

May 19, 2005

# Caring

## HEADLINES

# Nurse Week 2005

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**MGH** Patient Care Services  
Working together to shape the future



*Bonnie Eidens*

Staff nurse, Bonnie Eidens, RN, with patient,  
Sohrab Hashmi, on the Dialysis Unit

# Jeanette Ives Erickson

## MGH Nursing today: healing, leadership, and global action

**I**t started with a fast-paced, up-beat, rock-'n'-roll re-cap of the past ten years of nursing at MGH.

And for those of you who missed it, it was quite a ride! In her signature Nurse Week address (set to the tune of Jefferson Starship's, *We Built this City on Rock 'n' Roll*), senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson, RN, opened with a video retrospective of some of the most memorable moments of the past decade, including implementation of collaborative governance, development of the Clinical Recognition Program, achieving Magnet Hospital status, the introduction of new technology, the opening of many new units, the filling of key leadership positions, and of course, the legendary march to national championships for her beloved Patriots and Red Sox. Said Ives Erickson, "We may not have built this city on rock 'n' roll, but for me, our work together has been just as much fun."

Focusing on the triology of healing, leadership, and global action first articulated by Florence Nightingale, Ives Erickson framed our agenda for the next ten years. Too long to be included in its entirety, what follows is an abridged version of Ives Erickson's presentation.

"There exists a fleeting and deliriously exciting moment in the life of an idea when it teeters between what one person suspects and what everyone accepts. In that moment, months or years before it exerts any practical influence, the idea holds the greatest potential to inspire and incite. Opportunities, implications, and related discoveries open up from it in all directions like a hall of mirrors."

—"Introduction to the year's Best Innovations"  
*Harvard Business Review*, February 2005

This week is an opportunity to honor the important work of nurses and thank those who support our practice. Let us begin with a discussion of our vision, values, successes... and a few of our failures.

As members of the healing community, our work flows from a rich history of research and intimate experiences with patients.

Some of us have studied Florence Nightingale's vision of contemporary nursing and global wellness. Her work gives us a framework for the past and helps set the stage for the future.

When I first came to MGH and found a need to create systems that support patient care delivery, Nightingale became my role model. Her book, *Notes on Nursing*, speaks to the environment of care and of nurses' responsibility for that environment and the systems that keep patients safe.

Nightingale was influential in the community and in the world, like many MGH nurses who left the

comforts of home to serve in harsh conditions (in Iran, the Sudan, southeast Asia, and Ground Zero in New York City) to try to bring comfort to countless people with waning hope. Our humanitarian efforts have helped many of today's forgotten people in forgotten lands, many trapped behind closed borders, suffering under brutal regimes.

I was humbled and privileged this past February to visit our staff caring for tsunami survivors in Banda Aceh, Indonesia. What had been a bleak and comfortless existence, was transformed into a place of hope by the skilled and compassionate clinicians of MGH.

And of course, every day, thousands of patients receive exceptional care right here on Fruit Street and in our health centers in

Charlestown, Revere, Everett, Chelsea, the Back Bay, and the North End. MGH nurses are a symbol of what's right in the world and in the profession of nursing. And none of this would be possible without the support of everyone here at MGH.

Nightingale's achievements, like our own, include contributions to nursing theory, research, statistics, public health, and healthcare reform. Her legacy is relevant because the journey ahead holds many challenges:

- The nursing shortage
- The building of the new Knight Nursing Center for Clinical & Professional Development.
- Advancing our research agenda
- Overcrowding will lead us to build a new inpatient facility. Perhaps this new building will have universal rooms where patients don't travel—we do
- Perhaps all operating rooms will be ORs of the future

Our commitment to the future means an increased commitment to teaching the next generation of nurses. There will be a strong push to control ex-

penses due to shortfalls in Medicaid and Medicare reimbursement. Changes in our demographics and workforce will lead us to be more culturally competent. And hopefully those changes will include more men, Latino, Black and Asian nurses.

Advancements in technology will help us. (With a nod to Ed Coakley) The robots are coming! Combining the art and science of holistic nursing practice, education, and research is the way of the future.

We are the nurses Florence Nightingale envisioned. Every day, we deepen our understanding of the nurse as an instrument of healing. We create total healing environments and sacred spaces in our hospital and in the world.

In her book, *Notes on Nursing*, Nightingale identified concepts related to the nurse, the patient's health, and the environment. She emphasized that spiritual, social, and physical support, along with a comfortable and healing environment, influence all factors in healing. The active participation of the nurse is part of the healing process. So, if healing occurs both inward and outward, we as nurses have several responsibilities.

We need to develop our inner selves—develop an ability to be present to our patients and colleagues, and feel good about who we are as people and members of this community.

Nurses are responsible for creating a healing environment. In the coming months, we will talk more

"Leadership is much more an art, a belief, a condition of the heart, than a set of things to do.

The visible signs of artful leadership are expressed ultimately, in its practice."

—Max De Pree

Continued on next page

about how best to accomplish this, including:

- the importance of human interaction
- informing and empowering diverse populations
- healing partnerships
- nutrition: the nurturing aspects of food
- spirituality: inner resources for healing
- human touch
- healing arts: nutrition for the soul
- integrating complementary and alternative practices
- healing environments

A 2004 National Quality Forum report stated that: "Nurses, as principle front-line caregivers in the US healthcare system, have

tremendous influence on a patient's healthcare experience.

There is growing evidence that specific characteristics of nursing impact patient-care outcomes and hospital performance. Studies suggest a relationship between the number and type of nurses, the number of hours nurses work, and other variables about the nursing workplace. Evidence suggests that the number of direct-care nursing hours per patient day impacts a patient's length of stay.

The more highly competent nurses involved in the

care of the elderly reduces a patient's hospital stay by 0.5 days.

There currently exist 15 categories that describe nursing-sensitive care. This is the first time a set of national standardized performance measures have been brought together to assess the extent to which nurses contribute to healthcare quality, patient safety, and a professional and safe work environment.

(Some of the categories are: prevalence of pressure ulcers, falls, restraint use, access to smoking-

"Wherever there are people, nursing has the opportunity to support health and well-being in partnerships with others... Through cooperation and co-creation, a synergy will be formed that can transform the total well-being of society. Alone, nursing cannot do it. Without nursing, it cannot be done."

—J Koerner Nightingale II, *Nursing in the New Millennium*, 2001

cessation counseling, skill mix, etc.) The reason for measuring these standards is to provide consumers with a report card on how nurses contribute to a patient's stay.

MGH has volunteered to be a pilot site for implementation of these measures.

Now let's talk about leadership. I believe all nurses need to emerge as dynamic leaders to ensure MGH is guided to create healing environments for patients, families, and all who work for this organization.

Trans-visionary leadership means there's an active vision of desired outcomes—outcomes not previously achieved or commonly thought to be impossible. Perhaps

through "The Law of Explosive

Growth," we can change those things commonly thought to be unachievable. The Law of Explosive Growth says that leaders who develop other leaders multiply their growth as the leaders they develop, develop other leaders.

Leaders developing leaders.

We need to start thinking differently about leadership. It's not a job; it's a way of being. It's the responsibility of all nurses, in formal management roles like mine, as well as in staff roles like yours.

Part of our responsibility as professional nurses is to confront challenges by influencing health policy, the development of technology, and initiatives to improve health. It's our responsibility to confront injustices in our society. If

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"If you don't like change, you will like irrelevance even less."

—General Schensaki

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

"One of the common traits of good leaders is that they are compelled by the future."

—Frances Hesselbein



May 10, 2005

Mary Lowe

Staff nurse, Mary Lowe, RN, with patient, Emil  
Fleischaker, in the Respiratory Intensive Care Unit



## Strengthening patient- and family-centered care

icking off Nurse Week, executive director for the John D. Stoeckle Center for Primary Care Innovation, Susan Edgman-Levitan, PA, presented, “Strengthening patient- and family-centered care: strategies that work,” on Monday, May 2, 2005, in O’Keeffe Auditorium.

Stressing the importance of listening to patients, Edgman-Levitan reminded listeners that simply documenting information in patients’ records doesn’t tell us whether or not patients understand a particular intervention or instruction. Patients are the only ones in a position to judge certain aspects of care. What they tell us is invaluable.

“Bad news travels fast,” said Edgman-Levitan. Customer satisfaction is ‘lived’ in the community where good or bad news can make or break a hospital’s reputation. Public accountability is stronger than ever. Engaging patients and families in decision-making, care-planning, discharge planning, and patient-education is crucial.

Edgman-Levitan spoke about a patient-centered ‘aptitude,’ and how our hiring practices should target individuals who embody that aptitude. She shared this

quote from *The Customer Comes Second*: “You can’t teach people to be nice... Caring must be inherent to their natures—they have to feel it in their hearts. And if they do, their clients will feel it, too.”

First impressions are the most important—for patients and staff alike. When staff experience a meaningful, comprehensive orientation program it conveys an attitude of pride in oneself and in the organization; it instills a feeling of self-worth; creates a sense of belonging; and enhances the working relationship between staff and the organization. When everyone is aligned around the same mission, vision, and philosophy, there is a low tolerance for behavior that doesn’t support that mission.

When patients come into a hospital and experience good business practices, a positive care environment, and feel a sense of community, a connection is made. Loyalty is born. Edgman-Levitan suggests that loyalty can be nourished through subsequent hospitalizations with consistency of staffing, re-admission to the same ‘team,’ and primary caregivers for patients who return frequently.

Doing what we can to maximize a patient’s sense of control over his/

her surroundings instills trust and confidence. Even when their activities and abilities are limited, we can give them choices about what they *can* do. Do they want their curtains open or closed? Do they want the bed at a certain angle? Would they like to keep a journal or notebook?

Sharing information is another way to give patients a sense of control when they may feel they’re in a ‘helpless’ situation. Informed patients and families are partners in the healthcare experience. Sharing lab and test results, information in medical records, patient-education

materials, and the reasoning behind why we do interventions and procedures are all things patients want, and have a right, to know. Let the phrase, “Know it, tell it,” be your guide.

Checking a patient’s understanding of home-care and follow-up instructions by way of a discharge ‘quiz’ is more effective than simply reciting information or giving a patient a written sheet of information. Asking, “Mr. Smith, how long should you wait before taking a bath when you get home?” ensures that Mr. Smith understands the instructions and is more likely to comply.

Edgman-Levitan believes that walking a mile in our patients shoes is a good way to ensure we’re providing the best possible care. Do periodic walk-throughs of your unit to look for ways to improve care and services.

In closing, Edgman-Levitan shared this quote from Cedar-Sinai Medical Center clinical specialist, Marilyn Shirk, RN: “Talking with patients is often viewed as ‘not working.’ We have to start viewing this as our most important work.”



Susan Edgman-Levitan, PA,  
executive director, John D. Stoeckle  
Center for Primary Care Innovation

## Health disparities: Nursing's voice in practice

When a Caucasian person goes into a hospital secure in the knowledge that he'll receive the highest quality care, and a minority individual goes into the same hospital worried he'll receive less than adequate care, something is seriously wrong with the healthcare system. That was the topic addressed by director of the PCS Diversity Program, Deborah Washington, RN, in her Nurse Week presentation, "Health disparities: Nursing's voice in practice."

Washington looked at the past five decades chronicling various studies conducted on minority health and health care, but it wasn't until the 1990s that a focus on disparity and inequality really emerged as a demonstrable area of study among researchers. She shared the National Institutes of Health's definition of health disparities as: "Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific populations in the United States, including African American, Asian and Pacific Islander, Hispanic or Latino, Native American, and Native Alaskan."

Said Washington, "If we have our guard up, we're not hearing, we're not listening. If we're not listening to our patients, we're not providing good care. The first and most important thing we must bring to the bedside is an open mind."

Good nursing care, said Washington, involves advocacy (championing causes on behalf of our patients); explaining procedures (in a way that is meaningful and understandable to all); following up on issues (discussing options with other disciplines and involving the patient); and collaborating with patients and families (letting everyone know why a particular test or procedure is being performed).

Speaking as an African American, Washington explained that trust (or lack thereof) is one of the biggest obstacles in the African American community. For reasons well documented in our nation's history, there is a prevailing lack of trust among people of color when it comes to seeking care. "We must remember," said Washington, "that health disparities occur within a social context."

By way of demonstration, Washington asked a series of questions (from the Development and Testing of the

Health Care System Distrust Scale) designed to gauge the level of trust in the healthcare system among African American patients. Questions such as:

- Do you think there is a cure for AIDS that is not being shared with the public?
- Do you think medical experiments will be performed on you without your knowledge?
- Do you think people have access to your medical record without your consent?

It was startling to see the percentage of African Americans polled who agreed with those statements. Are those beliefs valid? *They are to the individuals who hold*

*them.* We cannot dismiss a lack of trust as 'someone else's problem.' It's up to us as clinicians to earn the trust of our patients, and we shouldn't need an 'invitation' to do that.

Racism, said Washington, is not always a pre-meditated outcome. A white caregiver doesn't have to treat a minority patient badly for racial disparity to exist. Simply treating a white patient more favorably has the same effect. Putting an end to health disparities requires

work on two fronts: improving our care at the policy level (national, state, and local), and establishing trusting relationships with all patients at the bedside.

We need to take the time. We need to be aware. We need to pay attention to the verbal and non-verbal cues our patients give us. A seemingly simple question could be a patient's way of assessing whether or not we are 'worthy' of her trust. We need to be courageous enough to enter into those relationships with our eyes and our hearts wide open.



Deborah Washington, RN  
director, Patient Care Services Diversity Program



## Grace Deveney and Kate Fallon: pioneers of healing in the Sudan

In two separate presentations, Thomas S. Durante refugee medicine fellows, Grace Deveney, RN, and Kate Fallon, RN, shared their experiences bringing humanitarian aid and nursing care to the people of Sudan, one of the most drought-ridden, politically unstable areas in the world.

Deveney, whose fellowship was affiliated with Concern Worldwide, began with a brief history of the social and political conflicts that have left much of that region of Africa without food, running water, shelter, security, or health care. To date, 180,000 people have been killed and more than two million displaced, living in refugee camps under the most dire conditions.

Deveney worked primarily as part of a nutrition program in El Geniena, in northwestern Darfur. The program used a community-based, therapeutic care model that brought treatment and services into the community rather than making families go to therapeutic feeding centers as had been the practice. Many families were unable, or unwilling, to seek care for their malnourished children because spending prolonged periods of time at feeding centers (children

were required to be accompanied by a caretaker at all times) took them away from their other children and other responsibilities.

The therapeutic care program targeted children under five, since that population was deemed most susceptible to malnutrition. In addition to malnutrition, Deveney and her international colleagues treated individuals with malaria, diarrhea, eye infections, chest infections, infestations, and many other chronic and acute conditions.

Part of Deveney's work involved training community caregivers so the program could continue after she and her colleagues left.

Fallon's fellowship was connected with the American Refugee Committee (ARC) and involved establishing and running mobile health clinics in the Nyala-Girayda 'corridor,' an area still at the center of much political unrest.

Said Fallon, "We had no guidance, no model to follow; we were essentially given this task and told to go do it!"

Fallon and her colleagues consulted other NGOs (non-government organizations), visited a number of villages to assess the health needs of the people, obtained basic medical supplies from UNICEF and other sources, and put a plan together to operate a mobile clinic.

The small group of caregivers learned quickly through trial-and-error, solving problems as they went, and soon became a cohesive team

of clinicians in the field.

At the peak of their learning curve, Fallon's team was visiting five villages a week providing assessment, consultation, treatment and medication to hundreds of 'beneficiaries.' They saw gun-shot wounds, knife wounds, skin ulcers, infections, malaria, and burns.

One of the unplanned interventions they introduced was a health education workshop for children to teach basic hygiene, tooth-brushing, hand-washing, etc., which, said Fallon, isn't easy when there's no running water.

Deveney and Fallon both lived in crude, primitive, dangerous conditions for the duration of their fellowship. They provided life-saving care to hundreds of Sudanese refugees.

Said Fallon, "I came to know and understand the people of Sudan on a much deeper level. It was the hardest work I've ever done. And I loved every minute."



Grace Deveney, RN (left)  
and Kate Fallon, RN  
Thomas S. Durant refugee medicine fellows

## Family-centered care at the MassGeneral Hospital *for* Children: how are we doing, how important is it?

Building on the presentation of Susan Edgman-Levitan earlier in the week (“Strengthening Patient- and Family-Centered Care”), Mary Lou Kelleher, RN, pediatric clinical nurse specialist, presented the results of her research study, “Family-centered care at the MassGeneral Hospital *for* Children: how are we doing and how important is it?”

She began with a brief history of the evolution of family-centered care, which today includes four key elements:

- dignity and respect
- information-sharing
- participation
- collaboration

To successfully deliver patient- and family-centered care, said Kelleher, we must first agree on what a family is. She put forth the following definition: “Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, grandparents, aunts, uncles (by blood or friendship) and siblings. Families live under one roof or many. You become part of a family by birth, adoption, marriage, or from a desire to be of mutual support—friendship. A family is a culture unto itself with different val-

ues and unique ways of realizing its dreams. Together, families are the best source of our rich cultural heritage and spiritual diversity. It is the family that creates neighborhoods, communities, states and nations.”

In 2000, the MGH Pediatric Service formally adopted family-centered care as its model of practice, rewriting its mission statement and guiding principles to reflect the shift in focus, and renaming the service, the MassGeneral Hospital *for* Children.

Providing a conceptual framework for her research, Kelleher described the paradigm shift toward family-centered care as a movement from a medical approach to a family-inclusive approach; from an individual focus to a patient and family focus; from efficiency-based care to nurturing care; from restricting information to freely sharing information; and from medical-acuity-based practice to value-based practice.

In an effort to gauge the success of MassGeneral Hospital *for* Children’s conversion to a family-centered care model, Kelleher crafted the research question: “What are the similarities and differences in

the way parents (families) and clinical staff rate the performance and importance of key components of family-centered care at MassGeneral Hospital *for* Children?”

From July through September, 2004, customer satisfaction surveys were given to family members and healthcare providers in the Pediatric Service. Seventy statements were put forth that fell into nine categories, and respondents were asked to rate each statement according to performance and importance. The rating scale included options ranging from ‘Very Unimportant,’ to ‘Very Important,’ and regarding performance, ‘Unacceptable’ to ‘Exceptional.’

Overall, there were some significant ‘statistical’ differences between the responses returned by family mem-

bers and those returned by care providers, but, said Kelleher, only a few of those differences would be considered ‘clinically’ significant.

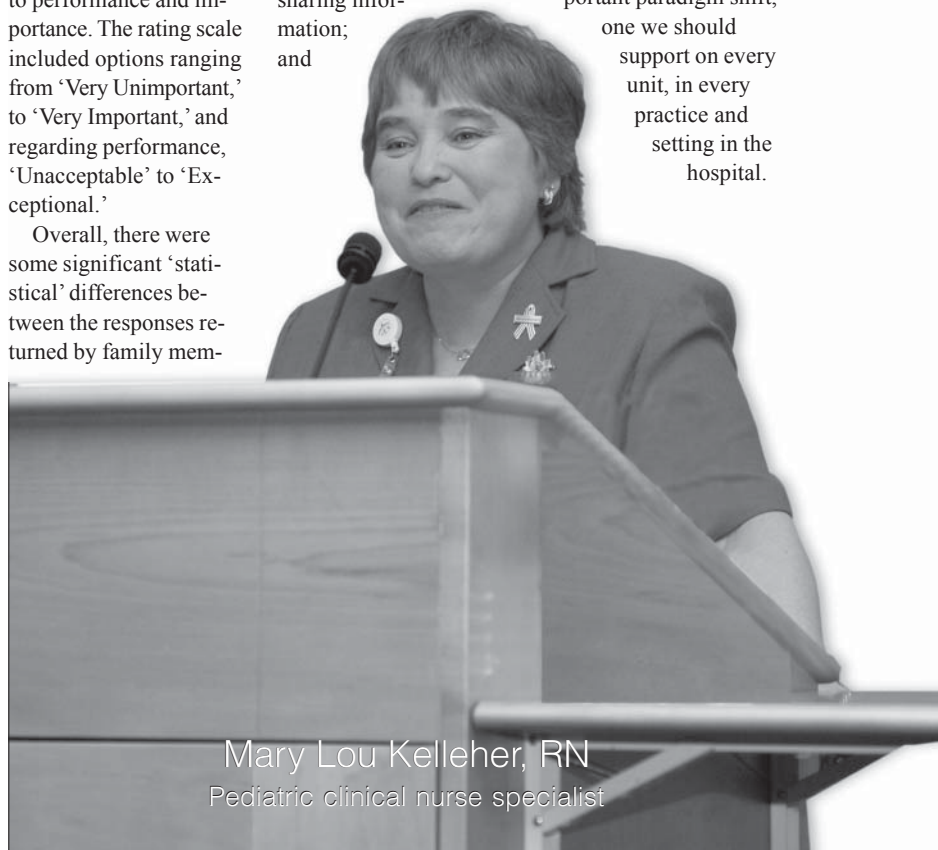
In general, families rated performance slightly lower than care providers rated performance; and when it came to importance, families rated items slightly higher in importance or the same as care providers. Results indicated a need to focus more on collaboration between families and healthcare providers; sharing information; and

developing and using support groups and networking opportunities.

The study has already prompted action regarding patient-education, signage, discharge planning, and a pilot program to assess the feasibility of including families during patient rounds. Kelleher plans to repeat the Family-Centered Care Customer Satisfaction Survey next year.

Following Kelleher’s presentation, Jeanette Ives Erickson, RN, senior vice president for Patient Care, challenged researchers to study family-centered care throughout the entire hospital, not just Pediatrics. Said Ives Erickson, “Family-centered care is an important paradigm shift,

one we should support on every unit, in every practice and setting in the hospital.



Mary Lou Kelleher, RN  
Pediatric clinical nurse specialist



## The impact of a multi-faceted intervention on nurse and physician attitudes and behaviors toward family presence during resuscitation

Emergency Department psychiatric clinical nurse specialist, Patricia Mian, RN, and staff nurse, Susan Warchal, RN, presented research they conducted along with Susan Whitney, RN; Joan Fitzmaurice, RN; and David Tancredi, MD, on "The impact of a multi-faceted intervention on nurse and physician attitudes and behaviors toward family presence during resuscitation."

Interest in conducting the study grew out of observations that the presence of family members during resuscitation continues to be controversial among caregivers; there are mixed opinions among nurses and physicians about this practice; there is potential for ethical conflicts among members of the resuscitation team; and there is a dearth of protocols and educational materials to guide practice in this matter.

Concerns among staff ranged from fear that family presence would interfere with patient care, be traumatic for family members, interfere with teaching opportunities, cause anxiety over clinical performance, and have reper-

cussions related to liability and confidentiality.

Even in light of those concerns, some thought that having family members present during resuscitation could help increase families' understanding of their loved one's condition, actually reduce fear and anxiety, provide greater comfort and support for patients, and help facilitate the grieving process.

So the purpose of this study was to design and implement a Family-Presence During Resuscitation Program, and evaluate nurse and physician attitudes and behaviors before and after program implementation.

Approval to conduct the pilot program in the ED came in January of 2002, and the initial baseline survey was conducted shortly thereafter. Following the initial survey, there were educational forums and implementation strategy sessions that included role-modeling; support and feedback; educational posters; primary nursing rounds; and attending an ethics conference.

The follow-up survey was conducted in May of 2003. Some of the questions included on the survey (both pre- and post-implementation)

were:

- If I were being resuscitated, I would want my family to have the option of being present
- I would want to be present during the resuscitation of a close family member
- Patients have a right to have family members present during resuscitation
- Family presence during resuscitation would make healthcare workers more liable to malpractice suits
- In the presence of family members, medical staff will change their decisions during resuscitation
- Family members may be upset

watching residents being taught during resuscitation

- The presence of family members during resuscitation would make me anxious

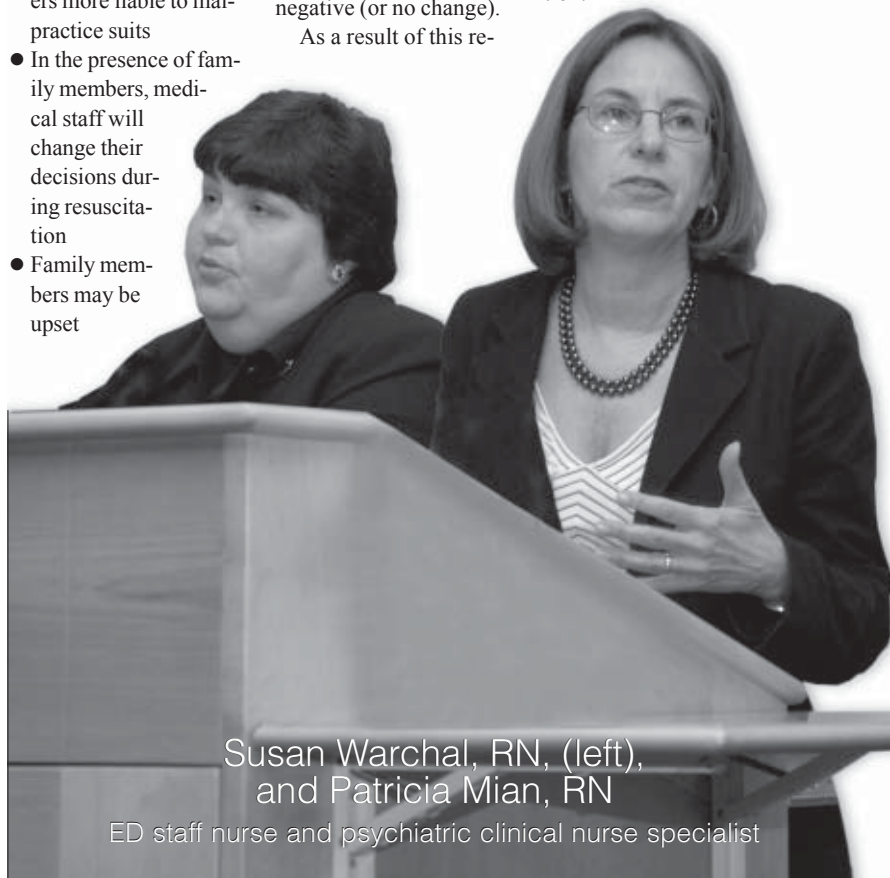
Respondents were asked if they thought any of the educational materials/forums influenced their attitude on having family members present during resuscitation, and whether their change in attitude could be characterized as positive or negative (or no change).

As a result of this re-

search, the Family Presence Program has been successfully adopted as the standard of practice in the ED.

One staff nurse wrote, "I had a critically ill patient who died. His son was present during life-saving efforts. After his father died, the son gave me a hug and thanked me for letting him spend that time with his dad. That experience convinced me that both the patient and son benefited from being together. Had I waited for a 'good' time to allow the son into the room, there wouldn't have been one."

Said a family member, "It was the hardest thing I've ever done, but I had to be there... no question."



Susan Warchal, RN, (left),  
and Patricia Mian, RN

ED staff nurse and psychiatric clinical nurse specialist

May 10, 2005



*Cheryl Joseph*

Staff nurse, Cheryl Joseph, RN, with patient,  
John Brogan, in the Post Anesthesia Care Unit

## Yvonne L. Munn Nursing Research Lecture: "From the bedside to research and back again"

Guest lecturer, Ruth McCorkle, RN, professor and director of the Center for Excellence in Chronic Illness Care at Yale University School of Nursing, delivered this year's Yvonne L. Munn Nursing Research Lecture, "From the bedside to research and back again: the journey of a nurse researcher," on Wednesday, May 4, 2005.

McCorkle began by sharing how she 'backed in' to her career in Oncology nursing in the 1960s, when she was an Air Force nurse. "I chose Oncology because no one else volunteered," she said.

By way of encapsulating her life's work, McCorkle reported on a number of studies she and others conducted over the years that have impacted patient and caregiver outcomes. In 1973, she embarked on a study of acute symptoms associated with breast cancer. It became apparent through her research that pain, immobility, and other symptoms were important aspects of the cancer experience.

In 1979, her team of researchers proposed a study to test and develop a battery of instruments to identify ways in which patients cope (or fail to cope) with certain psy-

chosocial variables associated with advanced cancer. It was in the course of this study that the Symptom Distress Scale (SDS) was developed. The SDS was a 13-item tool designed to measure the degree of discomfort experienced by patients based on specific symptoms they reported.

In 1980, McCorkle and her team developed the ESDS (Enforced Social Dependency Scale), a tool to help identify the state in which adult patients require help or assistance from others in performing activities that under ordinary circumstances they could perform themselves.

McCorkle was involved in a study that looked at the anxiety levels of patients with cancer, and how their anxiety levels changed as they passed through the various stages of their illness (diagnosis, to crisis, acute, stable, chronic, unstable, and ultimately, end-stage). They found that even when a pa-

tient's condition did not change significantly, the patient's anxiety (related to the disease) declined over time.

McCorkle reported on her "Series of Intervention Studies," conducted in 1983. This was a study to test the effects of home nursing care on patients with progressive lung cancer. Patients in three groups were followed for eight months. One group received office care only; one group received office care plus standard home care; and one group received office care plus oncology home care.

It was concluded that home nursing care assisted patients with minimizing distress from

symptoms and maintaining independence longer than those who received no home nursing care. Nurses were also able to help patients come to grips with the reality of their disease.

McCorkle shared the results of a number of other studies she and others conducted, including, "The effects of home-care nursing during terminal illness on the bereaved's psychological distress level;" and studies that focused on standardized nursing intervention protocols

(SNIPs) on patients and family caregivers. These studies led to the implementation of the Family Leave Bill (in 1992) and the Family Caregivers Education Program (in 1993).

In closing, McCorkle advised that one of the most important interventions caregivers can perform is determining whether patients have adequate home care when they're discharged from the hospital. Studies show that patients thrive better on their own, even post-surgically, than they do when discharged into situations where their caregiver is ill or severely burdened by the need to care for a loved one.



Ruth McCorkle, RN

professor, director, Center for Excellence in Chronic Illness Care, Yale University School of Nursing



## You've come a long way, babies! PICU staff reflects on past ten years

In her Nurse Week presentation, senior vice president for Patient Care, Jeanette Ives Erickson, spotlighted many of the accomplishments and milestones achieved by MGH nurses over the past ten years. Inspired to reflect on their own practice over the past decade, Pediatric Intensive Care Unit nurses realized they have much to celebrate, as well. Following is a list of *some* of the accomplishments and innovations achieved in the PICU since 1995.

- 1995 Increased focus on primary nursing
- 1995 Pediatric Bereavement Program is held for the fifth consecutive year.
- 1996 Brenda Miller, RN, appointed nurse manager

- 1996 Family-Centered Care formally adopted as philosophy of care, though family input and presence was always highly valued
- 1997 Dawn McLaughlin, RN, first PICU staff nurse to run in the Boston marathon to benefit Pediatric Hematology Oncology
- 1997 MGH is formally recognized as Pediatric Level One Trauma Center
- 1997 Pediatric Cardiac Surgical program revitalized with influx of increasingly high-acuity patients
- 1998 Continuous Venovenous Hemofiltration (CVVH) begins in Pediatrics as pediatric liver transplant program continues to grow (CVVH is an extremely complex form of dialysis administered by nurses)

- 1999 Kathryn Beauchamp, RN, joins staff as clinical nurse specialist
- 1999 First family members present during cardiac arrest of their child; family-centered care moves to new level
- 1999 Pediatric Conscious Sedation and Infusion Program opens in the PICU
- 1999 Nurse Partners, the pediatric after-hours telephone triage system, moves to the PICU for the summer prior to restructuring
- 1999 Louise Sethmann, RN, receives Stephanie Macaluso Award for Excellence in Nursing Practice
- 1999 Saint Teresa Benedicta is canonized in Rome. One of the miracles for which she is credited occurred in the PICU; several PICU

nursing staff attend the canonization

- 1999 PICU temporarily moves to Bigelow 12 during Ellison 3 renovations; enhancements include installation of Omnicell, new security system, and additional family sleep rooms to enhance family-centered care; art work added to reflect diversity of patients and families.
- 2000 Technology continues to improve; new monitors installed with introduction of end-tidal CO<sub>2</sub> monitoring (the measurement of carbon dioxide at the end of exhalation)
- 2001 Heidi Simpson, RN, and Beth Robbins, RN, graduate from first New Graduate in Critical Care Program. (Since then, four new grads have been hired each year with a minimum of two preceptors mentoring each)

*continued on next page*

PICU staff and their families at Summer Fun outing at Houghton's Pond



## Recipients of the 2005 Yvonne L. Munn Nursing Research Awards



Recipients of the 2005 Yvonne L. Munn Nursing Research Awards are (at left, l-r): Whitney Foster, RN; Anastasia Michaelidis, RN; Alyona Runyans, RN; Diane Carroll, RN; Marion Phipps, RN; (and Jennifer O'Neill, RN, not pictured) for their study, "Music as a Therapeutic Intervention in the Care of Neuromuscular and Neurosurgical Patients" (Above l-r): Virginia Capasso, RN, and Mary Larkin, RN, for their study, "Psychological Insulin Resistance: a Study of Patients' Attitudes, Perceptions and Fears."

### PICU Nursing

*continued from previous page*

- 2002 Pediatric Advance Life Support Program is revamped in accordance with new American Heart Association guidelines
- 2002 First PICU retreat held resulting in first PICU Conference for Community Affiliates. Conference titled, "The Rocky Road to Adolescence"
- 2003 Music therapy introduced with harpists volunteering as part of the HOPES Program
- 2003 Debra Burke, RN, appointed associate chief nurse for Women and Children's Nursing
- 2004 Pediatric nursing leaders (with representation from MGH/C, North Shore Medical Center, and Newton Wellesley), begin to meet regarding standardizing care across Partners

- 2004 First PICU staff recognized in PCS Clinical Recognition Program (Sarah Buck, RN, advanced clinician, and Dawn McLaughlin, RN, clinical scholar)
- 2004 PICU team receives Family-Centered Care Award, highest honor given at MGH for exemplary family-centered care
- 2004 Summer Fun grant (along with money donated by a grateful family) used to host picnic at Houghton's Pond for staff, family, and friends. (Dawn McLaughlin, RN, planned the event, which was fun and rejuvenating for all)
- 2004 Second Partners Affiliates Conference held entitled, "Primer in Pediatric Liver Transplantation"
- 2005 In a comprehensive, collaborative undertaking to improve patient safety, the medication distribution system for Pediatrics is redesigned. (The Rule of Six, a method used to

calculate pediatric medication dosages, is eliminated more than three years prior to JCAHO's mandate to do so)

- 2005 Technological analysis of 'smart' syringe pumps and a pediatric drug library is completed in effort to further enhance patient safety in the area of pediatric medication management (represents second major project of 2005 where Pediatric Nursing, Pharmacy, and Bio-Medical Engineering collaborate to improve care)
- 2005 PICU team receives Excellence in Action Award presented by Peter Slavin for exemplary, collaborative patient care (Beth Robbins, RN, and Phoebe Yager, MD, cited in award description)
- 2005 PICU nurse, Heidi Simpson, RN, travels to southeast Asia with MGH and Project HOPE to care for survivors of the tsunami disaster

### The next ten years

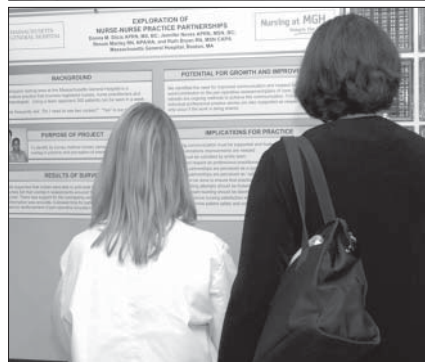
PICU staff look forward to moving into larger quarters some time in the near future, an ICU with private rooms, each with enough sleeping space for family members to stay in rooms with their children.

They foresee technological advances that will make pediatric procedures less invasive; a greater life expectancy for children with pediatric diseases as nursing and medical expertise continues to expand.

Says Brenda Miller, RN, PICU nurse manager, "The future will mirror the past as we continue to acquire new skills and greater knowledge. Adapting to a changing clinical practice requires flexibility and collaboration, two attributes that have been the hallmark of PICU nursing for the last decade."



# Nursing at MGH







Fun,  
Fulfilling,  
Formidable,  
Fantastic!



Simply  
the  
Best

## Jeanette Ives Erickson

*continued from page 3*

leadership is about advocating and empowering, I want to hear from you. That's what today is all about!

Let's move on to global action. Global action means more than taking care of those in need during a crisis. What is our role in government? In the debate over end-of-life care? In teaching wellness to the underserved? In understanding and interpreting the issues of the day?

The death of Terri Schiavo generated intensely polarized debate about the sanctity and quality of life. At MGH, we have our own debates about brain damage, the rights of families to determine their fate, and whether dying of dehydration is humane.

On one issue we can be clear. It is not up to politicians to determine a patient's course of treatment. It may seem an obvious thing, but knowing our patients is what should guide us in doing the right thing for each patient at the end of life. This is nursing's work. Don't *ever* let *anyone* take that away.

We are serious people, living in serious times. In our country, three million children go to bed hungry every day. Five and a half million people between the ages of 16 and 24 are homeless, hungry, and hopeless. Creating a vision for the next ten years

must take these statistics into consideration.

What about those days when our Emergency Department is on divert. Emergency Department diversion is a failure to create a healing

environment, to take a leadership position, and to act globally for our community.

If we are to remain the nursing service of choice, we need to ask ourselves what our priorities are for the next ten years.

(At this point, Ives Erickson posed several questions, asking participants to respond using an electronic, hand-held key pad. Four responses ranging from Strongly Agree, to Tend to Agree, to Tend to Disagree, to Strongly Disagree, were tabulated immediately and displayed on a video screen)

Some of the questions were:

- The nursing executive team (chief nurse, associate chiefs, nursing directors, nurse managers) emphasizes patient safety as much as financial and productivity goals

- Scheduling and work assignments are designed to promote safety
- This organization encourages error-reporting, analysis, and feedback without blame
- Our organizational culture continuously strengthens patient safety.

in the decision-making process about nursing practice

- You influence the quality of nursing practice on your unit

By this time next year, we will have a new strategic plan to help us shape the next ten years.

With your help, we will advance Nightin-

gram. We will re-examine our collaborative governance program. We will look at launching more advisory committees.

If, in fact, robots are coming, we need to prepare for these advances in technology. I look forward to the day when every nurse has a hand-held device to support clinical decision-making and document patient care.

In the coming year, we will advance the work of a new committee to implement an acute-care documentation system. Our goals: electronic flow sheets, electronic patient assessment tools, electronic progress notes. But before we automate, we need to review our practice and establish a culture where verbal and written communication are embraced.

In the coming year, we will advance our quality and safety agenda. Disclosure of errors and identification of potential errors will be a priority. Our responsibility is to create an environment where it's safe to disclose and discuss errors.

We will continue to identify and acquire technology that enhances patient- and employee-safety. Smart pumps are just one example.

We will address capacity management. We will study, gain understanding, and eliminate delays in care. We will design new facilities with enhanced structures to eliminate chaos. And we will partner with

*continued on next page*

**“May we hope that, when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joy of organizing nursing reforms, and who will lead far beyond anything we have done!”**

—Florence Nightingale

- We train and reward employees for safety
- The quality of the discharge process on your unit is very good
- Over the past year, the quality of the discharge process on your unit has improved
- You play a major role in ensuring that the Emergency Department stays off divert
- Having patients on stretchers in the Emergency Department corridors is a problem you should be asked to help fix
- You have an idea that would help to keep the Emergency Department off divert.
- It is important to position every nurse as a leader
- Interdisciplinary collaboration, including interdisciplinary patient care rounds, is the norm at MGH
- You have ample opportunity to participate

gale's philosophy and bring nursing practice to a new level locally, regionally, and globally. In the next decade, we will have an opportunity to create change—to create a revolution in nursing.

What will differentiate us will be our relationships with our patients, our collaboration with our colleagues, and our influence locally, nationally, and internationally.

The most notable work we will do will be in the arena of expert practice, the development of the next generation of nurses, and in outcomes associated with nursing research conducted right here on Fruit Street.

These are the means to an end—not the end of our vision.

We will set the bar high for advancing clinicians through the Clinical Recognition Pro-



May 19, 2005



*Courtney Craig*

Courtney Craig, RN, with mom-to-be, Dana Fiore, during pre-natal examination

## Jeanette Ives Erickson

*continued from previous page*

industry to do this work.

We will address quality and safety; clinical business development; clinical innovations; communication; information systems; new business opportunities; and process improvement.

We will do everything in our power to fill vacant nursing positions. We will be known as a learning organization as our nurses are recognized as world-

renowned preceptors and educators.

We will do everything in our power to end the nursing shortage.

Staffing ratios, scholarship programs, and mandates will not solve the problem. We need new answers.

I take full responsibility for articulating a vision for the future—one that has not previously been achieved or is commonly considered impossible.

Through my trust in you as individuals, my commitment to our patients, my passion for

our profession, and my belief in the need for everyone to have meaningful employment, I promise that MGH will be a beacon for professional nursing.

In the coming months, you will have an opportunity to influence the work ahead. I'll keep you apprised of this important work in future issues of *Caring Headlines*. It has been a pleasure to work with you for the past nine years. I know the years ahead are going to be incredible.

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May 10, 2005

*Deb Guthrie*

IV nurse, Deb Guthrie, RN, with patient,  
Sydney Parlow, on the Ellison 16 Medical Unit



# Heather MacDonald and Kristen Harding

Bigelow 14 vascular nurses, Heather MacDonald, RN (left) and Kristen Harding, RN, assist patient, Barbara Garvey, to ambulate with the help of a walker



To see educational offerings usually found on this page, visit the web calendar at <http://pcs.mgh.harvard.edu>.

May 10, 2005



*Katharina Ikels*

Staff nurse, Katharina Ikels, RN, with patient  
in the Burn Intensive Care Unit

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