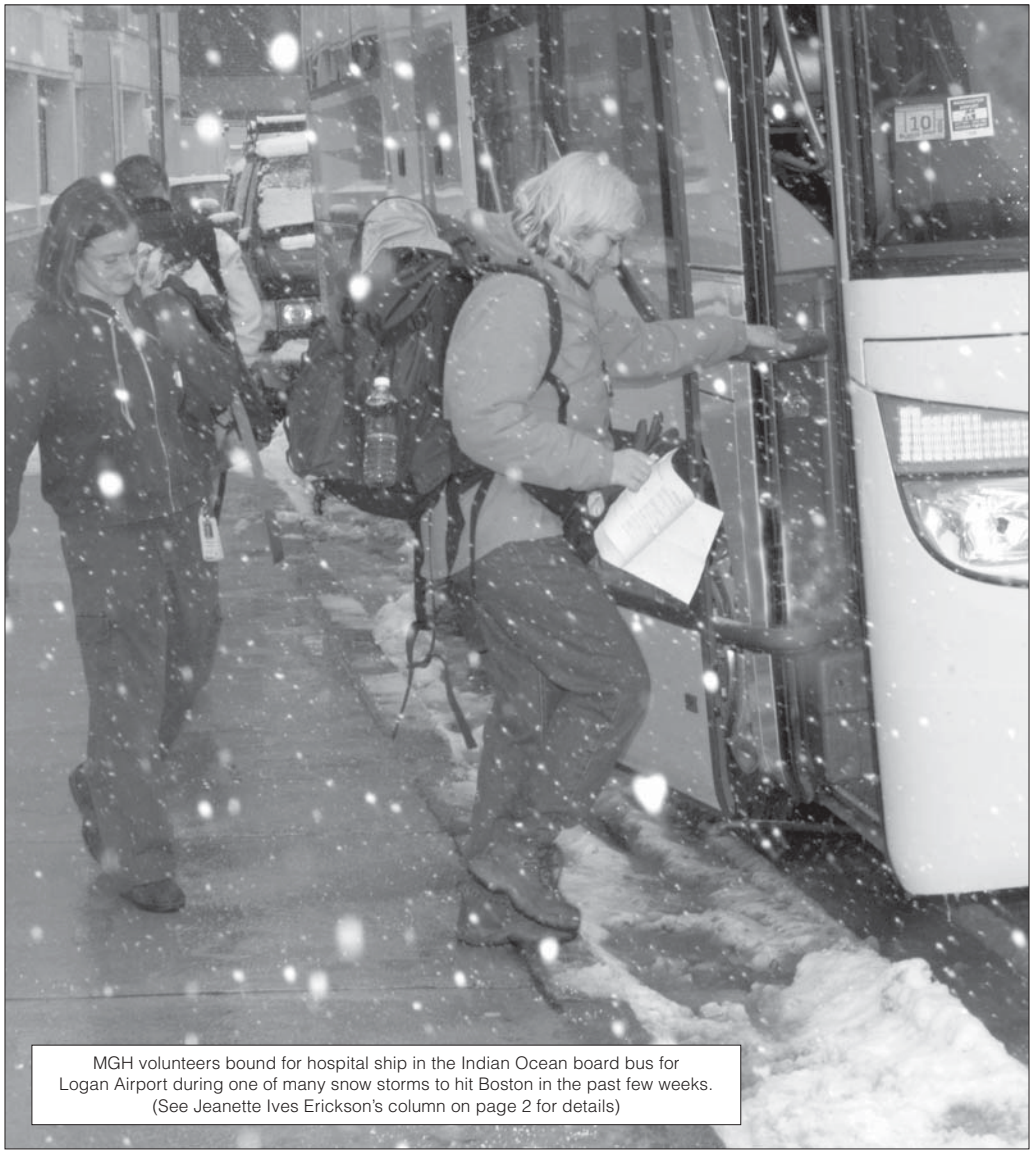
February 3, 2005

# Caring HEADLINES

# Operation Unified Assistance heads to Indian Ocean

## Inside:





MGH volunteers bound for hospital ship in the Indian Ocean board bus for Logan Airport during one of many snow storms to hit Boston in the past few weeks. (See Jeanette Ives Erickson's column on page 2 for details)

**MGH** Patient Care Services

Working together to shape the future

# Jeanette Ives Erickson

# Operation Unified Assistance

## *and other matters of courage and commitment*

On Wednesday morning, January 26, 2005, the first wave of MGH volunteers embarked on Operation Unified Assistance to bring medical aid and relief to survivors of the tsunami in Southern Asia. Their mission, in collaboration with Project HOPE, is to prevent further loss of life, provide much-needed medical assistance, and help restore and improve public health systems in affected areas.

MGH nurses, doctors, social workers, and one dietician will be part of a national, multi-disciplinary team based aboard a hospital ship in the region, a 1,000-bed floating medical facility currently deployed in the Indian Ocean.

Specifics of their mission will unfold as the situation evolves and staffing needs are identified. Mechanisms are in place for regular communication with the team so we can keep families and loved ones informed of their activities.

I can't tell you how proud I am of everyone who answered this call to deliver aid to people halfway around the world; and of those who stepped up in their absence to ensure that day-to-day operations at MGH continue uninterrupted. It's an amazing display of courage, generosity, and spirit, and I thank you all for your willingness to get involved.

**Johnson & Johnson's Promise of Nursing**

As many of you know, the Promise of Nursing gala celebration sponsored by Johnson & Johnson was cancelled due to our uncooperative New England weather. The fund-raiser netted more than $731,000 to support nursing scholarships, fellowships, and grants for program-development at nursing schools across Massachusetts.

At a time when Massachusetts is experiencing an 11% vacancy rate in nursing positions (expected to grow to 29% in the next 15 years) we are indebted to Johnson & Johnson for their proactive efforts in trying to curb this unprecedented shortage.

**Storm Watch 2005**

I'm happy to report that MGH remained fully operational during the blizzard and snow storms that blanketed Boston and surrounding areas in the past weeks. I've received numerous phone calls and e-mails from managers and supervisors commending staff for their efforts above and beyond expectations; and I witnessed many of those acts of selflessness first-hand. I thank you all for continuing to raise the bar on compassion and commitment. I'd like to extend a special thanks to operations coordinators, Judy Sacco and Charlie Ciano, who worked tirelessly and enthusiastically to coordinate food and overnight accommodations for staff who stayed.

Great job, everyone!

**Updates**

I'm happy to announce that Jennifer Roy has accepted the position of operations coordinator for the MICU, effective February 7th.

Julie Boussy has accepted a position as clinical supervisor.

Laura Rossi, RN, has accepted the position of staff specialist in the Office of Quality & Safety.

Volunteers for Operation Unified Assistance just before leaving for Southeast Asia

# More from our Thomas S. Durant fellows in Sudan

From Grace
December, 2004

Ironically, it wasn't a situation you'd think would inspire tears. It wasn't for the man on our nutrition team who lost his two brothers in an attack on the road going north; it wasn't for the woman who was raped nine months ago and then driven out of her home with her eight children by her husband because her child was born with Arab features. It wasn't for the baby who couldn't open her eyes because her conjunctivitis was so bad, and her mother didn't have the knowledge or resources to treat her; and it wasn't for the fragile little grandmother who was caring for her two orphaned, handicapped grandchildren—carrying the 7-year-old on her back because he had never learned to walk.

I felt sorry for all these people, but I never cried. Ridiculously, I cried during a demonstration of how to make corn soya blend into porridge. Staff members were well into a demonstration for a small group of mothers—laughing and chatting as they waited for the porridge to thicken. I was a bit distracted. As they chatted away in Arabic, I was watching four little boys outside our shelter. Knowing they were being watched, they were waving and shouting and jumping off things, as little boys do.

When the porridge was done we invited the boys inside to eat. Amani, our health educator, called them inside and, slightly unsure, they came.

Grace Deveney, RN
Thomas S. Durant fellow

Kate Fallon, RN
Thomas S. Durant fellow

Using a mug full of water and a sandy bar of soap, Amani washed their hands and faces, sat them down on a grass mat, and put the plate of porridge in front of them. I sat in the corner, thinking, "*This* is what it's all about." I watched them eat in silence. They ate with their hands—as they do here—the 5-year-old scooping up a handful and putting it into the hand of his 2-year-old brother before taking another handful for himself. I watched as they scraped the plate clean and then allowed Amani to wash their hands and faces again. The 5-year-old stooped down to allow the 2-year-old to climb on his back, and silently they walked away.

It was such a lovely thing to witness, and I don't know at what point it all became so sad to me. I just started thinking about the children at home and comparing them to these boys, and suddenly I had a lump in my throat.

It was so many things. I thought, do children at home even eat porridge anymore? And if they do how much do they complain about it first? I realized I had witnessed one of the realities for the children of Darfur. Eating here will never be about choice; it will always be about opportunity.

This realization was amplified by the boys' silence. They never said a word. Their silence filled me with deep sadness, but I didn't know why until the children had gone.

I realized then, that it was the intensity of their silence that was so disturbing. A fearfulness that if they made noise or moved too quickly the food would disappear or the provider of the food would change his mind and take it away. A learned reaction to a desperation I never knew as a child and will never truly understand.

I thought of all these things and cried. And as I cried I asked why (that important sort of why that has no answer). Once I started crying, I couldn't stop, and then I *was* crying for the man and his brothers and the woman who lost her place in the community and the baby and the grandmother who is so alone in her burden.

Amani put her hand on my shoulder, and as I looked at her I thought about how beautiful it was to see her wash the children's hands and faces—the tenderness and compassion in the way she interacted with them as though they belonged to her. I thought of the embraces for the man who had lost his brothers, the staff's impromptu collection for the woman with eight children, and the neighbor of the grandmother who carried her bag of porridge for her.

I remembered that the world is not perfect, but it's those things that seem so small that make such a difference. I remembered that a compassionate hand on my shoulder may not have the power to heal, but for a moment, it just might feel like it.

From Kate
December, 2004

It's hard to believe it's December already. It certainly doesn't *feel* like it. It's been another busy week. I made four trips to the mobile clinic. Crowd-control continues to be a problem. I only had one medical assistant, but I did manage to get a local person from the camp to help with wound treatment and injections, and we spent many busy hours seeing patients.

There are a million children running around in the middle of all this and it's hard to tell who's a patient and who's not. The shieks do their best to keep the crowds under control, but it's not easy. Mustafa (my registrar) suggested we move the

*continued on next page*

## Thomas S.Durant Fellows

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registration table outside of the clinic. It helped a little, but people still come up and just put their babies in my arms and start telling me how ill they are.

It's so hard to say no, but the fact is we simply can't treat everyone. There are too many people and too few staff. Sometimes, I leave the clinic feeling good, but most of the time, I feel like we've hardly made a dent.

It's hard turning people away. It's hard knowing there are people we can't help. One mother brought her baby to me with hydrocephalus (fluid around the brain). It was clearly hydrocephalus, his head was severely enlarged. I couldn't do anything for her except refer her to the hospital in Nyala (which is far away, and not free). The same thing happened with a little boy who had a tumor between his eyes, and another boy with a limp, possibly polio. There is nothing in my little metal box to help these people, and it's hard to tell them that.

On a happier note, the children here are the most beautiful kids I've ever seen. They giggle and follow me everywhere. One little boy at the mobile clinic in Dito was so cute. He followed me around and laughed as I made silly faces at him. At one point, when he got up the nerve, he came into the 'pharmacy' where Ismael and I were working to ask for a drink of water. Ismael said, "He just wants a drink from the cowaja." Which was true, as there was a water jug right outside he could have used. Soon, he came in again. I gave him a 'happy-face' sticker, which he was thrilled to get. Then all of a sudden, I realized he was sharing my seat with me. I was sitting on the edge of a wooden chair, and he had climbed up right beside me. I felt his warm little body on my back, and he rested his chin on my shoulder so he could see everything I was doing. I looked at him and laughed. He backed away, thinking he was in trouble, then seconds later, there he was again, my little shadow.

The little boy held the caps to the medicine bottles while I poured, and if something fell on the ground, he was right there to pick it up. I handed him the whole sheet of stickers so he could take another one, and the next time I looked, he had covered himself with happy faces! Three on his forehead, one on each cheek, one on his chin. I wished I had my camera. He really was the cutest kid. I could have taken him home with me. I think his name was Yassin.

**It's hard turning people away. It's hard knowing there are people we can't help. One mother brought her baby to me with hydrocephalus (fluid around the brain). It was clearly hydrocephalus, his head was severely enlarged. I couldn't do anything for her except refer her to the hospital in Nyala... There's nothing in my little metal box to help these people, and it's hard to tell them that.**

We see many anemic patients in Greiga and Dito. There are many patients with malaria, fevers, and leishmaniasis (infection from parasites carried by sandflies). There are respiratory infections and diarrhea. We try to avoid IV use as it's just an opportunity for further infection. However, the other day we saw a very sick young woman. She was very thin with a high fever, and she was clearly dehydrated (her eyes were sunken ).Trying to get an IV in her tiny veins was almost impossible, but we finally managed. After receiving a liter of fluids, she sat up, we gave her some water and Tylenol, and she looked much better . This is the kind of patient I like to see—one we can help.

The time is approaching for proposals to be handed in introducing new projects to be implemented. One idea is to help renovate the school in Donki Dreissa. The community identified education as its highest priority (after security) especially for the female population. I was surprised to hear this, but many members of the community adamantly insisted they wanted to see children in school, and they wanted girls to be educated. They want adult education, too, especially for women. I was surprised to hear the men (because men represent the community at these meetings) speak about how they value women and children and want them to have more opportunities for education. I was impressed. It was very forward-thinking, and I felt I may have underestimated this community.

I see this as a great opportunity to implement a health-education program. We could attract a lot of kids, provide sex-education, nutrition programs, health screenings, vaccinations, etc. It's the perfect way to continue our involvement and help the people of Donki Dreissa get the school and education they want for their kids. The possibilities are endless. It's very exciting to think about building a school, creating a safe place to learn, keeping kids healthy and informed.

I hope everyone is well at MGH. Keep those e-mails coming; I love them!

## Call for Proposals

**Yvonne L. Munn, RN, Nursing Research Awards**

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Week, May, 2005.

Proposals are due by March 1, 2005. Guidelines to assist in developing proposals are available at: http://pcs.mgh.harvard.edu/CCPD/cpd_award_munn.asp (no spaces)

For more information, contact Virginia Capasso, RN, at 726-3836 or by e-mail at vcapasso@partners.org

**Nurse Week 2005 will be celebrated at MGH May 1–6, 2005**

# Phillips 21 nurse has 'Lucky' encounter with patient at end of life

Kathleen Larrivee, RN,
staff nurse, Phillips House 21

My Name is Kathleen Larrivee, and I am a staff nurse on Phillips House 21. I've been a nurse for ten years and a member of the Phillips 21 staff for five. Phillips 21 is a fast-paced, high-acuity unit that sees a very diverse patient population. Oncology patients account for a large part of our census. Over the years, I've developed a passion for caring for patients at the end of life.

His name was Lucky, or at least that's what he told me to call him in his acute delirium. After reading the inter-disciplinary team's documentation about Lucky, I started to gain an understanding about what was happening to him medically, but it told me little about who he was as a person. To deliver personalized care, I was eager to learn about the 'real' Lucky. I knew this delirious man who was agitated and un-cooperative had an identity other than the one I was reading about. Like all experienced caregivers, I've come to appreciate how understanding a patient's medical condition and understanding his personal integrity are related.

That night shift with Lucky was medically challenging. This man with bladder cancer was now showing signs of hematological crisis. His platelet count was dangerously low; his prothombin time was rising; and his LDH was dramatically elevated. The physicians caring for him were working toward a differential diagnosis. His hematological data met the majority criteria for Thrombotic Thrombocytopenic Purpura (TTP), so emergent plasmapheresis was initiated in the middle of the night. Although the exact etiology of his hematological crisis was unknown, this was considered the most appropriate remedy.

As the night wore on, Lucky's discomfort from profuse lymphedema in his leg and the pain of bladder cancer became almost blurred by his delirium and agitation. When a confused patient fixates on a statement like, "I've gotta get out of here!" there's usually tremendous underlying meaning. He was clearly in distress. Managing Lucky's pain was also a primary clinical goal.

At 7:00am, my night shift ended. I left, not knowing how Lucky would progress medically and without knowing much at all about his personality, character, family, or personal life.

Six days later on a Saturday morning, I took report. Lucky was one of my patients. This man being screened for inpatient hospice, now had invasive bone-marrow cancer and bladder cancer recurrence. There was no curative treatment for him. I wish I could say I was surprised by this devastating prognosis, but I wasn't. I had known on Monday that although a differential diagnosis had not been reached, any potential diagnosis was not going to be good. It became even more important to me now to get to know this man.

When I entered his room, I saw the patient observer next to his bed. Lucky was at high risk for self-injury due to his confusion and agitation. He had attempted to pull out his intra-jugular central line. I noted that the bladder irrigant was flowing and the output in the three-way foley drainage bag could not have looked more ominous. Frank blood, copious amounts. His right leg was twice the size it had been on Monday when I last saw him. The intravenous hydromorphone he had received showed some decrease in verbal and non-verbal pain indicators, but not relief. He was writhing in bed, mumbling in non-sensible language. The medical resident and I met to discuss Lucky's symptoms and our plan for managing them. Lucky's physical appearance was striking. He had heavy beard growth and his hair was disheveled. Last weekend this man was pristinely shaven with not a hair out of place.

Soon family members arrived. Lucky was unable to tell me about himself, but I was sure with the help of his family, I would be able to learn more about him. A niece and nephew explained to me that Lucky was a hairdresser. He always put a huge emphasis on personal appearance, in particular, his hair.

"He combs his hair up like Elvis all the time," said the nephew.

I asked if he was usually clean shaven and they said they'd *never* seen him with any beard growth. In light of his platelet count and clotting issues, shaving him was a clinical risk, but one I chose to take. Maintaining his dignity was a more pressing concern. Slowly, and with utmost caution, I soaked his beard with warm water and shaving cream and began to shave him. Amid his ramblings of delirious thoughts, he instinctively moved his lips and cheeks in an effort to assist me in shaving him. I finished without causing any bleeding.

"That's what my uncle looks like," said the nephew.

I was starting to learn more about my patient.

Hourly, I changed Lucky's Murphy drip bags. I've seen so many patients with hematuria over the years, but not to

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## Clinical Narrative

*continued from previous page*

this degree. I got him to drink a few sips of water, but oral medications were not an option due to his risk for aspiration. Intravenous Haldol was decreasing his agitation and restlessness, but after two hours it would return in intensity. I was in close contact with the medical resident. I was glad he had been caring for Lucky all week and was very familiar with his plan of care.

Lucky's oncologist and other members of the team had had a meeting with Lucky and his family on Friday and discussed his prognosis and imminent death. Lucky's comfort became the primary goal of care. Since there was still some difficulty achieving this goal with Lucky's current pain medication, I suggested a consult to Palliative Care.

On Saturday evening, several more family members came to visit, all offering more insight into Lucky's true nature. He was a gentleman who, up until about a week prior to his admission, was active in community government. He was a father to three sons and a grandfather to grandchildren, ages 2-17. He loved to go to the track and once owned racing horses. (Now I understood why in a delirious state he chose the name Lucky!) I learned that he met his wife in hairdressing school and had been married for 47 years. His only living sibling was flying in from Florida on Monday afternoon.

After speaking with Lucky's niece and daughter-in-law, I learned that Lucky had lost his parents and other siblings to cancer. This family was not unfamiliar with the devastation of this disease.

Sunday brought more medical challenges and a consultation with Palliative Care. Palliative Care offered great assistance and recommendations for managing Lucky's increasing pain, agitation, and now constant twitching (thought to be associated, in part, with the hypercalcemia that was now irreversible). With increased doses of hydromorphone, Haldol, and Ativan, by Sunday evening Lucky's pain seemed to be under control. His agitation had subsided, and the twitching had decreased substantially.

I was scheduled to work the day shift on Monday and wasn't sure Lucky would make it through the night.

On Monday morning, Lucky was largely unresponsive except for brief periods when it seemed as if he was smiling. The twitching had stopped. He finally looked comfortable.

Lucky's wife visited alone that morning, and she watched as I bathed him. I asked her how long they'd been married and she said, It 'would have been' 47 years next month. She knew he was dying. She told me they had met in hairdressing school. "We always did each other's hair," she said. "He's done my hair my whole life. I'm going to have to find someone else to do it now."

She assured me she'd call me if Lucky needed anything. When I returned to the room later, she had left unannounced.

Soon, a brother- and sister-in-law arrived. "Why is this happening to him?" they asked. "He has so much to live for. My mother is in a nursing home with dementia; and he was fine just two weeks ago!"

We talked about the complexities of life and death and commiserated about how frustrating those unanswerable questions are. This family was very open and sharing and gave me a great appreciation for Lucky and his loved ones.

The next visitor was a gentleman who walked with a cane. "I'm not a family member, just a friend," he said.

After all the other visitors had gone, he sat by Lucky's side. "I've known him for forty years. He was my son's little-league coach and we became friends. I've seen this before. My son died of cancer when he was thirty-three, and his breathing sounded just like that. I watched my mother die, and her breathing sounded like that, too."

I reassured Lucky's friend that I was there to answer any questions and provide support. He tried to comfort me. He said, "There are a lot of good times in life. You have a lot ahead of you."

What a compassionate person, I thought.

Lucky had come up with a very appropriate nickname for himself. He *was* lucky to be surrounded by so many caring friends and family members. I feel lucky to have had the opportunity to learn more about him from his loved ones. Lucky, the patient and the person, died that Monday at approximately 5:00pm.

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

Kathleen truly provided holistic care in this very moving narrative chronicling Lucky's final hospitalization. From shaving him (despite the high risk of bleeding), to ensuring he received appropriate pain medication, to supporting his family during this time of great anguish, Kathleen never let the technical complexities overshadow the human side. She honored Lucky's last days by learning who he was, what his life was like, and how his friends and family felt about him.

Losing a loved one is never easy, but having a nurse like Kathleen to provide care and comfort is a gift.

Thank-you, Kathleen

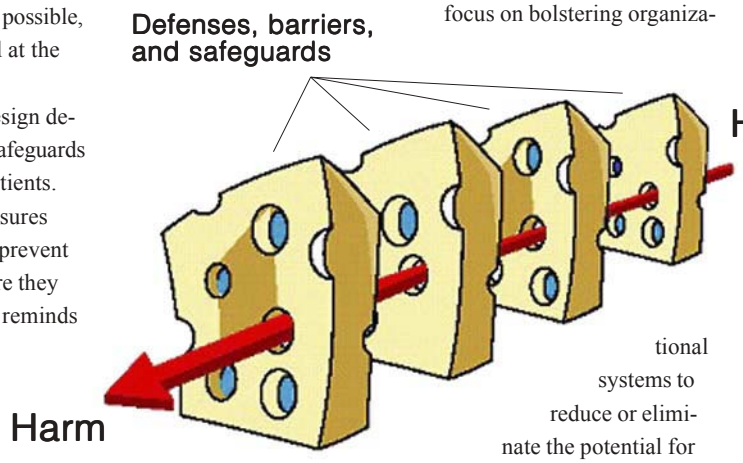
# Human error and systems thinking

*—by Georgia Peirce, director of PCS Promotional Communications and Publicity and National Patient Safety Leadership fellow*

As we examine James Reason's 'Swiss cheese' model for understanding human error (see January 20, 2005, *Caring Headlines*), we see that every human system has a potential for error. Neither the system nor the people working within it are perfect. Our goal is to ensure that practice is as close to perfect as humanly possible, both individually and at the systems level.

We continue to design defenses, barriers, and safeguards to keep harm from patients. And these safety measures consistently catch or prevent nearly all errors before they occur. But as Reason reminds us, all systems have potential holes or flaws. To make matters more complex, these holes are constantly shifting, shrinking, and growing, essentially becoming 'moving targets.' On those rare occasions when the holes in the defenses line up, there is a clear path for harm to reach the patient—for an adverse event to occur.

Reason theorizes that holes in defenses are the result of 'active failures' or 'latent conditions.' Active failures occur at the 'sharp end' of the system—the point where care is being delivered directly to the patient. Medical error pioneer, Lucian Leape, MD, in his landmark 1994 *JAMA* paper, "Error in Medicine," said that, "Most errors result from aberrations in mental functioning... [much of which] is automatic, rapid and effortless." Leape used the example of someone driving to work. "A person can leave home, enter and start the car, drive to work, park and enter the office without devoting much conscious thought to any of the hundreds of maneuvers and decisions that this complex set of actions requires." An example of active failure might be when a person automatically drives to work on her day off.




Human-error studies demonstrate that errors people make are predictable and more likely to occur within complex and/or poorly designed systems. Human nature cannot be altered; we are fallible, and error is an inherent part of our system. Our attention, then, must be on identifying where problems might occur and building robust safeguards against them. As Reason says, "We cannot change the human condition, [but] we can change the conditions under which humans work." Patient-safety efforts need to focus on bolstering organizational systems to reduce or eliminate the potential for error wherever possible—to identify and fix the holes in the system.

Latent conditions refer to 'organizational accidents waiting to happen.' They are the holes in the system, or in Reason's Swiss cheese model, the holes in the slices of cheese. Latent conditions are created at the 'blunt end' of the system, at higher levels in the organization, farther away from direct patient care. For example, imagine that a new, top-quality, patient-monitoring device was introduced at a healthcare institution. The quality ratings and costs of the equipment fell within acceptable parameters. However, months after roll-out, staff noticed that when used with a certain population of patients, programming the device became cumbersome. Staff learned to work around the problem, and no errors occurred for more than a year. But the new device still had the *potential* to cause a rare but very real adverse event. The situation came about as a result of a data-driven management decision at a very high level, and with the best of intentions. However, the latent condition embedded in the system could lay dormant for a long time before causing an error on that rare occasion when all the other tiny holes in the system lined up.

We can't change the fact that humans and the systems they work in are imperfect. We *can* continue to focus on creating a safe environment for the delivery of patient care at every level. At MGH there are countless improvement initiatives in place designed to reduce and minimize errors. We all play a vital role in this effort. Look for accidents waiting to happen—the holes in the Swiss cheese—and fix them, or find someone who can.

# NICHE Phase II: the Geriatric Institutional Assessment Profile (GIAP) Survey

*—by Andrea Bonanno, PT, clinical specialist, and Mary Ellen Heike, RN, staff specialist*

You may recall that we began our journey to develop a multi-disciplinary NICHE, (Networking to Improve the Care of Health-System Elders) program at MGH by asking nurses on inpatient units to complete the Geriatric Institutional Assessment Profile (GIAP) survey. Results from the GIAP will help us understand and assess our perceptions and knowledge about caring for elders and allow us to benchmark our care against care provided at other NICHE hospitals.

More than 37% of the nursing staff participated in the survey. On many units, more than 50% of the nursing staff completed surveys making them eligible to win a pizza party for their unit. Phillips House 21 was the lucky winner.

The next step will be to invite clinicians in other disciplines throughout Patient Care Services to complete the GIAP survey. It's important that caregivers in all disciplines complete the survey to get a true indication of the knowledge and perceptions of all staff who deliver care to hospitalized elders.

Information on NICHE and the GIAP will be distributed to clinicians in Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech-Language Pathology, Chaplaincy, Interpreter Services, and Social Services.

The GIAP is an important part of the assessment phase of the NICHE program.

For more information about NICHE or the GIAP survey, e-mail Mary Ellen Heike RN, or Andrea Bonnano, PT.

## Your Opinion Counts!

**Staff Perceptions of the Professional Practice Environment Survey – 2005**

Surveys will be mailed to all direct-care providers during the last week of February. If you don't receive a survey by March 4th, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are kept confidential.

**Please complete and return your survey by March 25, 2005.**

For more information, call 726-3111

## The Different Faces of Quality Improvement: Creating an Environment of Quality and Safe Practice

All members of the MGH community are invited to attend this educational offering to learn how to create and maintain the safest possible environment for patients, families, visitors, and employees. Topics will include:

Strategic Planning
Patient Safety Goals for 2005
The Role of Patient Safety Rounds
Planning a Project Improvement Initiative
Hand Hygiene

Keynote speaker, Anita Tucker, DBA, will speak on,
"The Impact of Operational Failures on Nurses and their Patients"

**Monday, February 7, 2005**
**8:00am–4:30pm**
**O'Keeffe Auditorium**

CEUs available
For more information, call 6-3111

## On-site/On-line RN to BSN degrees in Nursing

MGH nurses seeking a baccalaureate (BSN) in Nursing, come learn more about opportunities to earn degrees through on-site and on-line programs.

On-site program offered by Northeastern University

On-line (distance learning) program offered by St. Joseph's College of Maine

**Information Session**
**Monday, February 7, 2005**
**6:30am–8:00pm**
**Main Corridor**

For more information, contact Miriam Greenspan, RN, on-site/on-line education coordinator in The Center for Clinical & Professional Development at: 4-3506 pager: 3-0724 or by e-mail.
(Next class session in late March)



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For more information, call: 617-724-1746.

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February 17, 2005

# Magnet conference provides insight, energy, and opportunity

*—by Lauren Holm, RN, staff specialist*

Becoming a Magnet hospital is the highest recognition a hospital can receive for its nursing care. Less than 2% of hospitals in the United States receive this designation by the American Nurses Credentialing Center (ANCC). MGH was the first hospital in Massachusetts to earn Magnet status.

Recently, four MGH nurses attended the 8th Annual Magnet Conference in Sacramento, California. Staff nurse, Chelby Cierpial, RN, of Ellison 11; nurse manager, Adele Keeley, RN, of the Medical Intensive Care Unit (MICU); and clinical nurse specialists, Mary Lavieri, RN, of the MICU, and Mary Lou Kelleher, RN, from Pediatrics, were happy to have this opportunity to gather and share information from their various perspectives.

Kelleher submitted a poster abstract and gave a lecture entitled, "Magnetic Nurses Create a Pediatric Center of Excellence in a Large Adult Medical Center." Says Kelleher, "The conference was a great opportunity for networking. Many attendees seeking Magnet designation approached nurses from hospitals that had already been recognized. They wanted to know what it's like to practice at a Magnet hospital. The conversations were energizing." Kelleher connected with a psychologist in California who developed a tool that Kelleher will use as part of her Yvonne Munn research study.

Keeley and Lavieri presented a poster on, "The Organizational Structures that Support Nursing Research: a Lived Experience," showcasing their work in the area of end-of-life care (which they did in collaboartation with Ed Coakley, RN; Kathy Grinke, RN; and Kathryn Degenova, RN).

Keeley says attendees wanted to know how she combines her management and research roles, noting how impressive it is to have a nurse manager as co-principle investigator with a physician.

Lavieri presented on the "Get to Know Me" posters used in ICUs at MGH. The posters were developed with Marilyn Wise, LICSW, and feature a biographical sketch of ICU patients who are unconscious or unable to communicate with caregivers. Says Lavieri, "The posters were a big part of the presentation. It was great for attendees to be able to see actual Get to Know Me posters and discuss them with the creators."

Cierpial presented a poster on, "Discharge Guidelines after Coronary Procedures," showing research led by a staff nurse (in collaboration with Sioban Haldeman, RN; Judy Silva, RN; Catherine Wetzel, RN; and Colleen Gonzalez, RN). It was Cierpial's first poster presentation and a good opportunity to demonstrate the impact a staff nurse can have on improving patient care. Says Cierpial, "It was so nice to be able to talk with high-level nursing leaders, like the CNO from Johns Hopkins, and compare nursing practice between our two prestigious institutions. Nurses everywhere are faced with the same issues and the same concerns about keeping patients safe."

Approximately 800 of the 2,000 attendees at the conference were staff nurses. Says Cierpial, "They were very interested in nursing research at MGH and impressed that staff nurses play such a big role in that research."

Says Keeley, "I'm so proud of Chelby. She's a master's prepared staff nurse, doing important research at the bedside. She's making a real difference."

All who attended the conference agree that 'magnetism' is alive and well at MGH and at the Magnet conference.



**At left:** Staff nurse, Chelby Cierpial, RN, with her poster at the Magnet Conference in Sacramento.
**Below:** Clinical nurse specialist, Mary Lavieri, RN (left), and nurse manager, Adele Keeley, RN, with their poster.

| When/Where | Description | Contact Hours |
|---|---|---|
| February 15<br>1:30–2:30pm | **On-Line Clinical Resources for Nurses**<br>FND626 | - - - |
| February 17<br>1:30–2:30pm | **Nursing Grand Rounds**<br>"Continuous Opoid Infusions." O'Keeffe Auditorium | 1.2 |
| February 23<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar II**<br>Training Department, Charles River Plaza | 5.4 (for mentors only) |
| February 24<br>1:30–2:30pm | **Nursing Grand Rounds**<br>"Electronic Medication Records." O'Keeffe Auditorium | 1.2 |
| February 25<br>8:00am–4:30pm | **Preceptor Development Program**<br>Training Department, Charles River Plaza | 7 |
| February 25<br>12:00–4:000pm | **Basic Respiratory Nursing Care**<br>Ellison 19 Conference Room (1919) | - - - |
| February 28<br>8:00am–4:00pm | **Advanced Cardiac Life Support—Instructor Training Course**<br>O'Keeffe Auditorium. Current ACLS certification required. Fee: $160 for Partners employees; $200 for all others. For more information, call Barbara Wagner at 726-3905. | - - - |
| March 3<br>7:30–11:00am/12:00–3:30pm | **CPR—American Heart Association BLS Re-Certification**<br>VBK 401 | - - - |
| March 3<br>8:00am–12pm | **Congenital Heart Disease**<br>Haber Conference Room | 4.5 |
| March 4 and March 21<br>8:00am–5:00pm | **Advanced Cardiac Life Support (ACLS)—Provider Course**<br>Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room | 16.8<br>for completing both days |
| March 7<br>8:00–11:00am | **Advance Directives: Hard Facts, Humor and How To's**<br>O'Keeffe Auditorium | 3.3 |
| March 8<br>8:00am and 12:00pm (Adult)<br>10:00am and 2:00pm (Pediatric) | **CPR—Age-Specific Mannequin Demonstration of BLS Skills**<br>VBK 401 (No BLS card given) | - - - |
| March 9<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar I**<br>Training Department, Charles River Plaza | 6.0<br>(for mentors only) |
| March 9<br>11:00am–12:00pm | **Nursing Grand Rounds**<br>"Methadone: an Important Analgesic." Sweet Conference Room GRB 432 | 1.2 |
| March 9 and 10<br>8:00–5:00pm | **End-of-Life Nursing Education Program**<br>TBA | TBA |
| March 10<br>1:30–2:30pm | **OA/PCA/USA Connections**<br>"Professional Interactions in a Diverse Hospital Setting." Bigelow 4 Amphitheater | - - - |
| March 14<br>8:00am–4:30pm | **Intermediate Respiratory Care**<br>Wellman Conference Room | TBA |
| March 15<br>8:00am–2:00pm | **BLS Certification for Healthcare Providers**<br>VBK601 | - - - |
| March 16<br>4:00–5:30pm | **Natural Medicines: Helpful or Harmful?**<br>Founders 626 | 1.8 |
| March 17<br>7:30–11:00am/12:00–3:30pm | **CPR—American Heart Association BLS Re-Certification**<br>VBK 401 | - - - |
| March 21<br>8:00am–4:30pm | **Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other**<br>Training Department, Charles River Plaza | 7.2 |

*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 latest on transportation, parking, and construction at MGH

*Throughout the Big Dig, the Charles Street T-station construction, and many other construction projects in the area, numerous transportation and parking issues are going to arise. To keep MGH employees informed, Police & Security will provide regular updates in future issues of* Caring Headlines.

*Question*: Is it true that weekend parking is free?

*Jeanette*: Yes. Employees who sign up for a night/weekend garage access card can park for free on weekends, holidays, and at night. There's no charge for the card, but employees *are required to use the access card* when parking in the Fruit and Parkman Street garages. Drivers must exit the garages by 9:30am (Monday through Friday). Access cards do not work in the Yawkey garage.

*Question*: Sometimes I'm rushed and can't find my access card. Can I take a paper ticket on the way into the garage and use my access card on the way out?

*Jeanette*: No. If you take a paper ticket on the way into the garage, you are required to pay the cashier for ticketed parking before exiting. Using the access card when you exit, if you haven't used it to enter, will automatically disable your card.

More than 3,500 patients and visitors use the front garages on a daily basis. All ticket transactions are closely audited. When someone pulls a ticket to enter the garage and tries to exit using an access card, it throws off the whole audit. Every ticket that isn't processed both 'in' and 'out' triggers an investigation. To ensure compliance, a process was implemented a few years ago whereby a garage access card cannot be used out of sequence. The card must be used to both enter and exit the garage before it can be used to enter the garage again.

*Question*: Why do cashiers have to keep my access card when it's not working properly?

*Jeanette*: Cashiers only take an employee's access card when the Employee Parking Office is closed. This is so that staff of the Employee Parking Office can thoroughly test the card and review its history to identify the problem. We've discovered, on occasion, that cards malfunction and need to be replaced. But more often than not, cards have been used out of sequence.

*Question*: Why aren't employees allowed to park in the Yawkey garage?

*Jeanette*: As part of a written agreement with the city of Boston, employees are not permitted to park in the Yawkey garage. City officials and members of the community were concerned that if the garage were used for employee parking, it would force patients and visitors to park on local streets and in other non-MGH garages, adding to the parking shortage. Employees may be permitted to park in the Yawkey garage during certain emergencies (such as when the Fruit Street garage was closed for repairs in December).

*Question*: Are there any other parking spaces available for MGH employees?

*Jeanette*: There are some, but not many. Although the Big Dig and other construction projects have impacted parking, a limited number of spaces are available at the Museum of Science parking garage. For more information or to add your name to the waiting list, please call the Parking Office at 726-6686.

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