February 19, 2004

Caring HEADLINES

Inside:

One year after the Rhode Island fire, the healing continues

—introduction by MaryLiz Bilodeau, RN
clinical nurse specialist, Bigelow 13 Burn Unit

For most people, February 20, 2003, was just another day. But for the individuals impacted by the Station nightclub fire in West Warwick, Rhode Island, it was a day that changed their lives forever. One hundred people died in that fire, hundreds of others were injured, and many of those died in the days and weeks that followed.

Even before the fire was fully extinguished, many of the most severely burned patients were transported to MGH for life-saving care and treatment. Shriners Burns Hospital accepted adult patients for the first time ever. The entire MGH community rallied to provide aid and comfort to critically injured patients and their families.

Fourteen patients were admitted to MGH that day. Four have passed away. Ten have been

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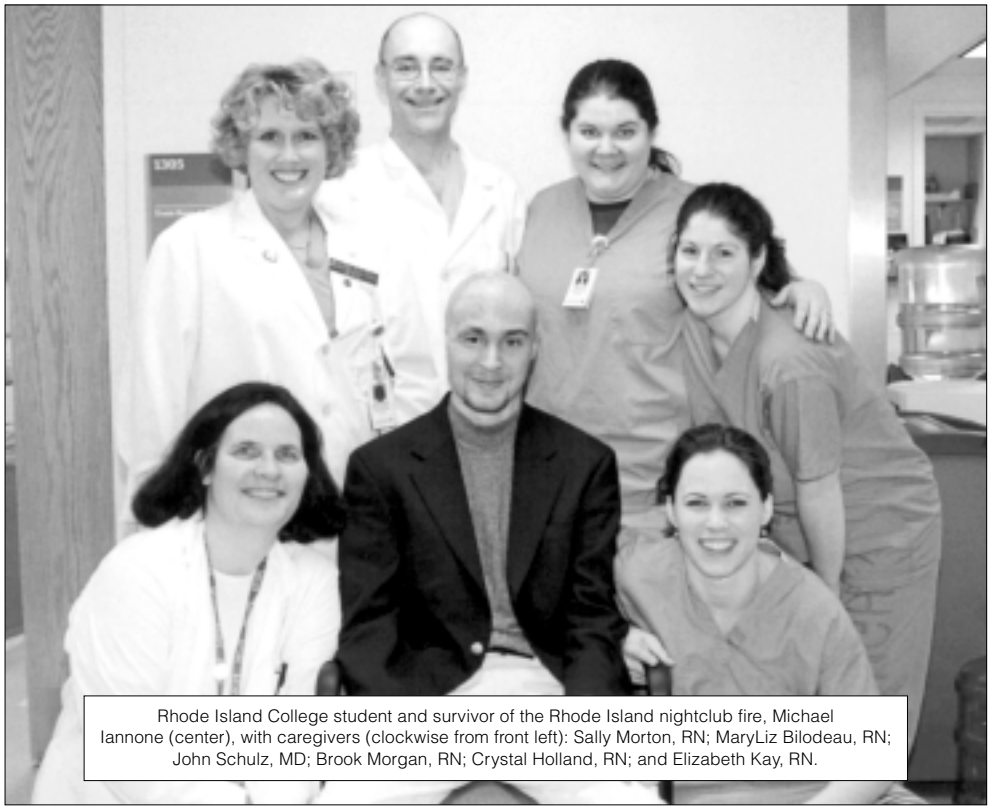

Rhode Island College student and survivor of the Rhode Island nightclub fire, Michael Iannone (center), with caregivers (clockwise from front left): Sally Morton, RN; MaryLiz Bilodeau, RN; John Schulz, MD; Brook Morgan, RN; Crystal Holland, RN; and Elizabeth Kay, RN.

MGH Patient Care Services
Working together to shape the future

Advocacy goes beyond the walls of MGH

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

As caregivers, healthcare administrators and support staff, we all know the importance of advocacy. We have come to think of advocacy primarily in terms of ensuring the best, most appropriate care for our patients, speaking up on their behalf, protecting their rights, their health, and their safety. But recently, I've come to think of advocacy in a larger context. I've come to think of advocacy, not only as it occurs inside the walls of this hospital, but as an important tool in shaping the environment beyond the boundaries of MGH. Like everything else, health care does not exist in a vacuum. We are dependent and inter-dependent on numerous other organizations, policies, people, and external forces that are often, but not always, out of our control. That's why it's important for law-makers, leaders of industry, and the general public to understand what healthcare providers do.

I've started to devote a significant amount of time and energy to informing legislators and the public about the work we do and the issues we face. And to my surprise, I've found opportunities to advocate for our professions in some very unlikely places.

In November, I added my voice to those of many other Boston leaders who were calling for more affordable housing in the city. Certainly, this isn't the typical venue where you would expect to find a nurse. But as I said, health care does not exist in a vacuum, and as it turns out, affordable housing is an issue that very much impacts MGH.

Recruitment and retention are among our top priorities. Through a variety of creative programs and incentives, we maintain a low vacancy rate, but not all factors affecting recruitment and retention are internal. We are constantly challenged by the high costs of parking, commuting into the city, and living within a reasonable distance of the hospital.

Affordable housing affects health care. If qualified healthcare workers can't afford to live in areas close to where they work, it affects our ability to hire and retain them. Affordable housing presents a challenge for hundreds of residents and interns who train at MGH every year, and for support staff who work in dietary, maintenance and administrative jobs.

Affordable housing is needed in communities all across the state, and it needs to be added in a way that revitalizes urban areas, respects the integrity of existing neighborhoods, and preserves the environment and open spaces that we have left.

I learned a valuable lesson from my involvement in this issue: it's not necessarily a bad thing to be the 'surprise guest' at a party. Housing issues generally attract housing advocates. But my presence brought a new dimension to the conversation, and it reinforced the vital role we play in the community.

I've already had an opportunity to apply this lesson to other issues. Dr. Slavin, Dr. Torchiana, and I have been to the State House on several occasions to discuss nursing staffing ratios and the implications they would have on hospitals and caregivers. We're finding that legislators are eager to hear our input and have the benefit of our experience.

We recently hosted State Representative, Peter Koutoujian, House Chairman of the Joint Health Care Committee who sat with nurses from different units and services throughout the hospital. We had an opportunity to describe to him the tools and strategies we employ to ensure safe staffing levels at MGH.

We need to identify more opportunities to add our voice to the broader issues affecting health care. In recent years, budget cuts have eaten away at the healthcare delivery system leaving many individuals without health coverage and healthcare providers without reimbursement for necessary services. Another round of state budget cuts is on the horizon. We must get involved. Our message must be heard.

In the coming months we'll be implementing a new on-line advocacy function. A user-friendly program will allow you to access the latest news, provide information on whom to call or write, and offer sample letters on which to base your own message. This is an exciting new feature and one that will make it easier to add our voice to the public debate over issues affecting health care.

Update

I'm pleased to announce that Susan Murphy, RN, has accepted the position of inpatient nurse practitioner for Thoracic and GI Oncology, effective immediately.

The Employee Assistance Program
presents

Training for Managers and Supervisors

If you spend 80% of your time dealing with 20% of your employees, you might benefit from this training. 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.

Pinning Ceremony acknowledges resiliency and the African American experience

The theme of this year's African American Pinning Ceremony, held Monday, February 2, 2004, was resiliency. And judging from the testimonials and introductions offered by the *pinners*, it seems each *pinnee* was more than deserving.

Honored this year, were: Michelle Anderson, RN, White 7; Angelleen Peters-Lewis, RN, Blake 4; David Miller, PCA, Phillips 20 (not present for ceremony); Ines Jackson-Williams, RN, Same Day Surgical Unit; and Christine Williams, RN, Ellison 19. They were pinned, respectively by: Deb Washington, RN, director of PCS Diversity; Mary Williams, RN, Bigelow 13; Joy Williams, RN, Vascular Radiology; and Gwenn Mitchell, LPN, of the Gillette Center for Women's Cancer.

In her introductory remarks, (Joy) Williams said of (Ines) Jackson-Williams, "She is a nurse who is admired and respected by many. She is a nurse who demands only the best of herself and others. She is a nurse whom I strive to be like in so many ways. She is my friend, my sister."

Capping off the ceremony that included a slide-show, the music of the George Russell Trio, and a tribute to Black History Month, was a special award presentation to Ruth Dempsey, RN, for her invaluable work as a teacher and mentor over the years. Said Deb Washington, "Ruth's name kept coming up as we discussed potential pinning recipients. It became clear right away that we had to do something to acknowledge her important work."

For information about the pinning ceremony, call Deb Washington at 4-7469.


Jackson-Williams and (Joy) Williams


Peters-Lewis and (Mary) Williams


Anderson and Washington


(Christine) Williams and Mitchell


Pinning ceremony recipients (l-r): Ines Jackson-Williams, RN; Michelle Anderson, RN; Christine Williams, RN; and Angeleen Peters-Lewis, RN (David Miller, PCA, not pictured)


Above: Ruth Dempsey, RN, professional development coordinator in The Center for Clinical & Professional Development, receives (surprise) award for teaching and mentoring.

(Photos by Paul Batista)

The Rhode Island Fire

continued from front cover

discharged and begun the long journey toward rehabilitation. They return to MGH often for clinic visits and reconstructive surgery.

One year after the tragic fire that altered so many lives, clinicians and support staff look back and reflect. One year after the Rhode Island fire, the healing continues.

"Fielding phone calls in the Blum Patient & Family Learning Center the morning after the fire was one of the most difficult experiences of my social work career. My position in the hospital doesn't present me with this type of crisis work on a daily basis, so I felt somewhat unprepared and feared I might be ineffective with those I was trying to help. The calls seemed endless as they came one after the next for hours. But the number of patients actually admitted to MGH was so small in comparison. It didn't hit me until a few days later—that many of the people I talked to had probably lost loved ones in the fire. I felt the full magnitude of their loss. I have renewed admiration for those who perform high-level crisis work as part of their daily routine."

—Michelle Hazelwood, LICSW

"A year has passed since the Rhode Island fire, and I am continually reminded by the media of how devastating an event it was for so many families. It's hard to believe they can find peace with such tragedy. I knew the patients who survived would have to endure many surgeries. They would need incredible inner strength. Though it has been physically and emotionally draining for staff as well, I think we find solace in seeing patients pull through, knowing we played an integral part in their recovery."

—Laurie Lynch, RN

"As the social worker for the Burn Unit, I find one of the hardest aspects of my work is seeing so many patients with minimal social support systems. In caring for patients of the Rhode Island nightclub fire, I saw a remarkable resiliency despite having experienced profound trauma, devastating loss, and disfigurement. They were future-oriented and optimistic. What most of these patients had in common was a strong social support system, which speaks to the importance of social support in recovery and healing, both physically and emotionally. Providing clinical counseling to the Rhode Island fire patients and their families was inspiring."

—Carla Cucinatti, LICSW

"As a nurse in the OR, I have treated many burn patients, but never has it been so physically and emotionally draining as it was treating the survivors of the Rhode Island fire. Their burns were so severe, they were so acutely injured, intubated, and sedated, I hoped they weren't in pain. I couldn't help thinking that these people were my age—innocent people in the wrong place at the wrong time. I couldn't help thinking they were young people, on career paths, with families. They were sons, daughters, brothers, sisters, parents. How difficult it must be for their families."

—Pamela Leclerc-Bovey, RN

Friday, February 21, 2003, is a day I will never forget. Five severely burned victims of the Rhode Island nightclub fire were patients in the SICU. The SICU is always a busy unit, but that day everything was multiplied tenfold. That day, teamwork was the order of the day. That day, you couldn't have asked for a better manager than Susan Tully. By afternoon, I had met with only one family; four patients were still unidentified. By the end of the day, one more person had been identified, and I spent time with his family as they tried to cope with what had happened. By evening, there were still three patients unidentified. I remember walking by their rooms thinking, 'People are out there looking for you. They'll find you.'

"By Saturday evening, all of the burn patients had been identified and begun their long journeys. For some, it would end in death. I spent many days with those families providing clinical counseling, support, and resources as their journeys unfolded. The memory of the emotional pain these patients and families experienced will stay with me forever."

—Rebecca Murphy, LICSW

"It's hard to believe a year has passed since the Rhode Island fire. My thoughts go so often to those who were lost and their families. But at the same time, I celebrate the survivors. When I see these patients for their reconstructive surgery in the OR, it's their optimism that humbles me. For many reasons, February 20th will be an anniversary I'll never forget."

—Elizabeth Viano, RN

"It was an amazing experience to be part of the staff caring for survivors of the Rhode Island fire. I am an OR nurse and I see trauma cases all the time, but this was a truly horrific event. It was so wonderful to see my colleagues come together to try to give these patients a second chance. Everyone gave a hundred percent and more. I feel very blessed to be part of such an extraordinary team."

—Emilia Comerford, RN

SICU nurses, Elizabeth Sgueglia, RN (left), and Mary MacLeod, RN

Continued on next page

"Usually, I work twenty hours a week as a part-time nurse. But in the weeks following the fire, I just couldn't stay away. My husband took time off from work so I could spend more time at the hospital. Even my children wanted to help. I worked with their teacher and came up with a plan where classes could make get-well cards, write poems, and draw pictures for the patients. I was thrilled that out of such a painful chapter, positive things happened."

—Patricia Gill, RN

"The Rhode Island tragedy tested our ability to quickly deploy large amounts of critically needed supplies, equipment, and linen to various locations. Teamwork was key. Medical staff and clinicians helped tremendously by communicating their needs quickly and concisely. We were in constant communication with our suppliers; we made regular, frequent 'sweeps' of the impacted units (the ED, the Burn Unit, the SICU) to make sure we delivered what they needed, where they needed it, as soon as they needed it. We set up portable carts and shelving outside patients' rooms for quick access. Stock levels were continually checked and replenished. Early in the morning, when we first learned about the fire, we called our supplier and had them stop the truck before it left the warehouse. We had them re-load with products we were going to need for the anticipated influx of patients, and we continued to communicate with our supplier throughout the day. We contacted other hospitals who helped us re-stock supplies that we were consuming at a much faster rate than usual.

"As part of the MGH family, we were proud to be part of the team caring for the survivors of the Rhode Island fire. We were able to keep important supplies coming so that caregivers could do their work without worrying about a shortage of critically needed supplies."

—Kathy Kelly, Materials Management

OR nurses, Sue Don, RN (left) and Elizabeth Viano, RN

"Everyone responded quickly to the crisis. Equipment and medications were delivered on a moment's notice. Patients were transferred, rooms were cleaned, orders were given—everyone worked together like a well-oiled machine."

—Bob Droste, RN

Burn Unit nurses, Elizabeth Kay, RN, and Richard Piccuito, RN

This tragedy reminded me of why I became a respiratory therapist in the first place. I wanted to make a positive difference in people's lives. I had never before been so profoundly saddened, and at the same time determined, and proud to be working with such an extraordinary group of people. It has become a point in my career that I will always return to—a testament to the human spirit to persevere."

—Terrence Brady, RRT

"Whenever I tell people I work as a nurse on the Burn Unit, I always get the same question: 'How can you do that?' Now and forever, I have a response, and it is simply: February 21, 2003... I wouldn't trade caring for this remarkable group of people for anything in the world. I'm so proud to be part of this team."

—Susan Tower, RN

OT uses creative problem-solving and clinical innovations to treat extensive hand injury

Cara Ventresca, OTR/L
occupational therapist

My name is Cara Ventresca, and I am an occupational therapist who specializes in hand injuries. I work as a senior therapist on the Hand & Upper Extremity Service, primarily treating outpatients who present with a wide variety of acute and chronic hand and upper-extremity injuries. As an OT, my training has instilled in me the importance of viewing each patient as a whole person (not just a 'hand injury'). My primary purpose is to improve and/or restore function. Of the thousands of patients I have seen, Bob will always stand out in my mind as one of the most challenging and rewarding. Though Bob has been in therapy for many months and has progressed well, I'm going to focus on his first few weeks of treatment. I think they demonstrate the challenge he presented and my problem-solving thought processes regarding how to address his devastating hand injury.

Bob is a 54-year-old, right-hand dominant, married laborer, originally from the island of St. Thomas. While working on a loading dock, Bob sustained a high-impact crush injury to his hand when a large piece of rigging equipment crashed onto the dorsum (back) of his right hand, degloving the skin on the palm and back of his hand, and nearly amputating his thumb. After many hours in surgery and seven days in the hospital where he was followed closely by the inpatient hand OT, Bob was ready to be discharged home and begin outpatient therapy with me.

Upon first meeting Bob and evaluating his hand, I was astounded by the sheer magnitude of injury to this man's hand. The most stunning aspect of Bob's injury was the amount of edema (swelling) in his hand and wrist due to the high-impact crushing mechanism of the injury. In all my years of treating hand injuries, I had never encountered edema of this magnitude. Bob's injured hand was easily twice the size of his non-injured hand. Aside from the edema, Bob also had multiple pins fixating his thumb fracture/dislocation, many large, open wounds on his hand, and the metacarpal-phalangeal (MP) joints of his fingers had been pinned into flexion by the surgeon to protect Bob from increased joint tightness that often accompanies significant edema.

Bob's injury presented several challenges, which I had to address early in my intervention to salvage any functional use of his hand. I knew I had to try to immediately minimize the edema. That much edema could easily lead to increased scar adhesion formation, increased joint and soft tissue stiffness, and increased pressure on (and possible necrosis of) the small intrinsic muscles of the hand, all of which could severely limit Bob's chances of regaining motion and functional hand use. Bob also had numerous open wounds, draining incisions, and pin sites that posed an increased risk of infection. Despite the best efforts of the inpatient hand OT, joint tightness and range-of-motion limitations had already set in. Bob's dominant hand was completely non-moving and non-functional. He was unable to feed himself with his right hand; unable to dress and groom himself without help; unable to drive himself to appointments; even unable to imagine when he might be able to return to work to support his family.

In spite of the terrible injury to his hand, Bob was an extremely pleasant man who always arrived with a cheerful greeting and a big smile. He was always accompanied by his wife, who appeared very supportive. Bob was very clear, however, from the outset that he came from a very 'traditional' background, one that prepared him to expect the women in his life (his wife and daughter) to take care of him. I picked up on this right away, and decided to incorporate his wife into his care from the beginning. After completing my evaluation, I spent the remainder of our first session carefully teaching Bob's wife how to change his dressings, clean his hand, and apply Coban, a compressive dressing that's wrapped around the hand, fingers, and wrist to decrease edema.

In subsequent visits, I continued to address Bob's edema through compressive dressings, retrograde massage (as much as the dressings and pins would allow), active range-of-motion exercises to produce a pumping mechanism, and patient-education regarding elevation and positioning. After clearing it with Bob's hand surgeon, I initiated sterile whirlpool treatments at the beginning of each session. The sterile whirlpool is designed to clean wounds, prevent infection, and promote healing. It provides heat to the soft tissue of the hand promoting increased elasticity and increased range of motion. However, one of the precautions against the use of whirlpool is that it can increase edema. I felt that the whirlpool could greatly benefit Bob because as his wounds healed and his range of motion improved, it would also help the edema subside. So I began the whirlpool treatments with some modifications. I lowered the temperature of the water in the whirlpool slightly to provide less of a heating effect. I modified Bob's position at the whirlpool so that rather than dangling his hand *down* in the water, he sat lower, with his whole arm in the whirlpool elevating his hand while it was submerged. I took careful measure-

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Exemplar

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ments of his edema before and after whirlpool treatments to make sure the edema didn't increase.

Bob's open wounds and incisions healed cleanly over the next few weeks, and the massive edema slowly began to subside. I continued to observe, however, that his fingers and wrist weren't showing the gains in range of motion that I expected. Aside from the edema, I attributed this to two major issues. One was that Bob seemed to be having difficulty carrying over the range-of-motion exercises I taught him at home. The other major issue, I felt, were the pins that were holding Bob's MP joints in flexion. While these had been placed to maintain the range of motion of the MP joints, instead they were intimidating Bob from trying to move any of the joints in his hand (except the thumb, which was securely pinned to allow healing).

I addressed these two issues promptly. Bob had mentioned that his daughter, who was thinking of becoming an OT or PT, sometimes helped him with his exercises at home. I asked Bob to bring his daughter in to observe a few of our OT sessions, and we spent time thoroughly reviewing his home exercise program. I showed his daughter how to place her hands to provide the best stretch for Bob's joints and how it felt to give him a gentle stretch without pushing so hard it would cause trauma or inflammation. We discussed how many times a day she could help her father with his exercises. Bob agreed that if she could help him with half his exercises each day, he could meet the challenge of doing the other half on his own. Once again, I realized that by including Bob's family, we could create a more effective team with the mutual goal of helping Bob to use his hand again.

I had a long discussion with Bob's doctor about the MP joint pins. I suggested that if he removed them, Bob might start to move his hand more and begin to use it functionally. The surgeon was hesitant to remove the pins, as Bob still had quite a bit of edema in his hand. I was convinced that by removing them, Bob would be motivated to move his hand more and incorporate it into functional activity. I felt that with diligent therapy, exercise, and dynamic splinting, we could prevent contractures, and actually help the edema to subside quicker. The surgeon did remove the pins at Bob's next visit.

Immediately following the pin removal, I fabricated a dynamic-flexion splint for Bob to wear (intermittently) throughout the day. This is a splint that provides dynamic traction to flex the MP joints and separate traction to provide composite digit flexion. After some initial surprise and hesitation at the intricacy and appearance of the splint, Bob loved it. He wanted to wear it all day long, as he felt it gave his fingers great stretch. However, part of the reason I suggested the pins be removed, was to allow Bob the opportunity to use his hand functionally. I made him a small splint to protect his (still healing and unstable) thumb and put him to work trying to use his injured, dominant hand. In therapy, I had him grasp cones, 'walk' his fingers up and down finger ladders, turn screwdrivers, and squeeze sponges. I instructed him to use his hand at home to open doorknobs, turn on faucets, turn newspaper pages, and continue to perform daily exercises with his daughter. I adapted his silverware, toothbrush, and pens using foam to build up the handles so he could grasp them more easily. As Bob began to see that he could use his hand to eat, groom, and write, he became more motivated and looked forward to seeing progress and more functional gains.

I have been treating Bob for many months now. There have been countless modifications to his home exercise routine. I have fabricated several other static and dynamic splints for him as needed. I've treated him through two additional surgeries, and I've continued to work with him, his family, his doctor, and his case manager to ensure he regains the highest level of functionality possible with the goal of being able to return to work.

Bob has regained most of the range of motion in his fingers and wrist, and has a strong grip. Most of his remaining functional limitations are due to ongoing problems with his severely damaged thumb. However, the function in his hand as a whole has far surpassed all our expectations. Bob has continued to present me with clinical dilemmas, but nothing quite as extreme as that first month of treatment when my clinical decision-making was tested and challenged every day. It has been very rewarding to work with Bob and see him progress so well, knowing that the risks I took and the treatment decisions I made in those first few weeks really paid off.

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

This narrative speak both to the complexity and ease of Cara's practice in treating Bob's extensive hand injuries. Cara identified the need to reduce the swelling as quickly as possible in order to help restore movement and range of motion to his hand. She took risks, involved his family, and advocated for the pins to be removed from his MP joints despite the surgeon's hesitation to do so. Cara explored creative ways to ensure that Bob was able to maintain his exercise regimen at home. As she helped him overcome each obstacle on their way to reaching his goal, she never lost sight of 'the whole person.' She never treated Bob as 'just a hand injury.'

Thank-you, Cara. This is a wonderful narrative.

The Pediatric Cardiac Program

—by Kathryn A. Beauchamp, RN
clinical nurse specialist

The look on the young mother's face told the story—smiling, with tears in her eyes, she reached out to touch her baby's pink fingers and then his face. With a look of wonder she whispered, "His lips are so pink."

Born with a congenital heart defect (CHD, which restricts blood flow to the pulmonary artery) and a ventricular septal defect, this baby had never had a healthy pink hue to his skin. He had a cyanotic heart lesion that prevented blood from oxygenating his lungs, resulting in lower-than-normal oxygen saturation levels.

Stories like this have played out many times in the Pediatric Intensive Care Unit (PICU) on Ellison 3 since the cardiac surgery program resumed five years ago. Rebuilding the program involved a multi-disciplinary approach that included the PICU team, cardiologists, cardiac surgeons, pediatric anesthesiologists, pediatric cardiopulmonary pump specialists, the cardiac OR staff, and nursing leadership from Ellison 17 and 18 (pediatric). The framework of a strong cardiac team was evident from the very beginning as repetition is the key to successful patient outcomes.

Coordinating equipment between the Cardiac OR and the PICU took high priority. Cardiopulmonary monitors, temporary pacemakers, emergency equipment, and syringe pumps were areas targeted for standardization. In a meeting with cardiac surgeons, the team determined what type of neonatal/pediatric equipment should be stocked in the emergency cardiac cart in the PICU. Having the right size equipment is important as patients can be neonates weighing 2.5 kg (5½ pounds) or school-aged children weighting 50 kg (110 pounds).

Working in collaboration with Barbara Hill, RN, nurse manager of the Cardiac Anesthesia Monitoring Nurses, and her staff in the Cardiac OR, educational sessions were held to educate staff in the use of PICU syringe pumps. Since all neonatal/pediatric medications are determined by the patient's weight in kilograms, anesthesia monitoring nurses had to learn the 'rule-of-six' calculation method for mixing continuous infusions (epinephrine, milrinone). Introducing this practice change in the OR eliminated the need to interrupt or change continuous infusions when patients arrive in the PICU.

It was reassuring, early on, to have a core group of senior PICU nurses who had cared for post-operative cardiac patients before to receive the first patients from the OR. Introductory CHD classes were held for all nurses, and one-on-one orientation was provided to credential each nurse in the care of cardiac patients. Prior to each cardiac surgery it became routine practice to review the function of the defibrillator, internal defibrillator paddles, Medtronic pacemaker, and the contents of the emergency cardiac cart.

Over the past five years the Pediatric Cardiac Program has continued to grow, handling complex congenital surgeries and interventional and diagnostic cardiac catheterizations on neonates and pediatric patients of all ages. Pediatric cardiology coordinator, Wendy Jennings, RN, has been invaluable in providing continuity of care for every patient in the Cardiology Service. Wendy ensures that patients and their families have a smooth transition during hospitalization and helps coordinate their discharge teaching with the nursing staff.

In partnership with Wendy, education for the nursing staff continues with year-round classes on congenital heart defects and information on a variety of cardiac subjects conveyed to all pediatric nurses via e-mail. With patient referrals coming in from a number of community hospitals and more babies with suspected CHD being med-flighted to MGH, educational sessions are now being offered to staff throughout the community.

It has been a very successful five years for our Pediatric Cardiac Program. We've seen babies we've cared for grow into toddlers as they progressed through a three-stage repair. Just this morning I was greeted with a big smile and a 'Hello' from a 12-year-old who had open-heart surgery yesterday morning. Pediatric patients… aren't they something!

If you would like to learn more about congenital heart defects, you can attend one of the four-hour Congenital Heart Disease classes being held during March and April. For more information, call The Center for Clinical & Professional Development at 726-3111.

Kathryn Beauchamp, RN (right) and Wendy Jennings, RN, with six-month old, Teddy Gray, who underwent cardiac surgery at two weeks of age.

Job Shadow Day at MGH

—By Galia Kagan Wise

Did you ever wonder why they call it Job *Shadow* Day? Every year Job Shadow Day, sponsored by the MGH Community Benefits Office, is coordinated to fall on or around Groundhog Day (see the connection?) This year, while the groundhog was searching for its shadow, ten East Boston High School students shadowed professionals at MGH to learn more about careers in health care. Job shadowing has proven to be an effective academic motivator that gives young people an up-close look at the world of future employment.

Students spent several hours on the MGH campus observing, asking questions, and occasionally participating in supervised, age-appropriate, work activities. This kind of exposure gives students a sense of the skills and education required to pursue jobs in health care, and an opportunity to learn how to start turning their desires into reality.

Launched jointly by the Boston Private Industry Council and Boston Public Schools in 1996, Job Shadow Day is now a national event thanks to a coalition of sponsors that includes: Junior Achievement, America's Promise, the US Department of Education, and the US Department of Labor. Job Shadow Day is supported by the MGH-EBHS partnership and is a program of the MGH Community Benefits Office. For more information about Job Shadow Day or other school partnership initiatives, call 4-8326.

Same Day Surgical Unit nurses, Amy Levine, RN (second from left); and Matthew Powers, RN (second from right), host students from East Boston High School during this year's annual Job Shadow Day. Students and staff enjoyed a visit from Job Shadow mascot, BJ Groundhog, III (which may not be his real name!)

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

Managing Editor
Susan Sabia

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Changes in the Clinical Recognition Program

—by Mary Ellin Smith, RN
professional development coordinator

January 1, 2004, brought several changes for the Clinical Recognition Program as we continue to learn from our experiences and recommend improvements to address the needs of clinicians. Changes include a transition of members on the review board, a change in the board's leadership, and a change in how the board will respond to incomplete portfolios.

The Clinical Recognition Program strives to ensure that the review board reflects the professional community of clinicians at MGH. With a little more than 18 months experience, that vision is becoming a reality. On January 1st, the Clinical Recognition Review Board welcomed seven new members, five of whom are recognized clinical scholars. As members of the review board, they will review portfolios; interview applicants, and make decisions about recognition for clinicians applying for advanced clinician and clinical scholar practice levels. New board members are:

- Neila Altobelli, RRT, clinical scholar, Respiratory Care Services
- Marie Elena Gioiella, LICSW, clinical scholar, Social Services
- Keith Perleberg, RN, nurse manager, Phillips 20 and 21
- Sandra Silvestri, RN, clinical nurse specialist, Main OR
- Jennifer Sweet, RN, clinical scholar, Blake 13 and 14
- Bernadette Reilly-Smorawski, RN, clinical scholar, NICU
- Debra Whitaker, RN, clinical scholar, Blake 6

Ending their tenure on the review board are:

- Lillian Ananian, RN, co-chair
- Evelyn Bonander, MSW, Social Services
- Dan Chipman, RRT, Respiratory Care Services
- Beth Nagle, RN, Center for Clinical & Professional Development

Mary Ellin Smith, RN, who served as the board's liaison, joins Ann Daniels, LICSW, as the new co-chair. Lillian Ananian, RN, had been co-chair since May of 2000.

The intent of the Clinical Recognition Program is to formally recognize professional clinical staff for their level of expertise. When portfolios don't reflect the themes of practice required by the guidelines, it can slow down the interview process. To ensure that staff are adequately prepared for their interviews, the Clinical Recognition Steering Committee has decided that the review board will return portfolios to clinicians when the required themes of practice are not clearly represented in their portfolios.

The Review Board will review portfolios and if, in their opinion, a theme is not present, a member of the board will notify the clinician. Clinicians will have the option of going forward with their scheduled interview knowing they will have to describe how the missing theme is present in their practice, or re-work their portfolio to more fully develop the missing theme. Review board members will provide guidance on how clinicians can articulate the missing theme.

For more information on the Clinical Recognition Program, including resources on how to develop portfolios and prepare for the interview, please contact Mary Ellin Smith, RN, at 724-5801.

At left: new members of the CRP Review Board are standing (l-r): Deb Whitaker, RN; Keith Perleberg, RN; Marie Elena Gioiella, LICSW; Jennifer Sweet, RN; and seated: Sandra Silvestri, RN; Neila Altobelli, RRT; and Bernadette Reilly-Smorawski, RN, LICSW

When/Where	Description	Contact Hours
March 1, 2, 22, 23, 29, 30 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** St. Elizabeth Medical Center	44.8 for completing all six days
March 2 8:00am–12:00pm	**BLS Heartsaver Certification** VBK 601	- - -
March 2 8:00am–4:30pm	**Chemotherapy Consortium Core Program** Wolff Auditorium, NEMC	TBA
March 3 3:00–7:00pm	**Congenital Heart Disease** Haber Conference Room	4.5
March 4 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
March 10 7:00am–12:00pm	**CVVH Core Program** Haber Conference Room	6.3
March 10 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
March 10 1:30–2:30pm	**OA/PCA/USA Connections** "Understanding Precautions & Precaution Signs." Bigelow 4 Amphitheater	- - -
March 10 4:00–5:00pm	**More Than Just a Journal Club** Walcott Conference Room	- - -
March 10 11:00am–12:00pm	**Nursing Grand Rounds** "Partnering to Make Technology Safe and Useful: How Nurses can *Be* the Difference." Sweet Conference Room GRB 432	1.2
March 11 8:00am–4:30pm	**Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other** Training Department, Charles River Plaza	7.2
March 16 8:00am–4:00pm	**Intermediate Respiratory Care** Respiratory Care Conference Room, Ellison 401	TBA
March 17 1:30–2:30pm	**USA Educational Series** Bigelow 4 Amphitheater	- - -
March 17 4:00–5:30pm	**Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements** Clinics 262	1.8
March 18 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Sentinel Event Identification and Follow-Up: Essentials of Developing Credible and Thorough Root Cause Analysis." Haber Conference Room	- - -
March 19 10:00–4:00pm	**A Safer Start: Empowering Pregnant Women Living with Domestic Violence** Wellman Conference Room	TBA
March 22 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)	- - -
March 23 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
March 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
March 25 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.

The impact of the Democratic National Convention on MGH

Question: Boston is scheduled to host the Democratic National convention in July. How do you expect this to impact operations at MGH?

Jeanette: The Democratic National Convention will be held in Boston Monday, July 26–Thursday, July 29, 2004. Approximately 50,000 people are expected to travel to Boston for the event. Given the proximity of MGH to the Fleet Center (where the main activities of the convention will take place), I think we can assume that traffic is going be an issue. Convention events are going to be held throughout the city, and we will try to keep staff informed of best traffic routes and alert you to any anticipated delays.

Question: Will roads in the immediate area of MGH be closed?

Jeanette: Specific information about travel and transportation routes won't be finalized until March at the earliest.

Question: Will the convention be held during the day or at night?

Jeanette: Convention activities are scheduled to begin at approximately 4:00pm each day, so the heaviest traffic should begin late afternoon and extend into the evening.

Question: Will MGH shuttles operate according to standard schedules?

Jeanette: MGH will use alternate routes and schedules, and details of the changes will be made public as we get closer to the date.

Question: Will I be able to park at The Fleet Center (where I am currently assigned) while the convention is in town?

Jeanette: The Orange/Nashua Street lot and the North Station/Fleet Center garage will not be available to employees during the convention. Employees who park in those lots will be asked to park in the new Yawkey Center Garage for the duration of the convention.

Question: Has MGH had any input into the planning and preparation of this event?

Jeanette: MGH is represented on various committees, planning groups, and security task forces that have been set up to manage issues associated with the convention.

The Employee Assistance Program
Work-Life Lunchtime Seminar Series
presents

"Nourishing your Newborn"

Presented by Germaine Lambergs, RN

Session is geared toward expectant parents, new parents, or employees considering having children. Will include a tour of the Mother's Corner at MGH.

Thursday, March 23, 2004
12:00–1:00pm
VBK 401

For information, contact the EAP at 726-6976.

Caring HEADLINES

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