

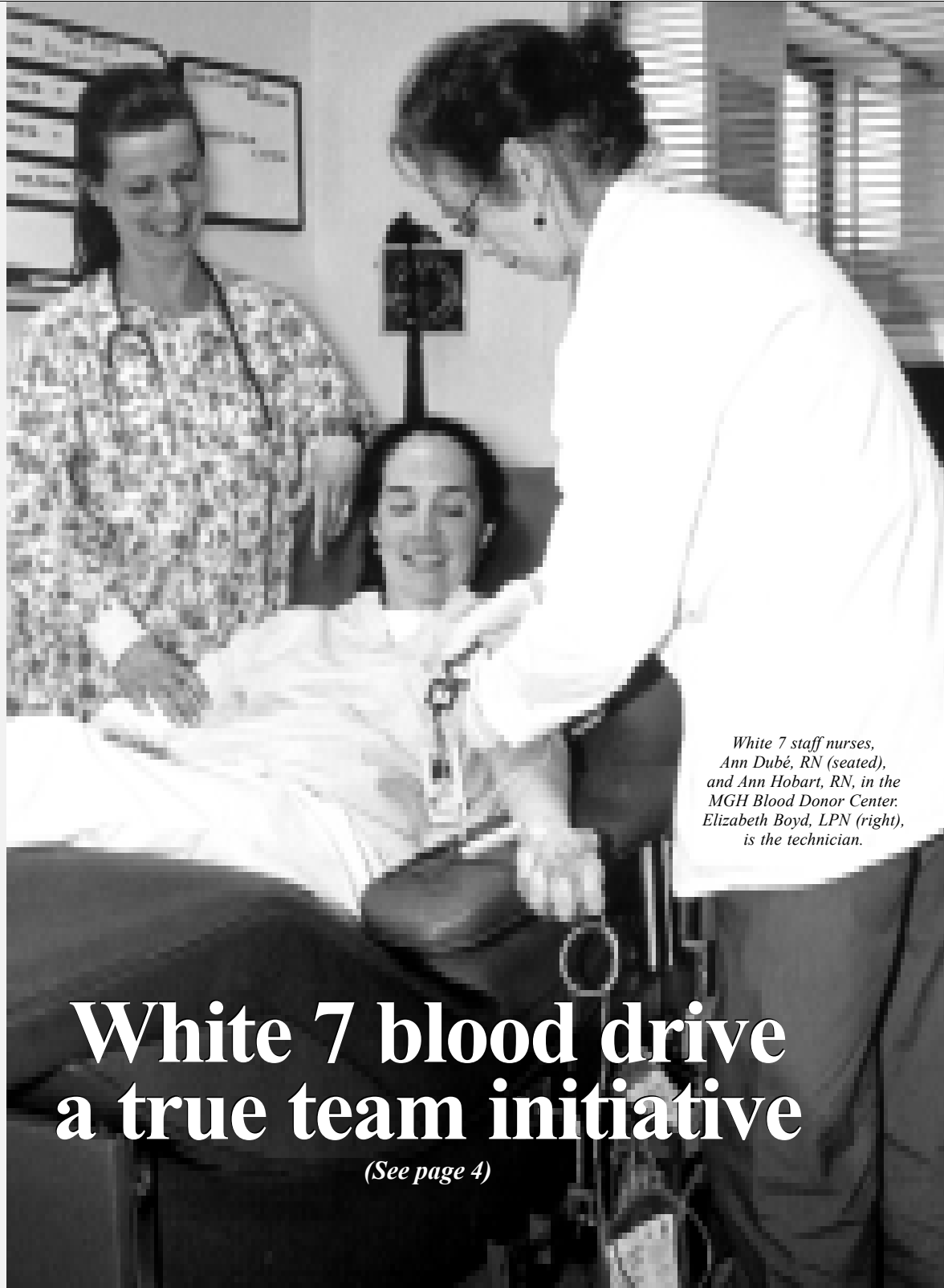
# Caring

## HEADLINES

May 1, 2003

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*White 7 staff nurses,  
Ann Dubé, RN (seated),  
and Ann Hobart, RN, in the  
MGH Blood Donor Center.  
Elizabeth Boyd, LPN (right),  
is the technician.*

## White 7 blood drive a true team initiative

*(See page 4)*

## Coping in the aftermath of tragedy

*After the troubling events of the past few months, we are all engaged in a process of healing. We have been deeply touched by tragedy, and we have come together as a hospital, and as a family, to help each other. I've witnessed incredible strength and compassion in these past weeks, and I think we're doing well in our efforts to support one another. I know I speak for the entire leadership team when I say, the best thing we can do to honor the memory of those we have lost is to continue the important work we are doing, caring for patients and serving the community. I thought it would be useful to hear from some of the individuals whose work at MGH helps us feel safe and supported in our work environment.*

**Evelyn Bonander,**  
**ACSW, director, Social Services**

Social Services has played a key role over the past few months in helping staff and family members through a particularly difficult time. A number of devastating events presented unique and unprecedented challenges to our entire hospital community. We have all been affected by these events in some way. It's important to recognize the impact these events have on our own emotional well-being. As healthcare providers, many of us are familiar with the cumulative effect that can result from prolonged exposure to stressful situations. It can lead to feelings of chronic anxiety, an inability to concentrate, sleeplessness, worry, and a general sense of 'unease.' We need to pay attention to those signs and give each other opportunities to talk, together and/or individually; and we need to provide time and space to grieve.

Also, it's important to understand that every person deals with stress

and/or adversity differently. Some people are able to express their feelings immediately while others may hold their emotions in for a long time. Some people grieve openly, others more privately. Grieving takes time and energy; some days and hours are better than others. There is no right or wrong way to experience grief. We need to respect our own and each other's outlets for coping.

It's a good idea to 'check in' with co-workers and colleagues periodically following times of great distress. A friendly, "How are you doing?" can open the door to meaningful dialogue and supportive conversation. This is appropriate in the days, weeks, and even months following a traumatic event.

Patients and families are also going through a difficult time as a result of these tragedies. You may find that patients want to talk and tell their stories as part of their healing process. Social workers are available to all patients and family

members who need support or want to tell their stories.

Staff should remember that the Employee Assistance Program (EAP) is a valuable resource; don't hesitate to avail yourself of their services, or refer a co-worker who may be having a difficult time.

**Allison Lilly, LICSW,**  
**operations manager,**  
**and Andrea Stidsen,**  
**LICSW, director,**  
**Employee Assistance Program (EAP)**

The one theme that links these recent incidents is the tremendous loss suffered by the MGH family and the incredible care we've been able to provide to each other and to our patients.

Many lives have been touched by these events, in ways we may not even know about yet. One thing we need to keep in mind is that every person's response is different, unique, and valid. Some people may prefer to grieve in solitude, while others may seek comfort in the company of their families, friends, and co-workers. What



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

ever our coping mechanisms are, we need to call on them now; we need to be true to ourselves and honor our honest response to these events.

Some individuals may have feelings of irritability; they may withdraw from typical interactions or experience other changes in behavior. These can be indications of emotional distress or internal struggle. It's important for all of us to be more tolerant, more empathetic, and more supportive during these times.

Not everyone is comfortable asking for help. It may be difficult for some of our co-workers to reach out. Now, more than ever, we need to make that extra effort to extend a helping hand. There are so many wonderful resources at MGH, there's no need for anyone to be alone if they don't want to be.

It's natural to want to talk about incidents that affect us deeply. It's a

form of healing. We encourage people to talk openly about their feelings. At the same time, we need to respect the 'cues' of those who may prefer *not* to talk. The important thing is for people to know that there is a safe environment for whatever form of expression their feelings take. The opportunity to talk and share is there if they want it.

It's also natural to be curious; to seek answers; to ask, 'Why?' Knowing answers and having information gives us a sense of control. But we don't want that curiosity to lead to rumors or false information that can be hurtful to others. When it's within your power, try to curtail non-constructive conversation and rumors.

The Employee Assistance Program (EAP) is available to all employees of MGH. Employees can call (6-6976) to speak with an EAP

*continued on next page*

## Coping After Tragedy

*continued from previous page*

consultant; they can schedule a personal visit to the EAP office (VBK 427); or they can arrange to have an EAP consultant come to their department for a group discussion or presentation.

Employees should feel free to contact EAP for counseling; information; help in identifying coping mechanisms and other resources; help in identifying support systems; or help in increasing awareness around safety issues. The EAP also coordinates a Critical Incident Stress Management Program specifically geared toward helping staff who experience traumatic incidents such as acci-

dental injury, death, suicide, etc. Post-incident services are available to individual employees and groups, and include consultations, de-briefings, follow-up, and referrals.

For more information, or to schedule a confidential appointment, call EAP at 6-6976.

**Bonnie Michelman, CPP,**  
*director,*  
**Police & Security**

Nothing I can say will help us feel better about the events we've experienced. What I'd like to do is try to put these events into perspective so we don't lose sight of the fact that MGH is a safe place to work.

First I'd like to assure you that the incident that took the lives of Dr.

Brian McGovern and Colleen Mitchell was in no way foreseeable. It could not have been predicted; it could not have been prevented. It was a sad, tragic act, but no one in the MGH community should be harboring feelings of guilt or blame.

Also, it's understandable that employees may feel fearful in the wake of such disturbing events. I'd like to try to allay those fears by sharing some information with you. It's estimated that there are approximately 115 million people in the workforce nationwide. Of that 115 million, 1,000 people die as a result of workplace violence. Of that 1,000, less than 5% (or an average of 45 people per year) are killed by random acts of violence in the workplace. I don't tell you this to minimize the tragedy in any way; only to assure you that the chances of it happening again are astronomically small.

We are fortunate that hospital leadership places a high priority on safety and security. Our Police & Security Department is a benchmark of excellence for healthcare organizations across the country. We orchestrate a multi-pronged, multi-dimensional security program that is strong, strategically sound, and rich in professional expertise.

Our department is staffed by an extraordinary team of dedicated and knowledgeable officers and support staff. We employ state-of-the-art technology and techniques to prevent and deter crime. We have designed and implemented policies and procedures to ensure the optimal safety of patients, staff, and visitors. And we offer numerous training opportunities and educational sessions to help prepare staff to handle situations that arise in the workplace.

MGH is a large, urban medical community. Approximately 70,000 people come through our doors every day. We all need to be vigilant and aware of our surroundings. We need to pay attention to the behavior of our patients and coworkers. We need to listen to that little voice inside that tells us something isn't quite right.

I urge every member of the MGH community to contact Police & Security (6-2121) at the earliest opportunity when and if you suspect anything unusual in the workplace. *Trust your instincts*; act sooner than later. The earlier Police & Security is notified, the more options we have in preventing or eliminating threats.

I cannot state strongly enough that MGH is a safe place to work and seek care. Please help us maintain this level of safety by continuing to be a proactive member of our community. Ensuring adequate security requires active vigilance, communication, and the vigorous participation of every employee.

Please call Police & Security (6-2121) for issues related to patient restraints, employee escorts, or any patient activities, actions, or behavior you deem questionable or suspicious.

### The Employee Assistance Program

Work-Life Lunchtime Seminar Series  
presents

#### "Keeping our Children Safe: Parenting in Unsafe Times"

Presented by  
Candelaria Silva, parenting specialist

Parents and caregivers have growing concern about the safety of children in today's world. This session will offer techniques to keep your children safe from strangers and predators, and discuss how to ensure that violence in the media does not affect your children.

**Thursday, June 19, 2003**  
**12:00–1:00pm**

**Wellman Conference Room**

**Wednesday, June 25, 2003**  
**12:00–1:00pm**

**Thorn Conference Room, BWH**

For more information, call EAP at 726-6976.

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

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

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

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

## White 7 nurse coordinates unit-based blood drive

White 7 staff nurse, Barbara Walsh, RN, was checking e-mail one day when she came across an All-User E-Mail from the MGH Blood Donor Center. The message informed staff about a critical blood shortage in the area and in the hospital.

Like everyone else, Walsh was concerned. But unlike a lot of us, Walsh did something about it. She thought it would be a great idea for her whole unit to participate in a blood drive. And in very short order, her idea became a reality.

Walsh visited the Blood Donor Center to pick up brochures and information about donating blood. She used that information to create a poster, which she displayed prominently on the bulletin board directly across from the nurses' station. Alongside pictures and testimonials of people who have benefited from receiving blood donations, was text that read:

*Critical Blood Shortage—Please join White 7 in our blood drive. All are welcome!*

According to Walsh, in no time at all, people started volunteering. Says Walsh, "I couldn't believe how quickly word spread and how eager people were to help. Literally, people saw the poster and volunteered without even having to be asked." Two student nurses from the IHP and the White 7 dietitian were among the

first to volunteer. And, says Walsh, two nurses who had never donated blood before stepped up and are now regular donors.

Every time someone on the unit gives blood a red 'blood drop' is added to the poster along with the person's name.

Walsh says she may have drawn some of her inspiration from personal experience. She recalled a time when someone in her family needed blood, and the call went out to

his co-workers. "His whole company turned out," says Walsh. "They came to the MGH Blood Donor Center by the hundreds! It was such a moving display of unselfishness."

Walsh also thought about police and fire fighters who routinely give blood for their fellow officers.

"If giving blood can be part of their routine," says Walsh, "there's no reason it can't be part of ours."

It's necessary to wait 56 days between blood donations. Many of the White 7 staff who gave in the first round of do-

nations are approaching eligibility again. So the unit is gearing up for 'phase two' of the blood drive.

With new restrictions on blood donation (people who have visited the United Kingdom for a total of 3 months between 1980 and 1996, or people who have spent more than five years in Europe since 1980, are no longer eligible to give blood) and an increasing shortage of blood and platelets nationwide, says Walsh, "It would be nice if other units got together and started their own blood drives."



White 7 staff who participated in blood drive are (standing, l-r): Susan Diehl, Marilyn Healey, Barbara Walsh, Nicole Binette, Kate Patton, Daniel Nadworny, and Bridget Walsh. (Kneeling:) Brenda Fletcher, Chelsea Morello, Erin Simmons, and Sherry Goddard.

## New admission pathway broadens nurses' access

**A**s a young girl, Dianna Ploss and her friends would regularly take a short cut from their neighborhood to the bowling alley behind Fenway Park. The route led her through the corridors of Peter Bent Brigham Hospital and Children's Hospital. Today Ploss has found another short cut that has allowed her to qualify for graduate school in less time than was previously possible.

Ploss is the first to enroll in the MGH Institute of Health Professions' RN-to-MSN Program through a new admission pathway that permits diploma and associate-degreed nurses to earn a master's degree, bypassing an intermediate bachelor's degree. Applicants must complete specific general education prerequisites, but the new pathway will save Ploss more than two years of schooling and thousands of dollars.

"This initiative opens the door for many students who would otherwise have to complete an RN-to-BSN program or get a bachelor's degree in another field before applying to the Institute's Advanced Nursing Program," says associate director, Carol Picard, RN, who created and oversees the new track.

## to MSN

By John Pierson

Twenty-eight full- and part-time students are currently enrolled in the RN-to-MSN Program, which offers selected courses on-line.

"Making it easier for diploma and associate-degreed nurses to gain additional skills can only add to their marketability and increase the likeli-

hood that they will stay in the profession," says Picard.

After working a number of jobs, and with the support and encouragement of a career counselor, Ploss went back to school at age 32, and graduated with an associate's degree in nursing. She could have gone directly into a bachelor's program, but as Ploss says, "I wasn't twenty

anymore, and I wanted to get into the workforce as quickly as possible."

Ploss passed her RN boards and started looking for a BSN program. While working as a nurse in the Cardiac Step-Down Unit at MGH, she enrolled at UMass Boston.

Last spring, Ploss started calling graduate schools. Her first call was to the Institute where she spoke with Picard, who said, "Don't do anything yet. We're going to be implementing a program that might be just the thing for you."

In January, Ploss transferred from UMass and became the first nurse to enroll in the IHP's RN-to-MSN Program. In two or three years Ploss will have her MSN and be ready to become a psychiatric nurse practitioner.

For more information about the graduate admission pathway for diploma- and associate-prepared nurses, send e-mail to Carol Picard at [cpicard@mghihp.edu](mailto:cpicard@mghihp.edu), or visit: [www.mghihp.edu](http://www.mghihp.edu).

## Nurse Recognition Week 2003

### Schedule of Events

**Sunday, May 4th**  
**Staff Nurse Reception**  
7:30-9:30am  
Trustees Room, Bulfinch 2

**Monday, May 5th**  
**"On Diversity, Marginalization, Empowerment, and Culturally Competent Care"**  
Afaf I. Meleis, RN, president, International Council on Women's Health  
11:00am-12:00pm  
Ether Dome, Bulfinch 4

**Tuesday, May 6th**  
**"A New Look at Patient Safety: Understanding the Complexity of Work"**  
Pat Ebright, RN, asst. professor, Indiana School of Nursing; and Kathy Rapala, RN, risk manager, Clarian Health Partners, Inc.  
7:45-8:45am and 2:00-3:00pm  
O'Keefe Auditorium (Reception to follow)

**Wednesday, May 7th**  
**Research Day: Scientific Sessions**  
"Quality of Life in Implanted Cardioverter Defibrillator Recipients: the Impact of Device Shock"  
Diane Carroll, RN, clinical nurse specialist  
"Evaluating the Environment of Care"  
Peggy Doyle Settle, RN, nurse manager, NICU  
10:00-11:30am  
O'Keefe Auditorium

Research posters on display throughout Nurse Week

**Wednesday, May 7th**  
**Research Presentation and Presentation of 2003 Yvonne Munn Nursing Research Awards**  
"Enhancing Behavioral Care for Youths with Diabetes"  
Margaret Grey, DrPH, associate dean for Research Affairs, Yale School of Nursing  
1:30-3:00pm  
O'Keefe Auditorium  
Reception to follow

**Wednesday, May 7th**  
**"Managing the Menopausal Patient in 2003: a Practical Approach"**  
Susan Oliverio, MD, MGH Women's Health Associates  
5:30-7:30pm  
O'Keefe Auditorium

**Thursday, May 8th**  
**"The Genius of Nursing"**  
Jeanette Ives Erickson, RN, senior vice president for Patient Care  
1:30-2:30pm  
O'Keefe Auditorium

**Thursday, May 8th**  
**Staff Nurse Reception**  
2:30-4:30pm  
Trustees Room, Bulfinch 2

## Final preparations for the magnet site visit

—submitted by the Magnet Steering Committee

**O**n June 10-12, 2003, appraisers from the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association, will conduct a site visit at MGH to see first-hand why the department of Nursing should be awarded the ANCC's highest nursing honor.

### *What is a magnet hospital?*

In the early 1980s, during a severe nursing shortage, research was conducted to determine characteristics of hospi-

tals that were able to recruit and retain nurses despite the shortage. Because of their ability to *attract* and *retain* nurses, these hospitals were called 'magnet' hospitals.

In 1993, 14 standards were drafted based on these characteristics, and a certification program was created that is available to all hospitals, across all healthcare settings. This prestigious program is administered by the ANCC, the nation's largest and foremost nursing accredita-

tion and credentialing organization.

Magnet certification brings important national recognition to healthcare organizations that demonstrate sustained excellence in nursing care.

The Magnet Recognition Program also provides a vehicle for the dissemination of strategies and best practices among nursing systems. As of April of this year, there are 69 magnet hospitals nationwide, which represents 1% of all hospitals in the US.

### *Why is being a magnet hospital important?*

More than 20 years of research shows that mag-

net hospitals have: lower patient mortality, fewer complications, improved patient safety, higher patient and staff satisfaction scores, and shorter hospitalizations.

Magnet certification recognizes and rewards the provision of outstanding care; it acknowledges commitment to quality and safety; it allows organizations to market themselves to patients and prospective staff as organizations with a strong nursing service; and it positions organizations nationally as a select few hospitals to achieve magnet recognition.

### *How do you become a magnet hospital?*

Hospitals seeking magnet certification submit written evidence supporting their application and

undergo an intensive site visit to determine if they meet the 14 standards of care and professional performance.

*What do appraisers look for during the site visit?* Magnet hospitals have what's called a 'magnetic personality.' This means:

- Quality nursing leadership that serves as a strong, knowledgeable advocate for staff
- An organizational structure that is decentralized, with strong representation from nurses
- A management style that invites participation and feedback
- Personnel policies and programs that are supportive, flexible and competitive
- Professional practice models that give

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Magnet champions, (left): Emilia Rudowski, RN, of the Main OR; and (l-r): Deb Pereira, RN; Leslie Clark, RN; and Carol Brown, RN, of Ellison 11, participate in recent Magnet Champion Retreat.

## Raising Environmental Awareness League (REAL)

The Raising Environmental Awareness League (REAL) was created to address the impact MGH has on the environment. The goal of this new group is to help MGH become an environmental leader among healthcare providers. REAL is volunteer-based and comprised of staff from many departments from Nursing to Biomedical Engineering.

The group came together out of common concern and a desire to examine the role healthcare employees, parents, friends and neighbors play in improving and preserving the environment.

REAL encourages all MGH employees to examine the impact they have on the environment at home, at work, and everywhere they go in their daily lives. For more information about REAL, including the dates of upcoming meetings, send e-mail to: [real@partners.org](mailto:real@partners.org).



Staff nurse, Rebecca Horr, RN, staffs educational booth in the Main Corridor disseminating information on environmentally safe products and practices.

## Preparing for Magnet Site Visit

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- nurses responsibility and authority for the care they provide
- Quality of care is an organizational priority
- Performance improvement is ongoing and nurses are involved
- Expert consultation and resources are available to support caregivers
- Autonomy for nurses allowing them to use independent professional judgment
- The hospital and community work together to improve health care
- Nurses function as teachers for patients, the public, and one another
- The image of nursing is held in high regard by other members of the healthcare team
- Interdisciplinary relationships are key,

and there is a sense of mutual respect among all disciplines

- Professional development is emphasized and supported

*What is the focus of the three-day site visit?*

Appraisers will attend collaborative governance meetings to get a flavor for the communication and decision-making structure of Patient Care Services. Collaborative governance allows clinicians to have input into key decisions that impact their practice and the quality of their work life.

Appraisers will attend meetings of the Clinical Performance Teams (CPM)—the multi-disciplinary, performance-improvement teams that identify ways to enhance clinical practice.

Appraisers will meet with staff nurses in a number of forums to learn about what attracted them to MGH and why they stay. They will want to hear about The Clinical Recognition Program, the newly-implemented program that recognizes clinicians for their acquisition of clinical expertise. They will speak to new graduate nurses to learn what strategies are in place to facilitate their transition from academia to practice. They'll meet with staff nurses who participated in creating the Nursing Image Campaign.

During their visit, appraisers will meet with senior leadership (including members of the Board of Trustees), physicians, and community leaders to hear their perspectives on nursing and nursing practice at MGH.

Patient care units will be a major focus of the

site visit. It won't be possible for appraisers to visit every unit because of the size of MGH and the length of their visit. Visits to patient care units will last approximately 20 minutes and will involve all members of the healthcare team and patients. Appraisers will want to hear about the unit's strategies on: continuity of care, staffing decisions, nurses' care-planning, orientation and professional development, interdisciplinary teamwork, evidence-based practice, appropriate delegation, and collaborative performance-improvement activities.

*Who will be involved in the site visit?*

Staff from nearly every unit will have an opportunity to interact with appraisers in a number of forums scheduled throughout the site visit. Appraisers may stop and speak

with any member of the MGH community so all employees should have a basic understanding of the magnet recognition process and be able to describe how their departments work in collaboration with nursing.

*How is the final decision made to award Magnet recognition to an organization?*

After reviewing an organization's written evidence and conducting a thorough site visit, magnet appraisers submit a written report to The ANCC's Commission on the Magnet Recognition Program. The report reflects their impressions of how the organization did or did not meet the standards and whether or not it exhibited a magnetic personality. The Commission makes the final decision based on information contained in the report.

## Complex pregnancy presents nursing challenges and learning opportunities

My name is Harriet Nugent, and I work full time on the Vincent Obstetrical Service. I am cross-trained in labor and delivery (including OR), post-partum, antepartum, and nursery practice. I have 14 years of med/surg experience and 8 years of obstetrical experience.

I was recently assigned to care for Mrs. G, a Vietnamese woman who had been on our Ante-Partum Service for several weeks. Mrs. G was pregnant with her second daughter and was experiencing many complications. She had been hospitalized five times for a chronic abruption of the placenta, which manifested itself in intermittent bouts of vaginal bleeding. She also suffered from gestational diabetes, which predisposed her baby to heart defects, lung immaturity, and hypoglycemia. Mrs. G's baby had been diagnosed with Truncus-Arteriosis, a life-threatening condition that would require immediate NICU care and open-heart surgery shortly after birth. During my care of Mrs. G, I was fortunate to be precepting Sarah, a new nurse on our staff. Mrs. G's care posed a nursing challenge and a great learning opportunity for my orientee.

I admitted Mrs. G to the Labor & Delivery Unit after she experienced a significant amount of vaginal bleeding. Her pregnancy had progressed to 36 weeks and the decision was made to induce labor. Upon meeting Mrs. G and her husband, I immediately sensed their fear. The pregnancy had been difficult on this family, and they needed someone with a calm demeanor to help them see it through. I felt their need for clear, accurate information and knew I would be an important vehicle in collaborating with the many disciplines involved. My role as a therapeutic practitioner was defined in those early moments. By actively listening and defining clear communication avenues, I was able to establish a strong rapport with Mrs. G and her husband. They needed to feel they were in a safe and caring environment, and I was able to provide that milieu for them. This made the process less daunting for this family.

I engaged Mrs. G and her husband in the induction process by explaining what we were doing and why. My orientee was involved from the start, learning and participating in Mrs. G's care. I explained the reasoning behind all interventions. There were many factors

to consider in Mrs. G's care. Continuous monitoring of the baby was essential to affirm fetal well-being. Obtaining current blood bank samples and baseline hematology studies would help us be prepared for the strong possibility of hemorrhage. Establishing adequate large-gauge IV access was also necessary in case there was a need for transfusion and/or an emergency C-section. I addressed all these immediate needs prior to beginning Mrs. G's induction.

As the nurse caring for Mrs. G, I helped facilitate the collaboration of many disciplines. There was consultation with the maternal-fetal specialists, Mrs. G's primary obstetrician, Neonatology, Pediatric Cardiac Surgery, Social Services, Anesthesia, and Nursing (both in OB and in the NICU). Language was a potential problem, given the complexity of Mrs. G's condition. A Vietnamese interpreter was made available, though Mr. and Mrs. G didn't feel it was necessary. I made sure Mrs. G and her husband felt comfortable with the give and take of information and had sufficient opportunity to ask questions. Mr. and Mrs. G were able to hear and understand the information they needed, as the birth of their child

became more of a reality. Sarah was able to observe the importance of careful collaboration among healthcare providers and understand the unique role of the nurse as a pivotal member of the interdisciplinary team.

I explained the induction process to Mrs. G. We would start pitocin slowly, and gradually increase the dose to stimulate contractions to prompt labor. Mrs. G had had a vaginal birth with her first child, so she had some idea of what to expect.

"I'm afraid of the pain and the bleeding," she said." I assured her that I would keep a close watch on her bleeding. I knew from experience that women of the Vietnamese culture are very stoic when it comes to pain. With careful prompting, I helped her define her needs, knowing she might need assistance in asking for pain relief. While watching for subtle cues, I assured her that I would consult with

the anesthesiologists and obstetrician for pain management. Mr. G was very attentive, and I helped him respond to some of his wife's comfort needs during labor. He helped her with the early contractions with position changes, massage, and reassurance.

Sarah and I continuously monitored the fetal heart rate, which was strong. This allowed us to proceed with the induction. Experience told me there was a high potential for things to change quickly. The uterine contractions could exacerbate the placental abruption, causing fetal distress and maternal hemorrhaging. I gave our resource nurse frequent updates in case the obstetrical OR was needed urgently. I took every opportunity to teach Sarah about the care needed during this high-risk pregnancy and delivery. We monitored Mrs. G's pain, her hemodynamics, her diabetes, and

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Harriet Nugent, RN,  
staff nurse, Vincent Obstetrical Service



## Exemplar

*continued from page 8*

her fluid-volume status, frequently consulting with the physician about our anticipated management, and always including the family in the plan of care.

Approximately two hours after initiating pitocin, Mrs. G began to pass a moderate to large amount of blood. I immediately notified the doctor, shut off the pitocin, administered oxygen via facemask, initiated a fluid bolus to increase volume of the intravascular space, and continued vigilant fetal monitoring. The doctor examined Mrs. G and decided to rupture the amniotic membranes to hasten delivery. If this wasn't tolerated well by mother or baby, a C-section would be performed immediately. I conferred with the doctor and alerted the rest of the team to prepare for imminent delivery. At the direction of the resource nurse, my colleagues opened the obstetrical OR, alerted the anesthesia staff and made sure the NICU team was ready. Meanwhile, my orientee and I continued to care for Mrs. G. We informed her and her husband of the plan, and they consented to a C-section if the situation warranted it. They were frightened but ready to proceed. I repeated the preparations for their baby's birth and gave them time to ask questions.

Rupturing the amniotic membranes stimulated more bleeding. Mrs. G began to pass large clots of blood, indicating an increase in the placental abruption. The fetal heart rate remained strong, but the amount of vaginal bleeding was deemed unsafe. Mrs. G was taken urgently to the OR for a C-section. I continued to keep Sarah involved in Mrs. G's care as the situation unfolded. She observed first-hand the importance of keen assessment and anticipation of a patient's needs. Prompt, calm action on Mrs. G's behalf helped ensure the best possible outcome for this family. Sarah learned a lot that day about complications of pregnancy, induction of labor, circulating in the OR, and preparation for neonatal resuscitation. But most importantly, she was able to see how caring, intuitive nursing care played an essential role in this family's care.

With all resources in place to care for mother and baby, the spinal placement and surgery

went very well. The baby was born with a vigorous cry, bringing tears of relief to her parents (and even some of the staff).

Anticipation of the neonatal resuscitation plan proved to be essential. I had carefully reviewed the infant's care with Neonatology earlier in the day. The infant's heart defect had allowed her to thrive in utero when functioning with maternal-fetal circulation. Once born, the baby would be unable to oxygenate her own blood. She would look healthy initially until the patent ductus closed. Withholding oxygen from this baby at delivery was essential so as not to prompt closing of the patent ductus. This allowed safe transfer to the NICU for immediate cardiac care. Some of these concepts were difficult to explain to Mrs. G while she was under so much stress, but a calm voice and warm words helped her understand the essentials of the care we provided to her baby at delivery.

During recovery, many of Mrs. G's family members visited. There were many generations present, and Vietnamese was the primary language spoken. They were excited about the birth and eager to welcome their newest family member. We escorted Mr. G and his older daughter to the NICU for a visit and to take some pictures. They returned to Mrs. G with a handful of precious photographs of their new baby. Mrs. G expressed relief and gratitude that the pregnancy was over and her baby was in good hands. She felt overwhelmed by the care and expertise that had been made available to her and her family. I helped her to verbalize her experiences over the last few months, culminating with the birth of her daughter. I knew the days ahead would be challenging, but I wanted

ed her to be able to savor this very special birthday.

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

This narrative weaves Harriet's skilled knowledge and understanding of the quickly changing labor-and-birth experience with her sensitivity to the needs of her orientee and her constant attention to the cultural needs of this family. Harriet anticipated the ramifications of rupturing Mrs. G's amniotic membranes and was prepared for an emergent C-section. Harriet was right—caring for Mrs. G did present a complex nursing challenge and a wonderful learning opportunity for her orientee.

Thank-you, Harriet.

## MGH Chaplaincy

The MGH Chaplaincy is pleased to announce the addition of Jewish and Episcopal services to our regular Chapel schedule. All services are held in the MGH Chapel unless otherwise noted.

### Buddhist

Meditation Sitting: Every Wednesday at 5:30pm

### Episcopal

Communion Service: Every Tuesday at 2:30pm

### Interfaith

Interfaith Service: Monday–Friday at 12:15pm

### Jewish

Shabbat Service: Every Friday at 11:00am

### Muslim

Prayers in the Masjid, at Founders 109,  
24 hours a day, 7 days a week.  
(Prayer schedule is posted outside the Masjid)

### Roman Catholic

Mass: 4:00pm daily, including weekends

All are welcome!

### Ethics Forum:

"Walking Through a Case:  
Recognizing, Reorganizing, and Responding to  
Ethical Conflict"

facilitated by

Ruth B. Purtilo, PhD,

Henry Knox Sherrill visiting professor,  
MGH Institute of Health Professions

Please join us for an interactive discussion

**Friday May 9, 2003**

**12:00–1:00pm**

**Sweet Conference Room, GRB 432.**

Bring a lunch; beverages and dessert  
will be provided

For more information, e-mail [erobinson@partners.org](mailto:erobinson@partners.org)

## Family-Centered Care Awards recognize excellence in pediatric care and service

This year's Family-Centered Care Awards were presented on April 7, 2003, in the recreation room on Ellison 18 before a growing crowd of supporters. Recipients of the award, which recognizes outstanding care and service to pediatric patients and their families, were: Alfredo Galavis, materials coordinator; Anita St.

John, RN, Cystic Fibrosis Program; Heidi Jupp, RN, Pediatric Hematology/Oncology Clinic; Karen DaRocha, RN, staff nurse, Ellison 18; and the pediatric care team in the Same Day Surgery Unit.

Said Judy Newell, RN, chair of the award selection committee, "It is appropriate that these awards acknowledge the caring service of so many

people in so many departments throughout the hospital. We do not provide care 'in a box.' Family-centered care relies on the talents and skills of clinicians and support staff from all disciplines—nursing, the therapies, chaplaincy, medicine, child life specialists, and so many more." Congratulations to the recipients, and to all who were nominated.



Pictured below are nominees and recipients of this year's Family-Centered Care Awards (front row: l-r): Dilva Silva, PCA; Reverend Linda Knight, chaplain; Karen DaRocha, RN; Marie Laguerre, PCA; and Heidi Jupp, RN. (Back row): Elizabeth Olear, research assistant; Pam Wrigley, RN; Bernie Warren, RN; Tina Regan-Harrington, RN; Andrea Cellini, RN; and Cheryl Gomes, RN. At right: Judy Newell, RN, chair of the Family-Centered Care Awards Selection Committee, presents certificate to materials coordinator, Alfredo Galavis.



## New booklet: *Preparing for your Pre-Operative Visit*

—by Bessie Manley, RN, nurse manager,  
Pre-Admission Testing Area

The Pre-Admission Testing Area (PATA) is an integral part of the pre-surgical assessment process for patients and families at MGH. PATA has gone through many changes since opening its doors in the spring of 1991.

PATA is a fast-paced clinic that screens approximately 60 patients per day who will be undergoing elective surgical procedures. The clinic is committed to an holistic practice model. The goal is to evaluate, assess, educate, and prepare patients and families for a safe and successful hospital experience.

PATA is staffed by a small complement of staff nurses, nurse practitioners, anesthesiologists, operation associates, and patient care associates. The clinic is a small but highly efficient unit.

Staff compile and/or create more than 160 pre-operative charts per day for patients undergoing surgery. These charts contain all the information (lab results, consents, medical work-ups, and consults) that the interdisciplinary team will need to provide seamless care.

Because the services provided in the PATA are specialized, and because pre-admission testing areas are not common to all hospitals, some pa-

tients have arrived in the clinic and asked, "What is a Pre-Admission Testing Area? Why am I here?"

To dispel any initial confusion patients may feel about visiting the PATA, staff have created a new patient education booklet, with funding received from the Making a Difference Grant Program. The booklet explains the process and what to expect when coming to the PATA for pre-surgical assessment.

Creating the booklet, *Preparing for your Pre-Operative Visit*, was a multi-disciplinary effort. Nurses spent long hours writing and revising the content to ensure they were conveying the most important and concise information to patients and families. Ensuring that the language, context, and content were at a level that all patients could understand was a priority. Taryn Pitman, RN, patient education specialist in the

Blum Patient and Family Learning Center, was instrumental in helping us achieve an acceptable level to meet the needs of our patients.

The next step was informing surgeons and their staff about our project and securing their participation in disseminating the booklets.

They agreed there was a need to educate patients about what to expect in the PATA.

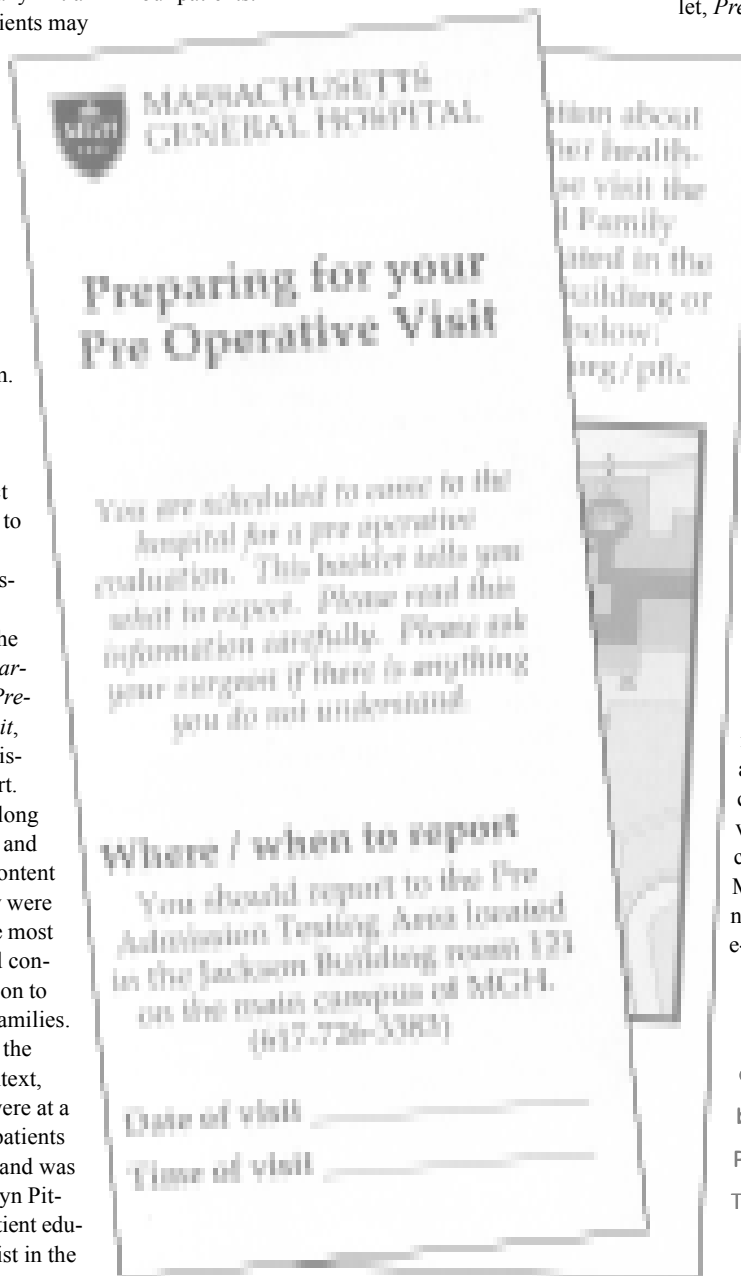
Then, there was the final phase of the pro-

ject: deciding what the booklet should look like. Al Pulito of Standard Register worked tirelessly to help create a booklet that was attractive, easy to read, and concise. Seven months after our initial idea, we had the new and improved PATA patient-education booklet, *Preparing for your Pre-Operative Visit* in our hands.

PATA is always striving to improve the patient process and relationships within the medical community. *Preparing for your Pre-Operative Visit* will soon be available in Spanish and other languages to help meet the needs of our diverse patient population.

For more information about the PATA clinic or the services it provides, contact Bessie Manley, RN, nurse manager, by e-mail.

New patient-  
education  
booklet for  
Pre-Admission  
Testing Area



## Bedside nursing: the role of a lifetime!

—by Joan Marie Stack, RN, MS, CAS,  
staff nurse, Bigelow 14

I would like to share the amazing journey that led to my return to bedside nursing on Bigelow 14. I've had my nursing license for more than 30 years, and have always worked, either full- or part-time as a nurse. I have had many diverse experiences encompassing many roles in nursing, including: head nurse (nurse manager), nursing supervisor, nursing educator, staff nurse, critical-care nurse, charge nurse, clinical instructor for both associate-degree and baccalaureate-degree students, classroom instructor, ACLS and BCLS instructor, graduate student, and graduate nurse practitioner student. Although I learned much with each new role, it has always been the role of staff nurse where I have found the most satisfaction and reward. It is in this role I truly feel I am a 'nurse.' I never really examined what that meant until I became a staff nurse at MGH in July of 2001. Since then, I have spent considerable time reflecting on my practice and my current choice of employment.

What led me to this place, at this time? Why do I stay? Because I know I'm in the right place. It wasn't easy to put my thoughts into words.

I turned to the classic

definition of nursing written by noted nurse, author, educator, and researcher, Dr. Virginia Henderson, in 1964. I learned this definition as a nursing student many years ago, and I have always tried to incorporate it into my nursing practice. She said: "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery, or to a peaceful death, that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise

the unique contribution of nursing to help the individual become independent of such assistance as soon as possible."

I think this description captures the essence of nursing, both as an art and a science. It describes what is unique about nursing and differentiates nursing from other disciplines. We're all human beings, and we all have the same basic need to be healthy, functional and free. Nursing plays a unique role in achieving these goals.

As I began to examine what it is about nursing I value most, I knew

those values would be reflected in my practice. Having worked in numerous roles as a nurse, I still find the essence of nursing is interacting with patients at the bedside. I enjoy both the scientific and humanistic aspects of nursing. I like using my head and my hands. I know I bring strong nursing theory and clinical knowledge to the bedside, and that includes principles of anatomy and physiology, pathophysiology, microbiology, pharmacology, infectious disease processes, human growth and development, and psychosocial theories. I would also include physical assessment skills, clinical judgement, and critical-thinking skills. Yet in this age of advanc-

ed technology, increased patient acuity, complicated health problems, multiple disease comorbidities, patient sensory or sleep deprivation, and the fast-paced environment, patients want and need to feel safe, to feel relief from pain, they want a kind word and a smile, personal attention, reassurance, answers, encouragement, understanding, healing, and hope. How can all this be provided at the same time? I believe the answer is in the direct nursing care provided by staff nurses at the bedside.

When I introduce myself to a patient and ask how she is, what she needs, I'm already performing my initial assessment  
*continued on next page*



Bigelow 14 staff nurse, Joan Stack, RN, enjoys a walk in the corridor with patient, Vernon Young, professor of Nutritional Biochemistry, at MIT.

## Bedside Nursing

*continued from previous page*

ment and formulating the focus of my nursing care for that day, for that patient. With 'Hello,' I am observing skin color and turgor, facial expression, mood, demeanor, mental status, respiratory status, level of consciousness, and any monitors, intravenous fluids, oxygen devices, or drainage systems that may be in place. Further interaction with the patient provides comprehensive physical-assessment data, including vital signs, status of skin integrity, heart, lung, and bowel sounds, peripheral perfusion and pulses, neurological status, mobility, and the ability to manage personal elimination, nutrition, and hygiene. Pain assessment and management are extremely important. The patient doesn't notice, but it is this process that contributes to the prevention of complications, to rapid intervention if a problem occurs, and to eventual healing and recovery, or to a humane and dignified death, if

that is to be the outcome.

This all relates to the definition of nursing put forth by Dr. Henderson. Her work has withstood the test of time, at least it has for me in my practice.

Staff nurses must be able to do all of the above for several patients at a time, and still provide individualized care for each person. And I'm only focusing on the patient—to address the interactions with families, physicians, and colleagues would require a whole other article.

In the midst of all this are the moments of softly whispered, 'Thank-yous,' the squeeze of my hand, the smile of someone going home, the rare but treasured thank-you note from a past patient, and the delight when someone remembers that my nursing care actually made a difference. For all these reasons, I know I am where I am supposed to be. And for the most part, I know it's all worth it.

I don't mean to sound idealistic. I know that nursing can be a tremendous amount of fun and gratifying beyond belief. It can

also be the most terrifying, physically demanding, intellectually challenging, and emotionally difficult work I've ever done. There are days, hours, and moments when I'm sure I can't do it. There have been times I wondered why I ever chose nursing at all. But then I survive the crisis, get through another shift, take care of another patient and those feelings dissipate. I know I'll continue to practice as a staff nurse until the next adventure in nursing finds me.

I suspect that my amazing journey is not over. There will be other twists and turns in the road and more surprises along the way. There will be more challenges, problems, opportunities, obstacles, fulfillment, and hopefully, more moments of humor, awareness, appreciation, and deep satisfaction.

The current stop on my journey is at the bedside on Bigelow 14. It is exactly the right place for me at this time. I hope I can continue to make a difference in the lives of my patients and share moments of camaraderie and laughter with my co-workers.

## Nurse practitioners in the ED

The MGH Emergency Department is pleased to announce the implementation of its new Nurse Practitioner Program. Experienced emergency nurse practitioners now work collaboratively with EM attending physicians and other clinicians to enhance care for patients in a timely manner.

Nurse practitioners are available during peak-volume times, usually between 9:00am and 1:00am daily in the Minor Multipurpose Area of the ED. Nurse practitioners are primary providers for select patient populations and work collaboratively with physicians on more complex patients.

As always, it is the patient's right to request either the EM attending physician or a nurse practitioner. We are pleased to be able to offer this new resource in the Emergency Department.

### Celebrate National Women's Health Week

#### 5 Simple Ways to Stay Healthy

Celebrate National Women's Health Week with the Women's Health Coordinating Council. Learn simpler ways to enjoy a healthier life:

- eat better
- move around
- quit smoking
- get regular medical exams and screenings
- be safe

**Wednesday, May 14, 2003  
9:00am-4:00pm  
Main Corridor**

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#### Publisher

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

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in writing by fax: 617-726-8594

or e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)

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#### Next Publication Date:

May 22, 2003



## New guidelines from the Anticoagulation Task Force

—by Katie Brush, RN, MS, CCRN, FCCM, and  
Harold J. Demonaco, MS, RPh

The Anticoagulation Task Force is rolling out new guidelines for the prevention and management of DVT/PE and other thromboembolic events. These guidelines are the result of research done by Dr. Elaine Hylek of the department of Medicine, and a comprehensive review of the literature by clinical experts. Recommendations have been made for 15 sets of guidelines to lower the risk of clot formation and bleeding by managing anticoagulation differently. The new guidelines can be found at: <http://is.partners.org/pathways>.

### Lowering the risk of clot

DVT prophylaxis can be safely managed in many patient populations using subcutaneous injections of low-molecular-weight heparin, specifically Fragmin®/dalteparin. Doses range from 2,500 to 5,000 units qd for most adult patients depending on the risks of clot. Fragmin®/dalteparin has a lower risk of heparin-induced thrombocytopenia (HIT Type 2) than traditional unfractionated heparin sodium.

### Lowering the risk of bleed

A more dramatic change is utilization of LMWH for the treatment of DVT.

[Clinicians: dosing with Fragmin®/dalteparin is 100mg/kg sc bid for most patients.] Achieving adequate anticoagulation is much smoother and more sustainable than with typical heparin-sodium infusions. There is usually no need for monitoring the anticoagulant effect with the use of Fragmin®/dalteparin. More importantly, complications from low-molecular-weight heparin are much lower.

### Decreasing length of stay

Patients receiving Fragmin®/dalteparin can go home and safely inject themselves daily while completing the transition

to oral warfarin therapy. To aid in this transition, downloadable patient-education information is available on unit computers, and patient-education videos are available (in English and Spanish). Educational booklets that reinforce injection techniques are available and will be resupplied as needed by the Blum Patient-Family Learning Center.

### STAT Pathway and the Anticoagulation Management Service

The Anticoagulation Management Service will be introducing the STAT (Safe Transitions in Anticoagulation Therapy) Pathway and other

services to areas of the hospital that discharge patients home over the next year. Last year, a multi-disciplinary group implemented guidelines for the management of patients after acute stroke with the STAT Pathway. In cooperation with Partners Homecare, Nursing, Case Management and Pharmacy, the STAT Pathway redefined how patients were transitioned from heparin therapy to warfarin. Key to the success of the pathway was early use of low-molecular-weight heparin, using Fragmin®/dalteparin, a standardized approach to warfarin dosing using a validated algorithm, and a high level of coordination. Although data is still being collected, after one year, 92% of patients in the pathway met national standards for the heparin

(using dalteparin)-warfarin transition. And they did it in fewer inpatient days allowing them to go home earlier with excellent coverage by Partners Home Care.

If you have a patient who is at risk for clotting or bleeding and she is not on low-molecular-weight heparin, you should ask yourself, "Why?" While not for every patient, most patients needing anticoagulation during their inpatient stay can and should be receiving a low-molecular-weight heparin. At MGH, the current choice is dalteparin.

Look for reference materials in your medication room and by e-mail soon. For more information, contact Katie Brush at 4-5889.

## Joint Commission Satellite Network Presentations

May 1st: "Patient Safety: Standards, Goals, and Reducing Risk Through FMEA (Failure Mode and Effects Analysis)"

June 5th: "Staffing Effectiveness: Finding Long-Term Solutions"

July 10th: "Medication Use: Preventing Errors"

August 14th: "Emergency Management: Creating and Implementing an Effective Plan"

September 18th: "Putting the Pieces Together: Self Assessment, Priority Focus Process, and Tracer Methodology"

October 16th: "Realizing the Vision: Effective Leadership"

November 13th: "Hospital-Wide Competency Assessment"

December 18th: "Performance Improvement: Achieving Results"

For information about these sessions, call 6-3111

## The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

### "Who's Driving Your Bus?"

Presented by

Suzanne O'Connor, RN, MS, CS,  
psychiatric clinical nurse specialist

Are you driving in the fast lane, but not enjoying the ride? Are you in the driver's seat of your bus? This session will focus on rejuvenating your spirit and bringing more fulfillment into your life. O'Connor is an expert on self-empowerment, healthy decision-making, and stress-reduction. Her humorous insights will give you the tools you need for the 'ride of a lifetime!'

Thursday, May 8, 2003

12:00–1:00pm

Wellman Conference Room

For more information, call 726-6976.  
CEUs available for nurses

# Educational Offerings

May 1, 2003

When/Where	Description	Contact Hours
May 9 and 19 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
May 12 7:30–11:00am, 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
May 12 8:00am–4:30pm	<b>Heart Failure: Management Strategies in the New Millennium</b> O’Keeffe Auditorium	TBA
May 12 5:00–9:00pm	<b>Congenital Heart Disease</b> Haber Conference Room	4.5
May 14 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
May 14 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
May 15 8:00am–4:30pm	<b>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</b> Training Department, Charles River Plaza	8.1
May 15 7:00–11:00am; and 12:00–4:00pm	<b>Congenital Heart Disease</b> Haber Conference Room	4.5
May 15 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Ethical Dilemmas in Clinical Practice.” O’Keeffe Auditorium	1.2
May 15 10:00–11:30am	<b>Social Services Grand Rounds</b> “Treating the Clinical Triad: Eating Disorders, Sexual Abuse, and Substance Abuse.” For more information, call 724-9115.	CEUs for social workers only
May 19 8:00am–12:00pm	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> VBK 601-607	---
May 20 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
May 19 5:00–9:00pm	<b>Congenital Heart Disease</b> Haber Conference Room	4.5
May 21 1:30–2:30pm	<b>USA Educational Series</b> Bigelow 4 Amphitheater	---
May 22 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Recognizing Patients with Delirium.” O’Keeffe Auditorium	1.2
May 22 7:00–11:00am; and 12:00–4:00pm	<b>Congenital Heart Disease</b> Haber Conference Room	4.5
May 23 8:00am–4:30pm	<b>Wound Skin Care Update: 2003</b> O’Keeffe Auditorium	1.2
May 27 and 28 8:00am–4:30pm	<b>BLS Instructor Program</b> VBK601	---
May 27 8:00am–4:00pm	<b>Shock: an Overview</b> Beth Israel Deaconess Medical Center, Sherman Auditorium	TBA
May 28 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
June 3 8:00am–4:30pm	<b>Chemotherapy Consortium Core Program</b> Wolff Auditorium, NEMC	TBA

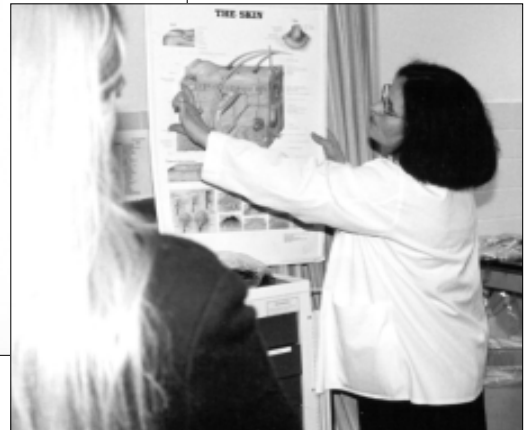
For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.  
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

## ConVal Regional High School students return to MGH

Students from ConVal Regional High School in Peterborough, New Hampshire, made their annual trek to MGH on March 21, 2003, to learn more about careers in health care. Their visit, coordinated by Julie Goldman, RN, clinical educator in The Center for Clinical & Professional Development, included presentations by representatives from Nursing, Radiology and Pharmacy; and tours of the operating rooms, the Cardiac Surgery Unit, Radiology, Pharmacy, Pathology, and the Burn Unit. Students had an opportunity to observe healthcare professionals at work and reinforce their interest in healthcare careers.



Above: Bigelow 13 staff nurse, Sally Morton, RN (left), gives ConVal Regional High School students a tour of the Burn Unit, explaining many of the highly specialized procedures and techniques used in caring for burn patients. At right: Morton explains the process of skin grafting.



# Caring

HEADLINES

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