00am–4:30pm | **Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other**<br>Training Department, Charles River Plaza | 7.2 |

*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.

## The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

**"Healthy Relationships"**

Presented by
Carol McSheffrey, LICSW

We all strive for healthy relationships with our significant others. But sometimes we lack the tools for developing and maintaining good relationships.
This seminar will help participants recognize indicators of healthy and un-healthy relationships and provide guidance to participants in defining and meeting their needs in relationships.

**Thursday, February 13, 2003**
**12:00–1:00pm**
**Wellman Conference Room**

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

## Save the Date

African American Pinning Ceremony

February 14, 2003
11:00am–12:00pm
O'Keeffe Auditorium

Presentation:
"The African American Community in Boston"

All are welcome

## Run for a Reason!

**Join the MGH Team Durant 2003 in support of the Thomas S. Durant, MD, Fellowship in Refugee Medicine**

Throughout his life, Dr. Tom Durant exemplified the importance of humanitarian service to refugees and victims of war and disasters. The Thomas S. Durant Fellowship was established to honor Dr. Durant's unique spirit of dedication and service.
The Fellowship sponsors healthcare professionals who wish to serve refugee populations and victims of complex humanitarian disasters.

The 2003 Boston Marathon will be held on Monday, April 21, 2003. We invite you to run with us or sponsor one of our runners. Our goal is to raise $5,000.00 per runner. Please indicate your interest in joining Team Durant (as a runner or donor) by contacting Laurence Ronan, MD, at lronan@partners.org or calling Stacy Lewis at 617-724-3874. Runners will be accepted on a first-come first-served basis.

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