

Caring

April 1, 2004

HEADLINES

MGH volunteers, ACCESO, reaching out to the people of Cuba

—by Donna Perry, RN, coordinator
International Nurse Consultant Program

building Community through
Exchange, Support and Outreach).
The organization is co-chaired by
Oswald (Oz) Mondejar, Human

Resources manager; Senator Jarrett Barrios; and myself. For one week in February, Oz and I, along with Steve Gardner, MD, went to
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It was our second trip to Cuba, the fourth for Boston-based, humanitarian organization, ACCESO (Americans and Cubans



Children with hearing and visual impairments after performing at the Cienfuegos Library in Cuba

MGH Patient Care Services
Working together to shape the future

Patient-centeredness: an interview with Susan Edgman-Levitan

Continuing our discussion on patient-centered care, I thought it would be helpful to invite Susan Edgman-Levitan, PA, executive director of the John D. Stoeckle Center for Primary Care Innovation at MGH to talk with us. Susan is a lecturer, researcher, author, and one of the country's most outspoken advocates for patient- and family-centered care and informed healthcare decision-making.

Jeanette: Susan, thank you for speaking with us. I wonder if you'd tell us a little about the work of the Stoeckle Center?

Susan: Sure. The Stoeckle Center is devoted to improving the experience of primary care for patients, families, and clinicians in adult and pediatric practices. We evaluate educational programs, tools, and interventions to identify effective ways to involve patients and families in

shared decision-making to improve the delivery of care for everyone.

Jeanette: What do you think is responsible for this renewed interest in patient-centered care across the country?

Susan: I think it's the result of three things. First, clinicians and senior leaders are recognizing that patient-centered care, as defined in *Crossing the Quality Chasm*, is an integral part of safe, high-quality, clinical care, something we all strive for. There is an interest in regaining a balance between compassion and caring and the high-tech curative advances at our disposal. Second, a number of national initiatives are seeking more accountability for, and transparency of, quality data. These initiatives will ultimately result in the routine reporting of quality measures to the public. More than 1,600

hospitals are participating in the National Quality Initiative, a partnership of several national organizations, including CMS, AHRQ, the AHA, JCAHO, and the National Quality Forum. Many of the participating hospitals, including MGH, are piloting the CAHPS survey that measures the dimensions of patient-centered care. And third, people have greater access to clinical information and higher expectations of what their care experience should be.

Jeanette: What is the biggest factor affecting patient-centered care?

Susan: There are many. But certainly one of the most important is effective communication. We have an obligation to provide our patients and their families with the information they need to make informed decisions about their care. When patients have questions about surgery, medications, diagnostic and treatment options, and screening tests, they need evidence-based information to help make the best choice for them.

Research on variation in care by Al Mulley here at MGH and Jack Wennberg of Dartmouth tells us there is tremendous variation in care across the country, driven primarily by provider choice, not patients' values and preferences. We need effective, easy-to-implement strategies to



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

help patients understand the risks and benefits of their options and whether or not those options are consistent with their values.

Jeanette: How do we build a culture of patient-centeredness?

Susan: It's important to realize that this work isn't going to happen overnight. It requires time, resources, strong leadership, and a sustained commitment to listen to our patients.

Time and time again we see that supporting patients involves supporting staff as well. When clinicians and others don't have the resources or systems in place to help them do their job well, they and their patients suffer. It's not a coincidence that hospitals providing the best patient-centered care are often the hospitals with the highest staff satisfaction.

I think creating a culture of patient-centeredness means hiring good people; putting systems in place that

make it easy for staff to do the right thing; providing consistent training for all role groups; and clearly delineating each role group's responsibilities.

A good way for managers to think about patient-centeredness is this: If you're not providing direct care to patients, then your job is to support the people who are. If you're not supporting staff, then staff can't support patients.

Training is another key issue. To create an environment where patient-centeredness is at the core of the hospital experience, training needs to extend beyond the 'nuts-and-bolts,' task-oriented responsibilities of each role group. All employees play a part in patient care, however removed from the bedside they may be. Training needs to reflect that philosophy at all levels.

Involving patients and families in the redesign of care is essential. Solutions we craft ourselves are often ex-

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Nursing Career Expo

PCS Human Resources is presenting a Nursing Career Expo. Invite your friends and colleagues to learn more about staff nurse (new grad and experienced), clinical nurse specialist, nurse manager, and surgical technologist opportunities at MGH.

**Sunday, April 4, 2004
12:00-3:00pm
North and East Garden Dining Rooms**

For more information, contact Sarah Welch at 617-726-5593 or e-mail shwelch@partners.org

Oxygen tank management: what you should know

Question: How are oxygen tanks managed/delivered to patient care units?

Jeanette: Materials Management provides par-level assessment of oxygen tanks on all inpatient units seven days a week. Outpatient units are serviced Monday through Friday. Materials Management handles more than 2,000 E-cylinder oxygen tanks each week.

When staff need additional E-cylinder tanks, they should call 6-8204. For emergency requests, staff should call Materials Management Oxygen Tank Delivery at pager number 3-3316.

Question: Do E-cylinders need to be stored in special containers?

Jeanette: Yes. Not only do Department of Public Health and JCAHO regulations require special storage of oxygen tanks, but unsecured cylinders can be very dangerous. Over-turned cylinders can result in gas leaks and other potential safety risks. Cylinders should be kept in carriers on wheelchairs and stretchers, in free-standing cylinder carriers, or in designated small E-cylinder containers located in clean equipment rooms.

Question: How do I know how long a particular cylinder will provide oxygen for my patient?

Jeanette: A full E-size cylinder contains (conservatively) about 450 liters of oxygen. A cylinder is full when the pressure gauge on the regulator reads close to 2,000psi (pounds per square inch). If a patient requires three liters of oxygen per minute, oxygen will last for approximately 150 minutes. If a patient requires ten liters per minute, oxygen will last approximately 45

minutes. Ideally, only full cylinders should be used when transporting a patient regardless of the flow rate required by the patient. Refer to the chart posted in clean equipment rooms for information on how long cylinders last.

Question: How do you set the flow rate on E-cylinder regulators?

Jeanette: Regulators used at MGH only allow specific flow rates to be delivered. The rate is indicated by the number visible in the window on the regulator. The full number should be visible in the window, and you should be able to hear a click as the flow is changed from one setting to

another. If the regulator is set between numbers, no flow will be delivered.

Question: What should you do if a regulator malfunctions?

Jeanette: Immediately report the problem by calling Materials Management at 6-8204 and attach an equipment problem tag to the regulator. Tagged cylinders should be left in their containers in the clean equipment room. A representative from Materials Management will pick up the malfunctioning regulators and cylinders. Equipment problem tags are available by calling 6-2274.

Jeanette Ives Erickson

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pensive to implement and unrelated to what patients tell us they need. Focus groups, surveys, and letters from patients are a rich source of information to guide our work. Patient and family advisory councils, such as the ones we have at MGH (in Pediatrics and the Cancer Center) are the most effective mechanisms for consistently incorporating patients' perspectives into the re-design of care.

Jeanette: What are some of the techniques you use to teach patient-centeredness?

Susan: One of my favorites is something we call a 'walk-through.' If you

have never been a patient, you have a very different understanding of what patients need. To help caregivers fully appreciate the patient's perspective, we ask managers and clinicians to do a walk-through of their particular care setting—to experience every aspect of care as if they were a patient.

One medical group in the Mid West had some of their doctors do a walk-through that included calling ahead to make an appointment at their own clinic (something they had never done before). They were shocked to hear a recorded message with numerous options (all directed at other doc-

tors) before hearing anything of relevance to their patients.

We often find that patients and caregivers are bothered by the same things. Fixing systems makes everyone happier.

Jeanette: Susan, thank-you so much for sharing this information with us. I know we'll be hearing more from you as we begin to re-design our own systems.

Susan: It's my pleasure. I'm happy to see such a strong commitment to patient-centeredness throughout MGH.

Update

I am pleased to announce that Erin Cox, RN, has accepted the position of clinical nurse specialist on Bigelow 14, effective May 3, 2004.

Safeguard your identity against theft

Did you know that:

- identity theft is one of the fastest growing crimes in the country?
- criminals steal billions of dollars every year with stolen identities?
- if your identity is stolen it could take years to clear your name and credit rating?
- in some cases the only way to rectify the problem is to apply for a new Social Security number?
- at least 50 MGH employees have been a victim of identity theft in the past 12 months?

Do you know how to protect your identity?

Do you know how to spot the signs that your identity has been stolen? Come to: "Safeguard your identity against theft," presented by Bonnie Michelman, director of Police & Security and Outside Services; and members of the Special Investigative Unit.

Thursday, April 8, 2004

1:00-2:00pm

Wellman Conference Room

For more information, call 6-2121

Reaching Out to the People of Cuba

continued from front cover

Cuba to continue relationship-building and to deliver much-needed books, medical supplies, and disability equipment.

A new stop on our itinerary this year was the Chernobyl Children's Project. In 1990, Cuba established a center to treat children, some of who are now second and third generations of people affected by the nuclear accident in Chernobyl. The center treats children with leukemia, tumors, and other health problems. More than 22,000 children have been treated at the Chernobyl Children's Project to

date. Most children are accompanied by a parent. The typical stay is approximately 45 days but can last as long as a year.

Cuba is a land of striking contrasts. A lack of material goods is immediately apparent. But at the same time, a wealth of human dignity is in great supply. If a society can be judged by how it cares for its weakest members, then the Cuban people are an inspiration to us all. Their kindness and generosity were witnessed at many of the places we visited, such as the Cienfuegos Library and the School for

Children with Physical Limitations. In both places, we were struck by the resilient spirit of the children who, despite significant physical limitations, burst forth in joyous song.

who had given birth to twin babies, prematurely, at 32 weeks. The babies were now a month old, and I noticed the twins were being cared for in separate bassinets. I asked the nurse if they were

their separation anxiety as they transition into the world. The NICU nurses had never heard of the technique and were very excited to try it. (When I returned to MGH, I sent the nurses at Cienfuegos Hospital several articles describing the benefits of co-bedding twins.)

I became particularly aware of the warmth of the Cuban people when I fell into a ditch one day while walking in Trinidad. Within seconds a half dozen people were at my side ready to help. Despite the fact that I was a total stranger, they surrounded me like family and helped me up with great care. One elderly woman touched the scrape on my knee and

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One of the most important goals of ACCESO is to bring Cubans and Americans together in an effort to increase mutual understanding. This work is more important today than ever before.

We were able to share our practice with a number of Cuban nurses during a visit to the Cienfuegos Hospital. While touring the Neonatal Intensive Care Unit (NICU), we met a young mother

aware of the 'co-bedding' approach. Co-bedding is a practice used extensively in hospitals in the United States. It involves keeping twins together in the same bed right after birth to ease

Donna Perry, RN (left), Oz Mondejar, (center back, partially obscured), tour guide, Jesús Noguera Ravelo (to the right of Mondejar), and Steve Gardner, MD (to the right of Noguera Ravelo), with children at the Chernobyl Children's Project (wearing MGH baseball caps)



Reaching Out to the People of Cuba

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offered advice on how to care for it.

We had the opportunity to visit Saint Lazarus Leprosarium (a center dedicated to the care of patients with leprosy). None of us had ever seen or cared for patients with leprosy before. We met with Dr. Roberto Hernandez, vice-director of the center, who informed us they had approximately 120 patients at the leprosarium and more than 10,000 people in Cuba who suffer from leprosy. Leprosy is a chronic infectious disease caused by mycobacterium leprae. It is treated with a multi-drug regimen for one year. Dr. Hernandez told us that once patients begin treatment they are not considered infectious. While at the leprosarium, we toured a women's dormitory. The room was sparse, but immaculate. It resembled an Army field hospital from World War II—metal-framed beds with only a few personal belongings on each nightstand. As I walked down the row of beds, I saw an image I'll never forget. Hunched over in a chair was the motionless form of an old woman. She was covered in layers of cloth. As we approached, a nurse removed the cloth covering her head and revealed a face etched with deep lines and scars. She was blind. Her rec-

ords indicated that she was 98 years old, but the nurse said they thought she was older than that. She had lived at the leprosarium for many years. When the cloth was removed, the woman lifted her head gently, like a figure in a music box, and began to sing in Spanish. Translating, the nurse told us she was singing:

Where are the angels?
Where are the angels
this morning?
They have gone to tend
the sick.

One of the most important goals of ACCESO is to bring Cubans and Americans together in an effort to increase mutual

understanding. This work is more important today than ever before. As the director of the Museum of Afro-Cuban History in the town of Regla reminded us, "The most important thing is that we all are brothers and sisters. At this historic time for our people, your presence here is vital. The relationship between Cubans and Americans is very deep. Even before the United States existed; before the Republic of Cuba existed, our people were linked; it is a very deep friendship. People may be different on the outside, but what is inside is the same. We can understand each other."

All of us who went to Cuba as part of the ACCESO delegation observed that special bond between the Cuban



98-year-old resident of the Saint Lazarus Leprosarium

and American people. As it is when any two cultures come together, there are beautiful faces to be discovered and

great inspiration to be found. Like the woman in the Leprosarium, we need only reach out and look beneath the cloth.



Nurse, mother, and twin babies in the NICU at Cienfuegos Hospital in Cuba

Veteran oncology nurse brings spiritual dimension to bedside care

My name is Esther O'Dette, and I am an oncology nurse on Ellison 14, the Medical Hematology-Oncology-Bone Marrow Transplant Unit. I have worked as a nurse at MGH for 30 years, and I've been an oncology nurse for more than 19 years. I'm also a spiritual caregiver, which enables me, through continuous training in Clinical Pastoral Education, to meet my patients and their families' spiritual and emotional needs. I've learned that spiritual well-being has a positive effect on people coping with life-threatening illness.

'Justin' was a 23-year-old young man who had been diagnosed with Hodgkin's disease. I was introduced to Justin and his family when he was admitted to Ellison 14 for a bone marrow transplant. He had suffered an MI while receiving GCSF (a treatment to increase white blood cells) in preparation for his transplant, and also had a factor V (blood) deficiency. Justin had a rocky hospital course, which included severe chest pain during his first day of conditioning with Cytosan. His post-transplant course continued to be a roller-coaster ride with frequent nausea and vomiting, dystonic reaction from medications, mucositis,

and a high level of anxiety. During his hospitalization, I developed a close relationship to Justin, his family, and his girlfriend.

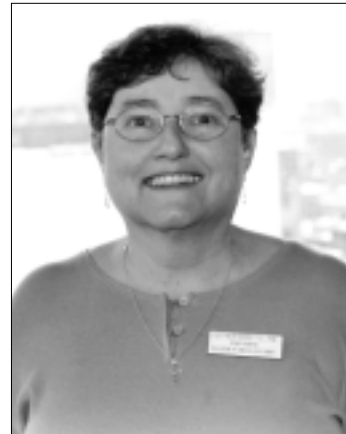
Justin and his girlfriend, Sue, had gone to New York for the weekend despite the fact that he was developing a cold. Their weekend was cut short when Justin's cough became worse and he became increasingly short of breath. On Sunday evening he was admitted to our unit and within a few hours he went into respiratory failure, was intubated, and admitted to the CCU. While on the unit, he underwent a bronchoscopy and an open-lung biopsy, which appeared to show signs of a fungal infection. Because of the relationship I had developed with the family, I along with several other of Justin's caregivers, frequently visited him in the CCU. Although Justin was intubated and sedated, I talked to him, explaining what was happening and reassuring him. I continued to be positive and pray with him. I also spent time listening to the concerns of his parents, their fears about losing their son, and their questioning of their faith in God.

A short time later, Justin was extubated and transferred back to Ellison 14. I'll never forget

that day and his reaction as he was brought into his room. His eyes were closed. As we transferred him into bed I said, "Hey Justin, it's Esther. You're back on Ellison 14, your home away from home."

He opened his eyes and gave me the biggest grin from ear to ear. It's that smile that I'll never forget. Though he could only whisper, his expression and body language said it all.

After a quick assessment, I realized my work was cut out for me. Justin had a chest tube, was receiving oxygen, and had IVs going into a central line placed in his neck. His oxygen saturation was between 94 and 100% if he remained calm and didn't move. With movement, his oxygen level would drop, his anxiety level would rise, and the cycle would begin. The higher his anxiety, the harder it would be for him to breathe, so I needed to keep him calm and relaxed to manage his respiratory status. I did this by speaking to him in a soothing voice while I rubbed his arm. I spoke to him about the fear he must be feeling at not being able to catch his breath. I used some meditation techniques that helped relax him and, in turn, helped his breathing. He didn't like wearing the oxygen mask, but at times it was neces-



Esther O'Dette, RN
staff nurse, Ellison 14

sary. Nebulizer treatments had been ordered, so I gave him those along with ativan and morphine when needed.

Unfortunately, Justin's course became rocky again when his chest tube was removed only to have it be reinserted the next day. The chest tube couldn't be removed because his lung was unable to maintain expansion without it. Justin became angry and frustrated. He wanted so much to get out of bed and move around his room, but each time we tried, his oxygen level dropped and his anxiety increased. With the help of Respiratory Care, it was decided to use a non-rebreather mask when Justin attempted any type of movement. I helped him to meditate when he tried to move, and this together with the mask helped decrease his anxiety level. After a few days, he was able to sit in a chair for short periods of time.

When his parents weren't present, Justin

and I would talk about a variety of things. He asked questions like, "Why is this happening to me?" or, "Will I ever get better?" He would say, "Esther, I can't live like this. I'm twenty-three years old. Will there ever be a time when I don't need oxygen?" And then he would cry. I always tried to meet him where he was and listen as he tried to understand what was happening to him. He was scared, but his strong faith kept him going. His mom and dad had a difficult time. Dad wouldn't always show his feelings, but I could sense his fear. Mom was very anxious and clung to the slightest improvement, which was important as it gave her hope.

There were many days when I would go home exhausted. It was difficult to watch Justin as his respiratory status worsened. I have two sons about Justin's age, and when I saw them I would think of Justin and what he should be

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Exemplar

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doing instead of lying in a hospital bed dying. I have strong faith, but that doesn't mean I don't struggle to understand why something like this happens.

One night, in a departure from their usual routine, neither of Justin's parents stayed with him. They allowed his girlfriend, Sue, to stay instead. This was a difficult decision for Justin's mother. Justin had a difficult time breathing that night, even with the non-rebreather mask, and there was only slight improvement by morning.

Justin was put on 70% high-flow oxygen. His doctor spent time explaining what was happening and told him there was a possibility he'd need to be intubated again. When the doctor left, Sue went to Justin and held him, they both had tears in their eyes. They were 23 years old, and their life together was going be cut short. I hugged them both and cried with them. Then I gave them some time alone. Instinct told me this might be one of their last opportunities to share their thoughts with each other.

When I returned a short time later, I spent time with them as they shared their fears and

frustrations. I was in awe to find such strength in these two young people. I held their hands and we prayed together. In my prayer, I mentioned all the things they had shared with me; this let them know I heard what they had said to me. My care at this moment became the 'silent sound of love,' which is the basis of my caregiving.

One of our MGH chaplains, who had followed Justin since his stay in the ICU, came in a few minutes later and spoke about the things we had discussed. We all prayed together. Justin was intubated in the next 24 hours and transferred to the ICU. During his stay in the ICU, Justin's mom and dad made many visits back to Ellison 14. We talked, and I supported them in their decision-making. I was never too busy to spend time with them. I had built a strong relationship with them as Justin's primary nurse and spiritual caregiver. They needed someone to listen, someone who understood their feelings, and I was able to provide that.

One evening, Justin's father came back to the unit and looked like he was 'coming apart at the seams.' He was crying and shaking. The pain in his eyes said it all. I invited him to sit at the nurses' station. Meg, another nurse on our unit, and I held his hand and talked to him. He was holding a telephone book, as he had just finished calling his family to ask them to come to the hospital. His fears had come true. Nothing else could be done for Justin. He was dying.

Justin's father asked if we would come to the ICU to be with them. Our colleagues immediately covered our patient assignments, and we went to be with Justin and his family. I spent time quietly talking to Justin, telling him that he would always be in my heart, and I would never forget him. I spent time with each member of the family, hugging them and crying with them.

Justin died surrounded by family members, his girlfriend, and sev-

eral nurses from Ellison 14. I went to his funeral and helped celebrate his life. This is what oncology nursing is to me—caring for the whole person: body, mind, and spirit. And my care isn't only for the patient, it's for the family, too.

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

The clinical and spiritual care Esther provided to Justin and his family was seamless. She managed his complex medical condition while at the same time meeting his and his family's need for spiritual guidance and emotional support. She used meditation and physical contact to calm Justin during periods of high anxiety.

It is a testament to Esther's exceptional care that Justin's family requested she and her colleagues be present for his death. What a difference Esther made in the lives of this family at a time of personal crisis.

Thank-you, Esther.

The Employee Assistance Program presents

Working and Breast-Feeding

presented by

Germaine Lamberge, RN

This presentation will provide expectant and nursing parents with basic information on how to use breast pumps and continue nursing while working. Session will include a tour of the MGH Mother's Corner.

**Tuesday, April 20, 2004
12:00–1:00pm, VBK 401**

For more information, contact the EAP at 726-6976.

The Annual Pain Relief Champions Course

A wide range of pain-related topics will be discussed. Participants will gain knowledge and skill in pain assessment and management and be prepared to be agents for improved care in their own work settings.

Part 1: Monday, April 26, 2004 **Part 2: Tuesday, May 18, 2004**
Wellman Conference Room **Walcott Conference Room**
7:30am–4:30pm **7:30am–4:30pm**

(Attendance on both days is encouraged)
Nursing contact hours and CMEs are available
Clinicians from all disciplines are welcome

For more information, contact Tom Quinn at 726-0746,
PainRelief@Partners.org, or <http://www.massgeneral.org/>

April is Occupational Therapy Month

Occupational Therapy is hosting two educational events focusing on cognition, vision, physical limitations, and how these factors relate to home safety and safety in the community. Information will also be provided on joint protection, arthritis, and ergonomics. Come visit the OT educational booth:

**April 19 and 23, 2004
11:00am–1:00pm
Main Corridor**

For more information, call 4-0125

Bridging faith traditions

—by Karen Schmidt, oncology chaplain

Every month, a group of Clinical Pastoral Education (CPE) alumni gather in the Chaplaincy Department for a special time of sharing, support, and learning. We are a group of social workers, nurses, physicians, and chaplains

from various faith traditions who have participated in the MGH Clinical Pastoral Education program under the direction of Reverend Mary Martha Thiel, who facilitates this gathering. Each time we meet, one member presents a topic to share with the group.

It's a wonderful way to witness how other caregivers have integrated spirituality into their practice and exchange ideas of spiritual caregiving.

Last winter, I gave a presentation on Parish Nursing. Having been a parish nurse in my UCC parish for three years, I had recently introduced the Prayer Shawl Ministry to my church. I explained how members of the congregation knitted prayer shawls for people in the community who were going through difficult times. Woven into the shawls are prayers of love, comfort, and healing for the person who'll be receiving the shawl.

Knitting a prayer

shawl is a ministry of love and compassion for the greater community and the world. It's a means of expressing the steadfast presence of the One we call Holy in our lives: whether it be God, Allah, Spirit, Sophia, Wisdom, Abba, Amma. Historically, we noted, prayer shawls come from the long and rich Jewish tradition.

Upon completing my presentation, alumni member, Rabbi Leslie Tannenwald, informed the group that she was in the process of preparing a group of five women at her temple in Chelsea for their Bat Mitzvah celebration in the spring. These women, most of whom were in their 70s, had missed out on the opportunity to have a Bat Mitzvah when they

were young, and now deeply desired to experience this coming-of-age celebration as adults. Leslie shared that the women were concerned that they couldn't afford a *tallit*, or Jewish prayer shawl, which is a special part of the Bat Mitzvah ceremony. Well, you can see where this is going...

With enthusiasm and excitement, members of the CPE group—Catholic, Protestant, and Jewish—decided to honor these women by knitting their tallitot. Many of our group had never knitted before, but learning became part of the fun! Under the direction of Rabbi Leslie and myself, needles, yarn and tzitit (fringe) kits were purchased, and a pattern was created. Terry Holbrook, RN; Mary Kraft,

MD; Sandra McLaughlin, LICSW; Mary Martha Thiel; Susan Warshal, RN, Rabbi Leslie and I set forth on our ministry of tallitot knitting.

Learning the significance of the Jewish prayer shawl was interesting to those of us from other faith backgrounds. In particular, the tying of the fringe, or

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Above: Reverend Mary Martha Thiel (left), facilitator of the MGH Clinical Pastoral Education program, is pictured with shawl recipient, Sara Lee Saievetz Callahan.

At right: Karen Schmidt, oncology chaplain (left), stands with Rabbi Leslie Tannenwald (right) and her mom, shawl recipient, Barbara Keiter.



Bridging Faith Traditions

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tzitit, at the four corners of the shawl was most intriguing and fun! And knitted through the strands of each shawl were blessings of hope, joy, peace and love.

On Saturday, June 7, 2003, we gathered at Temple Emman-

uel to celebrate the communal Bat Mitzvah of our shawl recipients and present these women with their tallitots. With Rabbi Tannenwald presiding, a prayer shawl was draped over the shoulders of each woman by the person who knitted it while the

following blessing was read:

May G-d's Grace be on This Shawl...

Warming, Comforting, En-folding and Embracing.

May This Mantle Be a Safe Haven...

A Sacred Place of Security and Well-Being,

Sustaining and Embracing You

In Good Times as well as Difficult Ones.

May You Be Cradled in Hope, Kept in Joy,

Graced with Peace,

And Wrapped in Love.

Amen.

A beautiful ceremony, the Bat Mitzvah celebration was a testament of interfaith solidarity, bridging faith traditions, and uniting people through a ministry of outreach, love, and care.

The Employee Assistance Program

presents

Training for Managers and Supervisors

Learn how the Employee Assistance Program can help with behavioral health, mental health, and substance-abuse concerns. Join us for a presentation that will include case studies and discussion.

Tuesday, May 4, 2004

3:30-5:00pm

Burr Conference Room 5

For more information, contact the EAP at 726-6976.

Susan and Arthur Durante Award for Exemplary Care and Service with Cancer Patients

The Durante Award recognizes (non-physician) clinicians, support staff, and leadership whose work with cancer patients reflects compassion and caring, exemplary performance, and outstanding work.

Two recipients are chosen; each receives \$1000 to be used to promote personal relaxation/respice.

Nomination forms are available on patient care units, at Cancer Center information desks, and in the Cancer Resource Room on Cox 1.

Completed nomination forms are due by Friday, April 9, 2004.

For more information or assistance with the nomination process, contact Julie Goldman at (617) 724-2295, or e-mail: jgoldman2@partners.org

Getting Started in a Nursing Career

The Nursing Career Ladder Initiative at MGH is hosting a Getting Started in a Nursing Career workshop.

Thursday, April 15, 2004

11:30am-12:30pm

in the Ether Dome

The session will answer many of the questions young people have when considering a career in nursing. Speakers will provide insight into the nursing profession, career opportunities, entry points for nurses, licensing and educational requirements, and information to help you determine if nursing is the right career for you.

The session is open to all MGH employees. For more information, contact Training & Workforce Development at 6-2230, or call Julie Goldman, RN, in The Center for Clinical & Professional Development at 4-2295.

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April is National Donate Life Month:

legislative initiatives change the landscape of organ donation

—submitted by the New England Organ Bank

During the month of April, hospitals and communities across the country observe National Donate Life Month to raise awareness around the critical need for organ and tissue donation. The need for transplantable organs and tissues is increasing at a rapid rate, and the need far exceeds availability. In an effort to reverse this imbalance and make the decision to donate more meaningful, states across the country are adopting measures to make it easier to become a donor and to recognize the right of individuals to have their decision honored.

More than half the states in the country have created donor registries, or computerized lists of people who have indicated their desire to be organ and tissue donors. In most cases, the lists are maintained by the state's department of Motor Vehicles and can be easily accessed by organ procurement organizations (like the New England Organ Bank) when someone dies.

Many states are combining registries with donor rights legislation. Donor rights legislation recognizes the right of an

individual to make the decision to donate without fear of having that decision overridden by surviving next of kin.

Massachusetts and Vermont are currently considering adding donor rights to their existing donor registry statutes; Rhode Island and Maine have adopted (and will soon implement) legislation that incorporates both registry and donor rights; and Connecticut and New Hampshire are studying the possibility of adopting both. It is hoped that within the next few years, donation decisions will be made predominantly by donors themselves rather than their next-of-kin.

As these changes take effect in our communities, hospitals play a critical role in alleviating the donor shortage. Hospitals are the first to identify and refer potential donors to organ procurement organizations. They provide a valuable service to their communities by ensuring that the wishes of those who want to donate are carried out.

2003 was a notable year for organ donation in the area, reports executive director of the New England Organ Bank (NEOB), Richard

S. Luskin. The organ bank recovered a record 649 transplantable organs, up from 637 in 2001. Says Luskin, "This good-news story is the direct result of the generosity of hundreds of donor families who said yes to donorship even as they grieved the loss of their own loved-ones. On behalf of many grateful recipients, we thank these families for their life-saving decisions."

Despite the continued generosity of many donor families, a shortage of donated organs continues. More than 83,000 people are currently on the national transplant list, and approximately 17 of those patients will die every day while waiting for a transplant.

NEOB is the federally-designated organ procurement organization for New England (Maine, New Hampshire, Rhode Island, portions of Vermont, Massachusetts, Connecticut) and Bermuda.

For more information on organ and tissue donation and how to obtain a donor card, please call the New England Organ Bank at 1-800-446-6362 or visit their website at www.neob.org.

Common myths about organ and tissue donation

Myth: You don't need to tell your family about your desire to be a donor because you've already signed a donor card, registered with the DMV, or affixed a sticker to your license.

Fact: In cases where a donor card or other indication of your desire to donate cannot be located, your family and/or next-of-kin will be asked to consent before any organs or tissues can be recovered. Telling your family of your desire to be a donor is the best way to ensure that your wishes will be carried out.

Myth: It would cost money to donate.

Fact: Organ and tissue donation is completely free. A donor's family incurs no charges for donation.

Myth: Donating organs and tissue is against your religion.

Fact: All mainstream organized religions support donation. It is typically considered a generous act and a personal choice of the individual.

Myth: Doctors may let you die if they know you're an organ donor so they can transplant your organs to others.

Fact: The medical team treating you is separate from the transplant team, and every effort

is made to save a person's life regardless of their intent to donate.

Myth: If you donate, your body will be mutilated; you won't be able to have a funeral; and your family won't be able to see you again to say good-bye.

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

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

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

Myth: You're too old to donate.

Fact: Strict age requirements for organ and tissue donation no longer exist. Medical professionals decide on a case-by-case basis which organs and/or tissues are suitable for transplantation.

Educational Offerings

April 1, 2004

When/Where	Description	Contact Hours
April 12 8:00am–4:30pm	Diversity in Childbearing O’Keeffe Auditorium	7.8
April 13 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
April 14 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
April 14 1:30–2:30pm	OA/PCA/USA Connections “I Speak Another Language; Can I Interpret?” Bigelow 4 Amphitheater	---
April 14 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
April 14 12:15–4:30pm	Pacing: Advanced Concepts Haber Conference Room	4.5
April 14 11:00am–12:00pm	Nursing Grand Rounds “Organ and Tissue Donation.” Sweet Conference Room GRB 432	1.2
April 15 1:00–2:30pm	The Joint Commission Satellite Network presents: “Infection Control: Reducing Risk and Preparing for Emerging Pathogens.” Haber Conference Room	---
April 16 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
April 16 8:00am–4:30pm	Heart Failure: Management Strategies O’Keeffe Auditorium	TBA
April 20 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
April 21 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
April 21 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements Clinics 262	1.8
April 22 1:30–2:30pm	Nursing Grand Rounds “Quality Improvement Update and Case Review.” O’Keeffe Auditorium	1.2
April 22 7:30–11:30am; or 12:30–4:30pm	Congenital Heart Disease Haber Conference Room	4.5
April 26 and 27 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: BMC; Day 2: VBK601	14.4 for completing both days
April 26 and May 18 7:30am–4:30pm	Pain Relief Champion Class Day 1: Wellman Conference Room; Day 2: Walcott Conference Room	TBA
April 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
April 30 8:00am–4:30pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
May 4, 6, 11, 13, 24 and June 1 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program NEBH	44.8 for completing all six days
May 6 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---

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>.

Safety in Motion: an update

—by Susan Kilroy, RN, and Marion Phipps, RN

In March of 1993, the Safety in Motion Committee, an interdisciplinary team charged with improving patient transportation throughout the hospital, reported on some of its preliminary work. The goal of the committee is to create a safe and efficient system for transporting patients from clinical units for testing and/or procedures, with an emphasis on improved communication between settings.

The committee's initial analysis revealed a high level of complexity and a broad scope of factors affecting patient transportation. In bi-weekly meetings, we began to set priorities

and divide our work into phases. We are happy to report that implementation of Phase I will begin on May 1, 2004.

A major task of the committee was determining what information should be passed on with the patient to receiving sites. Consultation between nursing staff and staff at testing sites helped pinpoint the need for communication of the following patient information at the time of transfer:

- precautions
- safety/fall risk
- primary language
- allergies
- life-sustaining treatment order
- medications
- vital signs

- current nursing assessment and patient condition

We considered the following questions:

- Can we modify an existing communication tool?
- Do we need to develop a new tool?
- Can we work with the systems already in place?
- How can we do this without reinventing the wheel?

After much discussion and debate, the committee agreed to use information currently found in the patient record or bedside book, rather than create a new tool. We agreed that nurses would write a brief note describing the patient's con-

dition prior to transfer. We needed, however, to consolidate this information, so that it would be readily accessible to staff at receiving sites. Some information, such as life-sustaining treatment orders, can already be found at the front of the patient record. Medication administration records and vital-sign sheets are located in the bedside book. Allergies are posted on the front of the patient record, as are precautions. So the decision was made to enclose the bedside book inside the cover of the patient record and send it along with the patient to the testing site.

A trial, or pilot, of this change was initiated on four clinical units. After a brief period of observation, learning from experience, and some simple ingenuity, the new system began to work smoothly. A sug-

gestion was made to secure the bedside book inside the record with an elastic band, which further improved the process.

Following the trials, focus groups were held with clinical staff, and feedback from these sessions identified more opportunities for improvement.

Prior to the May 1st implementation date, all clinical units and testing sites will receive educational posters describing the changes. Department leaders have been briefed on the changes and will receive written information to review with staff. Ongoing evaluation will be an important part of this project, and updates will be provided as other changes are identified.

For more information on the Safety in Motion initiative, contact Susan Kilroy at 4-2374, or Marion Phipps at 6-5298

Caring

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