September 18, 2003

Caring
HEADLINES

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Health Disparities Conference: a call to action

The topic was health-care disparities, but there was very little disparity in the message delivered by speaker after speaker at the Health Disparities Conference sponsored by the PCS Diversity Steering Committee on Friday, September 5, 2003. Despite a significant amount of work and education around diversity and culturally competent care, there is still a measurable gap in the quality of healthcare services provided to low-income and minority communities across the country and right here in our own state.

Senior vice president for Patient Care Services, Jeanette Ives Erickson, RN, set the stage by sharing a page from the American Hospital Association's report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." The report suggests that racial and ethnic disparities are caused by both patient-related and health-

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Deb Washington

Jarrett Barrios

Barbara Ferrer

Jeanette Ives Erickson

MGH Patient Care Services
Working together to shape the future

We got the call! MGH receives Magnet Hospital recognition

The American Nurses Credentialing Center had told us to expect the call at 11:00am Monday morning, so I was anxiously waiting by the phone. When the call came, the first thing Magnet commissioner, Linda Urden, said was, "Congratulations! MGH has just become the newest member of the Magnet Hospital family."

Needless to say, I was thrilled. I was proud. And I was enormously gratified that our long journey had resulted in MGH becoming the first hospital in Massachusetts to be recognized as a Magnet hospital. We are the 83rd hospital to receive this honor, which only 1% of all hospitals in the country have earned.

I immediately shared the news with MGH president, Peter Slavin, MD, who was overjoyed. He extends his congratulations to all members of the MGH community who worked so hard and who are so deserving of this recognition.

Most of you are familiar with the history and background of the Magnet hospital recognition program, but for those of you who aren't, let me briefly explain. The Magnet recognition program is the result of a research study conducted in the early 1980s that sought to determine the characteristics shared by hospitals that were able to attract and retain qualified nurses despite a national shortage. Hospitals that successfully attracted and retained nurses were called 'Magnet' hospitals.

Since formal inception of the Magnet program, Magnet recognition has come to mean much more than that. Studies comparing Magnet and non-Magnet hospitals show that Magnet hospitals:

- have a 4.6% lower mortality rate
- have a 60% lower morbidity rate among AIDS patients
- have higher patient safety scores (including fewer nosocomial infections, falls, and pressure ulcers)
- have improved safety in the workplace (including fewer needlestick injuries)
- have higher patient-satisfaction scores
- enjoy a higher nurse-retention rate with lower turnover rates and vacancies
- have shorter lengths of stay (including shorter and fewer ICU days)

This is important information for patients to have as they select and evaluate healthcare providers. Magnet hospital recognition tells patients that MGH is a place they can come for safe, high-quality patient care. And in the face of looming shortages, Magnet hospitals are better able to withstand national shortfalls in nursing and other healthcare professions.

Our journey was a long and rich one, made possible by the hard work of many people throughout the institution. We had the unwavering support of Peter Slavin and the entire executive team. We were buoyed by the enthusiasm and participation of all disciplines and clinicians within Patient Care Services. And we made excellent use of the inter-disciplinary teamwork that is the mainstay of patient care in every unit, setting, and service throughout MGH.

But there are a few individuals who deserve special thanks for the pivotal role they played in guiding our Magnet experience. I would like to take this opportunity to acknowledge the indispensible contributions of some of those key players:

- Marianne Ditomassi, RN, who co-chaired the Magnet Steering Committee and the Magnet Writer's Group
- Lori Clark Carson, RN, who co-chaired the Magnet Steering Committee
- Lauren Holm, RN, and Ed Coakley, RN, who provided seamless staff support
- Trish Gibbons, RN, and Keith Perleberg, RN, who co-chaired the Professional Development Workgroup

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Ives Erickson receives call from Magnet commissioner, Linda Urden, at 11:00am Monday, September 8, 2003, with news that MGH has just become the newest Magnet hospital.

Staff Perceptions of the Professional Practice Environment Survey

Question: What is the purpose of the Staff Perceptions of the Professional Practice Environment Survey?

Jeanette: The survey was developed to obtain feedback from staff about the practice environment at MGH. In order to enhance quality of care, it is important for staff to feel supported in their professional practice. The PCS leadership team uses survey responses to identify opportunities to improve the practice environment.

Question: Who participates in the survey?

Jeanette: The survey is sent to all direct care providers in Patient Care Services. Surveys will be mailed on September 30, 2003, and responses must be received by October 24th in order to be included in the final tabulation. As in past years, I'm looking forward to a high response rate.

Question: Does my participation really matter?

Jeanette: Absolutely. This survey is a reliable way for me to hear directly from staff about whether we have an environment that is supportive of your practice. And since the results are statistically tabulated, having a large sample size increases the validity of the findings. This is the fifth year we are conducting the survey. By comparing results from year to year, we can gauge if the environment of care is improving and identify opportunities for future improvement initiatives.

Question: Are there any changes in the survey this year?

Jeanette: Yes, a few important changes have been made, and I'm interested in hearing your thoughts.

- A few demographic-related questions have been added to help us better describe the sample of clinicians responding.
- A question has been added at the end of each section asking for your level of satisfaction. This will allow us to better measure the impact of each variable on personal satisfaction.
- On the introductory page you'll be asked if you want your comments to be shared, along with other people's general responses, with your department head (associate chief, department manager, etc.)
- A question has been added regarding on-line access to the survey. In the future we'd like to make the survey available electronically, and we want to get a sense of your interest in completing the survey on-line if confidentiality can be guaranteed.

Question: I noticed a number on my return envelope, and I'm concerned that my responses may not be confidential.

Jeanette: The number on the return envelope refers to the responder's cost center so that we can group data by department. There is no personal identification number and no way to link any response to an individual staff member. All results are completely confidential.

REMINDER!

The Staff Perceptions of the Professional Practice Environment Surveys must be returned by October 24, 2003.

If you have not received a survey, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are confidential. Please complete and return your survey by October 24th.

Your voice is important!

Call for Nominations

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

Nominations are now being accepted for The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award. The award was created to recognize clinicians within Patient Care Services whose practice exemplifies the expert application of values reflected in our vision. Staff nurses, occupational therapists, physical therapists, respiratory therapists, speech and language pathologists, social workers and chaplains are eligible.

The nomination process:

- Direct-care providers can nominate one another. Nurse managers, directors, clinical leaders, health professionals, patients and families can nominate direct-care provider.
- Those nominating can do so by completing a brief form, which will be available in each patient care area, in department offices, and at the Gray information desk.
- Nominations are due by October 2, 2003. Recipients will be selected in November.
- Nominees will receive a letter informing them of their nomination and requesting they submit a professional portfolio. Written materials on resume-writing, writing a clinical narrative, and securing endorsement letters will be enclosed.
- A review board including previous award recipients, administrators, and MGH volunteers will review the portfolios and select award recipients. The board will be chaired by Trish Gibbons, RN, director of The Center for Clinical & Professional Development.
- The award ceremony will be held on December 11, 2003.

Award and award-related activities

Award recipients will receive $1,500 to attend a professional conference or course of their choosing. They will be acknowledged at a reception of their peers and family members, and their names will be added to the plaque honoring previous Macaluso award recipients. Recipients will receive a crystal award from Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse.

For more information or assistance with the nomination process, please contact Mary Ellin Smith, RN, professional development coordinator, at 4-5801.

Finding the 'why' in what we do: *it's all about the research*

—submitted by the Nursing Research Committee; coordinated by Elise M. Gettings RN

The only prerequisites necessary to become involved in nursing research are an inquiring mind and an interest in finding ways to improve patient care. One of the most pivotal contributions a nurse makes is asking questions about the patient's experience, the patient's response to healthcare interventions, and whether those interventions are meeting the patient's needs. Nurses have the greatest opportunity to identify problems, observe patients' responses to treatment, and recognize patients' behavioral patterns.

Research plays an important role in health care. Nurses conduct research studies and review research literature to identify innovative strategies to customize care for each patient. Nursing decisions are based on evidence-based research. The Nursing Research Committee at MGH was established in 1997 as part of the collaborative governance structure. The PCS Nursing Research Committee is comprised of nurses from various units and settings from GI to OB, with varying levels of experience from novice to expert.

At its inception, the committee was charged with:

- fostering the spirit of inquiry around clinical practice
- supporting all nurses in the research utilization process
- promoting and communicating the results of institutional research
- encouraging and providing support for research-based practice at all nursing levels

The role of the staff nurse in research

Staff nurses play an important role in nursing research. The ideas and questions that foster research often come from the bedside. Who better to turn those ponderings into research than staff nurses? Many staff nurses at MGH have participated in and/or initiated research projects.

Robin Holloway, RN, staff nurse in the Pre Admission Testing Area, has been involved in both data-collection and research that has been published here at MGH. Holloway says, "Being a researcher is a positive experience; it doesn't matter what part you play in it. It allows you to infuse research into your practice and that only improves the care provided at MGH."

Staff nurse, Heather Vallent, RN, collaborated on a research project that investigated the visiting preferences of patients and nurses on a general medical unit and an intensive care unit. Says Vallent, "It can be difficult to reach a consensus of opinion about visitation. You have to weigh what the patient wants against what the bedside nurse thinks is appropriate. Staff nurses provide great insight into these issues."

If you find yourself at the bedside thinking, "I wonder why?" or "How come?" you're already participating in nursing research.

Nursing Research Day

Did you ever wonder about the impact of your diabetic teaching, the life experience of people with implanted cardiac defibrillators, how to evaluate a new piece of equipment, or the side-effects of IV biphosphonate therapy for bone metastases?

On Nursing Research Day 2003, you may have seen these topics addressed in poster displays throughout the hospital. MGH nurses presented more than 40

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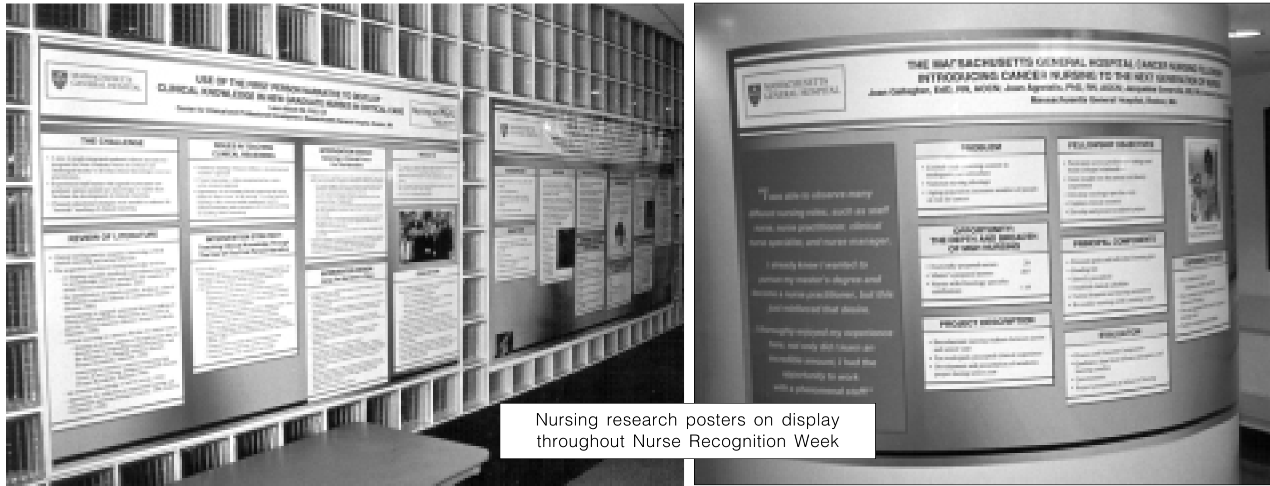
Members of the Nursing Research Committee (back row, l-r): Donna Tracey Plunkett, RN; Talli McCormick, RN; Robin Holloway, RN; Annmarie Hayes, RN; Mary Larkin, RN; Mary Lou Lyons, RN; Heather Vallent, RN; and Elise Gettings, RN. Front row: Susan Jaster, RN; Kathy Grinke, RN; Cathy Griffith, RN; and Diane Ladd, RN. (Not pictured: Ginger Capasso, RN; Mary Lou Kelleher, RN; and Donna Hills, RN)


Nursing research posters on display throughout Nurse Recognition Week

posters on a variety of topics from visiting in the ICU to caring for confused patients.

Each year, as part of Nurse Recognition Week, the Nursing Research Committee, in collaboration with the Center for Clinical & Professional Development, highlights the research projects of MGH nurses with poster displays and oral presentations. Typically, each year, a nationally known nurse researcher is invited to share his/her research findings with the MGH community.

Perhaps you want to start thinking about participating in Nursing Research Day 2004.

Did You Know...?

Before research evidence can be critically appraised, it needs to be seen. The Nursing Research Committee identifies simple and accessible ways to expose practicing clinicians to research findings. One such initiative is the *Did You Know...?* poster campaign. *Did You Know...?* poster inserts and handouts are disseminated across 65 departments throughout the organization. They are the product of interdisciplinary teamwork. Some topics covered in the *Did You Know...?* campaign include: "Accessing the source of research using computers and library services;" "Clinical practice;" and "The practice environment."

The *Did You Know...?* campaign encourages MGH nurses to develop, promote, and evaluate research utilization in their daily work. One poster author commented, "In putting it together I became more aware of the volume and quality of evidence."

The Nursing Research Committee archives all *Did You Know...?* information on their webpage for future reference and teaching purposes.

A quote from our newest member

Donna Tracey Plunkett, RN, staff nurse on the Endoscopy Unit, says, "Participating in clinical trials sparked my interest in other areas of nursing research. I believe nursing research offers an opportunity to increase nursing professionalism for the future and in the eyes of the community. I was asked by my nurse manager to represent the GI Endoscopy Unit on The Nursing Research Committee. I was excited to join the committee. I became a member in January, 2003. After only a few meetings the exceptional level of devotion, camaraderie, and professionalism became clear to me. I noted right away the number of advance-practice clinicians and realized this would not be like participating on other committees. The accomplishments of this committee have been profound, from coordinating Nursing Research Day, to the *Did You Know...?* poster campaign, to founding the Journal Club. I still find myself overwhelmed by the possibilities avail-

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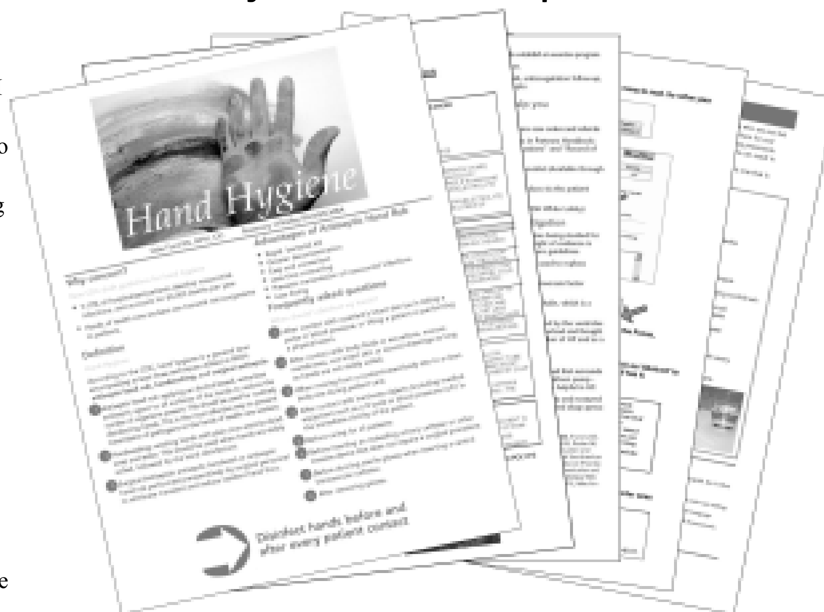
Did you Know...? posters



It's All About the Research

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able to me through this group. I'm not sure what project I'll join. But I do know I'll find support and encouragement from my nursing colleagues on the committee."

The Journal Club

The Nursing Research Committee is developing a Journal Club to acknowledge and discuss new research within the practice of nursing. The focus of the Journal Club will be dialoguing about how to incorporate nursing research into our practice with the goal of improving clinical outcomes. The Journal Club will provide an opportunity for nurses to meet regularly to review current nursing research, gain experience in evaluating the scientific merit of the research, and assess the clinical relevance of research for their practice.

Our hope is that the Journal Club will cultivate an environment that fosters critical thinking and scientific inquiry. The collaborative forum will provide an opportunity to analyze, synthesize, and integrate study findings into every day practice.

The Nursing Research Committee will invite MGH nurse researchers to present the findings of their research at Journal Club meetings. This spotlight on expert researchers will give participants an opportunity to meet and share experiences.

The first meeting of the Journal Club will take place January 14, 2004, and the group will meet six times a year. Meetings are open to any nurse who shares the spirit of inquiry and intellectual curiosity that is the essence of nursing at MGH.

Upcoming conferences

In November, 2003, members of the Nursing Research Committee will present at the Sigma Theta Tau International Conference in Toronto. The presentation will focus on how the activities of the Nursing Research Committee foster mentoring and leadership development.

Members of the committee will present at the Mayo Symposium on Clinical Models and Innovations in Rochester, Minnesota. At this conference, our presentation will focus on the success of collaborative governance and the impact it's had on the larger organization. The achievements of our committee are the result of staff nurses practicing in an environment where everyone has a voice. The impact and success of our work is measured each year by the Staff Perception of the Professional Practice Environment Survey.

The Nursing Research Committee is committed to promoting the utilization of research by helping staff interpret and integrate research findings into their daily practice. For more information on the work of the Nursing Research Committee, visit our website at: http://pcsnis5.mgh.harvard.edu/CCPD/Nursing_Research/abt_research.asp.

New members welcome

The Nursing Research Committee meets on the first Friday of every month from 1:00–2:30pm. If you would like to sit in on a meeting, please contact co-chair, Kathy Grinke, or Cathy Griffith. An application for membership can be printed from the collaborative governance website at:

http://pcs.mgh.harvard.edu/ccpd/Collaborative_Governance/CG_Application.pdf

The research nurse practitioner

A new component of the nurse practitioner role is burgeoning—that of research nurse practitioner. Although nurses' involvement in research is not new, the expanded role of research nurse practitioner is growing. It combines clinical and investigative endeavors, creating opportunities for nurse practitioners to assume more principal-investigator responsibilities. The research nurse practitioner is a member of an inter-disciplinary team that provides care to patients and volunteers in a research setting. Principal duties are related to research and patient care.

Research nurse practitioners provide clinical expertise to the research staff in formulating research protocols, patient recruitment, protocol implementation, collaboration with the principal investigator, data-collection and management, and record-keeping and monitoring. The research nurse practitioner might assist in writing manuscripts, perform independent searches of literature, and present study findings to interested groups.

The patient-care responsibilities of research nurse practitioners parallel those of a nurse practitioner in a clinical setting with the delivery of competent, compassionate care. The research nurse practitioner helps ensure that participants have optimal medical care, health maintenance, and health education.

This new role allows nurses in advance-practice roles to gain first-hand experience in carrying research projects through to their completion. This valuable experience can lead to becoming a principle investigator of your own research questions.

If you're a nurse interested in research and an expanded role, don't forget about the field of clinical research.

—by Annmarie Hayes, RN,
research nurse practitioner

It's not brain surgery

—by Tom Quirk, vice president, The Brain Aneurysm Foundation

We've all heard that phrase tossed around. "It's not brain surgery." But when it comes to brain aneurysms, it routinely *is* brain surgery, and usually on an emergency basis.

An aneurysm is a bubble that forms in a weak spot on the side of a brain artery, very much like a balloon. Aneurysms tend to form where an artery divides. There are two types of aneurysms: ruptured and unruptured.

An unruptured aneurysm can be evaluated, and the medical options may range from ongoing observation to immediate surgery. A ruptured aneurysm is a catastrophic event that requires rapid medical intervention.

Fifty percent of people who experience a ruptured aneurysm die outright. Of those who survive, one third recover with some deficit, one third recover with substantial deficit, and one third require some form of institutional care.

Most people believe that aneurysms are a rare occurrence. Sadly, that is not the case. Approximately 2 million people in the US are living with unruptured aneurysms. It is believed that an aneurysmal rupture, also known as a subarachnoid hemorrhage, occurs in approximately 12 out of every 100,000 individuals.

When someone suffers a ruptured brain aneurysm, his/her life is changed forever. The degree of lifestyle alteration depends on the severity of the event, but in virtually every case it is significant. Assuming the average family is comprised of three to four members, the number of people directly impacted by an aneurysm is more than 100,000 per year.

Immediately following an aneurysm, the survivor, and often his/her spouse, is unable to re-enter the work force. Depending on medical insurance and other considerations, enormous financial burdens can be incurred. Often, a family's income is decreased by 25-50% in the first six months.

Following the crisis stage, there are usually many months of rehabilitative care, both inpatient and outpatient, including speech, cognitive, occupational, and physical therapy. This is a difficult time for the survivor and family alike. Often the survivor is able to participate in basic activities of daily life, but activities such as driving, household maintenance, or steady employment may not be possible. Those are responsibilities that must now be assumed by the caregiver(s), often at the expense of employment opportunities and other associated costs.

The emotional impact of brain aneurysms can be overwhelming for survivors, caregivers, and the whole family as independence and physical and emotional intimacy may be lost forever. Parent-child relationships can suffer as family members feel cheated or shortchanged. Many relationships don't survive.

Brain aneurysms form silently, often the result of wear and tear on the arteries. Heredity, injury, or infection, can cause an aneurysm. Smoking, alcohol, and the use of oral contraceptives, have all been associated with the development of aneurysms. Most people with unruptured aneurysms are completely asymptomatic, while others experience loss of sensation, dilated pupils, double vision, eye pain, and localized headaches. Ruptured aneurysm victims consistently report experiencing, "the worst headache of their lives," nausea and vomiting, stiff neck, blurred or double vision, a sensitivity to light, and loss of sensation.

At the present time, there is no known way to prevent brain aneurysms as the etiology is not clearly understood.

There are, however, many tools available to help detect aneurysms: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Computerized Tomography (CT); and Computerized Tomography Angiography (CTA). Early diagnosis is key. Detecting a brain aneurysm prior to rupture may allow it to be treated with substantially less risk.

Currently, there are two accepted treatment techniques for both ruptured and unruptured aneurysms: clipping and coiling. Clipping involves a surgical craniotomy and the microscopic placement of a titanium clip on the outside of the aneurysm. Coiling involves threading a catheter from the groin to the brain and passing a platinum wire through the catheter into the aneurysm itself. Both are very effective and routinely performed.

Research is currently being conducted to explore innovative new approaches to treating brain aneurysms. But until a viable 'cure' is found, public awareness

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Research is currently being conducted to explore innovative new approaches to treating brain aneurysms. But until a viable 'cure' is found, public awareness is the best approach.

Being an educated consumer, one who can act as an effective advocate, is the best way to ensure early diagnosis and appropriate care.

Some facts about brain aneurysms

- More than 30,000 subarachnoid hemorrhages occur annually in the United States resulting in 15,000 deaths at rupture; 5,000 survivors who live with some deficit; 5,000 survivors who live with serious deficit; and 5,000 survivors who are institutionalized for life.
- Breast cancer deaths are some 41,000 and prostate cancer is the cause of approximately 32,000 deaths annually. Total annual deaths from all aneurysms, cerebral, abdominal, and thoracic, are 32,000.

PATA nurse uses information, empathy, and alternative therapy to support patient and family

My name is Regis MacDonald and I am a staff nurse in the Pre-Admission Testing Area (PATA) where I've worked for the past three years. Patients visit the PATA anywhere from four weeks to one day prior to elective surgery. This is where they have pre-op blood testing, electrocardiograms, nursing assessments, anesthesia evaluations, and for some, a medical history and physical exam. It's an opportunity to teach and prepare patients and families for the peri-operative experience.

For many patients, the PATA is their first introduction to MGH. They arrive anxious and concerned, many having only recently heard they have a medical condition that warrants surgery, or perhaps they've received bad news about a recent diagnosis. As a PATA nurse I pride myself on my ability to assess my patients and families' needs and provide them with the guidance and support they need to have a positive hospital experience. Every patient's experience is unique; I'd like to share one experience that touched me in a special way.

I met Ms. D, a 45-year-old woman, one January morning a week before she was scheduled for cancer surgery. She and her husband were still in shock about the cancer diagnosis. Ms. D had lost 55 pounds on a weight-reduction diet and maintained a healthy weight for more than a year. She expressed concern that the weight loss may have contributed to her contracting cancer. I realized she needed more education about her disease process. I reviewed with both of them that current research shows a well balanced diet contributes to good health and that weight loss does not cause cancer. I emphasized that in times of crisis people sometimes look for something to blame their illness on, not understanding how it could have happened.

Ms. D and her husband told me they felt comfortable talking with me and asked if it was okay to ask more questions. Often, patients open up when they're alone with a nurse in the PATA and we pride ourselves on our ability to establish intimate relationships in a relatively short amount of time. I assured Mr. and Ms. D that we encourage questions. They asked: What would happen if it snowed on the day of surgery? Should her children come to the hospital? Where would Mr. D wait? How would Ms. D feel after surgery? Who decides if more treatment is necessary? I answered as many of their questions as I could and referred Ms. D to her surgeon for the questions I couldn't answer.

They were distressed to learn that the pathology report would take several days. I explained that a pathology exam is a series of checks and balances that requires careful review to ensure arriving at the correct diagnosis.

Both Mr. and Ms. D were concerned about their children, an 18-year-old son and a 14-year-old daughter. They felt their son was dealing with Ms. D's diagnosis in an appropriate manner, but their daughter was displaying a lot of anger at home and at school.

I drew on my experience and education to assist me. I had attended a lecture by child psychiatrist, Paula Rauch, who had discussed how adolescents can have a difficult time talking about the potentially life-threatening illness of a parent. Dr. Rauch explained that parents need to try to see things from their child's point of view. Children will often avoid eye contact and not verbalize their fears, but still have strong feelings. Rauch suggested that letter-writing was an effective way for parents to communicate with their children during illness because it takes away the 'burden' of face-to-face communication. Ms. D liked that idea and said she'd give it a try. She wrote a note to her daughter telling her she was sorry for being sick and that she'd do everything possible to get well.

Regis MacDonald, RN, staff nurse, PATA

I gave them a 'prescription' to the Blum Patient & Family Learning Center for literature on Ms. D's type of cancer. These educational prescriptions were developed by staff of the Patient & Family Learning Center and nurses in the PATA as a means of providing relevant information to patients and families. Nurses in the PATA indicate the type of surgery or diagnosis and patients bring their prescriptions to the Patient & Family Learning Center where they receive written information or view videos explaining the surgical procedure. This is a wonderful resource for patients and families. They can build on the education they receive in the PATA and find valuable resources available to assist them in preparing for the procedure.

Therapeutic Touch (TT) is one of many services we provide to patients in the PATA. Therapeutic Touch involves the practitioner 'scanning' the patient's energy field and smoothing out any disruptions to help relieve anxiety and pain. Having spent time with Ms. D, I knew she would benefit from TT. She mentioned that she'd had Reiki in the past and had found it helpful. I told her I'd visit her after her surgery.

I visited Ms. D on her first post-op day. She wasn't feeling well,

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Exemplar

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complaining of pain and nausea. And she was drowsy from the medications. I decided not to ask her any specific questions, but assist her in getting more comfortable. I proceeded with Therapeutic Touch, and she was able to fall right to sleep.

Three days later, Ms. D called to tell me she was still in the hospital and asked me to come visit her. When I entered her room, her husband and son were there waiting to take her home. Mr. D greeted me with a big hug and thanked me for everything I did. I was surprised because I didn't feel I'd done anything special. He told me their daughter had been thrilled to get the letter from her mother—it had reassured her that her mother understood her fears and concerns. He also reported that the information from the Patient & Family Learning Center had helped answer all their questions. Ms. D told me she remembered my giving her Therapeutic Touch and felt better when she woke up from her nap. They were still waiting for the final pathology report, but they had a positive outlook. I gave them my business card and told them they could contact me for any reason, even if they just needed to talk.

It's important to stress that I always visit my patients post-operatively if they request it. I'm always amazed at how happy patients are to see me when I visit them on the units. I am very lucky to be able to practice at this level, sharing these kinds of relationships with my patients.

As I walked away from Ms. D's room I felt a powerful sense of accomplishment at being able to help a patient and her family through this difficult time.

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

Many patients and families have an opportunity to visit the Pre-Admission Testing Area prior to surgery. This important pre-admission visit allows nurses to assess a patient's physical condition, provide educational support, discuss discharge planning, and determine what, if any, other needs the patient may have. Regis' interventions during this visit and after Ms. D was admitted contributed to a positive stay for this family. So often, it's the simple, 'human' interactions between patient and caregiver that make the biggest difference. Regis was fully present to Ms. D and her family, and her interactions certainly made a difference.

Thank-you, Regis.

National Depression Screeing Day

The Employee Assistance Program will offer free, anonymous, and confidential screenings to all MGH employees

Thursday, October 9, 2003

For information on times and locations, call the EAP office at 726-6976

Cuba Revisited

A special Latino-Hispanic Heritage Month presentation sponsored by The PCS Diversity Committee; AMMP; and the Multi-Cultural Affairs Office

Presenters:
Carmen Vega-Barachowitz, SLP; Donna Perry, RN
Oz Mondejar, Human Resources manager
and special guest, Senator Jarrett Barrios

Wednesday, September 24, 2003
2:30–3:30pm
O'Keeffe Auditorium
For more information, call 724-0340

Women's Wellness Fair

Please join the Women's Health Coordinating Council for the third annual Women's Wellness Fair

October 2, 2003
10:00am–2:00pm
Under the Bulfinch Tent

The theme for this year's fair is "Women's Health Across the Lifespan." Educational material will be available on general health and wellness, menopause, caring for your aging parents, cancer prevention, exercise, fertility and much more.
Refreshments will be served.

For more information, please contact Mary Ellen Heike at 724-8044.

Joint Commission Satellite Network Presentations

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

Substance abuse and withdrawal in the acute-care setting

September 22, 2003
8:00am–4:30pm
O'Keeffe Auditorium

Program will include information on the new
Alcohol Withdrawal Clinical Pathway

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

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

Contact hours will be awarded to nurses

Revisiting the roots of palliative care

—by Todd Hultman, RN, staff nurse, Ellison 14

In May, 2003, I traveled to London because more than a half century ago a little-known nurse named Cicely Saunders provided end-of-life care to a patient named David Tasma, a refugee from the Warsaw Ghetto. David was dying, and he wanted to experience a 'good death' on his own terms. The special nurse-patient relationship they shared led Saunders to create St. Christopher's Hospice in London.

Twice each year, St. Christopher's hosts a week-long Multi-Professional Programme for clinicians from around the world. In the programme I attended, participants came from 14 countries, spanning five continents, and included nurses, physicians, social workers, chaplains, and counselors.

I had heard of St. Christopher's and Cicely Saunders in many lectures at the MGH Institute of Health Professions, where I'm working toward my master's degree in Nursing. I applied to the programme because my work experience on Ellison 14 (Hematology/Oncology) had sparked an interest in palliative care and hospice.

Shortly after arriving in London, I visited the Florence Nightingale Museum, a small museum located on the grounds of St. Thomas Hospital. The exhibits told a compelling story of a woman who felt a spiritual calling to care for others. Nightingale persevered in developing Nursing as a credible profession at a time when such efforts were not widely valued. The concept of 'spiritual calling' became an ongoing theme in the week ahead as participants in the palliative care programme spoke often of their sense of privilege at caring for patients at the end of their lives.

Todd Hultman, RN, with staff nurse at St. Christopher's

I began my training experience at St. Christopher's with a series of 'ice-breaking' activities. In one activity, participants were divided according to professional discipline and asked to share the frustrations and aspirations they felt within their field of health care. I was struck by the similarities among nurses in terms of their hopes and dreams for the future of nursing. One British nurse actually said, "We're just like that Tina Turner song, we're 'simply the best!' " I had to laugh and share with them the relevance of that statement to nursing at MGH.

As the week unfolded, tutors presented on a broad range of topics related to hospice care, palliative care, and bereavement. All presentations reinforced the importance of teamwork and collaboration. All professionals, regardless of discipline, are seen as stakeholders in holistic patient care. For example, patient rounds included nurses, doctors, physical therapists, and when possible, social workers and chaplains.

One concept that came up frequently was the idea of 'total pain.'

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St. Christopher's Hospice in London

Palliative Care Revisited

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Total pain refers to how a patient experiences pain physically, psychologically, socially, spiritually, and culturally. In assessing and treating a patient's total pain, nurses are trained to consider all these components so that maximal relief can occur.

Another key concept was the idea of 'social death.' Social death is the progressive self-withdrawal that is often observed in patients receiving hospice care. I was struck by the number of patient lounges at St. Christopher's that had the look and feel of homey parlors. These lounges allowed patients to interact and participate in group work and expressive therapies.

On an outpatient basis, social death was addressed in the Day Centre, a nursing-directed intervention geared to the psychosocial needs of patients who would otherwise isolate themselves at home. Hospice patients are transported by volunteers to the Day Centre, where they can participate in a wide range of expressive activities, receive physical therapy, or various other massage therapies.

Two important topics I was happy to see covered were family-centered care and sexuality in hospice. Palliative care is regarded as a proactive intervention for families regarding bereavement and grief. Issues of physical intimacy are addressed with patients, spouses, and partners as part of planning for the patient's comfort. When possible, interventions are developed to facilitate physical intimacy.

We also had the opportunity to speak with Dr. Saunders herself, endearingly referred to as Dame Cicely. Sitting in a room with Dame Cicely is like sitting in the presence of a steam locomotive. A robust woman in her eighties who still keeps regular work hours, she spoke of her personal history, of her relationship with David Tasma, and of her spiritual calling to hospice care. She shared that she had traveled to Boston to learn how dying patients are cared for in the United States.

Tutors at St. Christopher's believe that the Multi-Professional Programme is like casting pebbles into a lake. They have no control over the direction or distance the ripples take. They only know that the stones have been thrown.

The week ended with sadness and excitement. Excitement at renewing my motivation to pursue my interests in hospice and palliative care; and sadness at saying good-bye to a remarkable group of people. I know the connections I formed with other participants will continue for many years to come.

Ives Erickson

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- Jackie Somerville, RN, and Marie LeBlanc, RN, who co-chaired the Professional Practice Workgroup
- Dawn Tenney, RN, and Sally Millar, RN, who co-chaired the Knowledge Management Workgroup
- Theresa Gallivan, RN, and Judy Newell, RN, who co-chaired the Interdisciplinary Workgroup
- Chris Graf, RN, who co-chaired the Writer's Group with Marianne Ditomassi
- Debra Burke, RN, and Brian French, RN, who co-chaired the Champion Development Team
- All the members and staff support of all the workgroups and committees
- All 177 staff nurse champions who communicated our Magnet message to units throughout the hospital
- Negui Gomez and Jess Beahman for their support in formatting the written evidence

We all share this well-deserved honor; I hope you are as proud and thrilled as I am. Thank-you.

Update

I'm pleased to announce that Taryn Pittman, RN, has assumed management responsibilities for the Blum Patient & Family Learning Center. Taryn has been a member of the PFLC team since its inception. In her new role, she will be responsible for the day-to-day operations of the PFLC, working closely with patients, staff, volunteers, and consumers.

Get REAL!

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

Have you ever wanted to do something about it?

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

For more information, e-mail: peaceout@quik.com or rhorr@partners.org

POPPS Fair 2003

The departments of Police & Security, Outside Services, and Photography invite you to attend this year's Crime Prevention and Safety Fair

Thursday, September 25, 2003
11:00am–3:00pm
On the Bulfinch Terrace

The theme of this year's fair will be, "Protecting You in a Changing World," and will include demonstrations, displays, and educational booths featuring information on crime-prevention, safety tips for all age groups, and Internet safety.

The department of Photography will present demonstrations on location photography, framing, and poster printing, and will display entries in the 6th Annual Photo Contest.

Representatives from the MGH Safety Department, the Employee Assistance Program, HAVEN, and the MassGeneral Hospital *for* Children will be on hand to discuss their programs.

Free raffle!

For more information, contact Carolyn White of Police & Security, at 4-3030.

Health Disparities

continued from front page

care system-related factors, including:
Patient-related factors:
- socioeconomic differences
- health-education differences
- health-behavior differences

Healthcare system-related factors:
- cultural competence differences
- language differences
- discrimination
- workforce diversity differences
- payment/reimbursement differences for treating Medicare, Medicaid and uninsured patients
- insurance coverage differences
- data deficiencies

State Senator, Jarrett Barrios, spoke of health disparities from the perspective of public health policy and environmental considerations. Said Barrios, "I see disparities in health care as a civil rights issue as much as a legislative and social problem. Low income, minority, and immigrant communities are more likely to suffer from illness and disease as a result of environmental factors. Urban, industrial communities are more likely to have contaminants in their air, in their water, and in their soil. And violence is more prevalent in poorer communities. All of these factors impact social, psychological, and physical well-being."

Barrios mentioned two bills currently under consideration in the Massachusetts Senate, which address these issues. They are Senate Bill #1190 (The Clean and Healthy Communities Act) and Senate Bill #495 (An Act to Reduce Disparities in Disease Outcomes Through Improved Prevention, Detection, and Treatment for Uninsured Residents).

Barrios was followed by Barbara Ferrer, deputy director of the Boston Public Health Commission, who spoke candidly about the effect of racism on health disparities. After sharing some startling statistics on the incidence rates of diseases such as asthma, diabetes, infant mortality, and heart disease among African American versus white communities, Ferrer defined racism as, "Any type of action or attitude, individual or institutional, that prescribes and legitimizes a minority group's subordination by claiming that the minority group is biogenetically or culturally inferior."

> **"If racism was constructed, it can be undone. It can be undone if people understand when it was constructed, why it was constructed, how it functions, and how it is maintained."**
>
> **— from the People's Institute for Survival and Beyond**

Ferrer spoke about the legacy of slavery, discrimination, social stress, and the impact these phenomena have on physical health.

But perhaps the most important observation shared by Ferrer was this quote from the People's Institute for Survival and Beyond: "If racism was constructed, it can be undone. It can be undone if people understand when it was construct-

continued on next page

Panelists at the Disparities in Healthcare Conference are (l-r): Oz Mondejar; Ligaya Castillo, RN; Carmen Vega-Barachowitz, SLP; Ivonny Niles, RN; May Ling, RN; Ellen Forman, LICSW; and Margaret Brown, RN.

Health Disparities

continued from front page

ed, why it was constructed, how it functions, and how it is maintained."

As a strategy to eliminate health disparities, Ferrer suggested building community partnerships, promoting an anti-racist work environment, and re-aligning activities to address racism. "If we are to eliminate health disparities," said Ferrer, "it's going to require a commitment to social justice; a willingness to ask questions and listen to answers; community and institutional leadership who will tackle racism; and a willingness to commit resources to anti-racism work."

The morning ended with a discussion of health disparities by a panel of representatives from a variety of multi-cultural associations and affiliations. Panelists were:

- Margaret Brown, RN (New England Regional Black Nurses Association)
- Ligaya Castillo, RN (Philippine Nurses Association of New England)
- Ellen Forman, LICSW (MGH Social Services)
- May Ling, RN (Chinese American Nurses Association)
- Oz Mondejar (Massachusetts Governor's Commission on Employment of People with Disabilities; and MGH Human Resources)
- Ivonny Niles, RN (on behalf of foreign-born nurses seeking licensure in the US)
- Carmen Vega-Barachowitz, SLP (MGH Speech-Language Pathology)

Some of the 'talking points' that came out of the panel discussion included:

- Healthcare providers need to go that extra mile to reach out to people beyond providing patient care.
- We cannot make judgements and assumptions based on physical appearance.
- We can help resolve healthcare disparities through education, enlightenment, and a sharing of experiences.
- If we are not delivering culturally competent care to all our patients, we are not doing our jobs.
- Society's failure to address social and civil-rights inequities disproportionately impacts low-income and minority communities.
- We need to understand that every patient faces unique physical and environmental challenges and adapt our care to meet each person's needs.

Said Deborah Washington, RN, director of the PCS Diversity Program and conference moderator, "We've heard many important observations today; we've heard testimony about the shortcomings of the health-care delivery system to meet the needs of low-income and minority patients. Our job now is to formulate a plan of attack; to identify the changes we can make today, and make them. To identify the actions we can take today, and take them."

Disparities in health care has been identified as a new priority for the PCS Diversity Steering Committee. For more information, or to participate in this important work, contact Deb Washington at 4-7469.

It's Not Brain Surgery

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is the best approach. Being an educated consumer, one who can act as an effective advocate, is the best way to ensure early diagnosis and appropriate care.

The Brain Aneurysm Foundation was established to, "provide support networks and educational resources to raise public awareness regarding early detection and treatment of brain aneurysms." It was established in 1994 by Christopher Ogilvy, MD, Deidre Buckley, RN, and a brain aneurysm survivor. The foundation's Board of Directors is comprised of medical professionals, survivors, and family members of survivors. The foundation recently published the educational pamphlets, "An Introduction to Brain Aneurysms and Their Treatment," "Recovering from Brain Aneurysm Surgery," and "A Guide for the Endovascular Therapy Patient." In May, 2003, the foundation released two new videos: "Unruptured Aneurysms: The Arterial Challenge," and "Ruptured Aneurysms: What Now?"

The old saying, "Forewarned, is forearmed," is especially true when talking about brain aneurysms. Advocacy on your own behalf, or on behalf of a loved one, is essential.

Brain Aneurysm Awareness Week is September 15–19, 2003. The foundation is sponsoring a symposium on Thursday, September 18th from 6:30–9:30pm. For more information about brain aneurysms, the Brain Aneurysm Foundation, or the Brain Aneurysm Symposium, call 723-3870, or visit the website: www.bafound.org.

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

Next Publication Date:
October 2, 2003

A staff nurse perspective on pain management

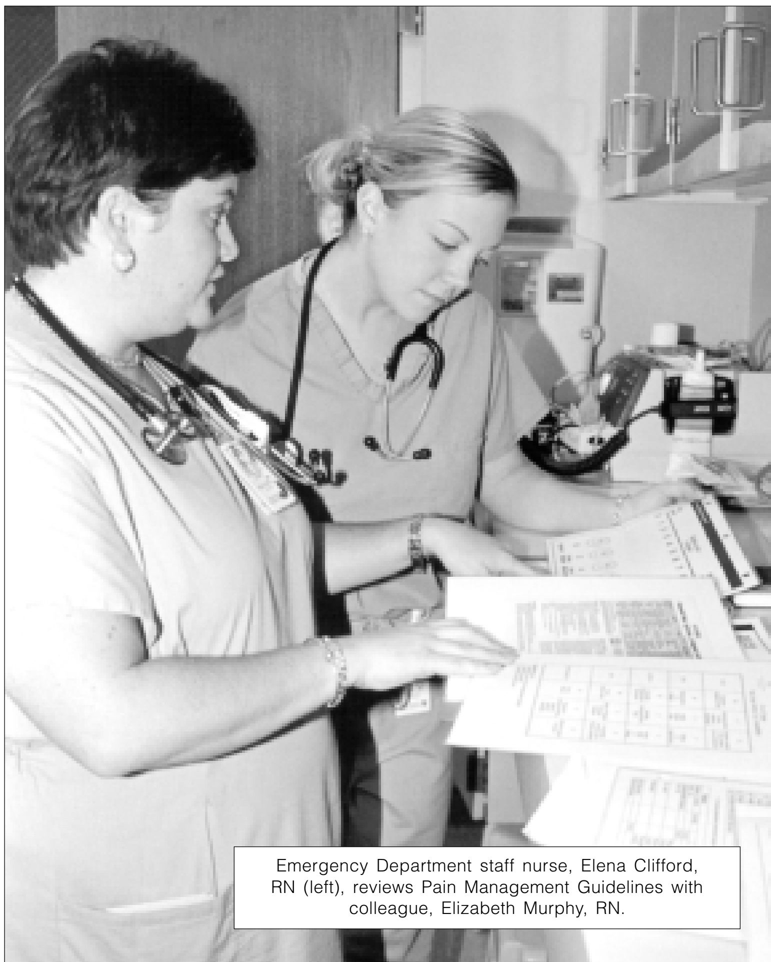
—by Elena Clifford, RN, staff nurse, Emergency Department

My pain mentor once told me, "If you lay hands on a patient, you are a pain nurse." A few months ago, my nurse manager asked me to become the ED representative to the Pain Task Force.

Patient Care Services' Pain Task Force is a panel of individuals from various disciplines who have come together to help promote pain awareness throughout MGH and its satellite facilities. The task force recognizes that pain-management is a multi-disciplinary responsibility and so includes representatives from Nursing, Pharmacy, and Physical and Occupational Therapy.

As a staff nurse, I'm able to give my perspective on how bedside clinicians observe pain and how the new Pain Assessment and Management Policy and Pain Assessment and Management Guidelines affect our practice and documentation.

As a member of the Pain Task Force, I helped develop the new Pain Assessment and Management Guidelines that were recently approved by the Nursing Practice Committee. The guidelines were written broadly enough to be adapted to any setting, discipline, or patient population. The new policy and guidelines are included in the Pain Resource Manual that has been provided by the task force to every patient care unit. The manual will soon be available on-line.



Emergency Department staff nurse, Elena Clifford, RN (left), reviews Pain Management Guidelines with colleague, Elizabeth Murphy, RN.

Prior to working in the Emergency Department, I practiced for several years in an outpatient pain center. When I came to MGH, I was one of the first to participate in the Pain Champions course offered by MGH Cares About Pain Relief.

Many of my ER colleagues knew of my background and asked me to collaborate with them when caring for patients with chronic pain issues. We worked together to develop a plan of care with the Emergency Department team and the patient.

In my experience, I have observed that patients go to the Emergency Department primarily because of pain—chest pain, abdominal pain, headaches, backaches, broken bones, etc. I see my colleagues treat pain not only with medicine, but with care and compassion. On the Pain Task Force, I work with colleagues committed to improving pain-assessment and pain-management in all patients, in all services, and in all settings.

Pain-assessment and pain-management are evolving practices, as new ways are developed to assess and treat pain. The new guidelines help clinicians recognize when a patient is experiencing pain (assessment), how to communicate with the team about pain (documentation), and how to treat pain appropriately (management).

Every individual, from neonates to geriatric patients, experience and express pain differently. There are tools to help clinicians assess pain in patients of all ages.

Opioids are not the only treatments for pain. There are a number of adjunctive therapies and non-pharmacological treatments (pet therapy, Therapeutic Touch, acupuncture, distraction, etc.) These are all acceptable methods of managing pain and should be used and documented as appropriate for each patient.

I am currently working with individuals and groups of clinicians in the ED to help implement the new Pain Assessment and Management Policy and Guidelines. Together with other pain champions, we are working to improve the care and treatment of patients with pain in the ED.

We can all strive to become pain champions.

Educational Offerings

When/Where	Description	Contact Hours
September 26 8:00am–4:30pm	**MGH School of Nursing Alumni Homecoming Program** O'Keeffe Auditorium	TBA
September 26 12:00–1:00pm	**Complicated End-of-Life Decision-Making** Walcott Conference Room	- - -
October 1 8:00am–3:00pm	**Management of the Burn Patient** Bigelow 13 Conference Room	6.9
October 2 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
October 2 3:00–7:00pm	**Congenital Heart Disease** Haber Conference Room	4.5
October 3 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
October 3 8:00am–4:30pm	**A Diabetic Odyssey** O'Keeffe Auditorium	TBA
October 6 8:00am–4:30pm	**Basic Trauma Nursing** O'Keeffe Auditorium	TBA
October 8 8:00am–4:30pm	**Caregiver Skills** Training Department, Charles River Plaza	7.2
October 8 1:00–3:00pm	**Health Literacy Program** Haber Conference Room	TBA
October 8 1:30–2:30pm	**OA/PCA/USA Connections** "TBD." Bigelow 4 Amphitheater	- - -
October 9 8:00–11:30am	**Intermediate Arrhythmias** VBK 607	3.9
October 9 12:15–4:30pm	**Pacing: Advanced Concepts** Haber Conference Room	4.5
October 10 and October 16 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
October 15 1:30–2:30pm	**USA Educational Series** "Work-Related Injuries." Bigelow 4 Amphitheater	- - -
October 16 1:30–2:30pm	**Nursing Grand Rounds** "New Nursing Graduate Critical Care Program." O'Keeffe Auditorium	1.2
October 16 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Realizing the Vision: Effective Leadership." Haber Conference Room	- - -
October 17 8:00am–4:00pm	**CCRN Review Day I** O'Keeffe Auditorium	TBA
October 17 7:00–11:am and 12:00–4:00pm	**Congenital Heart Disease** Haber Conference Room	4.5
October 20 8:00am–12:00pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Wellman Conference Room	---
October 21 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
October 21 8:00am–4:00pm	**Intermediate Respiratory Care** Bigelow 9 Conference Room	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.

Clinical Recognition Program

Clinicians recognized June–August 2003

Advanced Clinicians

- Elizabeth Kelley, RN, SDSU
- Denise Young, RN, Blake 7
- Karen Kelly, RN, SDSU
- Marilyn Wise, LICSW, Social Work
- Regis MacDonald, RN, PATA
- Steven Mason, RRT, Respiratory Therapy
- Nancy Aguilar, RN, Ellison 4 SICU

Clinical Scholars

- Bernadette Reilly-Smorawski, RN, Ellison 3 NICU
- Cuartor F. Wynne, RN, Blake 13/14
- Debra Whitaker, RN, Blake 6

As of September 1, 2003, 42 clinicians havebeen recognized as advanced clinicians; 19 clinicians have been recognized as clinical scholars.

The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

"Women and Depression"

Presented by Adele Viguera, MD

Clinical depression affects mood, mind, body, and behavior. Research conducted by the National Institute of Mental Health has shown that in the US, approximately 19 million people experience depression each year.

Unrecognized depression continues to cause unnecessary suffering, and women experience depression at roughly twice the rate of men. This session will address the unique causes and factors contributing to depression in the lives of women today.

Wednesday, October 8, 2003
12:00–1:00pm
Clinics Amphitheater

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

Golden Pen Award recipients

The following staff nurses received Golden Pens in the new program that acknowledges staff nurses for exemplary documentation:

PICU: Brenda Black, Cristin Carroll, Andrea DeSantis, Pat Fallon, Dawn McLaughlin, Eleanor McLaughlin, Francoise Mereus-Blaise and
Ellison 6: Kathleen Rogers and Kathleen Woods
Phillips 21: Bonnie Filicicchia and Andrea Hansen
Blake 11: Debboray Scannell and Patrycja Zielinska
Blake 14: Dana Alison
Dialysis: Bonnie Eidens and Mary Ann Maloy
Bigelow 11: Katie Horne, Kerri Kazarian, Stephanie Michaels, and Amy Stys
White 10: Carol Wicker

Once a month, one Golden Pen recipient is randomly selected to receive a $50 American Express gift certificate. This month, the gift certificate went to Kerstin Korpi of the NICU.

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