

Caring

HEADLINES

June 16, 2005

Inside:

Volunteer Recognition Day	1
Jeanette Ives Erickson	2
• Staff Perceptions of the Professional Practice Environment Survey	
Fielding the Issues	3
• Updating Computers	
Vascular Surgical Nursing	4
New Leadership	5
• Ann Daniels, MSW, New Executive Director for Social Services and Chaplaincy	
Clinical Narrative	8
• Ann Eastman, RN	
D'Amato Retires	10
Clinical Nurse Specialist	12
• Elizabeth Johnson, RN	
Quality & Safety	14
• New Patient Safety Journal	
Educational Offerings	15
Nursing Excellence Awards ..	16

MGH Volunteer Recognition Day: *honoring our own Good Samaritans*

See story on page 6



MGH volunteer, Charles McCarthy (right), is congratulated by chairman of the MGH Board of Trustees, Edward Lawrence, at recent Volunteer Recognition Day celebration

MGH Patient Care Services

Working together to shape the future

Staff Perceptions of the Professional Practice Environment Survey

Thank-you, thank-you, thank-you. Responses to the Staff Perceptions of the Professional Practice Environment Survey have been received and analyzed. Perhaps the best news in a report card full of good news is the overall response rate to this year's survey. An incredible 46% (or 1,322 clinicians) in Patient Care Services completed and returned surveys, and we're *still* receiving responses three months after the deadline. I can't tell you how thrilled I am.

Next on the list of good things to report is the impressive 90% of you who responded indicating you're satisfied or very satisfied with the MGH practice environ-

ment (up from 87% in the 2003 survey). This tells me that your input in past years has pointed us in the right direction, and we have been able to implement many of the changes you've suggested. A partial list of initiatives that were implemented as a result of the Staff Perceptions Survey include:

- the Culturally Competent Care Lecture Series
- the inter-disciplinary Clinical Recognition Program that was launched in 2002
- the expansion of the Knight Center for Clinical & Professional Development to offer a wider range of educational opportunities
- pagers were assigned to all clinical social workers

- the Materials Management-Nursing Task Force was established to improve communication and services between the two departments

- "Fielding the Issues" column was created in *Caring Headlines*

- nurse managers' span of control was reduced
- access to e-mail was expanded to improve communication with staff

As you know, the Staff Perceptions of the Professional Practice Environment Survey is intended to gauge staff's impressions of eight organizational characteristics including: autonomy; clinician-physician relationships; control over practice; communication; teamwork and leadership; conflict man-

agement (how we handle disagreements); internal work motivation; and cultural sensitivity.

I have presented the overall data for Patient Care Services in a number of forums, and you'll be hearing more about your discipline- and unit-specific results at staff meetings and in other venues. In general, clinicians agree that the strategic goals we've identified (see shaded box on this page) are important and, to a lesser degree, they feel we are effec-

tively meeting them.

Every year, we tweak the survey to ensure we're getting meaningful feedback about areas of most concern to staff and leadership. This year, we added two questions having to do with conflict management. Despite many educational programs and interventions aimed at improving our ability to handle conflict, this continues to be an area we need to focus on. This is good information to have.

continued on next page



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

Patient Care Services Strategic Goals

- Goal 1: We continuously create systems and processes that support the delivery of safe, efficient, timely, patient-centered care.
- Goal 2: We lead the industry in quality and safety.
- Goal 3: We position nurses, therapists, social workers, medical interpreters, chaplains and support staff to have a strong voice in issues impacting patient care.
- Goal 4: We are the 'employer of choice' for all professions and support staff and value diversity in our workforce.
- Goal 5: We identify, implement, and evaluate the impact of high-leverage system-improvement initiatives that promote individualized patient care and support those that provide care.

Purpose of Staff Perceptions Survey

- To offer clinicians an opportunity to participate in setting strategic direction of Patient Care Services and influencing the entire organization
- To provide an annual assessment of organizational characteristics influencing clinicians' satisfaction with their professional practice environment
- To enable us to compare patterns of change related to organizational characteristics
- To identify opportunities to improve the environment for clinical practice

Updating computers, monitors, and printers on patient care units

Recently, Information Systems, in collaboration with operations coordinators, conducted an assessment of all workstations on patient care units to evaluate their speed and memory capacity. More than 300 computers and printers found to be inadequate were replaced over the winter. Last week, approval was granted to replace existing monitors at nursing stations with flat-panel monitors.

Smaller, flat-panel monitors will free up space for additional computers to be installed on some units.

Question: What should I do if there's a problem with a computer, printer, or monitor on my unit?

Jeanette: Contact the Help Desk at 6-5085. You'll be asked to provide the control number, which is affixed to the front or top of the CPU (central processing unit). Give the technician as much detail as possible so your call can be appro-

priately triaged. Inform your operations coordinator about the problem so he/she can follow up and ensure the issue is resolved. (Forwarding the Help Desk-generated e-mail you receive to your OC is a good way to ensure accurate communication). The Help Desk will have an up-to-date listing of all OCs and their respective units.

Question: What about computers in private offices?

Jeanette: The Help Desk is your best resource in diagnosing a problem no matter where the computer is located. If it's determined that the computer, monitor, or printer cannot be fixed, you'll be notified, and arrangements will be made to replace the faulty equipment.

If shared workstation equipment needs to be replaced, Partners Information Systems should be notified. They will work with OCs to rectify the problem.

Question: The computer I use is new, but it's slow. Why is that?

Jeanette: A number of things can cause your computer to run slowly, but often it's the result of trying to download too much information. If you suspect this might be the case, contact the Help Desk and ask them to remove all unnecessary files and downloads. This will most likely improve performance, but if not, ask your OC to follow up on the issue.

Question: I've heard that we may be shifting to a wireless computer system. Is that true?

Jeanette: Transition to wireless computers is in the works, but wireless systems will not entirely replace the wired network. Wireless computers will augment existing systems where workflow and application issues dictate a need.

Maintaining electronic communication technology is an on-going process. It requires constant vigilance and support. We are committed to ensuring that our patients receive timely, efficient care, and high-functioning computers, printers, and monitors play a key role in that effort.

Jeanette Ives Erickson

continued from previous page

In the area of diversity and culturally competent care, there were numerous references to a need for more interpreters; but there was a noticeable lack of comments about any other aspects of culturally competent care. I don't want to minimize the importance of interpreters—our demand for medical interpreters has doubled in the past year. But I don't want to overlook areas where we may need to provide more support and/or resources. You're telling me that culturally

competent care is an area we need to focus on, and that's good information to have.

In general, despite a highly complex and increasingly demanding clinical environment, clinicians across Patient Care Services report a high level of satisfaction with the work environment. They perceive their practice to be autonomous with a high degree of control; they enjoy good working relationships with colleagues; they feel sup-

ported by good communication (though there is desire to expand access to electronic documentation and other reporting systems); they feel they are sensitive to diversity within patient populations and among staff; they feel a strong leadership presence; and they are motivated to excel.

In addition to extensive quantitative data (the aggregated results of all the 4-point, Likert-scale responses), there was considerable qualitative data (written comments), which allowed us to identify themes and provided added insight

into the quantitative results. Almost half, or 45%, of those who responded contributed an estimated 1,800 written comments. Some of the comments we received were:

- "Despite my concerns, I wouldn't want to work anywhere else."
- I love my work and have never... been so satisfied with what I do."
- MGH understands how important each department is. I look forward to coming to work every day."

I can't stress strongly enough how important this survey is to me. This

is my opportunity to hear directly from you about what's right and what's wrong with our hospital. I refer to the results of this survey frequently throughout the year as important decisions are being made about patient care, the physical environment, information systems, and much more.

Thank-you for taking the time to make your feelings known. Thank-you for your honesty. We will keep working to promote safe, cost-effective, high-quality care for our patients and their families. And this survey is an important part of that work.

What's new in vascular surgical nursing?

—by Erin Cox, RN, clinical nurse specialist,
and Sharon Bouvier, RN, nurse manager

Millions of people are affected by arterial and/or vascular disease or vascular anomalies. Despite prevention initiatives, public awareness campaigns, and new pharmacological agents, atherosclerosis remains one of the most common causes of death in the United States.

Recently, we've seen several innovations in the world of vascular surgery. For years, these complicated surgeries often had serious complications, long lengths of stay, and prolonged periods of rehabilitation. New techniques and technological advances now allow surgeons to correct some vascular abnormalities through minimally invasive, endovascular procedures.

The endovascular approach offers several advantages for patients compared to conventional surgical treatments. The endovascular AAA repair requires only two 3- to 4-inch bilateral groin incisions, versus the large thoracic or abdominal incision that might be required in an open repair. Endovascular patients are out of bed the next day, where the typical hospital stay for the conventional method is about three days. Endovascular patients are usually able to return

to activities of daily living four to five months sooner than with a standard surgical repair.

The newest endovascular treatment to be used at MGH is the carotid stenting procedure. A stent (a device that allows the vessel to stay open) is deployed through an arterial sheath (catheter inserted into the artery) to improve blood flow through a narrowing in the carotid artery. While data around this treatment is still being collected, the carotid stenting procedure is a viable option for many patients

including those who may not be candidates for surgical procedures.

What does this mean for vascular nursing? Our practice constantly changes and evolves to meet the needs of our patients and stay on the cutting edge of technology. We are challenged to think differently about

our nursing care. It's very common for vascular surgical patients to suffer from a number of other medical conditions. The vascular patient population is diverse; we care for patients with

continued on next page



Vascular nurse, Cheryl Codner, RN, spends some quality time with patient, Cornelia Downes



Staff nurses, Kathy Hurley, RN (left) and Christina Bavaro, RN, with patient, Chet Bukowski, on the Bigelow 14 Vascular Unit.

Daniels named executive director for Social Services and the Chaplaincy

Ann Daniels, MSW, PhD, interim executive director for Social Services and the Chaplaincy, was officially appointed executive director on June 2, 2005. She becomes only the fifth director in almost a hundred years of Social Services at MGH, succeeding Evelyn Bonander, ACSW, who retired July 2, 2004, after 19 years in the position.

Daniels received her master's degree in Social Work from Simmons College School of Social Work, and her PhD from Smith College School of Social Work. She has been part of the MGH Social Services Department since 1974, as unit supervisor, associate director, and clinical director, taking on the role of interim executive director almost a year ago.

Says senior vice president for Patient Care Services, Jeanette Ives Erickson, RN, "We knew when Evelyn left, it was

going to be very difficult to fill her shoes. Over the past year, the transition under Ann's leadership has been absolutely seamless. I'm confident we found the right person for the job!"

Steve Taranto, director of Human Resources for Patient Care Services, agrees. "After an exhaustive two-year, national search, it turned out that the best candidate was right in our own back yard."

Having been part of the MGH community for almost 30 years and a member of the PCS Executive Committee since assuming interim responsibilities, Daniels has had ample opportunity to build relationships and establish a solid track record in clinical social work, patient- and family-centered care, MGH systems, shared decision-making, and research.

Earlier this year, the Society for Social Work Leadership in Health Care presented Daniels

with the Hyman J. Wiener Award for exemplary leadership. In 2004, she received the Centennial Excellence in Supervision Award from Simmons College School of Social Work.

Karen Tanklow, LICSW, clinical social worker, says, "Ann embodies everything a great social worker should. She's an outstanding leader; one who leads by example and encouraging others. She's an outstanding clinician who's never given up her clinical interests even while holding a demanding administrative position. She is a woman of great humor who always has compassion for her staff and the clients they serve. Ann became interim director at a time of great change. But she assumed this responsibility with the confidence, grace, skill, and humor we've come to expect. She helped move the department forward at a very challenging time."



Ann Daniels, MSW
executive director for Social Services
and the Chaplaincy

Trish Gibbons, RN, associate chief nurse for the Knight Center for Clinical & Professional Development, worked with Daniels during the design and implementation of the inter-disciplinary Clinical Recognition Program. Says Gibbons, "Ann carries on the ideals of Ida Cannon, founder of medical social work. Like Cannon, Ann is convinced that medical practice cannot be effective without examining the link between illness and the social conditions of the patient. Her leadership and mentoring of others has ensured that the field of medical social work

continues to be alive and visible at MGH.

Chaplain Mike McElhinny says, "The Chaplaincy is very pleased that Ann is the new executive director. Time was taken, many impressive candidates were considered, and in the end, the best possible choice was made. We're grateful that Ann accepted this position and we look forward to her leadership, dedication, sense of humor, and compassion."

Patient Care Services and the entire MGH community extend a warm welcome to Ann Daniels, new executive director for Social Services and the Chaplaincy.

Vascular Surgical Nursing

continued from previous page

chronic wounds, gangrenous extremities, post-amputation, blood-clotting abnormalities, post-operative interventions, and infections. New surgical and endovascular options improve out-

comes for highly functioning patients and improve the quality of life for many chronically ill patients.

On the Bigelow 14 Vascular Unit, our interdisciplinary team initi-

ates a patient-centered plan of care early in a patient's hospital stay to ensure thorough preparation for discharge and follow-up care. Patients require frequent, comprehensive assessments as complications must be addressed as quickly as possible. With the RN Arterial Sheath Removal

program, we're able to accept patients directly from interventional areas (the operating room or cardiac cath lab).

June 11-18, 2005, is National Vascular Nurse Week. This is a time to reflect on the great progress that has been made in our specialty, and reaffirm our commitment

to this patient population during this time of incredible growth and change. Please join me in recognizing and saluting the important work of vascular nurses at MGH.

For more information about vascular nursing or new endovascular procedures, call Erin Cox at 6-6100.

Volunteer Recognition Day: singing the praises of our unsung heroes

What is it about celebrating the selfless acts of others that makes people feel so good? Is it a sense that we're in the presence of overwhelming kindness? Is there an inexplicable high that comes from witnessing generosity of spirit? Whatever it is, it's in abundant supply in the MGH department of Volunteer Services, and it was celebrated in grand fashion on June 2, 2005, as MGH paid tribute to its 'unsung heroes.'

Addressing a packed Walcott Conference Room, senior vice president for Patient Care, Jeanette Ives Erickson, RN, called MGH volunteers our 'go-to team' when it comes to making a difference in the lives of patients. Comparing them to the biblical Good Samaritan, she said, "They are the ones who stop, who serve, who give of themselves with no thought to personal gain or reward. They care for our patients and one another as they quietly, persistently brighten the lives of those around them."

MGH president, Peter Slavin, MD, thanked

'our friends in the pink jackets,' saying, "You are our unsung heroes whose good deeds are rewarded neither by pay nor promotion. Today, we have the opportunity to give you the accolades and applause you so richly deserve."

Slavin noted that the 182,483 hours worked by MGH volunteers this past year translate into the equivalent of 88 full-time employees (or \$3,202,576).

Edward Lawrence, chairman of the MGH Board of Trustees, said, "There's no way to thank you enough for the important contributions you make to our hospital. The spirit, warmth, support, and generosity you show is part of our great tradition. It is an extraordinary gift that means so much to so many."

Slavin, Ives Erickson, and Lawrence all thanked Pat Rowell, director of Volunteer Services, for her compassionate leadership and commitment to excellence

in guiding this incredible team.

Annual volunteer service awards were presented to:

- Rose Buonopane
- Ellen Connell
- Nancy Hiller
- Nicholas Krebs
- Elaine Kwiecien
- Lorraine Kushner
- Joan Litchfield
- Sandra Lanier
- Jill Martuza
- Dave Moccia
- Duncan MacDonald
- Nancy Magoon
- Margaret Puszczewski

Lynn Duff received the Janet Ballantine Oncology Volunteer Award; Charles Mc-

Carthy was the recipient of the Jessie Harding Outstanding Volunteer Award; operating room nurse liaisons and the Post-Anesthesia Care Unit received this year's Trustees Award for promoting a strong and supportive relationship with volunteers; and special recognition was given to Garrick Richardson and the Cancer Center Infusion Unit volunteers.

Earlier this year, the MGH Volunteer Department was honored with the President's Award for Outstanding Program Development by the New England Association of Directors of Hospital Volunteer Services. The award recognizes the

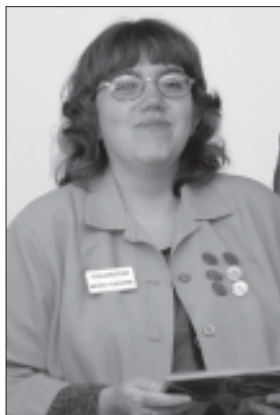
successful collaboration of many departments within the hospital (OR Administration, Information Systems, and the Volunteer Department) to enhance systems and ultimately improve care to our patients.

MGH volunteers provide an invaluable service to the hospital, to our patients, and to staff. And just in case the message didn't come through loud and clear on June 2nd, the entire MGH community appreciates all that you do!

For more information about the services provided by MGH volunteers, call the Volunteer Office at 6-8540.



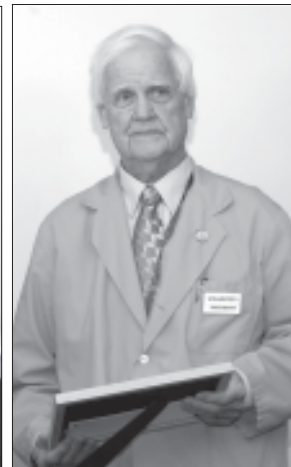
Rowell



Slavin

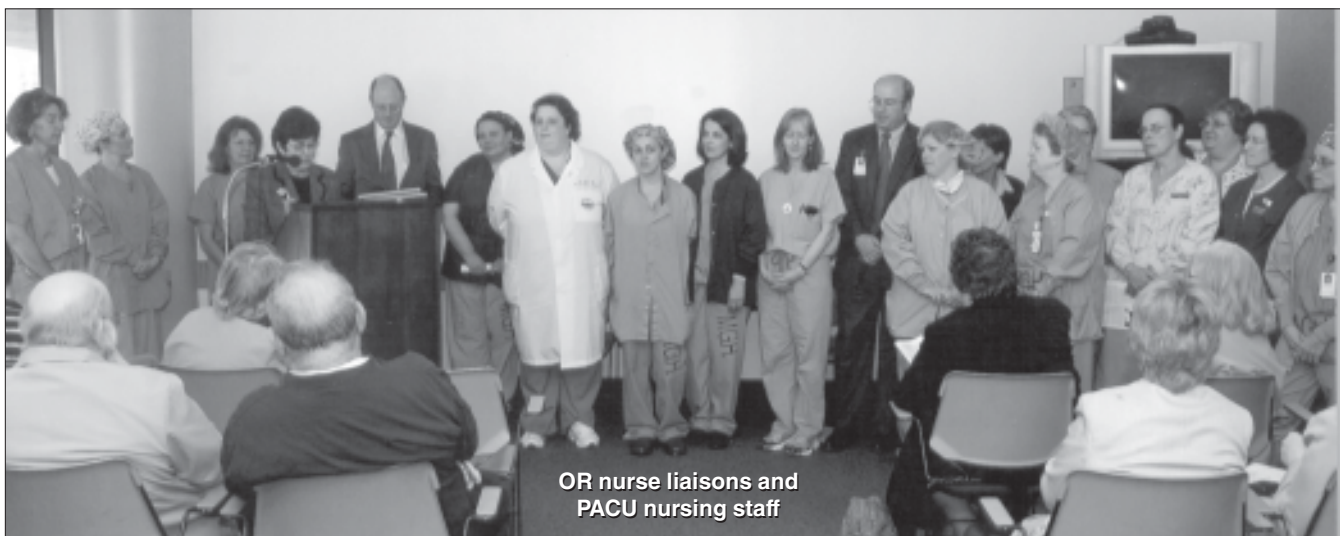


Ives Erickson



June 16, 2005

Congratulations and thank-you very much!



OR nurse liaisons and
PACU nursing staff

(Photos by Abram Bekker)

Tony and me: challenges in caring for a patient in restraints

My name is Ann Eastman, and I am a staff nurse on the Bigelow 14 Vascular Unit. Among the many difficult decisions nurses make, some of the most difficult have to do with maintaining the safety of patients at risk for doing themselves harm. One such patient in my experience was 'Tony,' a man who was brought to the MGH Emergency Department from a community hospital.

While at the community hospital, it was learned that Tony had had a thrombectomy (removal of a blood clot) from his left femoral artery some time prior to this admission. This time, he presented with a cold left leg and, presumably, another clot. He was transferred to the MGH Emergency Department, and from there was taken to surgery.

The first information I got about Tony was the nurse's report from the Post Anesthesia Care Unit that described him as, 'feisty' and said he 'settled down when left alone.' With this information and a very scant history, I was prepared to meet Tony.

As soon as Tony arrived on the unit, I knew I was facing a challenge. He was sitting up on the stretcher arguing loudly

with a nursing assistant, refusing to get off the stretcher, demanding to get up and walk, and ignoring any suggestions she made to him.

I introduced myself, told him that sitting up was very dangerous for him in that it could cause his artery to bleed or result in the formation of a new clot. He informed me that I talked too much and told me to, "Shut up."

With sufficient help and coaxing, we managed to get Tony into bed. He was impatient with having his vital signs monitored and having his wound assessed, though he finally allowed us to do both. He insisted on getting up to urinate, ignoring our explanation about the catheter draining his bladder. It was all we could do to keep him in bed.

I decided that a little less stimulation might help. I demonstrated how the call bell worked, told him to call if he needed anything, and assured him I'd be back. This strategy failed within minutes when he again tried to get out of bed.

Noting a need for reinforcements, I asked a resident from the team to come in and speak with Tony. He and the senior resident both came, explained the procedure and the after care to Tony

again. He said he understood and would comply, but sat up again as soon as they left.

Clearly, I was losing ground. I asked a co-worker to talk with him, thinking a fresh face might help. Amy arrived, spoke with him, and things seemed to smooth out somewhat. But within minutes Tony was again saying he could do whatever he wanted and had his legs up and over the side rail.

That was the point of no return. Tony was continually putting himself in jeopardy. The risk of an arterial bleed requiring re-operation was very real. In the worst-case scenario, a re-bleed could result in the loss of a limb or even death. Tony was not receptive to any restrictions. I had to act quickly.

I asked the residents for an order to restrain Tony and keep four side rails up on his bed. With help, I restrained Tony. At first, it was just the operative leg and opposing arm, but ultimately all four limbs had to be restrained. Having to do this within the first half hour of our meeting was not a good sign.

With Tony restrained and relatively safe, I gave myself a few moments to reflect and re-think my strategy. I had done several things al-



Ann Eastman, RN,
staff nurse, Bigelow 14

ready: I had explained the plan of care to Tony; answered some of his questions; tried having a different caregiver intervene (including a male caregiver as some patients respond differently to different genders); tried to minimize my interventions to only the most necessary post-operative checks; and sought to decrease his stimuli.

All had failed.

With Tony secure, I had time to review some more of his record. He had come to the community hospital Emergency Department with a 'cold leg.' From the notes, I could see that Tony had had a thrombectomy on the same vessel several years earlier. But he had been unable to give any further history or the names of any medications he might be taking.

I looked to see who his next of kin was. No one was listed.

I was short on information and long on issues. I tried to consider what the causes of Tony's be-

havior might be. Post-anesthesia delirium was a possibility, but Tony had not received a general anesthetic. Maybe some other medication was the cause. Another possibility was a communication issue. But Tony seemed to understand what we were telling him. He could do what was asked of him if he wanted to. But was he able to grasp the significance of more complex ideas? That was the question. Could this be drug- or alcohol-related? It was possible but unlikely. Withdrawal symptoms usually manifest after more time has elapsed. What about dementia?

Attempting to conduct a formal mental status check was not realistic. But Tony knew the date, his location, and he was aware that he had just had surgery. Did he just dislike me? That didn't seem to be it, as the residents and Amy had no more success than I did. I remembered reading 'feisty' in the notes and

continued on next page

Clinical Narrative

continued from previous page

'settled down when left alone.' It wasn't an answer, but it might be a strategy.

Sometimes people who are fearful do better when left alone to settle down and reorganize. Talking with patients about their fears can sometimes agitate them further.

Tony was already restrained. I had tried several strategies to calm him and they had failed. The restraints needed to stay to prevent Tony from causing harm to himself. I came to this conclusion reluctantly. Restraining patients is a very complicated issue. It is, in effect, taking away a patient's mastery of his own person; it is a kind of imprisonment that can increase feelings of vulnerability in someone who very likely already feels vulnerable. It can, in and of itself, put patients at risk for psychological harm, increased agitation, and destroy their trust in caregivers.

Some literature suggests that restrained patients have a higher mortality rate. There are also lesser but significant physical risks—the possibility of aspiration; the chance of developing an abrasion; injury to the restrained limb that could present significant and potentially long-term care and/or life-style issues.

There is also risk for caregivers. Being the

person who retrains another is repugnant to many of us. It goes against our sense of morality. And there is a responsibility you assume for a patient who has become essentially helpless.

Caregivers face a risk of injury when we unrestrain patients to provide care. Tony was angry and asserting himself *before* he was restrained. What would he be like when he was un-restrained?

Balance is so important—that delicate balance between keeping a patient safe from almost certain harm while introducing an alternate, potentially harmful, intervention. For me, in this instance, the decision to restrain Tony was difficult, but it was the right decision at the time. It was the best way to ensure Tony's safety.

Any risks that might be presented by the restraints were significant, but not immediate, and they could be reduced by trying to help Tony understand what was happening, enlisting his cooperation, and un-restraining him as soon as it was safely feasible.

I moved Tony to a more visible location (the bed closer to the door) so we could monitor him more easily without entering 'his space.' I made a conscious effort to limit my interventions to only the most essential and to be quiet when I

was with him. I obtained an order for Haldol, which would be helpful if Tony's mental state continued to deteriorate.

Throughout the afternoon, Tony relaxed a little bit. As my shift ended, I passed on all we had done and learned, the strategies I developed for his plan of care, and I hoped Tony would be better when I returned two days later.

I got my wish.

When I returned to work, I found Tony to be pleasant and cooperative. He was out of restraints, wasn't requiring any medication for delirium, wasn't in any type of withdrawal, and was cooperating fully with caregivers. I was told he had no memory of his first day on the unit.

The plan of care we developed for Tony had been employed by my colleagues, and we were all satisfied that it had been successful in helping deliver the best care we could under the circumstance.

I'm still not sure what happened to Tony. I do know he needed protection and my resources were limited. No family members; no first-hand insight into his personality or coping skills; no real physical or medication history; and little input from the patient himself to guide me. I made a decision that was very difficult for me, one I feel is fraught with risks. But I needed to keep Tony safe and ensure his well-being to the best of my ability. I

sought the assistance of my colleagues, weighed all options, reviewed my experiences, and finally, reluctantly, decided that restraining Tony was what he needed me to do to keep him safe.

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

Few situations cause as much inner conflict and angst as the decision to restrain a patient. And rightfully so. Ann's narrative gives us an inside

look at her decision-making process as she worked to balance Tony's autonomy and dignity with the very real possibility that he could do himself harm. No clinician takes restraining a patient lightly. Ann weighed all options and considered all factors before making the difficult decision to restrain Tony. This story had a happy ending because Ann acted responsibly and did what was necessary to ensure Tony's safety.

Thank-you, Ann. This is an important narrative.

Workplace Education Program

End-of-Year Celebration!

Please come to the MGH Workplace Education Program's end-of-year celebration as students learning English as a second language are recognized for their accomplishments

June 24, 2005

1:30–3:00pm

Under the Bulfinch Tent

The Workforce Education Program is currently assessing students for its fall classes.

For more information, call 617-724-3976

Racial and ethnic disparities in healthcare

Featuring *Worlds Apart*, a documentary film capturing the experiences of patients with chronic medical conditions as they face the cross-cultural challenges of today's healthcare environment.

Monday, June 27, 2005

12:00–1:00pm

O'Keeffe Auditorium

Sponsored by MGH president, Peter Slavin, MD, the Committee on Racial and Ethnic Disparities; Patient Care Services; the Community Benefit Program, the Multi-cultural Affairs Office, AMMP, and the MGPO

D'Amato remembers 30 years of clinical research nursing

—by Bonnell Glass, RN, nurse manager, GCRC

"I still find research nursing every bit as exciting and intriguing as the day I started on Bulfinch IV all those years ago. Inquiring minds have a need to know. I like being on the cutting edge and taking the path not known."

—Marian D'Amato, RN

On Monday afternoon, May 9, 2005, friends and colleagues of Marian D'Amato, RN, gathered in the Trustees Room to

celebrate Marian's 30-year career at MGH as a clinical research nurse. Marian began her research nursing career in

1974 on the Bulfinch Ward IV Metabolic Unit, a 10-bed inpatient unit on the first floor

of the Bulfinch Building, just below the Trustees Room. Over the past few months, Marian has reflected on her more than 30 years of practice. "There's nothing else I would have wanted to do," she says. "Anything else would have seemed boring."

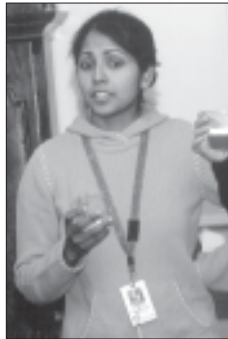
Marian brought 15 years of clinical experi-

ence to the research practice she joined in 1974, including a year as a new graduate at Beth Israel Hospital, three years of private duty in the Baker Building (caring for medical, surgical, thoracic, neurology and burn patients), three years in the Respiratory ICU on Phillips House 2, and eight

continued on next page



Marian D'Amato, RN



(Photos by Abram Bekker)

D'Amato Remembers

continued from previous page

years of clinical nursing in Canada.

With a 30-year lens, Marian recalls many landmarks and highlights in the evolution of human research at MGH. Ward IV Metabolic Unit had been operating since 1925. In 1945, Edward Mallinckrodt, Jr, a close friend of Dr. Fuller Albright, prominent MGH researcher, began donating a significant amount of money to Ward IV. In 1949, the unit was named Mallinckrodt Ward IV in his honor.

Funding for research came from many sources: institutes, foundations, NIH, MGH, and grants to individual investigators. Most studies were in endocrine, metabolic and bone disorders with inpatient stays of one or two weeks. Gradually, studies became shorter and an outpatient component was added to the practice. In the 1970s, studies diversified and became multi-disciplinary. Investigators from Pediatrics, Dermatology, Cardiology, Neurology and Psychiatry brought their studies to Ward IV. In 1977, the Metabolic Unit applied for and became funded as the General Clinical Research Center (GCRC) by the National Institutes of Health.

In 1985, the GCRC moved to a renovated White 13 with ten inpatient beds and an expanded outpatient unit.

Marian recalls working with many endocrine fellows over the years, some of who are now leaders of clinical research at MGH: David M. Nathan, MD, medical director of the GCRC; Anne Klibanski, MD, associate director of the GCRC; and William F. Crowley, Jr, MD, direc-

tor of Reproductive Endocrinology. times a day and give themselves bolus doses of insulin. They came to the unit frequently over years for testing. It was very gratifying to find that keeping blood glucose in tight control really *did* make a difference in preventing complications. All participants felt better than they ever had before, physically, mentally and emotionally

"There's nothing else I would have wanted to do. Anything else would have seemed boring."

tor of Reproductive Endocrinology.

In their remarks, Nathan and Klibanski described Marian's many contributions to their training as physicians and investigators and the work they shared. They told heartfelt stories of the difference Marian made in the lives of the people she cared for, the accuracy of the research data she collected, and the steady, vigilant presence she brought to all aspects of scientific inquiry.

Some of the highlights Marian recalls include:

- Being protocol nurse for the ten-year Diabetes Control of Complications Trial. Adolescents and young adults were given mini-insulin pumps, taught to set basal rates, check blood glucose four

- Trials of implantable insulin pumps with remote control to achieve tighter glucose control and improved health and well-being
- The Precocious Puberty Study where 5-year-old children were given GNRH analogue to slow down GNRH secretions to stop pubertal changes. Building relationships with the children was so gratifying. It was wonderful to follow them over the years and see, when the study ended, that they returned to normal hypothalamic and pituitary function and experienced puberty at the normal age with full reproductive function.
- The Male Hypogonadal Study examined LH/FSH secretions in normal and hypogonadal males. The study

had many phases, ultimately studying older married males who wanted to have children. Marian remembers when the first subject became a father. Coincidentally, he visited MGH recently and told Marian about his two daughters who are now in university

- The Female Infertility Protocol where subjects received GNRH by pump to mimic a normal menstrual cycle. Marian recalls how exciting it was when they had their first pregnancy and normal birth

Marian played many roles during her career on the GCRC. She was preceptor, teacher, mentor, scheduler, payroll officer, interim manager, resource nurse, veteran clinician, and protocol nurse. Marian developed and defined the role of protocol nurse. She taught us to understand the science of the question and the clinical condition; to work with investigators during the developmental phase of studies raising questions and concerns that would strengthen the proposal, improve the accuracy of the data, and ensure the safety and comfort of subjects; guide

the creation of orders for study visits; prepare lab slips, flow sheets, templates, labels, teaching pamphlets, and guidance for all staff.

Protocol nurses are an essential part of the research process and key members of the team. Says Marian, "Critical thinking skills are essential. There's a fine line between providing quality patient care and conducting quality research and not compromising one for the other."

We are indebted to Marian for all she has taught us, for all the people she's known and cared for, for the discoveries she's been part of, and for her many contributions to this rich history.

In her remarks that day, Marian thanked Jeanette Ives Erickson, RN, senior vice president for Patient Care for all she has done to make MGH such an excellent place to practice nursing. She thanked Jean Nardini, RN, for her guidance and support during the time Jean was nurse manager of the GCRC. And she thanked her White 13 colleagues.

And we would like to thank *you*, Marian. You are "simply the best!"

Caring
HEADLINES

Back issues of *Caring Headlines* are available at: <http://pcs.mgh.harvard.edu/>

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

Clinical narrative-writing made easy

—by Elizabeth Johnson, RN, clinical nurse specialist

Clinical narratives are an important component of nursing practice and professional development at MGH where clinicians enjoy the time-honored tradition of recording clinical experiences for reflection, analysis, and memory preservation.

Teachers have used narratives as learning tools since ancient times, but it was Patricia Benner, RN, who provided the seminal work that led to widespread valuing of the narrative for educational purposes as well as professional development. Benner's work was so significant in the field of nursing that other disciplines followed, establishing workshops, courses, and institutes dedicated to narratives in practice. Writing narratives enables clinicians to integrate formal knowledge with the less predictable world of actual practice, thereby deriving greater meaning from both.

A clinical narrative is a first-person story about a practice event that had special meaning for the writer. The narrative includes a description of what happened as well as the writer's concerns,

fears, and thoughts about the experience over time.

Writing a narrative, especially for the first time, can be a daunting task. Clinicians sometimes resist because they don't know how to start and feel overwhelmed at the sheer idea of it. Clinicians have reported feeling discouraged, confused, and uncomfortable talking about themselves. These feelings resonate with me, even though I'm convinced that compelling benefits come from the narrative-writing experience.

To keep from getting bogged down in the mental 'straight jacket' of writer's block, it's helpful to have a mental framework to guide your writing process. I have developed a structure, summarized by the acronym, TIER, that has helped me get started on a number of occasions.

The TIER approach (Topic, Introduction, Event, and Reflection) is a way of organizing the writing process, breaking it down into manageable steps:

Step 1: Identify a topic. It can be an event that occurred at a single point in time or a story that played out over a long period of time.

Whatever the topic, it should relate to a situation in which the writer was actively involved; you want to write from personal experience. Any patient situation that's memorable for its cognitive, emotional, clinical, or spiritual insights is appropriate for developing as a narrative. While the situation may involve the application of theoretical knowledge, it should also involve significant personal investment.

Step 2: Introduce yourself and your topic. One of the hardest things about writing is composing the first sentence.

There's nothing wrong with using a standardized beginning: "My name is Elizabeth Johnson, and I have been an oncology nurse for 20 years. I'd like to share a story about..."

This formulaic opening introduces me, my topic, and the situation I'm going to write about in the first two sentences. I can go back later and revise or even eliminate it, but it got me started, and that's what I needed.

Step 3: Describe the event(s) as if you were writing a first-person story. Paint a verbal picture of the patient and the situation. Be sure to include your thoughts and feelings as the event unfolded. These thoughts and feelings are known as, 'reflection in action,'

and they're important because they shed light on the mental processes that led to a particular action. Recalling thoughts and feelings helps mine rich material from which insights can be derived later.

Relating events in chronological order is a useful way to tell a story, but it's not the only approach. Some writers start in the middle or at the end of the story, because it helps frame the story in a way that's meaningful to them. Sometimes imagining you're telling the story to another person can help you organize your thoughts in a way that makes sense to you.

Step 4: The last part of the narrative reflects

continued on next page



Clinical nurse specialist, Liz Johnson, RN (standing), and new oncology staff nurse, Olga Chigevski, RN, review the TIER approach to clinical narrative-writing

Clinical Narrative-Writing

continued from previous page

on the events you've just described. This is called, 'reflection on action.' It's an analysis of what happened and your involvement in the situation. This part of your narrative should explore the meaning the experience had for you.

The following questions can be helpful in expanding your analysis of the experience:

- How does a particular theory help explain what happened; how does the event illustrate the dynamics of a particular theory?
- What did you learn as a result of this experience and reflecting on it later? What insights came to mind as you reflected on the experience?
- How will writing a narrative affect your practice?
- Why was the situation memorable to you?
- How would the situation have unfolded differently if key elements had been different?
- How did your presence impact the process? The outcome?
- How did your actions and presence affect the patient?
- What did you learn about your practice and your development as a professional as a result of the experience?
- In reflecting on the experience, what are your thoughts and feelings about your profession? Are they the same or different from when you were a less experienced clinician?

Once you've finished writing your narrative, re-read it. Additional thoughts are likely to occur to you. You may also dis-

cover depth in your practice you never knew existed.

Following are some common comments I hear from staff about writing clinical narratives:

"I don't know what to write about. My mind is a blank."

Don't spend a lot of time worrying about the topic. Any patient, event, or clinical situation will provide plenty of material. If you really feel stuck,

Once you've finished writing your narrative, re-read it. Additional thoughts are likely to occur to you. You may also discover depth in your practice you never knew existed.

ask a colleague to recall a noteworthy event; you may be too immersed in the day-to-day work of your unit to identify an isolated incident. Strategic questions about your day, your patients, or your practice should lead to an appropriate topic. Write about that event using the TIER approach.

"I'm not a very good writer."

The purpose of writing narratives is to illuminate and explore aspects of clinical practice, not become the next Margaret Mitchell. The writing process is an important strategy for developing insight about one's practice, but the sophistication of the language isn't as important as the self-dialogue and interpersonal exchange that comes from creating the narrative.

"When I write about my practice, I feel like I'm bragging and that makes me uncomfortable."

Remember that the focus of your narrative is the patient, the situation, or the event. Your thoughts and actions are critical elements in the evolution and outcome of the situation. Writing about something you did well provides valuable information (reflection-in-action and reflection on action) that's critical in helping you develop your practice. Also, if others read your narrative, it's a good way to share best practices and allow others to learn from your experience.

"I feel too vulnerable to write about a mistake or a bad outcome."

Writing about mistakes or negative experiences requires courage. But that kind of self-disclosure also reveals a high level of professional integrity. Writing about negative experiences can actually be re-affirming and reveal hidden factors about what led to the negative outcome. It's widely accepted that people who discuss their mistakes become more confident clinicians in the long run. Narratives about mistakes or poor outcomes reinforce a culture of problem-solving as opposed to blame. Mentors educated in the process of *unbundling* (discussing the elements of) clinical narratives understand the importance of supportive, non-judgmental dialogue in developing practice.

For more information about clinical narrative-writing, contact Liz Johnson at 4-4118.

Published by:

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

Publisher

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

Managing Editor

Susan Sabia

Editorial Advisory Board

Chaplaincy (interim)
Marianne Ditomassi, RN, MSN, MBA

Development & Public Affairs Liaison
Victoria Brady

Editorial Support
Marianne Ditomassi, RN, MSN, MBA
Mary Ellin Smith, RN, MS

Materials Management
Edward Raeke

Nutrition & Food Services
Martha Lynch, MS, RD, CNSD

Office of Patient Advocacy
Sally Millar, RN, MBA

Orthotics & Prosthetics
Mark Tlumacki

Patient Care Services, Diversity
Deborah Washington, RN, MSN

Physical Therapy
Occupational Therapy
Michael G. Sullivan, PT, MBA

Police & Security
Joe Crowley

Reading Language Disorders
Carolyn Horn, MEd

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech-Language Pathology
Carmen Vega-Barachowitz, MS, SLP

Volunteer, Medical Interpreter, Ambassador
and LVC Retail Services
Pat Rowell

Distribution

Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

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 9, 2005



New patient safety journal

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

January marked the launch of the new *Journal of Patient Safety*, the official publication of the National Patient Safety Foundation (NPSF). Published quarterly by Lippincott, Williams & Wilkins, the peer-reviewed journal combines research and real-world findings in virtually every area of patient safety.

"This is a new publication, dedicated to presenting the emerging science of patient safety," says Nancy W. Dickey, MD, *Journal* editor and president and vice chancellor for Health Affairs, A&M

System Health Science Center. "It's [our] intent to provide a vehicle to track the research advances, application of research, and lessons learned from the field as solutions are applied."

The journal focuses particularly on patient-care concerns during care transitions, partnering with patients, information technology, and promoting a culture of safety. Dickey welcomes articles that report on implementation of the 2004 Patient Safety Goals and requirements as defined by the Joint Commission on Accreditation of Healthcare Organizations, including:



- improving the effectiveness of communication among care-givers
- eliminating wrong-site, wrong-patient, wrong-procedure surgeries

- improving the accuracy of patient identification
- improving the safety around using high-alert medications
- improving the safety of using infusion pumps
- improving the effectiveness of clinical alarm systems
- reducing the risk of health care-acquired infections.

For more information about submitting articles or subscribing to the *Journal of Patient Safety*, please visit www.npsf.org and click on the *Journal of Patient Safety* graphic. Click on, "Journal website" on the right-hand side of the page for detailed instructions on how to submit materials for publication.

June Vacation Club for 6-12 year-olds

June 20–July 1, 2005

MGH Backup Childcare Center

Hours: 7:30am–5:45pm

\$275/week; \$60/day per child

Activities are subject to change but may include: a picnic at Paul Revere Park; mad science; strawberry shortcake festival; movies; swimming; a visit to the Museum of Science and the USS Constitution; and a tour of Bunker Hill Monument

The Backup Childcare Center can provide care for younger children (15 months–5 years)

For more information, call Patty Pirone
at 617-724-7100

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

June 16, 2005

When/Where	Description	Contact Hours
June 28 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
July 7 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
July 12 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
July 13 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
July 13 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
July 13 11:00am–12:00pm	Nursing Grand Rounds “Nursing Assessment and Management of Patients with Peripheral Arterial and Venous Disease.” Sweet Conference Room GRB432	1.2
July 13 4:00–5:00pm	More than Just a Journal Club Thier Conference Room	1.2
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 VBK 401	---
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 VBK 401	---
August 9 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
August 10 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
August 10 8:00–11:45am	Intermediate Arrhythmias Haber Conference Room	3.9

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>.

Flaherty, Jones, nominated for *Nursing Spectrum's* Nursing Excellence Awards

This year, two MGH nurses were nominated for *Nursing Spectrum's* annual Nursing Excellence Awards. Eileen Flaherty, RN, nurse manager of the Bigelow 11 Medical Unit was nominated 'unanimously' by her entire staff for outstanding leadership; and Dorothy (Dottie) Jones, RN, senior nurse scientist in The Knight Center for Clinical & Professional Development, was nominated by clinical nurse specialists, Marian Jeffries, RN, and Marion Phipps, RN, in the area of advancing the profession of nursing.

At a special gala celebration at the Seaport

Hotel in Boston on May 24, 2005, Flaherty was named recipient of the Nursing Excellence Award for Leadership.

In their letter of commendation, Flaherty's staff wrote, "Eileen

is a true leader, mentor, and advocate. She has dedicated herself to creating a work environment that is both enjoyable and safe. Her exemplary

and selfless leadership has engendered a strong, devoted, and empowered team. She takes the role of nurse manager to a new level, encouraging us to practice at our best, and challenging us to see the lessons in every patient-care situation. Eileen is always available to staff, providing strong, determined leadership in

the care of our most challenging patients."

Of Jones, Jeffries and Phipps wrote, "Dr. Jones has been involved in many initiatives that advance the practice of nursing. Her enthusiasm and energy are infectious. Through reflective discussions with her, we have grown as professionals, and our CNS group has become more cohesive. She exemplifies the best in what it means to be a nursing leader, mentor, and teacher. Her wisdom is a balm in this time of chaos in health care and all the changes in our profession."

The full story of the Nursing Excellence Awards can be seen in the June 6, 2005, issue of the New England Edition of *Nursing Spectrum*. Congratulations to both Eileen and Dottie!



Dorothy Jones, RN
senior nurse scientist, Knight Center for
Clinical & Professional Development



Eileen Flaherty, RN
nurse manager,
Bigelow 11 Medical Unit

Caring

HEADLINES

Send returns only to Bigelow 10
Nursing Office, MGH
55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston MA

