

Caring

July 1, 2004

HEADLINES

Healing Through Art

—by Nancy K. Hunton

Paintings by young artists are now on display at the MGH Cancer Center thanks to a program known as Kaleidoscope. Colorful artwork created by pediatric cancer patients and their siblings hangs in the Pediatric Hematology-Oncology Clinic, transforming the unit into a bright, welcoming art gallery.

The Kaleidoscope program, which began last May, is coordinated by Joan Drescher, artist-in-residence, who provides the art supplies with which pediatric patients create paintings, sculptures, mandalas (circular designs), decorative tiles, and elaborate hats. Twice a week, Drescher wheels her now-familiar Imagination Kart, adorned with bells and kites, to patients' bedsides.

"It's made a tremendous difference in how

kids view treatment," says Drescher. "Art is a great diversion. It helps children relax and cope with the stress of being in the hospital." And nurses and family members often get into the act, too.

Kaleidoscope is a collaborative effort between Mass- General Hospital for Children and Illuminations, the professional, rotating art exhibit in the Cancer Center. A photograph of the artist

and a statement about the work accompany each piece.

Beth Homicki, program manager of Illuminations, works with Drescher to present the exhibits. "The program enhances communication," says Homicki. "Children can express what they're feeling through art."

Drescher and Homicki recently presented, "Kaleidoscope: The Many Ways Children with Cancer Turn Visual Arts into Healing," at the annual conference of the Society for the Arts in Healthcare, held in Washington, DC.



Artist-in-residence, Joan Drescher, helps budding young artist express himself as part of the Kaleidoscope program

(Photo by Abram Bekker)

Inside:

- Healing Through Art..... 1
- Jeanette Ives Erickson 2
 - What is "Family?"
- Fielding the Issues 3
 - Bi-lingual Visitor Volunteer Program
- Biomedical Imaging Core Program 4
- Welcoming People with Disabilities in the Workplace 5
- Exemplars 6
 - Nancy Davis, RRT
 - Carolyn Pelley, RRT
- Raising Awareness around Gay and Lesbian Issues 8
- Food-Service Improvements . 10
- Educational Offerings 11
- Making a Difference Grant Program 12

What is family: creating a patient-focused environment for all who seek our care

I've thought a lot recently about what constitutes 'family' in the healthcare setting. At MGH, where our highest priority is safe, high-quality, patient-focused care, our definition of family is very important. It affects who is granted visitation rights, who is included in healthcare decision-making, who has access to confidential health information, and who can benefit from health-insurance coverage.

In recent years, our concept of family has

changed dramatically as a number of societal factors have altered our understanding of what family really means. A half century ago, a family was a man and a woman living together under one roof with their children and perhaps their parents and grandparents. Today, a family can be a single-parent household; an un-wed, adolescent mother and her baby; a widowed senior citizen in an assisted-living community; or a same-gender couple raising children in a loving relationship.

Family can no longer be thought of in the context of the 1950s. In an article entitled, "Promoting Resilience in Families Experiencing Stress," Joan Patterson defines family as, "a group of people living together in close contact, who take care of one another and provide guidance for their dependent members." Isn't that a wonderful definition?

At MGH, we have long understood the importance of family involvement in the delivery of high-quality care. In society at large, but in health care especially, adopting the broadest possible definition of family creates a climate of inclusion, acceptance, and comfort. At MGH, 'family' is whoever the patient says it is.

A story in this issue of *Caring Headlines*, entitled, "Raising Awareness around Gay and Lesbian Issues," talks about a program held here at MGH recently. In the article, Donna Perry, RN, professional development coordinator in The Center for Clinical & Professional Development, talks about families of origin and families of attachment. Families of attachment are the people we feel closest to, whether they're related to us by blood, or friendship, or marriage, or partnership. They are the



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

people we want with us in times of vulnerability and crisis. They are the people we trust, the people we rely on, the people we love.

Each person decides who his or her family of attachment is. In healthcare, we respect a person's family of attachment the same way we respect their family of origin.

Gay, lesbian, and transgender individuals may not feel comfortable sharing information with caregivers about their sexual relationships, identity, or practices, which can compromise the quality and effectiveness of the care they receive. As healthcare providers, there are a number of things we can do to create a more open and welcoming environment for all patients.

Physical cues are important. Pictures or posters showing racially and ethnically diverse, same-gender couples let patients know they're in a welcoming place. Rain-

bow flags, pink triangles, GLBT (gay, lesbian, bisexual and transgender) newspapers and magazines are a sign of acceptance. Prominently displayed non-discrimination statements let patients know that equal care will be provided regardless of age, race, ethnicity, religion, physical ability, sexual identity or sexual preference.

Encourage openness. Use inclusive language. When taking oral histories, instead of asking if a patient has a husband or wife, ask if they are single, partnered, involved with multiple partners, separated from a partner, or in an alternative living situation. Don't make assumptions about the gender of a patient's partner. Clarify any terms or behaviors you don't understand to ensure effective communication. Follow patients' leads in terms of how they describe themselves and their families. Avoid using labels. Remind

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Call for Nominations

Marie C. Petrilli Oncology Nursing Award

Nominations are now being accepted for the Marie C. Petrilli Oncology Nursing Award, an award that recognizes the high level of caring, compassion, and commitment reflected in the nursing care of oncology patients at MGH. Any MGH nurse who cares for patients with cancer is eligible. Two nurses will be selected; recipients will receive \$1000 each.

Employees, managers, physicians, patients and family members may nominate a nurse by completing a brief nomination form, which is available on all inpatient units, at the Gray and Cancer Center information desks, and in the Cox 1 Cancer Resource Room. A letter of support must accompany the nomination form.

Nominations should be received by July 29, 2004. For more information, call Julie Goldman, RN, at 724-2295.

Bi-lingual Visitor Volunteer Program

Question: I've heard people talking about a bilingual visitor program. What is that?

Jeanette: The Bi-lingual Visitor Volunteer program is a program that will be starting soon at MGH. The purpose of the program is to make the hospital experience more inviting and less stressful for non-English-speaking patients by bringing them together with MGH staff members who speak their language.

Question: It sounds like a good idea, but why is that important?

Jeanette: It has been observed in a number of settings that non-English speaking patients welcome the opportunity to connect with others who speak their language and understand their culture. Patients have expressed relief and comfort at being able to communicate in their native tongue. Though these observations were made informally in various patient-care situations, we wanted to develop this into a formal program.

Question: Will it be an extension of the Interpreters program?

Jeanette: No. Medical interpreters have a very specific role and have undergone rigorous training and preparation to become medical interpreters. Employees who sign up to be part of the Bi-lingual Visitor Volunteer program are not expected to interpret in medical situations or assist clinical staff in providing care. Their sole contribution is providing patients with an opportunity to interact with staff members in their native language.

Question: How will the program be implemented?

Jeanette: First, there will be a pilot program to test the initiative. A few bi-lingual employees will be asked to visit patients on specific units and present feedback to a program planning committee. Based on the feedback we receive, a program will be developed that can be rolled out to all units.

Question: What impact do you think this will have on patients and staff?

Jeanette: We hope that patients will feel welcome and that this service will assist them in talking to staff about issues that will make their hospital stay more comfortable and enjoyable.

As caregivers, we know that bedside conversations provide a great opportunity to get to know and learn more about our patients. We become better advocates and develop a stronger understanding of the culture, customs and traditions of other countries.

Question: How does a person sign up for the program?

Jeanette: After the pilot program is conducted, the committee will have a better sense of what's needed to implement the program to the larger hospital community. At that time, there will be a formal effort to recruit volunteers. So stay tuned.

Jeanette Ives Erickson

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patients that discussions between patients and caregivers are confidential.

No conversation about family would be complete without mentioning children. We need to be vigilant about the mes-

sage we send to children, those who are living in same-gender households, those who have friends in alternative-living situations... we need to be vigilant about the message we send to *all* children. This is when their

own identities and their perceptions of the world are taking shape. This is when we have a real opportunity to make a difference in how children perceive and value themselves and others. This is why our definition of family is so important.

So, as others may struggle to decide what 'family' really means, caregivers at MGH recognize the broadest possible definition of the word; we respect families of origin, families of attachment, families with alternative life styles, families of all shapes and sizes.

At MGH, family is whoever the patient says it is.

Have you reached Critical MASS?

Critical MASS, a state-wide coalition to end health disparities in Massachusetts, has launched a new website:

www.enddisparities.org

Please visit the site for information, or to submit ideas about programs that target health disparities

Call for Nominations

Janet Ballantine Oncology Volunteer Award

Nominations are now being accepted for the Janet Ballantine Oncology Volunteer Award, which recognizes volunteers who extend themselves to make cancer care easier and more personalized for patients and families. Any MGH volunteer who cares for oncology patients is eligible. One volunteer will be selected; the recipient will receive \$500.

Patients, family members, employees, managers, physicians, and other volunteers may nominate a volunteer by completing a brief nomination form, which is available on inpatient units, the Gray and Cancer Center information desks, and in the Cox 1 Cancer Resource Room.

Nominations should be received by August 4, 2004. For more information, call Julie Goldman, RN, at 724-2295.

GCRC Biomedical Imaging Core program opens in Charlestown

—by *Bonnell Glass, RN, nurse manager, GCRC*

The General Clinical Research Center (GCRC) celebrated the official opening of the Biomedical Imaging Core (BIC) program at the Charlestown Navy Yard (CNY) on Thursday, June 24, 2004. The GCRC is an inpatient/outpatient research facility funded by MGH and the National Institutes of Health (NIH) with the mission of providing a means to conduct clinical research with human subjects to advance scientific knowledge about disease treatment and prevention.

The celebration was planned to coincide with Clinical Research Day at MGH. Dr. Elias Zerhouni, director of the National Institutes of Health, was on hand for the opening of the Biomedical Imaging Core program, one of only a few such centers in the US designated and funded by the NIH.

Patient Care Services staff are essential members of the BIC clinical research team, which consists of: clinical research nurses, a nurse practitioner, research nutritionists, clinical practice assistants, and operations associates. GCRC staff work with clinical investigators to review, plan, prepare, and conduct structural and functional imaging studies to improve diagnostic and prognostic

capabilities for physiological, psychological, psychiatric, and neurological symptoms. The BIC supports studies of both normal volunteers and patients in order to better understand brain function in health and disease.

Numerous studies of the brain have been conducted on animals. Many of those studies, however, don't translate to human applications. Now, we have the opportunity to study human brain activity under a variety of conditions. Many GCRC clinical research nurses have been protocol nurses for protocols currently underway or in development at the BIC. It has been a fascinating pro-

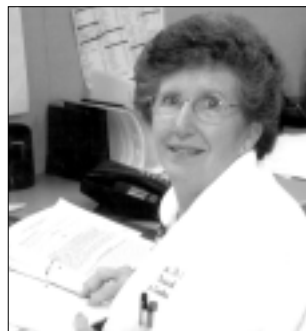
cess, gaining scientific knowledge and new clinical-investigation techniques to serve a growing number of patient populations. We are invigorated by this opportunity to advance nursing practice and collaborate with physicians and scientists to discover new ways to diagnose and treat disease.

The BIC is an integral part of the GCRC

program whose primary site is on White 13 with a satellite site at MIT. It functions under the direction of David Nathan, MD, program director of the GCRC, and Anne Klibanski, MD, associate program director of the GCRC. Professional

leadership includes: Gregory Sorensen, MD, director of Biomedical Imaging Core program; Randy Gollub, MD, co-director; Karen Hopcia, RN, clinical nurse specialist; Mary Sullivan, RN, nurse practitioner; Bonnell Glass, RN, nurse manager; Mark Vangel, imaging statistician; Ellen Anderson, RD, bio-nutrition manager; Edwin Andrews, GCRC administrative manager; and Kashawna Harling, BIC administrative coordinator. MGH pres-

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Staff of the new GCRC Biomedical Imaging Core program are (l-r from top): Mary Sullivan, RN; Kathleen Egan, RN; Randy Gollub, MD, and Kashawna Harling; and 'acting' patient, Joanne Vozzella, with Denise Keefe, RN. For information about the BIC, visit the GCRC website: at: www.mgh.harvard.edu/GCRC.

(Photos provided by GCRC)

Focus on the skill and ability that people with disabilities bring to the workplace

On June 9, 2004, W. Roy Grizzard, Jr., EdD, Assistant Secretary for Disability Employment Policy at the US Department of Labor, visited MGH to speak on the topic of, "Employment: The Great Equalizer for People with Disabilities." Grizzard explained that the Office of Disability Employment Policy grew out of a realization that people with disabilities need to be an integral part of the American workforce.

Prior to becoming Assistant Secretary, Grizzard worked as a teacher and school administrator. During the course of his

talk, he revealed how he had gradually lost his vision to retinosa pigmentosa. Though he was fully able to work, he faced transportation issues when he became unable to drive. Support from family and colleagues allowed him to continue working.

Grizzard spoke eloquently about the contributions people with disabilities make. "Once a physical need is accommodated," he said, "people with disabilities bring far more in skill and ability to the workplace than disability."

The program was sponsored by the MGH Office of the President and the MGH Council

on Disabilities Awareness, and co-sponsored by AMMP, Human Resources, the Community

Benefit Office, Multi-Cultural Affairs, and Patient Care Services.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, closed by paraphrasing a quote from author, Lawrence Bixby: "Each disability is like a hurdle in

a steeplechase. If you throw your heart over, the horse will follow.' I ask each of you to approach the challenge of making MGH a welcoming place for people with disabilities in the same way. Throw your heart over—others will follow."



W. Roy Grizzard, Jr., Assistant Secretary for Disability Employment Policy at the US Department of Labor, speaks on, "Employment: The Great Equalizer for People with Disabilities."

(Raw photos by Abram Bekker)

Biomedical Imaging Core

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ident, Peter Slavin, MD, is the principal investigator of the NIH Grant. Clinical research nursing practice and support services fall under the direction of Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Theresa Gallivan, RN, associate chief nurse.

The BIC supports MGH, MIT, and other investigators who perform clinical research using the imaging resources of the MGH

department of Radiology and the Martinos Center at the Charlestown Navy Yard. MGH investigators have played a leading role in advancing technology that dramatically improves the quality and range of anatomical and functional images generated by magnetic resonance imaging (MRI), positron emission tomography (PET), x-ray computer tomography (CT), magnetoencephalography (MEG), optical and near infra-red imag-

ing, and ultrasound imaging technology. Imaging techniques have evolved into powerful non-invasive diagnostic tools.

The BIC was made possible by:

- funding from the National Center for Research Resources division of the National Institutes of Health
- allocation of space at Charlestown Navy Yard adjacent to the imaging facility
- designated use of the imaging facilities and equipment at MGH Charlestown

- a commitment by the leadership of the Martinos Center to advance clinical research
- participation from an active community of clinical investigators
- specialized statistical consultation and support to biomedical imaging studies
- support for medical-image analysis and data-management
- the participation of expert research nurses, research nutritionists, pharmacists, administrators, and support staff

Currently more than a dozen protocols have

been designed, approved, funded, and implemented with dozens more in development.

Staff would like to thank Patient Care Services and all those in the MGH community who helped plan and create the state-of-the-art Biomedical Imaging Center. Please join us in acknowledging the official launching of this journey of discovery.

For more information, visit the GCRC website: at: www.mgh.harvard.edu/GCRC (no spaces) or the National Center for Research Resources website at: www.ncrr.nih.gov/clinical_rsrch.asp.

Respiratory therapists find end-of-life care poignant, rewarding

*M*y name is Carolyn Pelley. As a new graduate, I began my career as a respiratory therapist at MGH, 'floating' to various intensive care units throughout the hospital. About eight months after being hired, I was offered a position as a primary respiratory therapist in the Respiratory Acute Care Unit (RACU). This is where I met Mr. C.

Mr. C was one of the bravest men I've ever had the pleasure of knowing. He arrived in our Emergency Department with severe respiratory distress. He had a long history of emphysema related to smoking, and had lived with moderate distress at home. His breathing was so compromised in the ED that he needed to be intubated, but he wasn't sure that was what he wanted. Along with his family, his team of doctors, respiratory therapists, and nurses, Mr. C ultimately decided to be intubated. He was placed on a mechanical ventilator, transferred to the Medical Intensive Care Unit (MICU), where he remained until he was hemodynamically stable. He was then transferred to the RACU for help weaning from the ventilator.

The first time I met Mr. C, his condition was fairly stable. I had been notified that Mr. C had a tracheostomy tube, which was partially occluded. We were to assist in turning Mr. C to stabilize his airway. Other than regular ventilator checks, suctioning, broncho-dilator therapy, and turning assistance, I didn't have much contact with him throughout the day. When I returned to work the next day, I noticed that Mr. C wasn't in his room. I was told he had become

unstable and been transferred back to the MICU.

When he returned to the RACU a few days later, his vent settings had increased. He was able to breathe in pressure support mode, but due to advanced lung disease, he required a high positive end-



Carolyn Pelley, RRT
respiratory therapist

expiratory pressure (PEEP) setting. Even with a PEEP of 12 centimeters of water and the lowest sensitivity setting allowed, he was still, at times, unable to trigger the ventilator to get a breath. We measured his auto-PEEP and matched it to the ventilator setting. Day by day, Mr. C's auto-PEEP increased.

During his second stay in the MICU, Mr. C and his family were told that Mr. C's breathing wasn't getting any better, and that weaning from the ventilator could take a long time. Mr. C said he wanted to try for one month, and if he was still unable to breathe on his own, he wanted to be removed from the ventilator to pass on.

During that month in the RACU, Mr. C was nothing but

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*M*y name is Nancy Davis, and I have worked as a respiratory therapist at MGH for three years. For the past two years, I've worked primarily in the Respiratory Acute Care Unit (RACU), which is where I met Margaret.



Nancy Davis, RRT
respiratory therapist

Margaret was a lovely woman in her 70s who had a history of peripheral vascular disease, CAD, CHF, asthma, HTN, and Afib. She had been intubated for respiratory failure and been sent to the RACU when she was unable to wean from the ventilator. Margaret was awake, alert, and pleasant despite her many health issues. She was well-coifed and often wore make-up. Her daughters fixed her hair and applied lipstick to boost her spirits. They explained she was the type of woman who never left home without her hair and make-up looking just right. This struck a familiar chord with me having known many such women, including the woman who raised me. I felt an immediate bond with Margaret, who always had a beautiful smile.

While we were making slow progress weaning Margaret from the ventilator, she continued to have setbacks. She would have improvement in some areas, but her white blood count was climbing and she had developed yet another pneumonia. Margaret's vascular surgeon called a family meeting with the RACU team. Aggressive interventions were discussed, but Margaret declined in favor of comfort measures only. She understood that this decision could be reversed at any time; and she wanted to see her children

It was decided that we would continue to support Margaret on the ventilator and she could use a PMV (a device that fits over the trach and allows the patient to speak) when her family arrived the next day. I spoke with the attending physician, and we agreed that I would stay in Margaret's room to monitor her whenever she used the PMV. We were in agreement that Margaret and her family would be my top priority that day. Fortunately, the rest of the unit was fairly quiet, and I was able to be there for Margaret and her family whenever they needed me.

When her family arrived, I explained that Margaret wanted to speak with them but needed the support of the ventilator, and because of that, I would have to remain in the room during their visit. I assured them I didn't want to intrude on their privacy; that this was a patient-safety issue, and they were agreeable.

Margaret was grateful to be able to explain to her family her decision to decline further treatment. She told them how much she loved them and not to be

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Exemplar (Pelley)

continued from page 6

pleasant. I developed a nice rapport with him and his family. We made several attempts to wean him from the ventilator, but never successfully, and after each attempt he required more support than the last.

Along with the speech-language pathologist, I was able to deflate Mr. C's tracheostomy cuff and allow him to speak for about ten minutes at a time, which he and his family really appreciated.

At the one-month mark, we held a family meeting to discuss Mr. C's future care. The RACU team felt that Mr. C would probably never wean from the ventilator. We mentioned the possibility of Mr. C going to a rehabilitation facility, or living at home on a ventilator; neither of which was acceptable to him. He felt it was time to pass on. We told Mr. C that when he was ready to be removed from the ventilator, we would comply with his wishes. After the meeting, Mr. C told us he wanted to be removed from the ventilator the next morning. He also said that before he died, he wanted a cheeseburger, a Coke, and some vanilla ice cream. It was a wish we were more than happy to fulfill.

After Mr. C spoke with his doctors, the SLP and I adjusted his cuff so he could have one last conversation with his family. Because of the fragility of his condition, I had to remain in the room during this final exchange. 'Sad' is an understatement. With his room full of family, they talked about where he wanted to be buried; how much he lov-

ed his family and hoped they would look out for each other. I had grown close to Mr. C and his family, and this conversation brought tears to my eyes. When Mr. C felt he had said what he needed to say, we re-inflated his cuff.

Later that evening, Mr. C's cheeseburger, Coke, and ice cream arrived. Due to the risk of choking, the SLP and I stayed in the room while he ate. Giving him this food was like giving him a million dollars. Amazingly enough, he was even happier than he usually was. After he finished, we suctioned him and let him spend some quality time with his family.

My shift ended at 7:00pm. I gave report to the incoming therapist and went home, thinking about Mr. C all night. I wasn't scheduled to work the next day. It may sound strange, but I wanted to be there for Mr. C's last day. I wanted to make sure everything went perfectly for him and his family. Unfortunately, that didn't happen.

When I did return to work, I spoke to staff and learned that things couldn't have gone better, for which I was glad. I went to Mr. C's wake, which made me feel better about missing his last day. He looked so peaceful. His family was glad to see me, and I was happy that Mr. C got what he wanted.

The days that Mr. C spent in the RACU were a roller coaster ride for me. I was happy interacting with Mr. C and his family, but extremely sad during our last evening together. Mr. C's bravery was unlike anything I've ever known. I'm very glad to have known Mr. C, and to have helped grant his ultimate wish.

Whenever I order a cheeseburger now, I think of Mr. C.

Exemplar (Davis)

continued from page 6

sad—this was what she wanted. I was struck by the strength of this woman who was so ill.

Throughout the day, family members came to visit. We placed the PMV for short periods of time so she could speak with them, and we removed it when she tired. Her sons and daughters shared stories with me about Margaret, and at one point when many tears were being shed, I felt my own eyes well up. I tried to hide my tears from the family, but one of them saw and came over to me. He joked about it, but I apologized; I felt it was unprofessional. He said, "Don't ever be sorry about feeling so deeply for your patients. You'll never know how comforting it is to know you care that much."

When the whole family had gathered and a family friend (who was a priest) arrived, it was time to grant Margaret's wish and let her go. The priest gave her his blessing. Comfort medications were given. She was taken off the ventilator, and put on humidified air. Two of her sons stayed with her during the night.

When I came back to work the next morning, I immediately asked about Margaret. I was told she was still with us. Her sons had gone home for a few hours sleep and would be back soon. After getting report, I went to her room and spent a few minutes with her, holding her hand and speaking to her softly. I left knowing it was the last time I would see her alive.

A few hours later, I was in another patient's room when Margaret's nurse asked if I could come to the nurses' station. He said Margaret's family wanted to see me before they left. Two of her sons were wait-

ing at the nurses' station. "We couldn't leave without thanking you for all you did for our mother and for us." They said they never would have known Margaret's wishes if we hadn't made it possible for her to speak. I assured them it was a part of my job; I felt privileged to have been a part of such a peaceful death. They were very grateful that their mother's last days were spent with the kind, compassionate staff of the RACU.

Though it's been almost a year since I met Margaret, I still think about her often. She was a gentle but strong woman, and I'm grateful I was one of her caregivers. We see a lot of suffering and death in this profession, sometimes painful, sometimes violent. I was fortunate to be a part of such a peaceful, beautiful death. When I think about Margaret, it restores my spirit and reaffirms my belief that the health-care field is where I belong.

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

Both of these wonderful exemplars highlight the exceptional, compassionate care provided by respiratory therapists as they navigate the complex and poignant territory of end-of-life care. Carolyn and Nancy were fully present to their patients and their families. Whether it was fulfilling a last wish to taste a cheeseburger or speaking to loved ones one last time, their priority was always their patients' safety and well-being. Nancy and Carolyn's knowledge of technology, their skill at applying it, and their commitment to providing patient- and family-centered care made it possible for Margaret and Mr. C to experience, as Nancy described it, "a peaceful, beautiful death."

Thank-you, both.

Raising awareness around gay and lesbian issues

On June 11, 2004, a number of MGH employees came together in the Trustees Room on Bulfinch 2 to learn more about gay and lesbian issues and why those issues are important in the healthcare setting. The program, "Gay-Lesbian Issues and Family Values," was co-sponsored by the Patient Care Services Diversity Steering Committee and MGH Human Resources.

Donna Perry, RN, professional development coordinator for The Center for Clinical & Professional Development, opened the program with her presentation, "Why does Same-Gender Marriage Matter in Health Care?" Perry spoke about the mission of MGH to provide patient- and family-focused care. She spoke about the social stigma still associated with being gay and the impact that has on the delivery of quality care. Caregivers need to be aware of the issues facing gay and lesbian patients and try to create a non-judgmental atmosphere where patients feel safe talking about every aspect of their health.

Perry noted that healthcare issues are among the many fac-

tors driving same-gender marriage legislation—to ensure spousal visitation rights in hospitals and shared healthcare decision-making. Perry noted that there are families of 'origin' and families of 'attachment.' Families of attachment are the people who have knowledge of, and affection for, the patient. Said Perry, "Providing family-focused care means showing respect for every

member of the patient's family of attachment."

Cuban-American diversity consultant, Victoria Mederos, shared a number of personal stories in her presentation entitled, "Our Household." She recounted experiences reflecting instances of discrimination, acceptance,

and the true spirit of community that she and her African-American partner enjoy in their current living situation. One anecdote she shared had to do with a neighbor who questioned why it was important that she and her partner be able to marry. Said Mederos, "It's important to be true to yourself and be able to live openly in the world

the way everyone else does." Mederos closed by saying,

"Every time we grant people rights, we become a better society. Separate is not equal. We need to continue to empower ourselves."

Jill Zellmer, of Speak Out, the nation's first gay, lesbian, bisexual, and transgender speaker's bureau, also shared some anecdotal stories that chronicled her journey as a lesbian born and raised in a small mid-western town, coming out to her family, going away to college, getting married, and adopting a child

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At recent program focusing on, "Gay-Lesbian Issues and Family Values," (clockwise from center) are: Deborah Washington, RN, director of PCS Diversity program; Jill Zellmer from Speak Out; Vicky Mederos, diversity consultant; Oswald (Oz) Mondejar, human resources manager; Ed Ford of Boston Prime Timers; and Donna Perry, RN, professional development coordinator

Raising awareness around gay and lesbian issues

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with her partner. Zellmer spoke of her own 'internalized homophobia,' recalling a time when she and her partner went shopping for a new mattress. By her own admission, she was mortified at the idea of lying down on a mattress in public with her same-sex partner. "These are the 'self-loathing' attitudes we need to overcome," she said, "as we become more comfortable being true to ourselves."

Ed Ford, president of Prime Timers, a brotherhood of mature gay and bisexual men, spoke about his youth and early adulthood, hiding his sexuality, not being true to himself, not being fair to his wife and children.

"Coming out is a life-long process," said Ford. "But in every gay person's life there is a defining moment when you realize you need to be who you really are." He called on senior centers

There are families of 'origin' and families of 'attachment.' Providing family-focused care means showing respect for every member of the patient's family of attachment.

to address the needs of all senior citizens, not just heterosexual elders. And he reminded people that, "We're not alone out there. We have many, many allies. But we need to be visible, and we need to be true to ourselves."

The program was facilitated by director of the PCS Diversity program, Deborah Washington,

RN, and human resources manager, Oswald (Oz) Mondejar. In closing, Washington observed, "Listening to our speakers today we see the ways people hurt each other in our society. We need to stop that. And we need to start in health care. If not in health care... then where?"

Mondejar praised MGH for creating a work environment that judges its employees on merit. "This is the first employer I've ever had," said Mondejar, "where I feel I can be open about my life and speak comfortably about my family without fear. Programs that address gay and lesbian issues broaden our scope of diversity and go a long way toward creating a welcoming environment for patients, families, and staff."

See you in September...

The application period for membership in collaborative governance committees begins September 1, and runs through October 15, 2004.

Collaborative governance is an opportunity to influence the strategic direction of Patient Care Services and participate in achieving the goals established by the PCS Executive Committee.

Collaborative governance is a philosophy. It's a way of thinking about how decisions are made within and among members of the professional community.

For more information about collaborative governance, the individual committees, or to obtain a membership application, go to: http://pcs.mgh.harvard.edu/ccpd/cpd_govern.asp

And look for the collaborative governance information booth in the Main Corridor in September.

Educational Offerings available on-line

The Center for Clinical & Professional Development lists educational offerings on-line at:

<http://pcs.mgh.harvard.edu>

For more information, or to register for any program, call the Center at 6-3111.

Caring HEADLINES

Back issues of *Caring Headlines* are available on-line.

Go to the Patient Care Services website at: <http://pcs.mgh.harvard.edu/> and click on 'Caring Headlines'

For assistance in searching back issues, contact Jess Beaham, web developer, at 6-3193

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Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible.** *Caring Headlines* cannot guarantee the inclusion of any article.

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.

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July 15, 2004



Nursing, Nutrition & Food Services working together to enhance food-delivery services

The Nutrition & Food Services and Nursing Performance Improvement Task Force began meeting in the fall of 2001 to address ways to improve food service and enhance overall satisfaction among patients and families. Co-chaired by associate chief nurse, Jackie Somerville, RN, and director of Nutrition & Food Services, Helen Doherty, RD, the team was comprised of nurse managers, operations coordinators, operations associates, clinical dietitians, food service technicians, and nutrition supervisors. The team examined existing systems, identified problem areas, and collaborated in designing and imple-

menting solutions. Their work began as a pilot program on Ellison 7 and Blake 6 exploring ways to maximize or modify systems to ensure that:

- patients received their meals/snacks in a timely fashion
- patients were happy/satisfied with the food they received
- the responsibilities of Nursing and Nutrition & Food Services staff were clearly delineated
- food service was a positive, collaborative experience for patients, families, and staff

In December of 2002, the Nutrition & Food Services and Nursing Performance Improvement Task Force received a

Partners in Excellence Award for their accomplishments, which included:

- using the "Did You Know?" poster campaign as a vehicle for communication and education
- improving the NPO vs. Delay functions
- working with the POE Committee to improve the communication process for changes in diet
- exploring the availability of off-hour food service for patients
- enhancing unit-based education with regular presentations to nurses, PCAs, and OAs

The task force disbanded in November of 2003. Says Somerville, "It was a great multi-

disciplinary group that worked together to share perspectives and educate each other about opportunities to improve systems. And we continue to work together to improve services to patients and families."

Recently, another round of service enhancements was announced, including the creation of a new menu selection form that is more inviting and easier to use. Selection forms will be clearly labeled to indicate special diets. This will serve as a quick reference guide for nurses and patients; and foods not permitted on certain diets will not be included on selection forms.

Patients will now be able to submit their dinner-menu requests on the same day. Menu selection forms must be received by Nutrition & Food Services by 2:00 each afternoon.

Helpful nutrition selection guides have been prepared by clinical registered dietitians. The guides are written in plain language and provide basic information on nutrition and food choices.

Other improvements are still in development, including an automated diet order process using POE, which will transmit orders directly to Nutrition & Food Services.

For more information about food-service improvements or the work of the Nutrition & Food Services and Nursing Performance Improvement Task Force, contact assistant managers, John Delvecchio at 4-4038, Sara Estabrook at 4-1764, or Jackie Somerville at 4-6317.

BORN recommends renewing licenses before Democratic National Convention

The Massachusetts Board of Registration in Nursing (BORN) is encouraging all nurses whose licenses expire at the end of July or the beginning of August to renew their licenses as soon as possible to avoid any confusion, lapses, inconvenience, or delays that may be caused by the Democratic National Convention (DNC).

The BORN office is located at 239 Causeway Street, which is within the designated high-security zone for the DNC. Due to limited public and private transportation, security restrictions, and crowds in the area during the week of July 25, 2004, it is expected that the BORN office will be difficult to access.

At press time, the Massachusetts Board of Registration in Nursing was planning to remain open during the convention week, but was considering operating on a limited schedule.

Nurses, please make every effort to renew your licenses before July 25th. If you don't yet have a renewal application, call the BORN office 617-727-9961.

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. Participants will be given tools to help with time-management, stress-reduction, and staying focused on work.

**Thursday, July 22, 2004
12:00-1:30pm
Sweet Conference Room GRB 4**

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

Educational Offerings

July 1, 2004

When/Where	Description	Contact Hours
July 9 and 12 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
July 13 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)	---
July 14 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
July 14 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater. “Emergency Preparedness.”	---
July 14 4:00–5:00pm	More Than Just a Journal Club Walcott Conference Room	---
July 14 11:00am–12:00pm	Nursing Grand Rounds “The Aging Nurse.” Sweet Conference Room GRB 432	1.2
July 15 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
July 20 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
July 20 8:00am–4:00pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
July 21 8:00am–12:00pm	BLS Certification—Heartsaver VBK 601	---
July 22 1:30–2:30pm	Nursing Grand Rounds “Pilot Hospice Inpatient Bed Program.” O’Keeffe Auditorium	1.2
July 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
August 5 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
August 11 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
August 11 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater. “Infection Control.”	---
August 11 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
August 11 12:15–4:30pm	Pacing: Advanced Concepts Haber Conference Room	4.5
August 11 11:00am–12:00pm	Nursing Grand Rounds “Delirium.” Sweet Conference Room GRB 432	1.2
August 19 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
August 23 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)	---
August 24 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
August 25 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)

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>.

Applications now being accepted for Making a Difference Grant Program

So many ideas. So little time. MGH employees have always been a rich source of new ideas for how to improve service to our patients, their families, and our colleagues. On June 7, 2004, a reception was held in the Trustees Room on Bulfinch 2 to celebrate 23 innovative projects funded by the 2004 Making A Difference Grant Program. Grant recipients presented posters and spoke with administrators, clinicians, and staff who dropped by to learn more about funded projects. Patient Care Services was well represented at the event; PCS staff were involved in the majority of the projects funded.

Applications are now being accepted for the 2005 Making a Difference Grant Program. All MGH employees are eligible to apply. For information, contact the Service Improvement Department at 724-1004 or e-mail Mary Cunningham. Applications must be received by August 15th.



Michael Anderegg, MD, of the MGH Cancer Center, and Michele Lucas, RN, at Making a Difference poster-presentation reception

(Photo provided by Service Improvement Department)

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