

Caring

July 7, 2005

HEADLINES

2005 Cronin Raphael Award: a heartwarming ceremony

—by Julie Goldman, RN, professional development coordinator

There were tears of joy, tears of remembrance, tears of pride, and tears of empathy. For a typically happy occasion like an award presentation... there were a lot of tears! But this wasn't a typical award ceremony.

The Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy honors the memory of Paul Cronin and Ellen Raphael, two patients on Phillips 21 who died within months of each other in 1997. As described in the December 16, 2000, *Caring Head-*

lines, "The night Paul Cronin was to propose marriage to long-time girlfriend, Ellen Raphael, he started experiencing symptoms of a serious illness. Eighteen months later, he lost his battle with brain cancer and died at the age of 59.

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Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy recipient, Yi Lin 'Hope' Kuo, RN (center), with members of the Cronin and Raphael families at ceremony on Phillips House 21

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Fast times at MGH: many services available to support staff

While many other industries may be experiencing lulls in business or a slow-down in day-to-day operations, the healthcare industry in general, and MGH in particular, are busier than ever. The stress and fast pace of a hectic workplace can make it difficult to balance the competing demands of our personal and professional lives. But at MGH, we're fortunate to have a number of services available on campus to help make those personal demands easier to meet. I want to make sure you're aware of some of the programs and services available to you. Did you know:

The Back-Up Child Care Center, located in the Warren lobby, cares for toddlers, pre-school, and school-aged children on a back-up basis when primary child care is unavailable. Teacher-directed and free-expression activities are encouraged in a safe, supportive, and educational environment. For information, call 4-7171.

The MGH Photo Lab, located in the Bulfinch basement offers on-site film-processing, passport photos, picture-framing, photo-restoration and re-touching. They can be reached at 6-2237.

For the convenience of employees, the Harvard University Employee Credit Union has a branch office located on the first floor of the Clinics Building (with ATM machines at that location and in the Charlestown Navy Yard at 149 13th Street). Employees' family members are also eligible to join. For information, call 617-726-1630.

General Hair Care (formerly Images), the on-site hair salon, offers haircuts, coloring, facial waxing, and a wide array of cosmetics and professional hair-care products. Appointments or walk-ins are accepted; and there's a new-employee discount every month.

The MGH General Store has an extensive selection of medical uniforms, footwear, and supplies, as well as many unique gifts, accessories, gift baskets for all occasions, and a full-service florist. Free gift wrapping is available with every purchase.

Eat Street Café, located in the White basement, is a full-service cafeteria that 'caters' to the nutritional needs and desires of a culturally diverse workforce and patient population. They have a wide variety of options ranging from pizza and salads to sand-

wiches, soups, grilled dishes, desserts, and much more. Meals are available to go, and every day a nutritionally balanced meal is identified through the Nutra-Alert Program. For information, call 4-6368.

All benefits-eligible MGH employees can join The Club at Charles River Park, a full-service fitness center located at 8 Whittier Place. Membership is offered at a special hospital-subsidized rate that can be automatically deducted from an employee's paycheck. For information, call 6-2900.

Employees who work 20 hours or more a week and don't take a parking deduction are eligible to receive a partially subsidized T-pass which is distributed with paychecks on the last Thursday of every month. For information, call 6-3368.

In partnership with Jewish Vocational Services, MGH offers a number of on-site English for Speakers of Other Languages classes, emphasizing fundamental reading and writing skills. Classes meet for 90 minutes twice a week during the academic calendar year. For more information, call Jane Ravid at 4-3976 or Heather McNemar at 6-2388.

The On-site/On-line Education Program of-



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

fers MGH nurses the opportunity to further their education through RN-to-BSN-degree and BSN-to-MSN-degree programs using partnerships with Northeastern University, St. Joseph's College of Maine, and/or the IHP. For more information, call 4-3506.

The Support Services Employee Grant Program helps employees, financially, to return to school and acquire the skills or education they need to advance their careers. Grants can be used for tuition, books, lab fees, and other costs related to professional development. For information, call 4-3055.

Employees in good standing are eligible to participate in the Tuition Reimbursement Program (after six months of employment). For specific information on this program, call Training & Workforce Development at 6-2230.

TQ3Navigant is the official travel agent for

all MGH business travel. With a simple phone call and your PeopleSoft number, it's quick and easy to make hotel, rental car, airline, and other travel arrangements. Call 617-451-4200.

Every week the MGH Perks Office sends out an e-mail describing numerous discounted events and opportunities available to MGH employees, including discounted movie tickets, tickets to sporting events, concerts, and other local special events. For information, call 4-7835.

Adjacent to Ruth Sleeper Hall is the MGH Bike Cage where employees can park (and lock) their bikes if they choose to ride their bicycles to work. For information, call 6-8886.

Free, day-long shuttle service is available to take employees to and from parking lots and Partners-affiliated hospitals and health centers. For information on sche-

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Dispelling myths about the PCS Clinical Recognition Program

Question: When was the Clinical Recognition Program implemented?

Jeanette: The PCS Clinical Recognition Program was implemented in 2002. It provides a way to formally recognize clinical staff for their expertise in caring for patients and families. The Clinical Recognition Program recognizes that valuable contributions are made by staff at every level (entry, clinician, advanced clinician, and clinical scholar); and that excellence is a goal common to all clinicians. When clinicians achieve a level of practice, it is noted in the Peoplesoft database by their managers. Currently, all clin-

icians within Patient Care Services participate in the program, 103 at the advanced clinician level, and 44 at the clinical scholar level.

Question: How is the program working?

Jeanette: We have to remember that we're still in the early stages of development. Programs of this magnitude usually take five to seven years to be fully implemented and have their impact on clinical culture felt. I'm pleased with the number of clinicians recognized at all levels. However, there are still 'myths' about the Clinical Recognition Program I'd like to clarify for you.

Question: Is there an educational requirement to apply for advanced clinician or clinical scholar?

Jeanette: This is a myth. There is no educational requirement for advanced clinicians or clinical scholars. Staff who have received associate, diploma, bachelor's, master's and doctoral degrees are eligible for recognition and have been recognized. The Clinical Recognition Program is about clinical practice. It's about the knowledge and skills you bring to: clinician-patient relationships; teamwork and collaboration; and clinical knowledge and decision-mak-

ing (and for Occupational and Physical Therapy, movement is another area of practice considered).

Question: Do you have to publish in order to be recognized as an advanced clinician or clinical scholar?

Jeanette: This is also a myth. While some advanced clinicians and clinical scholars have published articles in various journals, it's not a requirement for recognition at any level in the program.

Question: Is it true that to be recognized a clinician must be certified in ECMO, CVVH, or other advanced competencies?

Jeanette: Another myth. While some clinicians who have been recognized are accomplished in those therapies and others, those skills are not a requirement for recognition. Recognition is based on practice and whether or not clinicians meet the criteria for the level they are applying to, not their ability to perform a specific skill, therapy, or intervention.

Question: Do clinicians have to be a member of a committee to be recognized as an advanced clinician or clinical scholar?

Jeanette: You do not have to be a member of a committee to be eligible for recognition. It's true that at the advanced-clinician or clinical-scho-

lar level, staff are comfortable within the three themes of practice. They look beyond individual patients to patterns of needs among patient populations, the practice and educational needs of their colleagues, and systems that need to be responsive to patients and families. Clinicians can accomplish this by being a member of a committee or by working with colleagues on a day-to-day basis to achieve the best possible outcomes for patients and families and to advance excellent practice.

Question: I've heard the interview part of the process is intense. How should I prepare?

Jeanette: Many clinicians feel that talking about themselves and their practice is difficult. Staff who have been recognized tell us the best way to prepare for the interview is to:

- review your portfolio
- ask a colleague, manager, or clinical specialist to conduct a mock interview with you
- talk with someone who's been through the process who can share their experience and offer advice
- relax

I would also encourage you to visit our website (at: <http://pcs.mgh.harvard.edu>, and click on Clinical Recognition Program) for more information on the program or tips on how to prepare for the interview.

Jeanette Ives Erickson

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dules, routes, and pickup locations, call 6-2250.

At a time when many of us feel like we live at work, it's nice to know there are so many programs and services available on campus to make our lives easier. And these are just a few of the options we have. I didn't even mention Coffee Central; our partnership with Bank of America that allows employees to enjoy direct-deposit banking with limited fees; MGH Mail Services, that offers FedEx and UPS shipping (with credit-

card payment only), on-line shipping, and FedEx, UPS, and US Postal Service mailboxes outside the Mail Room in the Gray basement (for more information, call 6-4368); free parking in the MGH garages evenings, nights, and weekends; and newspaper machines in the Main Corridor and outside the Jackson Building entrance. We really are fortunate to have so many conveniences to help us accomplish our tasks efficiently so we can focus on the important things.

Update

It's my pleasure to announce that Patricia Owens, RN, has accepted a position as clinical nurse supervisor. She will be working full-time nights and brings considerable skill and ability to the role.

Karen Pickell, RN, has accepted the position of nurse practitioner on the White 11 General Medicine Unit. She will assume responsibilities on July 11, 2005.

Karen Fitzgerald, RN, has accepted the position of clinical nurse specialist for the PACU.

Infant massage: nourishing your baby's mind and body

—by Laurel McConnell and the OB Family Education Program

Infant massage is not a new idea. It's an ancient art that is practiced all over the world. In the United States, however, the art and practice of infant massage began to disappear in the last century. For many decades parenting experts advised a 'hands-off' approach to babies. But as recent research studies have confirmed, touch is nourishing to babies. Touch is extremely important for healthy development. Babies need touch as much as they need food to grow physically and emotionally.

The stimulation of skin during massage carries a message of warmth, caring, and love. It helps your baby develop trust. It brings you a sense of relaxation and allows you to share special time with your baby. Massage helps you understand your baby's cues. It helps you understand what your baby is telling you. By taking the time to just 'be' with your baby, you're letting him know how important and special he is. You're building and strengthening a bond that will grow and hopefully last a lifetime.

Research tells us that infants who are massaged gain weight faster than those who aren't. Massage helps mature

the nervous system, improve digestion, relieve colic (intestinal pain), and improve muscle tone and circulation. Massage has been known to relieve discomfort from teething, congestion, constipation and emotional distress. It improves infants' sensory awareness and increases vocalization.

When you massage your infant, you're giving her your full attention. You're focused on her, talking to her, and your loving touch and eyes bring her focus to you. She then begins to respond. As you engage each other, you continue

to bond and nurture the attachment you began at birth. An intimate relationship develops between you and your baby that can bring infinite rewards and pleasure.

Infant massage is about love. There's no right or wrong time to learn it, and it's never too late to start. Your strong but gentle touch, the rhythm you create, your eyes, your smile, and your voice are all part of the experience.

Expectant parents often learn infant massage pre-natally so they'll be prepared right from the start. Others learn after their child is born.

Whether your baby is a newborn or several years old, massage can bring wonderful, immediate, lasting results.

For more information on infant massage, consult:

- *Your Amazing Newborn*, by Klaus and Marshall
- *Infant Massage, a Handbook for Loving*,

by McClure and Vimala."

- *Parents*
- *Baby Massage, a Practical Guide to Massage and Movement for Babies and Infants*
- www.massgeneral.org/familyeducation
- www.nurturingparenting.com
- www.iaim.net
- www.zerotothree.org

Research on infant massages shows benefits in:

- *bonding*; an intimate interaction promotes the parent/child bond and attachment
- *stimulation*; enhances brain development, increases circulation and respiratory function
- *stress-release*; helps baby and parent release tension and learn to relax
- *sleep-improvement*; many babies sleep longer and deeper
- *communication*; touch sends a message of love and trust. Massage helps babies be heard allows a time for them to communicate with you
- *builds confidence*; touch helps parents understand their baby's body language and needs



Laurel McConnell, infant massage instructor (background), observes as mom 'tries her hand' at infant massage

(Photo provided by staff)

Cronin Raphael Award

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Three months after his death, Ellen learned that she, too, had cancer, and within weeks passed away at age 42.”

In recognition of the exemplary nursing care Cronin and Raphael received during their stay on Phillips 21, their families established this award to recognize clinical and/or support staff who consistently demonstrate excellence in addressing the needs of patients and families.

This year’s recipient, Yi Lin ‘Hope’ Kuo, RN, became a nurse in Taiwan before coming to the United States. In her letter of nomination, colleague, Molly Vaillancourt, RN, said of Kuo, “On a daily basis, Hope demonstrates excellence in advocating for her patients. She is a peaceful intermediary for staff and families, she has unwavering commitment, and she always provides kind, compassionate care. Hope is

known to her colleagues as a gentle, caring, nurturing soul.”

Accepting the award, a tearful Kuo said, “Ever since coming to this country, I was looking for a place where I could fit in, where I belonged. When I found MGH and Phillips 21, I found that place. My family was not able to be here today, but I feel like I am with my family when I am with all of you. Keith [Perleberg] is such a warm and wonderful manager; his door is always open.”

Kuo revealed that she’d been diagnosed with a serious illness this past year. In her heartfelt (and sometimes heart-wrenching) speech, she said, “If you have never been sick, you don’t know how painful treatments can be. You don’t know what it feels like to need help to go to the bathroom. You don’t know what it feels like to have to take your clothes off in front of doctors

and nurses. My experiences as a patient have made me a better nurse.”

Walter Zawacki, RN, a nurse currently being precepted by Kuo, described her as, “a thorough and caring person who’s always willing to go the extra distance for her patients. It has been such a gift to work with her.”

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, remarked that while Kuo’s experiences as a patient would no doubt make her a better nurse, her career to date has already proven her to be an exemplary caregiver. “Paul

and Ellen would be proud,” she said, “that you were chosen to carry on the legacy of outstanding patient advocates who’ve received this award.”

Speaking on behalf of the Cronin and Raphael families, Ellen’s sister, Jayne Raphael Simmons, observed, “On my way here today, I was thinking about the qualities that best represent what this award was intended to recognize, and I fixed on the words ‘courage’ and ‘connection.’ After hearing about

Hope’s experiences this past year, I’m struck by what a perfect choice she was for this award. The courage she showed and the connections she’s made with patients and colleagues is truly what Paul and Ellen were all about. And her name is Hope,” she added. “How perfect is that? Paul and Ellen both clung to hope right up to the end of their lives. I think they’d both be very happy to see you receive this award today.”



Award recipient, Yi Lin ‘Hope’ Kuo, RN, with (clockwise from top left): Preceptee, Walter Zawacki, RN; senior vice president for Patient Care, Jeanette Ives Erickson, RN; nurse manager, Keith Perleberg, RN; associate chief nurse, Theresa Gallivan, RN; and members of the Cronin and Raphael families

Patient education: integrating knowledge and skill into practice

—by Cheryl Brunelle, PT; Charlotte Schmidt, RD, LDN; Angela Sorge, RN;
PCS Patient Education Committee

Mr. Lopez is a 68-year-old Hispanic male who was admitted to MGH following an episode of angina and shortness of breath associated with coronary artery disease (CAD). Upon admission, Mr. Lopez had a coronary stent placed and was found to be in congestive heart failure (CHF). He has had hypercholesterolemia, hypertension, and smokes a pack of cigarettes a day. He took Lipitor, Atenolol, and Aspirin prior to admission. He's married with two adult children. He is a retired longshoreman who worked on the Boston fish piers all his adult life. Mr. Lopez speaks some English and completed sixth grade. His wife and family are supportive and speak fluent English. He lives a sedentary life-style, but walks his dog a short distance each day.

Mr. Lopez will need education on many topics prior to discharge. How would you approach this?

With any patient, the first step in teaching is to assess the patient's educational needs. Determine if there are any communication or language barriers. Find out what the patient's learning style is, and assess whether he or she is ready to

learn. Determine the patient's knowledge deficits. Once this assessment is made, education planning can begin.

Identify resources that will be useful, such as communication tools if there's a language barrier. Obtain CAD/CHF educational materials. Print information from CareNotes, Medline Plus, or MGH-produced patient-education materials. Review all printed information before giving it to the patient.

The teaching intervention should address each point identified in the planning stage. It's helpful to involve the patient's family, as they may be able to help the patient make the appropriate life-style changes. Pick a time and place that's convenient for the patient and family. Ensure that the patient and family are comfortably seated and that the health-care professional and interpreter are seated close enough to allow for appropriate eye contact. The room should provide as much privacy as possible (curtain pulled, door closed) with minimal noise.

Teach in a manner consistent with the patient's individual learning style. Be encouraging to help build the patient's confidence in his/

her responsibilities.

After every explanation, have the patient 'teach back' the information by repeating what he or she has learned.

A good question to ask is: "When you get home and your family asks what the nurse/physical therapist/dietitian said, what are you going to tell them?"

If the patient needs help, ask questions to guide him in the right direction. Try to avoid yes/no questions, as you may not get an accurate

reflection of the patient's understanding. Allow the patient and family to ask questions. Make certain that the patient and family have contact phone numbers for questions after discharge. If the patient requires more help, a plan for further patient-education should be established and documented.

Mr. Lopez's expected discharge is 24 hours after admission. So discharge education-planning should begin immediately. A nurse has assessed Mr. Lopez's educational needs. It has been discovered that he doesn't fully understand his diagnosis, medication dosages/instructions,

treatment plan, follow-up care, the importance of smoking-cessation and life-style management, including cardiac rehabilitation and nutrition. An interpreter will be needed to ensure Mr. Lopez fully understands the information being presented (even though his family speaks English).

The nurse concluded that Mr. Lopez is an auditory/visual learner because he does little reading and spends time watching television. Mr. Lopez has a sixth-grade education. Patient-education materials should be written at or below sixth-grade level, so they

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Patient-Education Resources

On-line patient-education resources:

- Interpreter Services: <http://www.massgeneral.org/interpreters/index.asp>; phone: 617-726-6966
- CareNotes: <http://www.thomsonhc.com/carenotes/librarian> (English/Spanish)
- HealthGate: <http://www.massgeneral.org/pflc/learning.asp> (English/Spanish)
- MedlinePlus: <http://www.massgeneral.org/pflc/learning.asp> (English/Spanish)
- MGH Discharge Instructions: under Patient Education: <http://ccmu.massgeneral.org/pathways/> (English/Spanish)
- DrugNotes: <http://www.thomsonhc.com/carenotes/librarian> (English/Spanish)
- MGH Formulary: LexiPals: <http://crlonline.com/crlonline> (16 languages)
- Medication Schedule: MGH Discharge Instructions: <http://ccmu.massgeneral.org/pathways/> (6 languages)
- Stop Smoking Referral: <http://www.massgeneral.org/qss>

Other resources:

- Point-To-Talk booklets: available upon request (segments available on-line)
- Printed materials: e.g. MGH CHF Booklet: Standard Register, Order # 0084070
- Patient-education videos: video list on channel 31, Dial 724-5212 to order videos, follow voice prompts: Numerous titles available
- CHF (English #008, Spanish #013)
- Heart Healthy Eating (English #029, Spanish #030)

Patient Education

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should be appropriate for Mr. Lopez. Review all materials before giving them to Mr. Lopez and his family.

Mr. Lopez has said he would be willing to watch educational videos. He and his family have a low confidence level with the subject matter, as they're not familiar with CAD or CHF. There may be cultural factors that need to be identified in order to transfer care to the home environment. Following the assessment, the nurse begins planning. She prints information in Spanish about Mr. Lopez's discharge medications from DrugNotes and LexiPals. She knows the medication schedule is available in the Partners Handbook if needed. Consults for smoking-cessation and nutrition are ordered.

As caregivers are about to implement the teaching plan, it's determined that Mr. Lopez feels more energetic mid-morning after he's had breakfast. Each discipline makes arrangements to avoid foreseeable interruptions.

It has been established that Mr. Lopez is a visual learner, so he will benefit from patient-education videos available in his room (on-demand) through the MGH patient-education channel. Education is conducted with the help of an interpreter, and the

patient is provided with:

- information and referral to the smoking-cessation program
- a video on CHF and written information to reinforce what has been learned
- an explanation of his medications and a written list/prescriptions for home
- information and refer-

ral to cardiac rehabilitation, including identifying the most convenient center for Mr. Lopez, contact information, and an explanation of the referral process

Other communication tools, such as Point-To-Talk booklets, can be used if an interpreter is not available. (Point-To-Talk booklets contain common phrases in the patient's language and in English, allowing the patient to 'point' to an appropriate phrase and its English translation). Point-To-Talk booklets are available in 17 languages from MGH Interpreters Service.

Mr. Lopez and his family should be encouraged to ask questions or voice concerns at any time. There are things Mr. Lopez needs to know before going home. He needs to know how to monitor his fluid intake and daily weight. It would be a good idea to have Mr. Lopez and his family demonstrate this several times before being discharged. Mr. Lopez should be able to state when it would be neces-

With any patient, the first step in teaching is to assess the patient's educational needs. Determine if there are communication or language barriers. Find out what the patient's learning style is, and assess whether he or she is ready to learn.

sary to call the doctor, when his follow-up appointment is, and what to do in an emergency.

The final part of the patient-education process is documentation. It's the responsibility of health-care professionals to accurately document all education provided to patients and families. From the time of admission to the time of discharge, the inter-disciplinary teaching record is used to document all patient-education. This record plays an essential role. It lets health professionals know if the patient needs further education, and if so, what that education is.

The Post Hospital

Care plan in CAS is also used to document *all* discharge teaching. Upon discharge, patients receive a copy of the care plan, so it's important to include all written discharge information and follow-up phone numbers.

Some patients are discharged to other facilities or discharged home with a visiting nurse. All information must be faxed to the appropriate agencies, and a follow-up verbal report is needed.

As this scenario demonstrates, Mr. Lopez required a great deal of patient education. As lengths of stay decrease and patient acuity rises, the need for efficient, comprehensive patient-education is crucial.

The Staff Nurse Patient Education Internship offered annually by the Blum Patient & Family Learning Center provides an excellent opportunity for staff nurses to develop knowledge and skills in providing patient-education. A patient education specialist mentors the eight-week internship, and upon completion the intern is able to identify quality on-line patient-education

materials and resources; develop and implement a unit-based patient-education project; apply health literacy or 'plain language' principles to patient-education materials; and work with unit staff to enhance unit-based patient-education processes and initiatives.

The application process includes a cover letter, resume, letter of endorsement from a manager or CNS, an interview, and a proposal for a unit-based patient-education project. In addition to learning project-management and implementation skills, the internship shows you how to access quality healthcare information on the Internet by using a media evaluation tool. Patient-education plays a pivotal role in patient care. It's the responsibility of healthcare providers to ensure that information is accurate and appropriate.

For more information regarding The Staff Nurse Patient Education Internship, contact Taryn Pittman, RN, patient education specialist and manager of The Blum Patient & Family Learning Center at 617-724-3822 or by e-mail.

Caring
HEADLINES

Back issues of *Caring Headlines* are available on-line at the Patient Care Services website: <http://pcs.mgh.harvard.edu/>

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

Physical therapist helps patient and family reach goals and return home safely

My name is Carolyn Tassini, and I am a staff physical therapist with experience caring for cardiac and neurology patients (primarily neurology). For a Saturday, my day was going pretty smoothly. Patients were available when I was scheduled to see them, and my day was progressing in a relatively efficient manner. At 3:50pm, my pager went off. "Is anyone available to see a patient for discharge on Ellison 8?"

I looked through my list of remaining patients, checked with the nurses, and returned the page to offer my help. I was then informed that the patient was on White 8, not Ellison 8. That meant the Medical Unit not the Cardiac Service. I re-assured myself that I could handle this case.

I quickly made my way to White 8. The nurse was waiting for me. She said the team wanted to discharge Mr. D that evening. I looked at my watch: 4:00. Several thoughts went through my mind. If the team intended to send this gentleman home that evening, they must have no doubts about his safety. I located his chart and started to review Mr. D's record. He was a 78-year-old man with a history of diffuse Lewy

body disease (a form of dementia) who presented with a two-week history of black and tarry stool. He had poor food intake over the last three or four months with a 20-pound weight loss. He was admitted with a gastrointestinal bleed, that had resulted in a 10-point drop in his hematacrit. The source of the GI bleed had not yet been identified, and the patient's family did not want an endoscopic procedure (which might reveal the source), so the plan was to treat him conservatively at this time.

I finished reviewing the chart and the wheels in my head started turning. What were the most important pieces of information I'd need for this examination? Given his history of dementia, I would certainly need a family member to be present. And not just a family member, I'd need the individual or individuals who would be caring for him at home. It seemed clear that nothing could or should be done without them.

The patient's wife and daughter were present and awaiting my arrival. I introduced myself to Mr. D, then sat with his family. It was evident that Mr. D, though the patient, was not going to be the only

focus of my examination. I asked his wife what had brought them to the hospital; how things were going at home; what Mr. D did; and what she did. I asked how long Mr. D had been this way; if she had any other support at home; had they both been safe; had either of them fallen; etc. I asked question after question until I felt I had a good understanding of Mr. and Mrs. D's situation. She explained that her goal was to return home with Mr. D. She would refuse any nursing-home or rehabilitation placement.

It was time to assess Mr. D's functional level now that I had an understanding of his pre-admission status, knew his hematacrit was back to normal, and knew this was the primary concern of the team.

In an approach that is somewhat different for me, I decided to see how Mr. D's wife worked with him. How did she mobilize him? Was it safe? She transitioned him to a sitting position, then to standing, and it was clear she was working hard to support her husband. As she brought him to standing, he continued to speak in nonsensical phrases. I asked her if this was how he functioned at home, and she said, "Sometimes."



Carolyn Tassini, PT
staff physical therapist

But it changed throughout the day.

We decided to take a short walk, as they would do around the house. Mrs. D fully supported her husband as they made their way to the hallway. Curiosity got the best of me. I asked if I could facilitate his gait, and she gladly shifted assistance to me. Mr. D required moderate assistance to ambulate with and without the use of an assistive device. He demonstrated impaired motor control with limited initiation and motor planning, decreased balance and balance reactions. It was a challenge to manage him. We returned to his room and got him back to bed.

I sighed as I sat with Mrs. D and her daughter. I believe the words I used were, "I'm torn." Given my current Neurology rotation, it had been a while since I'd seen a patient with purely medical issues and dementia. Clearly, from his history and current presentation,

Mr. D was well below his baseline. I wondered though, if even his baseline status was safe? Mrs. D had told me that at home, Mr. D had fallen five or six times over the last two months and the chart documented his drastic weight loss. I spoke at length with Mr. D's family about my concerns. I know it's best for people to be at home if at all possible, as it results in increased activity to meet environmental demands. It's also my understanding that patients with dementia often do better in a familiar environment. I thought his current presentation might be partly a result of being in an unfamiliar setting with two days of bed rest. Mr. D's wife and daughter quickly latched on to this hypothesis.

I tried to consider other issues that might be contributing to his clinical picture. For example, he'd had several falls recently—could he

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Clinical Narrative

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be experiencing traumatic brain injury? Could his recent change in balance, gait, and mental status be related to some other central-nervous-system dysfunction such as hydrocephalus?

Regardless, Mrs. D wanted to take her husband home, and he was relatively safe with her at present. My concern then shifted to her health and safety. We spoke about the progressive nature of the disease and how Mr. D had been declining. We spoke of the toll this would take on her as a caregiver and what their future options might be. We talked about what the impetus would be for making the transition to the next stage of care. I felt we each had a good understanding of the other's feelings. I explained to Mrs. D my concerns about discharging Mr. D, primarily my concern about him falling and secondarily, her health and safety. She continued to request that he be discharged home.

I looked at my watch. 5:30. I knew it was too late to set up home services at this point. The focus of my plan of care shifted to Mrs. D. She agreed to have home physical therapy visits and was open to the idea of increasing the hours of their existing home-health-aide coverage. I decided the safest way to

discharge Mr. D would be to wait until Sunday afternoon when we could schedule a time for instruction and training in guarding and transfer techniques. This would also allow time to put home services in place.

We all agreed to the plan. I spoke with the nurse and the resident and left a message with the case manager about the recommendations. While the case was closed on paper, it tormented me all night and throughout the next day. Had I made the right decision? Should I have 'forced' rehab? Did I do what was best for the patient and his caregivers? What else could I have done?

Sunday came, and I made certain early in the day that the necessary home services had been put in place. I returned in the afternoon for a family instruction and training session as scheduled the day before. Mr. D didn't look much different, still significantly impaired from his baseline. Mrs. D was instructed in safe-guarding techniques and recommendations were reviewed. We discussed my concerns again, and I advised the family to continue to closely monitor his mental status and mobility. I strongly urged them to return to the hospital for further testing if Mr. D continued to decline. The medical team was in-

formed of the discharge recommendations and agreed to the plan.

I had done all I could, and now I had to let them go. I checked in with them one more time, and coincidentally, Mr. D's primary care physician was present at the time. I spoke with him about my concerns, and he thanked me for my help. He reinforced the physical therapy recommendations.

That was the last I heard of Mr. and Mrs. D. It's interesting—you put so much time, effort, and thought into a patient and family, coordinating care, making the best decisions you can, then they're gone. I found this case challenging in many ways, though none very different from those encountered on any other day. Mr. D was like any other patient, a man with dementia whose family loved him and wanted to take him home, who would do everything possible to make that happen.

Working in an acute-care setting presents many challenges, including high medical acuity, short lengths of stay, the need to manage high patient census. This case required me to think, plan, and execute my recommendations quickly to establish a discharge plan that was appropriate for Mr. D and his family. To this day, I'm not sure there was a 'correct' answer. Our goals for discharge and the plan of care we established were directed toward Mr. D's family;

and given that safety was a primary concern it was crucial that the family understood my concerns. Conversations were held with family members and all members of the care team to ensure Mr. D received optimal care.

Should a similar situation arise, would I do the same thing? I think I would. I think I provided appropriate and thorough instruction and education to Mr. D's family. I coordinated care (including Case Management, Nursing, the medical team, and the primary care physician). I provided all necessary information.

Acute care is such a dynamic environment. With its short lengths of stay, acute and ever-changing medical needs, decisions must be made quickly and with appropriate clinical input, thought, and education to best serve our patients and their families. Every day new challenges arise. Despite these challenges, there's nothing I would rather do. For a short period of time during that busy weekend, I walked that fine line and became part of this family. I was let into their

lives and practiced as a competent physical therapist to make this family's goals and desires a reality.

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

This is a theme that will resonate with all caregivers—that feeling of investing so much in the care of a patient and his family and then 'letting them go,' wondering about their health and safety once they're outside our walls. Carolyn's narrative speaks beautifully about that 'leap of faith' that was necessary to return Mr. D to his home and family. She did everything in her power to ensure that appropriate services were in place and that Mrs. D had adequate teaching in safety and transfer techniques. She did everything possible to reduce Mr. D's risk of falling without compromising her clinical judgment. With respect for the family's wishes and confidence in her own experience, Carolyn helped make it possible for Mr. D to return home.

Share your practice
Share your knowledge
Write an exemplar
for *Caring Headlines*

Professional Achievements

Somerville receives Arthur L. Davis Publishing Agency Scholarship

Jacqueline Somerville, RN, associate chief nurse, received the Massachusetts Association of Registered Nurses' Arthur L. Davis Publishing Agency Scholarship on April 30, 2005.

Edwards is president-elect of ASPMN; and presents at Annual Meeting

Annabel Edwards, RN, adult nurse practitioner for the MGH Pain Center, recently became president-elect for the American Society for Pain Management Nursing (ASPMN).

She presented a concurrent session entitled, "Opioid-Induced Hyperalgesia," at their Annual Meeting in Albuquerque, New Mexico, March 31–April 3, 2005.

Levine appointed chairperson of NUNAS

Amy Levine, RN, of the Same Day Surgical Unit, was appointed chairperson of the Northeastern University Nursing Alumni Society (NUNAS) in April, 2005.

Staff present at Eastern Nursing Research Society meeting

Amanda Coakley, RN; Jacqueline Somerville, RN; Maureen Ward; Sharon Bouvier, RN; Eileen Flaherty, RN; Marie Leblanc, RN; Joan Stack, RN; Heather McDonald, RN; Joan Tafe, RN; Maureen Bonanno, RN; and Maria Romanoff, RN, presented their poster, "The Response of a Pet Therapy Encounter on Patients, Volunteers, and Nurses Across Three Different Clinical Sites," at the Eastern Nursing Research Society meeting, in New York on April 9, 2005.

Cox certified

Erin Cox, RN, clinical nurse specialist for the Bigelow 14 Vascular Surgery Unit, was certified as a medical-surgical clinical nurse specialist.

Daniels receives Hyman J. Weiner Award

Ann Daniels, LICSW, executive director for Social Services and the Chaplaincy, received the Hyman J. Weiner Award from the Society for Social Work Leadership in Health Care, in Houston, Texas, in April.

Smith receives Clinical Educator of the Year Award

Emily Smith, PT, physical therapist, received the Clinical Educator of the Year Award at the Clinical Education Symposium, held at the University of Massachusetts in Lowell.

Jampel presents at Clinical Faculty Institute

Ann Jampel, PT, physical therapist, presented, "Innovative Approaches to Clinical Education," and "Fostering Clinical Instructor Development Through Use of a Small Group Case Analysis Format," at the New England Academic Center Coordinators' Clinical Faculty Institute, at the University of Massachusetts in Lowell.

LaSala, Moulaison, and Zapolski present at AONE

Walter Moulaison, RN, nurse manager, Cynthia LaSala, RN, clinical nurse specialist, and Deborah Zapolski, RN, staff nurse, presented, "Building an Effective Nursing Team: the Link to Quality Patient Care Outcomes, Workplace Satisfaction, and Knowledge Development in Licensed and Unlicensed Nursing Staff," at the American Organization of Nurse Executives Annual Meeting, in Chicago, April 15–19, 2005.

Kelly certified

Nancy Kelly, OTR/L, occupational therapist, was certified by the American Board of Physical Therapy Specialties.

Doherty publishes

Regina Doherty, OTR/L, occupational therapist, wrote "The Impact of Advances in Medical Technology on Rehabilitative Care," in, *Educating for Moral Action: a Source Book in Health and Rehabilitation Ethics*.

Coakley presents in New York

Amanda Coakley, RN, and Anne Marie Barron, RN, presented their poster, "Experiences of Nurses Providing Therapeutic Touch in an Inpatient Oncology Setting," at the Eastern Nursing Research Society, in New York on April 9, 2005.

Grace, McLaughlin, publishes

Pamela Grace, RN, and Moriah McLaughlin, RN, staff nurses on the White 7 General Surgery Unit, published the article, "When Consent Isn't Informed Enough: What's the Nurse's Role when a Patient has Given Consent but Doesn't Fully Understand the Risks?" in the April, 2005, issue of the *American Journal of Nursing*.

Cox, Martin, present at National Association of Clinical Nurse Specialists meeting

Ann Martin, RN, clinical nurse specialist for General Surgery, and Erin Cox, RN, clinical nurse specialist, for Vascular Surgery, presented, "The CNS and Evidence-Based Practice: Implementing a Beta-Blockade Therapy Program," at the National Association of Clinical Nurse Specialists' meeting in Orlando, Florida, on March 12, 2005.

Prater presents at MONE meeting

Marita Prater, RN, nurse manager for White 8 and 10, General Medicine, presented, "Focusing on Nursing: One Manager's Journey," at the Massachusetts Organization of Nurse Executives' meeting, April 26, 2005, in Waltham.

Carroll presents paper to Eastern Nursing Research Society

Diane Carroll, RN, clinical nurse specialist, presented her paper, "Peer Advisors Improve Physical Health Outcomes in Elders," at the Eastern Nursing Research Society's 17th Annual Scientific Sessions in New York City, April 7–9, 2005.

Social workers present at American Trauma Society Conference

Clinical social workers, Kathy Clair-Hayes, LICSW; Carla Cucinatti, LICSW; Nancy Leventhal, LICSW; and Rebecca Murphy, LICSW; presented, "Kids Express: First Aid for Families When Trauma Strikes," at the American Trauma Society Conference Social Workers Seminar in Arlington, Virginia, April 27–29, 2005.

Capasso receives Clinical Excellence Award and research grant

Virginia Capasso, RN, clinical nurse specialist for The Knight Center for Clinical & Professional Development and co-director of The MGH Wound Care Center, received the 2005 Clinical Excellence Award from the Massachusetts Association of Registered Nurses on April 29, 2005.

Capasso received a research grant for her study entitled, "A Comparison of Three Methods for Wound Volume Measurement," from the (Boston College) Alpha Chi Chapter of Sigma Theta Tau International on April 11, 2005.

Savidge presents at UMass Lowell

Edgar Savidge, PT, physical therapist, presented, "Small Group Case Analysis Format," at the New England Academic Center Coordinators Clinical Faculty Institute, at the University of Massachusetts in Lowell.

Tyrrell presents at MONE Leadership Workshop

Rosalie Tyrrell, RN, professional development coordinator, presented, "Understanding and Leading a Multi-generational Workforce," at the Massachusetts Organization for Nurse Executives (MONE) Leadership Workshop on April 27, 2005.

Goostray, Sullivan, present in New Orleans

Erin Sullivan, operations coordinator, Main OR, and Alan Goostray, RN, clinical service coordinator, Main OR, presented their poster, "The Anatomy of a Construction Project," at the Association of Peri-Operative Registered Nurses' Annual Congress, April 3-7, 2005, in New Orleans.

Ashland, Terres present in Philadelphia

Nancy Terres, RN, MGH Institute of Health Professions, and Jean Ashland, CCC-SLP, speech-language pathologist, presented their poster, "Tracking Patterns of Children's Feeding Problems in a Hospital-Based Feeding Team," at the Society of Pediatric Nursing in Philadelphia in April, 2005.

Tyer-Viola presents at Nursing Research Summit

Lynda Tyer-Viola, RN, clinical nurse specialist, presented, "Development and Psychometric Evaluation of Pregnant Women with HIV Scale," at the HIV Nursing Research Summit: ANAC, in Palm Springs, in April, 2005.

Kaye, Kingston, certified

Susan Kaye, RN, and Jane Kingston, RN, staff nurses on the Ellison 16 General Medicine Unit, were certified as medical-surgical nurses.

Edwards, Birkemose, certified

Erica Edwards, RN, and Patrick Birkemose, RN, staff nurses on the Ellison 9 Coronary Care Unit, were certified as critical care nurses.

Monahan presents at Respiratory Care Conference

Logan Monahan, OTR/L, occupational therapist, presented "The Role of the Occupational Therapist," at the Respiratory Care Conference in Boston on March 14, 2005.

Baronofsky publishes

Devora Baronofsky, RN, staff nurse on the White 7 General Surgery Unit, published, "The Massachusetts General Hospital Magnet Experience," in the *Massachusetts Report on Nursing* in March, 2005.

Lavieri publishes

Mary Lavieri, RN, clinical nurse specialist for the Blake 7 Medical Intensive Care Unit, wrote, "Making a Change: Implementation of Evidence-Based Practices in Critical Care," in the *Merrimack Valley Chapter of the American Association of Critical-Care Nurses Newsletter* in April, 2005.

Kelleher presents at Phillips M. Payson Conference

Mary Lou Kelleher, RN, pediatric clinical nurse specialist, was the keynote speaker at the 13th Annual Phillips M. Payson Conference, Safe Patient- and Family-Centered Care, on April 1, 2005, in Portland, Maine, where she presented, "Advancing the Journey: Leadership for Family-Centered Change."

Myers certified

Michele Myers, RN, staff nurse on the Yawkey 8 Oncology Infusion Unit, was certified as an oncology nurse.

Cierpial certified

Chelby Cierpial, RN, staff nurse on the Ellison 11 Cardiac Access Unit, was certified as a medical-surgical clinical nurse specialist.

Johnson certified

Elizabeth Johnson, RN, clinical nurse specialist for the Ellison 14 Oncology/Bone Marrow Transplant Unit, was certified by the Oncology Nursing Society as an advanced oncology clinical nurse specialist.

Harker, Robbins, present in Minneapolis

Jane Harker, RN, and Christopher Robbins, RN, presented, "The Dave Project" (collaborative on-line website) on May 17, 2005, at the Society of Gastrointestinal Nurses and Associates Annual Conference in Minneapolis.

Hart presents in Phoenix

Erin Hart, RN, pediatric nurse practitioner, presented, "Recognition and Treatment of Common Neonatal Orthopaedic Problems," and, "A Day in the Pediatric Orthopaedic Clinic: Common Diagnoses and Clinical Management," at the National Association of Orthopaedic Nurses Annual Congress in May, 2005, in Phoenix.

Keeley honored by UMass Boston's Master of Arts Program

Adele Keeley, RN, nurse manager of the Medical Intensive Care Unit, received an award from UMass Boston's Master of Arts Program for contributions to the field of Dispute Resolution with her thesis, "Negotiation Skills for the Staff Nurse: One Nurse Manager's Epiphany."

Stengrevics certified

Susan Stengrevics, RN, clinical nurse specialist for the Ellison 10 Cardiac Step-Down Unit, was certified as a medical-surgical clinical nurse specialist.

Somerville appointed associate clinical scientist

Jacqueline Somerville, RN, associate chief nurse, has been appointed associate clinical scientist with The Phyllis F. Cantor Center at the Dana-Farber Cancer Institute.

Law presents at APTA conference

Suy-Sinh Law, PT, physical therapist, presented, "Physical Therapy Profession," and, "Professional Organizations Fair," as part of the Xcel/The Females' Center of Excellence and Leadership at the American Physical Therapy Association of Massachusetts in Boston on March 10, 2005.

SDSU nurses present in New Orleans

Amy Levine, RN; Janet Quigley, RN; Ruth Bryan, RN; and Jane Wardrobe, from the Same Day Surgical Unit, presented their poster, "A New and Improved Approach to our Turnover Team," at the Association of Perioperative Registered Nurses Congress, April 3-7, 2005, in New Orleans.

Levin receives National Leadership Award, presents in Phoenix

Barbara Levin, RN, of the MGH Orthopaedic and Neuroscience Service, received a National Leadership Award from the American Association of Legal Nurse Consultants. Levin presented, "Standards of Care in Nursing Practice: Ethical, Legal, and Moral Issues," at the National Association of Orthopaedic Nurses Annual Congress in May, 2005, in Phoenix.

A mother's last wishes; a nurse's final act of love

—by Linda Bracey, RN, operating room nurse

In 33 years of nursing, I've experienced many wonderful, heart-wrenching, tremendously difficult, and thoroughly fulfilling moments. Taking care of people and their families through trying times has been very rewarding. But your perspective changes somewhat when you care for a loved one, especially a parent.

This past year, I had the privilege of caring for my mother and helping with her healthcare issues in the weeks before her death. She appointed me her healthcare proxy while she was a patient at MGH. While all this was going on, my son and daughter-in-law made me a grandmother. Now, I knew what it felt like to be a member of 'the sandwich generation,' excited to have a new granddaughter, but saddened by my mother's health problems. I found myself torn emotionally. My mother was able to see and hold her great-granddaughter before her fateful journey, and I was extremely grateful to God for letting this happen.

My mother had had end-stage liver disease for many years. She also had severe peripheral vascular disease. She had been a smoker for 40 years and a social drink-

er. But she out-lived my father and the majority of her life-long friends. Her wish was to remain at home for as long as possible. Though she didn't like being alone, she valued her independence. After seeing her great-granddaughter, my mother decided to go to MGH for a second opinion on her medical condition.

She had had severe abdominal ascites for six months, and felt she wasn't getting any better. Maintaining her independence was of utmost importance to my mother. For 82 years my mother's mind had been sharp. This was a saving grace for me in helping her decide what route to take.

Her initial stay at MGH was one week on White 9 where she got great care. Because of her age and medical condition, it was recommended that she have a short stay at a rehabilitation facility. The morning she was to be discharged, she experienced a massive esophageal bleed. I was told she lost 1,500cc of blood.

That day, I was the resource nurse in the operating room (OR), so I was able to help coordinate emergency services for my mother. She was immediately scheduled for an endoscopy. The procedure took three

hours. They had to band three major varices (veins). Everyone involved was tremendous in the tender care they provided. After the procedure, she was taken to the Surgical Intensive Care Unit (SICU) where she remained for a week. When she woke up, my family and I were in awe—the survival rate for this type of bleed is usually very low.

Prior to my mother's illness, I had arranged to take time off to care for my granddaughter in another state. The trip was postponed because of the severity of my mother's condition. But after she stabilized and seemed to be on the mend, we discussed it again. My mother insisted I go. She said I'd be only a phone call and a plane ride away.

I left on the Friday before Mother's Day. We celebrated Mother's Day together before I left. My children and I gave her clothes to wear while she was in rehab. Rehab was still her main goal, bringing her a step closer to home and independence. We made sure she had a vase of stargaze Lilies, her favorite flower. We arranged for a stylist from the MGH Images Salon to come to her room and do her hair. Having her hair done always made her feel beautiful.



Linda Bracey, RN, at work at the Gray OR desk

From the SICU, my mother went to the Bigelow 11 Medical Unit. The nurses and medical staff there gave my mother exceptional care. Being on a medical unit surrounded by 'elderly people' did not sit well with my mother. In her mind, she wasn't old. Her sense of humor kept her young. But being sick gave her no choice but to do what she had to do. She was still determined to go to rehab and then home.

While staying with my son in another state, I was in daily contact with my mother, my family, and the nurses and doctors. Being the healthcare proxy, I wanted to be well-informed so I could make the right decisions for my mother. For about a week, she seemed to be doing very well. Then, doctors informed me of increasing abdominal ascites and pleural effusion. They

had to drain 1,000cc of fluid from her abdomen and 650cc from her chest. Her convalescence at this point was a roller-coaster ride, one day up, down the next.

Her sheer determination to get home got her well enough to go to rehab. I spoke to her on the phone before she left MGH, and she was very excited. For her, it meant home was the next step. It was important to me, being so far away, that she was happy with the care she was receiving.

My sisters and I had many discussions, and my decisions as healthcare proxy came after speaking with my mother and her healthcare team. We were united in our decision as to what direction my mother's care should take to secure the best outcome for her.

After being transferred to the rehab facility, my mother's health took a turn for the worse. My

continued on next page

Nurse's Final Act of Love

continued from previous page

sisters wanted her transferred back to MGH. My mother didn't want to leave rehab. I spoke with the care team at the rehab facility. My mother was considered terminally ill, and they recommended we proceed with comfort measures. After talking to my mother about her condition, we agreed she would remain in rehab. She was still in control, and if that's what she wanted; so be it.

I spoke with her by phone the following morning. She was sitting up eating breakfast—her usual—coffee and a blueberry muffin. She was still sharp as ever and her sense of humor was intact. I asked if she wanted me to come home. I could be there in 13 hours. She said 'No,' she'd see me Sunday when I was scheduled to return home.

That Friday night my mother took a turn for the worse, and comfort measures were initiated. Her systems were failing, and she slipped into a coma. My sisters, my daughter, and my husband stayed with her all day Saturday. They updated me throughout the day. Before I left my son's house, I wrote my mother's eulogy. That Saturday night, my son and I drove back to Boston. We left his house at 8:00pm and arrived Sunday morning at 8:45. During the night my daughter and husband reassured my mother that I was on my way.

When I arrived at rehab, my family gave me some time alone with my mother. I sat with her and read her my synopsis of her life. She was always a stickler for correct English usage, so I

asked for her approval. She had been lying still, taking shallow, rapid breaths. When I finished, she squeezed my hand and moved her eyes, as if to say, 'Okay.' My eyes filled up. For most of my life, my mother and I were on opposite sides of the fence about so many things. This reaction told me I had her acceptance and approval.

I gave my mother a body massage, and she seemed to be at peace when I finished. I was emotionally drained, so my husband and I took a walk leaving my mother with my sisters. When I returned, I learned that my mother has passed away.

I spoke to her nurses, and they allowed me to give my mother post-mortem care. This brought me much comfort, since this would be the last act of love I could show her.

Upon returning to work after my mother's funeral, a colleague handed me a copy of *Caring Headlines*. It was the special Nurse Week issue, and on the cover was a picture of my mother with the nurse who had cared for her on Bigelow 11. It was such a shock to see her face. I wish I'd known her picture was going to be taken. Maybe it could have been the two of us on that cover: nurse, mother, daughter. It would have been a nice, lasting tribute.

A year has passed since my mother died, and a day doesn't go by that I don't think of her. As a nurse, and as a daughter, I have no regrets about the care and love I gave my mother in her last days. She was always in control, she always made her choices known, and I helped her follow through on those wishes. Everyone wants their parents to live forever. For all the years she took care of me, the least I could do was help her die with dignity.

Perhaps this article can be that lasting tribute...

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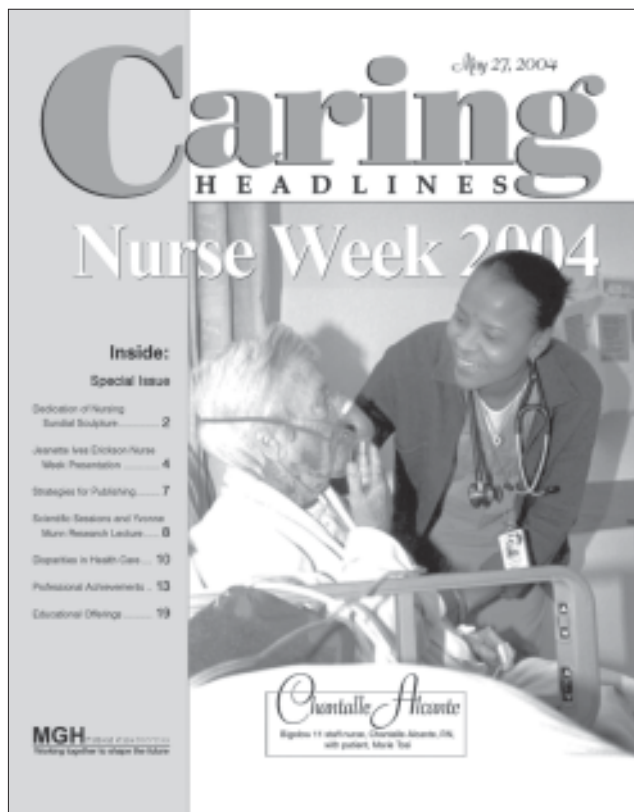
Submission of Articles

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.

Next Publication Date:

July 21, 2005



MGH Quit Smoking Service offers help to inpatients

For many people who smoke, finding the time and will-power to quit can be a challenge. Sometimes a hospital stay is a good opportunity to quit smoking. Being in different surroundings where cigarettes aren't readily available can help smokers prepare themselves for the process of quitting. To help MGH patients who want to take advantage of this opportunity, the MGH Quit Smoking Service offers resources that can help.

A smoking counselor from the MGH Quit Smoking Service is available to visit patients at the bedside and provide information about the most effective treatments, such as the nicotine patch or gum, and to help patients manage their nicotine withdrawal while they're in the hospital.

Smoking counselors can help patients who are ready to quit begin the process. Smokers who quit while hospitalized can have speedier recovery times and lower their chances of future illness.

Says Nancy Rigotti, MD, director of the MGH Quit Smoking Service, "Hospitalization provides a unique opportunity for patient-education at a time when smokers are especially receptive to cessation interventions. We would like to encourage clinicians to call our service when they identify patients who might be interested in quitting. Even if a patient isn't ready to quit, our services can help provide support while they're in the hospital unable to smoke."

Clinical studies have shown that smoking cessation counseling during hospitalization and for one month post-discharge increases long-term smoking cessation by 82%.

For more information about the MGH Quit Smoking Service or to refer an inpatient, call 617-726-7443.

How do you get there from here?

Navigating your computer to access on-line resources

Do you have questions about culturally competent care or the healthcare practices of patients from other countries or backgrounds? If so, there's an on-line resource you should know about.

- Go to the Patient Care Services website at: <http://pcs.mgh.harvard.edu/>
- Click on Professional Resource Departments
- Click on Medical Interpreters
- This will bring you to a page with a map of the world and several options:
 - General Information (about medical interpreters)
 - Requesting a medical interpreter
 - Working with medical interpreters
 - Becoming a medical interpreter
 - Culturally Competent Care
- If you click on Culturally Competent Care, you will come to a page that offers the following options:
 - Language map (tells you what languages are spoken in different countries)
 - Point-to-Talk Booklets (gives you common healthcare phrases in English and 19 other languages)
 - Bits of Culture
- If you click on Bits of Culture, you will come to an alphabetical list of countries. Clicking on any country will bring you to a page with information about that country's language, geographical location, cultural values, healthcare values, religion, beliefs about death, and this reminder:

"This information is to give you a perspective about a country's general cultural information and should not influence your approach to individual patients. People's behaviors, attitudes, and decisions about healthcare are based on their individual beliefs and experiences."

If you know of a particularly informative website and you'd like to share it with your colleagues, contact the *Caring Headlines* Story Desk at 4-1746, or e-mail Susan Sabia

Call for Abstracts

Second Annual Women's Health Research Celebration October 21, 2005

The Women's Health Coordinating Council's Research Committee invites the MGH community to participate in the 2nd Annual Women's Health Research Celebration. We are now accepting abstracts for clinical and basic science research topics that address women's health care. May include studies specific to the health concerns of women throughout the life-span or studies that include a separate analysis of outcomes for women as part of the study population.

Cash prizes for the five best research abstracts will be awarded during the celebration. All accepted posters will be displayed on the main floor of the hospital throughout the week of October 24th

Deadline for submissions is Monday, July 18, 2005

All abstracts should be submitted on-line at:
<http://intranet.massgeneral.org/whcc/abstractform.htm>

For more information, contact Mary Ellen Heike, RN, at 4-8044

Educational Offerings

July 7, 2003

When/Where	Description	Contact Hours
July 20 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
July 25 and 26 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: CSEMC; Day 2: VBK601	14.4 for completing both days
July 26 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
July 27 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
July 27 10:00–11:00am	Searching for Journal Articles (Medline) FND626	---
July 27 11:00am–12:00pm	Searching for Journal Articles (CINAHL) FND626	---
July 28 1:30–2:30pm	Nursing Grand Rounds “Unit-Based Ethics.” O’Keeffe Auditorium	1.2
July 29 12:00–3:30pm	Basic Respiratory Nursing Care Ellison 19 Conference Room (1919)	---
August 2 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
August 3 8:00–11:00am	On-Line Clinical Resources for Nurses FND626	---
August 4 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
August 9 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK401 (No BLS card given)	---
August 10 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
August 10 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
August 10 12:30–4:30pm	Pacing Concepts Haber Conference Room	4.5
August 10 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
August 10 11:00am–12:00pm	Nursing Grand Rounds “Mental Status Change.” Sweet Conference Room GRB 432	1.2
August 18 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
August 24 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
August 25 1:30–2:30pm	Nursing Grand Rounds “Caring for Patients with Dementia.” O’Keeffe Auditorium	1.2
August 26 12:00–3:30pm	Basic Respiratory Nursing Care Ellison 19 Conference Room (1919)	---
September 1 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---

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>.

Silence is golden... and sometimes even a little magical

—by Jennifer MacKenzie, RN

Someone once asked me, “Do you know the words ‘silent’ and ‘listen’ have the same letters; they’re just arranged differently?” What a profound observation, I thought.

As we silently listen to another’s thoughts, concerns, and stories, we bring comfort and a sense of connection to those we listen to. Silence and listening are powerful ways of connecting with another person, especially in a nurse-patient relationship. As a nurse, I have come to appreciate and embrace silence, something I would have actively avoided as a student or new grad. The thought of an ‘awkward’ moment of silence would have had me running for the hills or filling the air with meaningless chatter.

I reflect on this when I think about the circle of life, living, and dying. Oncology nursing is a specialty where nurses enter—I mean literally, enter someone’s life. A door is opened, and it’s our privilege to accept the invitation to share the journey of each patient we meet.

Recently, I was given a gift, a gift I get to re-open every day, whether I’m with this person or she happens to come into my thoughts. And every time I think about it, the bow gets bigger and the gift has more to offer. Mrs. N was a spicy, little woman with so much to say. Her sense of humor and mine were a match from the first moment I entered her room. On that first day, the tasks of administering medications and completing my assessment were put

aside as an instant friendship was born. Her smile lit, and continues to light up a room. The sparkle in her eyes gives hope to all who come in contact with her. She will forever remind me that as long we see another sunset, we are survivors of that day.

Mrs. N was a long-time resident on our unit. We said good-bye when she left to go to a rehabilitation facility. We kept in touch through prayer. Just recently, Mrs. N returned to our unit for the last time. Our jokes and sense of humor are replaced with moments of silence and holding hand. The scent of her lavender lotion fills the room as I rub her arms and legs, keeping her connected with a simple touch. She looks up at me and says the only words that are spoken, “Jen, I love you.”



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The perfect moment has just been shared.

She asks me when God will take her soul, a question you’re never fully prepared for. But I am inspired by her willingness to accept what is happening.

The morning comes and her husband walks into the room. Again, silence. He tells her he loves her, and she just smiles. Forty years of marriage summed up in a smile. A complete shift in life summed up in a smile, a consoling gesture, a lasting memory.

Two years as a nurse, long shifts, worrying if everything’s been done, is somehow replaced with one golden moment: the magic of silence and the gift of one relationship. I am truly blessed to walk through the doors of MGH each day and wonder what new gift is in store for me.

When I’m asked if I like what I do, if I made the right decision in becoming a nurse, I smile and say, “I couldn’t picture myself doing anything else.”

Caring

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