

Caring

HEADLINES

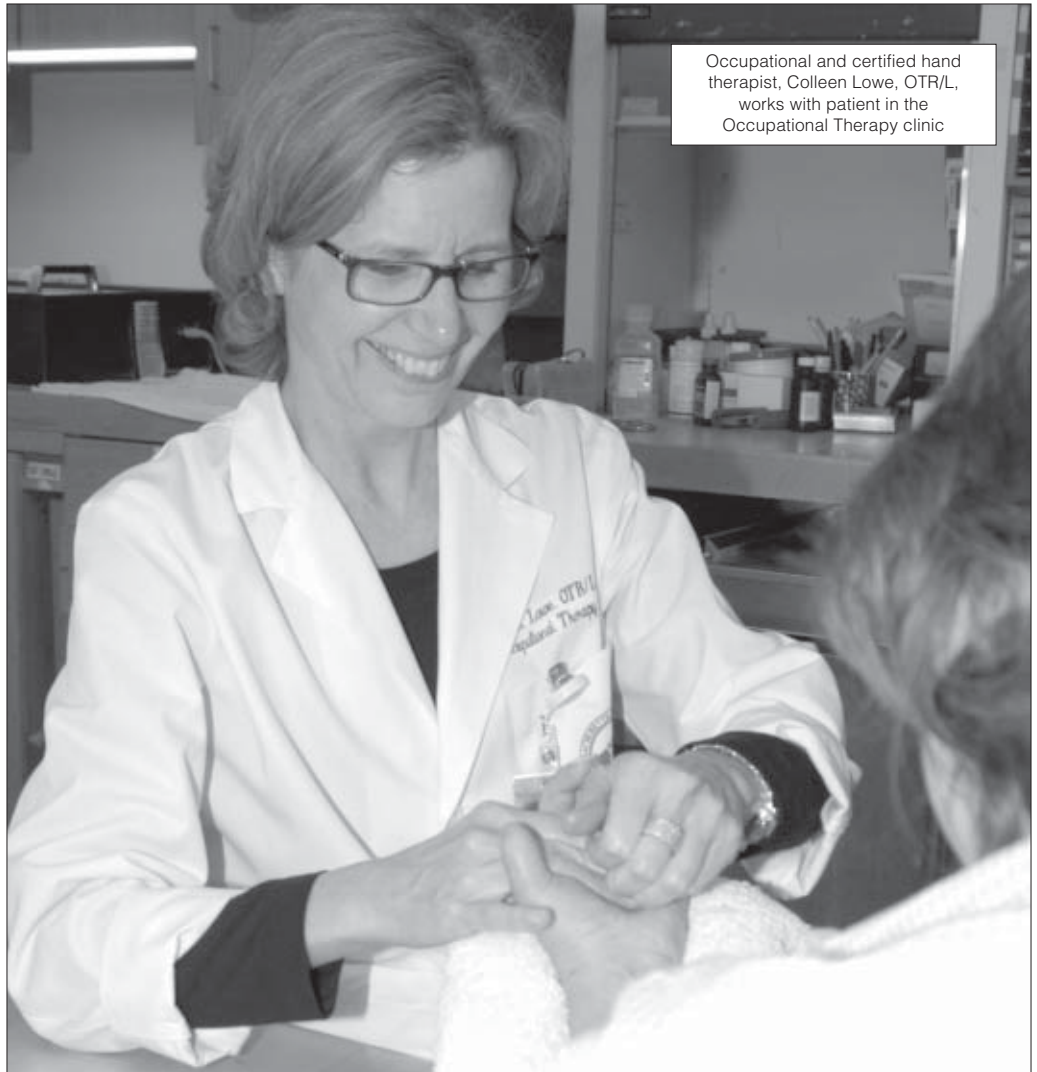
May 5, 2005

Occupational Therapy Month at MGH

(See stories throughout this issue of Caring Headlines)

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Occupational and certified hand therapist, Colleen Lowe, OTR/L, works with patient in the Occupational Therapy clinic

Addressing the needs of individuals with disabilities: beyond compliance

You may recall that the MGH Council on Disabilities Awareness was created in November of 2003 to evaluate, make recommendations, and help raise awareness around issues of access for individuals with disabilities. Under the auspices of MGH Human Resources, the Council is a multi-disciplinary team co-chaired by Oz Mondejar, vice president for Human Resources at SRH, and Carmen Vega-Barachowitz, SLP, director of Speech, Language & Swallowing Disorders; and supported by the MGH Diversity Committee.

The mission of the Council is to help MGH move beyond the mandates of compliance and ensure a welcoming and accessible environment to everyone who comes through our doors regardless of physical ability. Education and information play a key role in the Council's strategy to improve access and enhance the overall experience for patients, family members, staff, volunteers, and visitors to MGH.

One of the first activities sponsored by the

Council on Disabilities Awareness was an interactive learning experience in which five individuals with disabilities were invited to MGH to help identify areas of our physical environment that need improvement. These one-on-one tours of MGH generated a number of suggestions and recommendations, many of which have already been addressed; others are in various stages of resolution. All who participated in the event agreed it was an illuminating experience.

"Opening Doors: a Dialogue on Disabilities," was another educational program sponsored by the Council. A four-person panel comprised of MGH patients and/or visitors with disabilities shared their observations as people who frequent MGH. They spoke about the challenges they face once inside our doors. As hoped, the dialogue helped inform those who attended about the shortcomings we still need to address to make our hospital accessible to everyone.

Other awareness-raising events sponsored by the Council included Dr. Roy Grizzard's visit

to MGH. Grizzard, Assistant US Secretary for Disability Employment Policy, spoke about the importance and advantages of hiring individuals with disabilities.

The documentary film, *After Words*, shed light on the impact of aphasia on individuals affected by this speech-language disorder. Some of the individuals who appeared in the film were on hand to answer questions, which spurred a lively and informative discussion of aphasia and other forms of communication disorders.

Our work around raising disabilities awareness and improving the physical environment of MGH is an ongoing process. The Council on Disabilities Awareness meets monthly to review and discuss concerns brought forward regarding access issues, customer-service issues, and environmental barriers encountered by patients, staff, or visitors with disabilities. These discussions drive our efforts to meet and exceed mandatory compliance expectations.

Recently, MGH was honored to receive the 2004 Exemplary Em-



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

ployer Award from the Commonwealth of Massachusetts Governor's Commission on Employment of People with Disabilities (on display across from Coffee Central). It feels good to be recognized for this important work. But we cannot rest on our laurels. Ensuring a safe and accessible environment is everyone's concern. We will continue to provide educational forums, acquire appropriate assistive technology, and work to engage the entire hospital community in these important initiatives.

You can help. Please be vigilant as you walk the halls of MGH. If you see a potential barrier or an opportunity to improve our hospital by making it more welcoming to individuals with disabilities, please contact either Carmen Vega-

Barachowitz (at 4-0762) or Oz Mondejar (at 573-2412).

Thank-you.

Updates

I'm pleased to announce that effective May 2, 2005, Mimi Bartholomay, RN, assumed the position of clinical nurse specialist for the Yawkey 8 Infusion Center.

Reverend Angelika Zollfrank recently joined the MGH community as chaplain and pastoral educator for the Clinical Pastoral Education Program for Healthcare Providers.

The Johnson & Johnson nursing fund-raising event that was cancelled due to a blizzard this winter was held on April 27th at the Westin Hotel at Copley Place. The celebration was well-attended and raised more than \$725,000 for nursing scholarships and faculty grants.

Reporting critical results

Question: Will Nursing be involved in the next JCAHO visit this fall?

Jeanette: Yes. JCAHO will come to MGH in the fall to evaluate the clinical laboratories as they do every two years.

There is reason to believe that Nursing will be asked to participate in this visit as it relates to point-of-care testing and the handling of critical results.

Question: What might that participation look like?

Jeanette: It is expected that JCAHO surveyors will ask about our policy on handling critical results, our Guidelines for the Reporting and Retrieval of Lab Results. They may ask if there is a central location where critical results are recorded?

Recently a new Critical Results Documentation Record has been introduced on all inpatient units. It's a record of when critical results are called back to non-licensed support staff such as operations associates.

Question: Why is it important to keep a record of when critical results are called back to non-licensed support staff?

Jeanette: JCAHO is interested in the length of time it takes for a critical result to be identified in the laboratory and arrive

in the hands of a licensed clinician. Currently, clinical labs have a system that records when a critical result is identified and when and to whom the result is reported. When a nurse or physician is notified, the loop is complete. However, when the call is made to an operations associate (which is about 60% of the time), there is still a need to track and record the time at which the result was reported to a licensed clinician.

Question: How are we doing as a department in reporting these results to a licensed clinician?

Jeanette: Very well. The average length of time between when a critical result is called back to an inpatient unit and when it is reported to a licensed clinician is 1.8 minutes. In ICU settings, nurses often know critical lab results before

they receive the call from the lab, because they're working in the CAS system and are on the alert for lab results.

Question: What else might they ask a nurse about critical results?

Jeanette: They may ask if nurses were involved in writing the policy regarding the reporting and retrieval of laboratory results, and whether they were involved in determining the standard for when a critical result is reported to the clinician.

Staff nurses in four ICUs (high-volume areas for critical lab results) have worked on this project along with laboratory staff collecting data and monitoring how results are handled in real time. Nurses will meet with laboratory staff to help determine a standard for how critical results are reported.

Community Benefit Program celebrates 10th Anniversary

The MGH Community Benefit Program will celebrate its 10th anniversary this year

Monday, June 6, 2005

1:45 to 3:00 PM

under the Bulfinch tent

Come join keynote speaker, Senator Edward Kennedy, as we celebrate ten years of partnering to improve community health.

Light refreshments will be served.

MGH Perioperative Nursing Education and Orientation Program

If you are currently an experienced nurse and have an interest in working in the Operating Room, the Perioperative Nursing Education and Orientation Program may be for you. The program begins June 6, 2005.

For more information, contact Michele Andrews at 617-724-6052

Elder Care Monthly Discussion Groups

presented by

The Employee Assistance Program, and facilitated by Barbara Moscovitz, LICSW, geriatric social worker

Caring for an aging loved one can be challenging. Join us for monthly meetings to discuss legal, medical, coping and other issues.

Next meeting: May 10, 2005

12:00–1:00pm

Bulfinch 225A Conference Room

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

Clinical Pastoral Education fellowships for Healthcare Providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2005 MGH Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients/families and who wish to integrate spiritual caregiving into their professional practice

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 9:00am–5:00pm. Additional hours are negotiated for the clinical component. Please apply at your earliest convenience. Space is limited.

For more information, contact Reverend Angelika Zollfrank at 726-2220

Speech Language & Swallowing Disorders

Is your child disorganized?

—by Alexis Treat, CCC-SLP, speech-language pathologist

Ten-year-old Joey's room is always a mess. His clothes are all over the floor, and there are papers and books all over the desk. Papers explode out of his backpack every day after school, and he never seems to give his parents important notices and permission slips. Teachers report that Joey frequently forgets to turn in his homework. They also notice that Joey has a hard time getting started on tasks, especially writing. With help, he is able to come up with some ideas for writing, but his thoughts and sentences tend to be disorganized. His parents notice that Joey has difficulty telling a story about something that has happened at school. He starts in the middle of the story and jumps around from beginning to end. Sometimes, Joey doesn't know what to say at all. It's hard for his friends and siblings to understand what Joey is telling them. His parents notice that he has difficulty remembering important details from long stories.

There are many children with profiles similar to Joey's. Some of these children have been diagnosed with a learning disability, attention deficit disorder (hyperactivity), or executive function disorder; others have not. Many children who have been diagnosed present with underlying deficits in planning and organization. These children may have difficulty organizing materials to complete school assignments. They may have difficulty planning the steps necessary to complete long-term assignments. These same children often have difficulty organizing their thoughts and ideas when explaining an event to a listener. They may have difficulty planning and generating ideas for a written story. They may have difficulty storing, organizing, and recalling important details from stories they have read or heard.

Children like Joey can benefit from interventions that introduce strategies to help organize their belongings and structure their

language so they can better explain their thoughts and understand others.

Since many deficits result from a lack of internal structure and organization, these children need explicit instruction in this area. For example, intervention may introduce children to a system that helps them keep track of school materials. They may be introduced to strategies that help them break down long-term assignments into manageable steps they can monitor in an assignment book. Therapy might address their ability to generate, plan, and sequence ideas for a written story through the use of visual webs and outlines. They may be introduced to strategies that help them organize information they hear or read so they can effectively recall this material. Explicit instruction in organization is often the key to success for these children.

Speech-language pathologists are among the many professionals who work with children like

Joey. A learning disability, attention deficit disorder, or executive function dis-

order can be formally identified by a neuropsychologist or neurologist. However, speech-language pathologists often assess the impact of disorganization on a child's language expression, language comprehension, and academic functioning. Specially trained speech-language pathologists provide therapy and intervention. They frequently work with children and families to generate and implement organizational strategies and systems to compensate for areas of need.

The MGH department of Speech Language & Swallowing Disorders provides diagnostic and treatment options for children with language and organizational weaknesses. In addition to individual speech-language therapy sessions, the ambulatory practice on the main campus conducts small-group interventions that address language organization. For more information about the services provided by the department of Speech Language & Swallowing Disorders, please call April Hildebrand at 617-724-0767.



Speech-language pathologist, Kimberly Stewart, CCC-SLP, works with 9-year-old, Ian Malone

Frequently asked questions

Question: What and when is Better Speech and Hearing Month?

Answer: Since 1927, the American Speech-Language-Hearing Association (ASHA) has celebrated May is Better Speech and Hearing Month to increase public awareness of communication and swallowing disorders. During May, speech-language pathologists and audiologists provide information to help people identify, prevent, and treat speech, language, swallowing, and hearing impairments.

Question: What do speech-language pathologists do?

Answer: Speech-language pathologists are professionals trained in the study of human communication, its normal development, and its disorders. By evaluating the speech and language skills of children and adults, speech-language pathologists determine if communication problems exist and the best way to treat them.

Speech problems can affect pronunciation, voice, and fluency. Language problems can affect the ability to express and/or understand thoughts and ideas. Speech-language pathologists are involved in identifying and treating reading and writing difficulties.

Speech-language pathologists are trained to identify and intervene in swallowing disorders in individuals of all ages, from neonates to elders.

Question: What is the preparation for speech-language pathologists?

Answer: In order to be recognized by ASHA, speech-language pathologists must possess a graduate degree and Certificate of Clinical Competence (CCC), which requires a supervised clinical fellowship of one year and a passing score on the national examination.

In addition to national licensure, speech-language pathologists must pass state licensure standards and, if working in public schools, pass state education requirements. All speech-language pathologists must be knowledgeable in the science, diagnosis, and treatment of speech, language, cognition, voice, and swallowing mechanisms.

Question: How are speech-language pathologists involved in the diagnosis of swallowing disorders?

Answer: Dysphagia is the medical term used to describe difficulty swallowing foods, liquids, or saliva. These difficulties can occur in the oral, pharyngeal, or esophageal phases of swallowing. Speech-language pathologists are trained to assess and treat oral and pharyngeal dysphagia.

Assessment for dysphagia can include a bedside swallow exam, a Modified Barium Swallow, or for more critically ill patients who need an objective assessment at the bedside, a Fiberoptic Endoscopic Evaluation of the Swallow (FEES).

Dysphagia is a symptom, not a disease. The most common diagnoses associated with dysphagia are:

- stroke
- brain injury or tumor
- head and neck cancer/surgery
- cerebral palsy

What is Reading?

Reading can be broken down into *decoding* and *comprehension*.

Decoding is the process of word identification.

In order to accurately identify a word, an individual must recognize letter symbols, map those symbols onto sounds, and follow rules and patterns that govern when particular letters and/or groups of letters make particular sounds.

When a reader becomes fluent, this process happens automatically.

Comprehension is the ability to understand what is read. It can be thought of at the word, sentence, and text levels. When reading, an individual must know, or be able to infer, each vocabulary word. That word must be placed into the context of a sentence; and that sentence must be placed into the context of a paragraph.

In order to put this information together, individuals must understand the basic structures and components of a narrative and expository text.

- progressive neurological disease (Alzheimer's, Parkinson's, ALS)
- premature babies

Question: What do speech and language have to do with reading and writing?

Answer: Speech-language pathologists evaluate and treat both spoken (listening and speaking) and written (reading and writing) language disorders. Spoken language is the foundation for written language, in that we use the same underlying language systems to listen and speak as we

do to read and write.

Phonology, the pattern of sounds used to construct words in spoken language, is the same sound system used to map letters to read and spell words. Syntax (word-order), morphology (affixes), semantics (meaning, vocabulary), discourse (narrative and expository structures), and pragmatics (social skills) are used to comprehend both what we hear and what we read. We use the same systems in writing to construct text that makes sense and conveys information to others.

What is Aphasia?

Aphasia is an interruption in a person's ability to use language processes to communicate with others. Communication problems can be either receptive (difficulty understanding what is said and/or problems with reading comprehension) or expressive (problems producing words, written or verbal, to express thoughts). In many cases patients have both receptive and expressive deficits.

Aphasia results from stroke or other injuries to the brain. Therapy for individuals with aphasia varies depending on the severity and types of language deficits present. A speech-language pathologist can assess the aphasic person's abilities and determine an appropriate therapy program.

What is Writing?

Writing can be broken down into *processes* and *products*.

The *process* of writing includes brainstorming or planning, organizing, creating a draft, revising, and editing. This process must be made explicit for many individuals and is crucial to generating a sufficient product.

The *product* of writing can be viewed from the word, sentence or text level. The word level includes spelling and vocabulary. The sentence level encompasses grammar and complexity of structures. The text level includes overall organization into the structures of narrative and expository texts.

Speech Language & Swallowing Disorders

New name: the department of Speech Language & Swallowing Disorders

The MGH Speech-Language Pathology Department has been in existence since 1930.

Initially called the Language Clinic, it was established on an informal basis under the direction of Edwin Cole, MD, as part of the Neurology Outpatient Department. The clinic was later formalized and incorporated into the department of Neurology.

The purpose of the Language Clinic was to provide evaluation to a small number of patients with language problems. A major step toward formalizing the work came after World War II when, through the Veteran's Administration, the Language Clinic became the primary center in the eastern United States for developing techniques for treating patients with aphasia. As a result, the

Language Clinic obtained permanent staff and fixed space within the hospital. Although the end of the war decreased the demand for services, an increased demand evolved for evaluation and treatment of children with impairments in speech and language. The Language Clinic continued to grow as medical and educational research created a broader understanding of the fundamental causes of speech and

language disorders, and new treatment approaches were developed.

During the mid-1970s the Language Clinic underwent major expansion and became known as the Speech-Language Pathology Department. Since then, the department has continued to grow, keeping pace with what has occurred nationally. The number of professionals in the field has increased significantly, as has the scope of practice and practice settings.

Speech-language pathologists are employed in schools, hospitals, clinics,

offices, and private corporations. The scope of practice for speech-language pathologists now includes written language, cognition and memory, and swallowing disorders. At MGH, our interventions for children and adults with swallowing disorders account for more than 50% of our volume in the inpatient and ambulatory practices.

To better reflect current practice, the department has changed its name from the department of Speech-Language Pathology to the department of Speech Language & Swallowing Disorders.

Speech and Language Developmental Milestones

Listening

Birth–3 months:

- startles to loud sounds
- quiets or smiles when spoken to
- seems to recognize your voice and quiets if crying
- increases or decreases sucking behavior in response to sound

4–6 months:

- moves eyes in direction of sounds
- responds to changes in tone of your voice
- notices toys that make sounds
- pays attention to music

7 months–1 year:

- enjoys games like peek-a-boo and pat-a-cake
- turns and looks in direction of sounds
- listens when spoken to
- recognizes words for common items like cup, shoe, or juice
- begins to respond to requests (“Come here,” “Want more?”)

1–2 years:

- points to a few body parts when asked
- follows simple commands and understands simple questions (“Roll the ball,” “Where’s your shoe?”)
- listens to simple stories, songs, and rhymes
- points to pictures in a book when named

2–3 years:

- understands differences in meaning (“go/stop,” “in/on,” “big/little”)
- follows compound requests (“Get the book and put it on the table”)

3–4 years:

- hears you when you call from another room
- hears television or radio at the same loudness level as other family members
- answers simple “who, what, where, why” questions

4–5 years:

- pays attention to a short story and answers simple questions about it
- hears and understands most of what is said at home and in school
- uses the same grammar as the rest of the family

Talking

Birth–3 months:

- makes pleasure sounds (cooing, gooing)
- cries differently for different needs
- smiles when making visual contact

4–6 months:

- babbling sounds more speech-like with many different sounds, including p, b, a
- vocalizes excitement and displeasure
- makes gurgling sounds when left alone or when playing with you

7 months–1 year:

- babbling has both long and short groups of sounds such as “tata, bibibibi”
- uses speech or non-crying sounds to get and keep attention
- imitates different speech sounds
- has one or two words (bye-bye, dada, mama) though they may not be clear

1–2 years:

- says more words every month
- uses some one- and two-word questions (“Where kitty?” “What that?”)
- puts two words together (“More cookie,” “No juice,” “Mommy book”)
- uses many different consonant sounds at the beginning of words

2–3 years:

- has a word for almost everything
- uses two or three words to talk about and ask for things
- speech is understood by familiar listeners most of the time
- often asks for, or directs, attention to objects by naming them

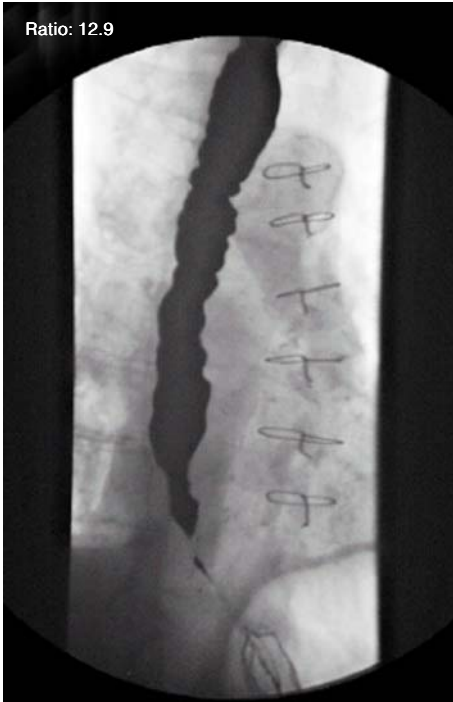
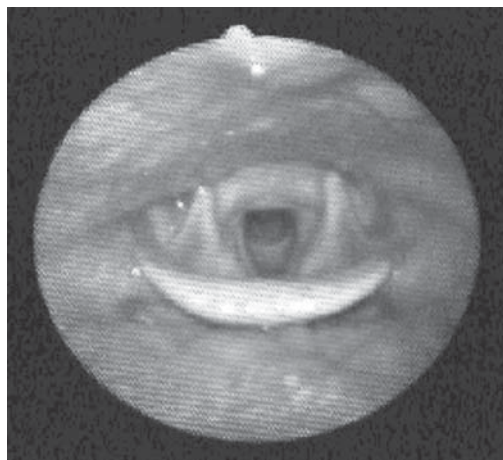
3–4 years:

- talks about activities at school or at friends’ homes
- people outside family usually understand child’s speech
- uses a lot of sentences that have four or more words
- usually talks easily without repeating syllables or words

4–5 years:

- voice sounds clear like other children’s
- uses sentences that give lots of details (“I like to read my books”)
- tells stories that stick to topic
- communicates easily with other children and adults
- says most sounds correctly except a few like: i, s, r, v, z, j, ch, sh, th

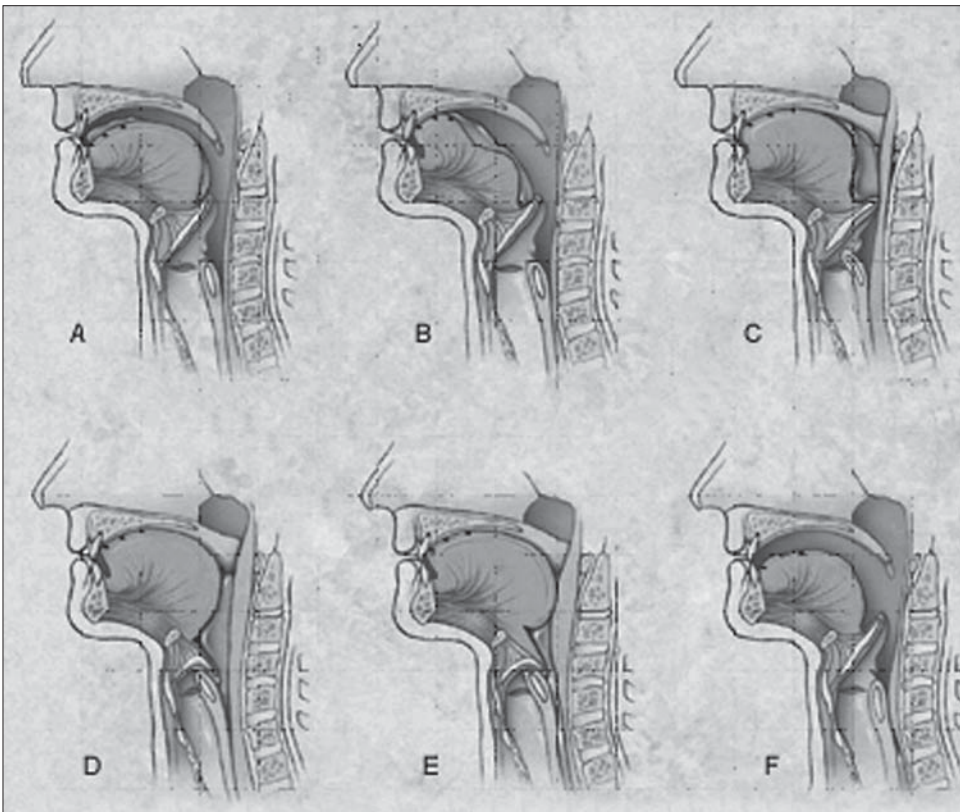
What is the difference between a Modified Barium Swallow, a Barium Swallow, and FEES?



A Modified Barium Swallow is used to evaluate oropharyngeal swallowing, including the oral cavity, pharynx, larynx, and cervical esophagus. It assesses the efficiency of mastication, bolus transport, and airway protection. When a patient aspirates, strategies are implemented to try to increase airway protection and swallowing efficiency.

A Barium Swallow typically evaluates the esophageal swallow from cervical esophagus to gastroesophageal junction (the entrance to the stomach). It looks at mucosal abnormalities and esophageal function. A Barium Swallow might detect aspiration but does not explain it. Typically, if aspiration occurs, the study is terminated.

FEES (Fiberoptic Endoscopic Evaluation of the Swallow) evaluates pharyngeal and laryngeal anatomy. FEES assesses the efficiency of airway protection and pharyngeal clearance related to swallowing, and it allows us to see if the patient benefits from compensatory strategies to improve airway protection and swallowing efficiency.



Graphics clockwise from top left:

- Barium Swallow, evaluates the esophageal phase of swallow
- Modified Barium Swallow (lateral view), evaluates the oral/pharyngeal phase of the swallow as well as airway protection before, during, and after swallow
- Fiberoptic Endoscopic Exam of Swallow (FEES), evaluates airway protection efficiency before and after swallowing
- Diagram illustrating the phases of swallowing
 - A,B, the oral phase
 - C, the transition between the oral and pharyngeal phase
 - D,E, the pharyngeal phase
 - F, the esophageal phase

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OT offers opportunities for teaching, learning, and treating patients

—by Sharon Serinsky, OTR/L, pediatric occupational therapist

“**B**ecome a teacher.” Those were my father’s words of advice as I embarked on my college education. As a pediatric occupational therapist, I am an educator in so many diverse and rewarding ways that go way beyond the scope of what my father envisioned for me.

My role as a pediatric occupational therapist is to help children learn new developmental skills in all areas of children’s occupation, including being an active participant in the important tasks of childhood: playing, participating as students in educational settings, and as active members of communities.

Pediatric occupational therapists also assume the important responsibility of educating parents and teachers in understanding the nature of children’s challenges and disabilities so they can actively integrate into familiar environments.

Last July, I became a member of the Occupational Therapy team at

MGH. After years of working in school settings and early intervention programs, I was ready for a change. My responsibilities revolved primarily around the outpatient Pediatric Therapy Team (PTT). The PTT is an integrated team consisting of a pediatric speech-language pathologist, a pediatric occupational therapist, and a pediatric physical therapist. We conduct intensive developmental evaluations of children from pre-school to middle-school-aged students.

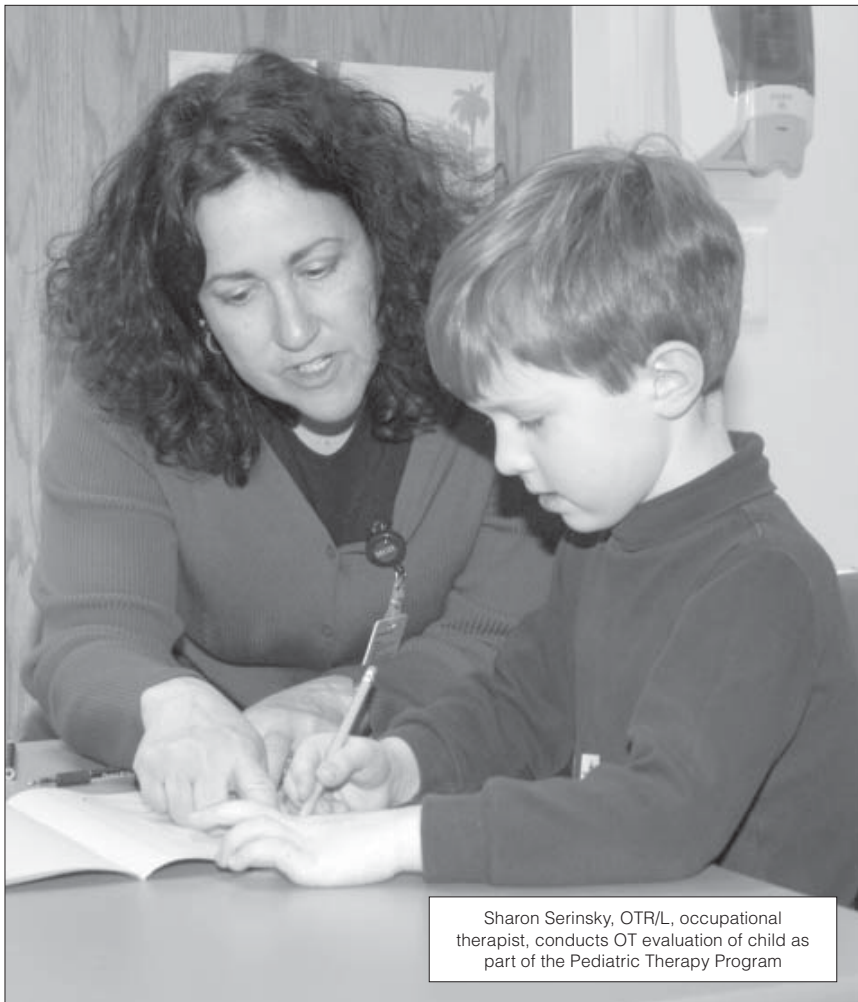
Depending on the child’s needs, the occupational therapist’s role as an evaluator is to assess not only fine motor skills and coordination, but sensory integration, sensory processing and modulation needs, motor planning skills, handwriting abilities, visual perceptual skills, and self-care skills. Standardized tests, developmental checklists and clinical observations are all part of the assessment process. The child’s responses to the testing environment is also important: is he distracted; is she able to attend for the typical age-expected time frame; what is his learning

style; what is the parent/child interaction; does she have the ability to self-calm and respond in structured situations; how does he respond to various kinds of sensory input; and what kinds of accommodations and therapeutic interventions can help? All these responses are observed and recorded. These are the skills that are so important to learning and playing: children’s occupations.

At the end of the day, the entire team meets to discuss findings, develop a list of strengths and weaknesses, and develop recommendations. We then meet with the parent(s) at length to discuss our findings. The parent returns home with a page of written information, and a full-length report follows in four to six weeks.

I thrive on working with a caring team where the focus is on helping the child and family. PTT is a relatively new team, yet there is a true sense of camaraderie and many opportunities to learn from one another.

My initial PTT evaluation was with a very active, easily over-stimulated child. Instead of completing the assessment individually, the team quickly changed strategies to perform an arena assessment so that the process could be meaningful and productive for this family. This is what PTT does so well—we provide families with comprehensive, *continued on page 15*



Sharon Serinsky, OTR/L, occupational therapist, conducts OT evaluation of child as part of the Pediatric Therapy Program

Meaning, motivation, and goals: an important part of occupational therapy

—by Logan Monahan, OTR/L, occupational therapist

As an occupational therapist working with adults in a hospital setting, I am frequently faced with the challenge of getting a patient to participate in a difficult task while keeping his/her motivation level high. The tools I use to accomplish this include identifying the patient's best learning style; discovering with the help of the patient and/or family what is meaningful and motivating; and understanding

the patient and/or family's goals.

I never thought I'd have occasion to use these skills on the side of a mountain in 20-degree weather with young children. But that's exactly what I did last winter when I volunteered to be a ski instructor for children with disabilities.

Nashoba Valley runs an adaptive ski program for children 5-18 years old who have disabilities including autism, Asperger's disease, blind-

ness, attention deficit disorder (ADD), and mild motor impairments. Being a mediocre skier and having no experience with the pediatric population, I was a little hesitant to volunteer for this program. But an encouraging e-mail from the program director convinced me to sign up.

After working on my own skiing skills, attending an in-service as well as informal training, I thought I was ready to ski the Black Diamond

with a class of 50 kids. However, during my first lesson, I found myself at the bottom of the bunny slope with a 6-year-old boy named 'Toby.' Toby was not able to maintain eye contact or answer questions. Panicked, I looked at the other volunteers and thought, "How am I going to get this boy to ski?"

I remembered reading in Toby's file that he had difficulty with abstract ideas and needed direct, concrete instructions and descriptions. By paying attention to his learning barriers, we were able to give him the kind of instruction he needed and would learn from. Soon, the other volunteer and I had Toby half-way up the slope. But how to get

him *down*—that was the question.

Once again I thought back to Toby's file and the list of positive expressions his parents used to motivate him. I tried these phrases and watched as Toby began his descent down the hill. By using familiar and consistent phrases, we were able to encourage Toby to ski. Over the next hour, the volunteers and I tried in vain to teach Toby to turn or brake, but every time, he came straight down the slope at top speed. Disappointed at my lack of teaching success, I skied over to Toby's parents after the lesson. To my surprise, his parents didn't share my disappointment. I was met with positive feedback and expressions of gratitude. Their son had skied and that was their only goal; not that he skied like a pro, just that he made it down the mountain and had fun.

Through this volunteer experience, I was able to use some of the same skills I use at MGH with a whole new population in an entirely different context. It reinforced for me the importance of understanding and incorporating an individual's learning styles, motivating factors, and goals into all interventions. With these components, interactions with clients are more engaging and meaningful. I'm looking forward to next year when I can once again apply my skills on the slippery slopes.



Occupational therapist, Logan Monahan, OTR/L, evaluates patient, Karen Orlandino, on the Ellison 12 Neurology Unit

Speech-language pathologist addresses complex issues associated with Huntington's disease

My name is Allison Holman, and I am a speech-language pathologist. I have worked at MGH and in the field of Speech Pathology for three years. I work with inpatient adults who have developed language, speech, swallowing, or cognitive sequelae secondary to medical, surgical, and/or neurological injuries.

I met 'Tammy' one week after she had been admitted to MGH. Tammy had Huntington's disease, an autosomal dominant genetic neurodegenerative disease that affects the central nervous system, most notably, the basal ganglia and frontal cortex in later stages. Huntington's disease (HD) results in persistent involuntary writhing movements (chorea), changes in muscle tone, dysarthria (motor speech impairment), dysphagia, and dementia. Patients are usually asymptomatic until they reach their thirties or forties, then they deteriorate during the course of 10 to 15 years.

Tammy was 33 years old and had developed acute respiratory distress following aspiration of vomit one evening while being cared for at a respite facility. She required emergent intubation and was transferred to MGH. My services were request-

ed shortly after she was extubated to evaluate her oropharyngeal swallow function.

My expectation after reading through her brief but concise medical history was that she would be progressively declining across all modalities, such as her ability to communicate (both linguistically and motor speech), her ability to move, and her ability to safely swallow. Tammy had been followed by an outpatient clinician in our department for her severe dysarthria and oropharyngeal dysphagia for which she was known to be aspirating small amounts of all consistencies. She had been tolerating the aspiration without any respiratory compromise until this admission, and both Tammy and her parents wanted her to continue to enjoy eating and drinking for as long as possible.

My first encounter with Tammy was in the ICU while the Neurology team was rounding at her bedside. Tammy lay still in bed, her eyes and mouth open wide at rest. She did not respond to the poking and prodding of physicians trying to stimulate a response, she just continued to lay still with her gaze fixed toward the wall. Once the team left her room, I carefully assessed Tam-

my to see if I would be able to evoke a response and possibly communicate with her. She did not respond to any stimulation (touch, sound, or thermal). Following my brief but very informative session with Tammy, I spoke with the Neurology team and the nurse to relay my thoughts. I suspected it was premature to make any judgments or long-term recommendations concerning Tammy's ability to safely swallow. I wanted to continue to gather information about her and speak with her parents, who were very involved with her care. Tammy had a naso-gastric tube for nutrition and medication delivery.

On day two of assessing Tammy's progress at the bedside, I met her mother, father, and sister. They were warm, caring, well informed, and optimistic about their daughter's recovery. I knew they had a close relationship with the outpatient speech pathologist and I felt it would be appropriate if we collaborated on Tammy's care, initially, so I could gain the family's trust and confidence.

We spent several sessions talking about Tammy and our plan in the coming days once her status improved. Tammy's parents made it clear they did not desire



Allison Holman, CCC-SLP
speech-language pathologist

any long-term, non-oral means of nutrition, i.e., a feeding tube, as they felt it would be stripping away Tammy's quality of life.

Tammy made little gains in terms of her interaction with external stimulation, ability to communicate, follow instructions, and most importantly, manage her secretions over the next few weeks. I began to feel pressure from her family and the Neurology team as the primary issues keeping her in the hospital were swallowing and nutrition issues and treatment for her pneumonitis.

I spent time speaking with my colleagues about the psychosocial and emotional issues associated with Tammy's care. I felt that because of Tammy's significantly impaired cognitive state and overt signs of a weak and ineffective swallow, as seen during several feeding trials at the bedside, there was a strong

possibility she may never safely return to oral feeding. I wanted to make the appropriate recommendations for quality of life and comfort and not violate Tammy or her family's wishes.

I spent time speaking with her family in the conference room on the unit and with the attending physicians to relay my thoughts and concerns about her progress. I suspected that neither Tammy's family nor the team fully understood how impaired Tammy's swallow function and airway protection was at this time.

I felt conflicted as she clearly experienced distress and discomfort when small trials were attempted. After stating my concerns to the family and the team and documenting them in her chart, I decided to join the family when they expressed a desire to attempt feeding. A few small drops were placed in her oral cavity, and

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Occupational therapist brings critically needed care to underserved population in Honduras

—by Joanna Akladiss, OTR/L, occupational therapist

My name is Joanna Akladiss, and I am an occupational therapist with more than four years of acute-care experience in the outpatient setting. While my career is in its infancy, I continue to seek ways to challenge my clinical reasoning skills, extend my knowledge beyond the workplace, and renew my commitment to my practice.

Before coming to MGH, I had the honor of working with Dr. Ros-

quete, a remarkable man and tremendous hand surgeon in Maine. Mission work has been his way of rejuvenating himself as a physician and reminding himself of what is important. For the last ten years he has traveled to San Pedro Sula, Honduras, to provide surgical care to people living with upper-extremity injury or deformity. It was with a leap of faith that I left his practice to work at MGH and pursue the professional challenges I was seek-

ing. And it was without hesitation that I agreed to join him months later on a journey to Central America.

Dr. Rosquete had recruited many other physicians and nurses for past trips, but I was the first occupational therapist with hand therapy experience asked to join the team.

My preparation for the trip began by asking fellow therapists at MGH to save scrap materials such as thermoplastic, Velcro, and wound-care

supplies. I was able to take many supplies with me, but as I suspected, it wasn't nearly enough. As the weeks before the trip approached, I continued to prepare myself materially and ready myself mentally for the patient population I would be treating and the conditions in which I'd be working.

On the day we arrived at the hospital in Honduras and began screening patients, I realized my clinical preparation had exceeded my emotional preparation. We spent eight hours in the heavy heat of the hospital clinic, made up of two desks and two X-ray view boxes. We assessed patients and determined

who would have the best post-operative surgical and functional outcomes. People lined up outdoors, some after walking for an entire day carrying the X-rays they had saved up for. We examined adults and children who had suffered severe burns, gunshot and machete wounds that had gone untreated, and babies with congenital deformities.

I spent most of my day 20 minutes from the hospital, at the Teleton Foundation in Honduras, a non-governmental, social service facility that provides care to disabled individuals. I began my first few days offering treatment ideas, and making splints for long-term patients. The occupational and physical therapists were overwhelmed with patients with upper-extremity contractures and spasticity. Without the aid of an interpreter, I attempted to give lessons in splinting and receive a lesson on conserving materials and creative treatment planning with limited resources. I was disappointed not to see more patients I'd screened earlier in the week return post-operatively. A handful of people came into the clinic each day, and I learned how difficult it was for them to pay for transportation from their homes or the hospital. Hoping that many would turn up after I left, I tried to communicate splinting principals and treatment pro-

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Occupational therapist, Joanna Akladiss, OTR/L, makes a splint and shares a laugh with patient, Hallie Baker, in the outpatient clinic

(Photo provided by staff)

MGH staff attend 2005 NICHE conference

—by Sheila Golden-Baker, RN, Alison Squadrito, PT, and Mary Ellen Heike, RN

We are members of the MGH NICHE Committee (Networking to Improve the Care of Health System Elders) who were fortunate enough to attend this winter's 2005 NICHE Conference in New York City.

The four-day conference is sponsored by the New York University Division of Nursing & Education Development Center for Health Care Practice in collaboration with the John Hartford Foundation. NICHE helps hospitals provide optimal care for older adult patients. The NYU NICHE group developed tools that help hospitals analyze current practices and attitudes of staff as they relate to caring for older patients. They've developed models that can be used to help improve the care provided to hospitalized elders, including educational programs, units designed specifically for geriatric care, and the establishment of an interdisciplinary resource team. Hospitals can implement any or all NICHE programs based on the results of each individual hospital's analysis.

Fifteen committee members attended the conference in 2004. Returning in 2005, we were pleased to find we could look at the program with

a new perspective due to the progress the MGH NICHE group has made in this direction. We came away with great enthusiasm for the initiative as well as fresh ideas and new contacts.

The conference focused on three areas:

- How to implement a NICHE program and the different NICHE models
- Clinical Best Practices related to Geriatric Syndromes
- A Users Group, networking opportunity

One practice shared by a group of nurses from Hawaii was particularly compelling. It

dealt with the use of sitters (observers) with older patients. They created a hospital-wide program that requires a geriatrician consultation for any patient over 65 years old who has an order for a sitter. Using this approach, they were able to improve patient outcomes and reduce the number of sitters used in their hospital. A similar approach could be considered at MGH.

Overall, we were struck by how passionate NYU staff was about the care of older adults and how open they were to sharing their resources and ideas. We returned to MGH refreshed and with

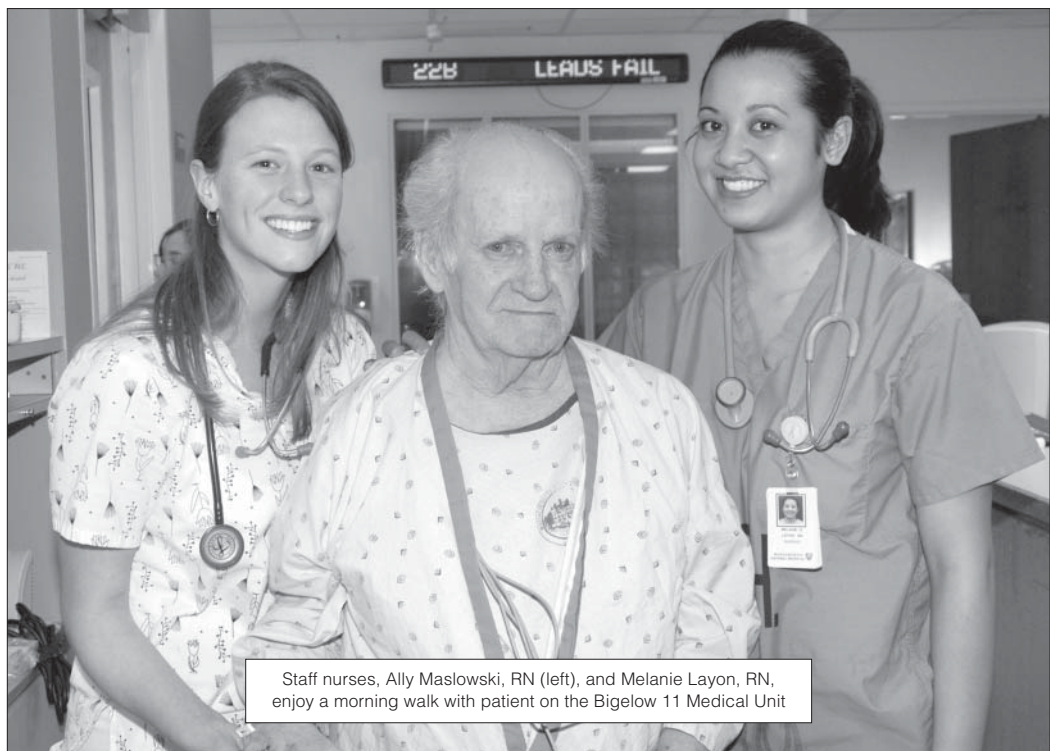
renewed enthusiasm and excitement about the MGH NICHE initiative.

For more information about NICHE or the resources available for caring for older adults, visit the following websites: niche: <http://www.hartfordnurseonline.org/program/s/niche/index.html>, or geronurseonline.org/ (no spaces).

Look for future articles in *Caring Headlines* spotlighting the work of the MGH NICHE initiative.



Physical therapist, Alison Squadrito, PT, assists patient in using a walker



Staff nurses, Ally Maslowski, RN (left), and Melanie Layon, RN, enjoy a morning walk with patient on the Bigelow 11 Medical Unit

Pneumovax Program: phase two

—by Janet Madigan, RN, project manager

Phase two of the Pneumovax Program was rolled out in Provider Order Entry (POE) on May 3, 2005. In this phase, a screen appears to the first provider (physician, resident, nurse practitioner or physician assistant) signing on to write orders for their patients 65 years old and

older. The screen shows a pre-selected order for pneumococcal vaccine. Providers have the op-

tion of accepting the order, declining the order, or deferring the decision for up to five days.

Set	Order
<input checked="" type="checkbox"/>	PNEUMOCOCCAL VACCINE POLYVALENT 0.5 ML IM x1 <DI>
<input type="checkbox"/>	I do not want this patient to have the Pneumococcal Vaccine because the patient has already received it.
<input type="checkbox"/>	I do not want this patient to have the Pneumococcal Vaccine because the patient has a contraindication.
<input type="checkbox"/>	I do not want this patient to have the Pneumococcal Vaccine for a reason other than those listed above.
<input type="checkbox"/>	Defer decision about ordering the Pneumococcal Vaccine until tomorrow.

More Info OK

On the sixth day, a decision to accept or decline must be made.

When vaccine is ordered, a nurse screens the patient for eligibility using the revised Pneumococcal Vaccination Screening and Administration Form (84592 rev. 2/05). The form is also used to document the administration of the vaccine. The original copy is placed in the medical record, and the copy is given to the patient for his/her records.

At discharge, a prompt

appears on the discharge screen for nurses to document whether or not the vaccine was given during this hospitalization. This documentation carries over into the Post Hospital Care Plan, the Patient Care Referral, the Face Sheet, and the Discharge Note. If the vaccine is declined because of prior vaccination or adverse reaction, the POE screen will not appear on subsequent admissions.

For more information, contact Janet Madigan, RN, project manager, at 6-3109.

Humanitarian Aid (Akladiss)

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protocols to the other occupational therapists, so care could be carried out with whatever supplies would be left.

In the afternoons, I'd return to the hospital and attend to those who had returned for wound care. Most dressings had lost all moisture to the 102-degree temperatures and clung tightly to wounds. Not one patient pulled his hand away as I tried to change the dressing. No one complained of pain. They sat quietly, squeezed my hand for comfort, and expressed their gratitude.

Later, I checked on those who had stayed overnight in a room of about 20 people. Their pain was controlled only by the ibuprofen we brought, their bodies cooled only by a fan. I observed in the operating room in an effort to gain

a better understanding of procedures and techniques, so I could better serve patients in the days after surgery.

Each of the patients I had the honor of meeting left an impression on my heart. I memorized the faces that came through the door, and have recognized them in photographs by their stories, not just their injuries. One day I had the opportunity to meet a remarkable young boy while our team was in search of another. We were notified that there was a 7-year-old boy who had been attacked by two older boys attempting to steal seven dollars. We went to a neighboring hospital to look for him as we learned he had sustained significant injury to his hand and neck. When we found the boy, he was

resting with his mother. To our surprise, he had arrived when a surgeon was available to treat his hand injury. After offering our prayers, we decided to tour the rest of the hospital.

The Emergency Room was over-populated with patients, many of whom had been waiting for two weeks and had yet to be seen. The Orthopedic Unit was filled with people with hip and tibia fractures who had been lying in bed for more than four weeks, also waiting to be seen by a doctor. As I walked one corridor, my eyes met those of a 15-year-old boy who was sitting in a wheelchair. He asked me (in Spanish) if I was there to see him. I smiled and told him I only had the pleasure of visiting. He was a paraplegic who, for a long time, had ambulated by crawling on his hands with his legs dragging behind. A surgeon had seen him several months before after he

developed an infection and ulcers in his lower legs. Following surgery, he resumed his prior means of ambulation as he still couldn't afford a wheelchair. Needless to say, the subsequent damage to his limbs was beyond repair. Now, his legs hung lifeless below the knee, swollen, with muscles and bone exposed. He explained that he was in need of bilateral, below-the-knee amputation and would patiently wait his turn.

Leaving that day, I grieved over his condition and was moved by his attitude and spirit. I thought about the week's events and all the work we had done. I thought of the people who would wait like he did, because there were so many of them, and so few of us. My mind turned to images of the hospital behind me, mold growing on the walls, the rooms filled with bare beds and barbaric equipment.

Heading back to the hotel, I pictured the clinic at home in Boston, abundant with materials and gadgets. I thought of how comfortable I had become knowing I was always prepared to care for people appropriately with ample resources. I thought of MGH, where no patient is turned away and the highest standard of care is expected. I convinced myself that by helping one person in much different circumstances in Honduras, we had helped not only that person, but the entire family. I pledged that I'd return next year even better prepared to help those who still needed our care. In the meantime, I'd pay tribute to them by keeping them in the forefront of my mind and sharing my experiences with my colleagues. My hope is that others will be inspired to share in the commitment to help those in need beyond the walls of MGH.

Bringing lessons of health and safety to the Workplace Education Program

On Wednesday, March 30, 2005, clinical educator, Mary

McAdams, RN, was the guest speaker at one of the MGH-JVS Workplace Education Program classes. Addressing stu-

dents of many diverse backgrounds who speak a variety of languages, McAdams talked about common accidents that

can occur in the home and strategies for prevent-

ing them. Using educational videos and demonstrations, she informed students about signs to look for that could indicate stroke, heart attack, choking, poisoning, and a number of other health hazards. The Heimlich maneuver and calling 911 were among the topics discussed.

In addition to learning valuable health and

safety tips, it was an opportunity for the class to engage in meaningful, real-life conversations and to hone their English-language skills.

Many English as a Second Language classes are offered through the MGH-JVS Workplace Education Program. For more information, call lead teacher, Jane Ravid, at 6-3268.



After being introduced by unit service associate and student, Rachida Elabassi (below left), clinical educator, Mary McAdams, RN (top left), speaks to the class about preventing injuries in the home. Students (above, l-r): Jadwiga Klincewicz, Crispina Ribeiro, and Maria Teixeira and (below): Yu-Kaung Kyan, Lucinda Dossantos, and Jorge Saldarriaga listen intently



MGH celebrates Occupational Therapy Month with visit from Travis Roy

On Thursday, April 14, 2005, in the Wellman Conference Room, the MGH Occupational

Therapy Service hosted a special presentation by Travis Roy, former Boston University hockey player who suffered a

career-ending spinal cord injury in his first 11 seconds on the ice.

Roy shared his experiences as a medical and rehabilitation patient, and recounted his journey to become a successful author and motivational speaker. It was a timely and inspirational presentation for Occupational Therapy Month that delivered an important message about medical care and the ability to overcome life-changing obstacles.



(Photos by Paul Batista)



Occupational Therapy (Serinsky)

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un-biased assessments completed in one day with the goal of answering questions and providing the beginnings of a solution.

In addition to PTT evaluations, I perform individual Occupational Therapy evaluations. With my background in sensory integration, I often evaluate pre-school

children with sensory integration processing problems. Parents or pediatricians may suspect a problem but need the expertise of an occupational therapist to fully identify it.

I am certified to provide a comprehensive sensory integration evaluation for older students from four to ten years

old known as Sensory Integration and Praxis Tests. At the end of every evaluation, parents are provided with verbal feedback and are later sent a full report. Reports include recommendations and home-programming suggestions.

Despite a very full schedule, my day goes by very quickly. Within Occupational Therapy

Summer help available

The City of Boston's Summer Jobs Program may be the solution to your department's vacation coverage this summer. The Summer Jobs Program provides meaningful part-time employment for Boston youth, while providing staffing support for MGH and Partners departments. This resource is available through two MGH Community Benefit youth employment programs: SummerWorks and Jobs for Youth (J4Y). Each program is supported by an on-site program manager who works closely with participating departments and student employees. Programs are funded through Human Resources and are available at no cost to individual departments. The only requirement is a commitment to provide a meaningful work experience in a supportive environment.

Jobs for Youth (J4Y)

For more than a decade, MGH has provided Boston high-school students with part-time (25 hours per week) employment throughout the hospital. Jobs for Youth links students from East Boston High School and other partner schools with dynamic job opportunities at MGH. The program combines professional-development workshops with real work experience to help students make informed career decisions. For more information, please call 4-8326.

SummerWorks

Summer Works is a career exploration/summer internship program for graduating eighth-graders from the James P. Timilty Middle School in Roxbury. Now in its seventh year, SummerWorks combines weekly interactive workshops with real work experience. Students spend 25 hours per week at the work site, Monday-Friday.

For more information, please call 4-6424.

Services, I have observed truly caring professionals who support each other in case management, who understand current research and therapy, and who provide wonderful profes-

sional support to one another. Being an occupational therapist encompasses many roles that allow me to engage in meaningful work as teacher, learner and therapist.

Time out: What is your role in ensuring patient safety?

—by Ruth J. Bryan, RN

We've all seen stories in the media where the wrong surgery was performed on the wrong person or the wrong body part. In 2002, the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) established its first set of National Patient Safety Goals to promote safety through preventative measures and patient-care initiatives. One of the seven goals was ensuring the accuracy of patient-identification and procedure-verification using a 'time-out' in the operating-room setting.

At MGH we've used a time-out policy in Operating Rooms (ORs) since early 2001. In the next few weeks you'll be hearing more about a new policy at MGH entitled, Universal Protocol: Correct Patient, Correct Procedure, Correct Site. The JCAHO has modified its original time-out patient safety goal to include *all* invasive and operative procedures performed on patients in the OR and treatment areas. This new policy will affect patient care in all areas of the hospital and health centers.

The purpose of the Universal Protocol: Correct Patient, Correct Procedure, Correct Site poli-

cy is to take a momentary time-out to ensure we're performing the correct procedure on the correct patient at the correct site on the correct side.

One aspect of current practice about which we need to raise awareness is the language we use when discussing procedures with patients. An example is how we talk about procedures with patients. When confirming a procedure, do you say: "You're having a needle biopsy, is that right?" Or do you say: "You're having a left-sided needle biopsy, right?" Or do you say: "You're having a needle biopsy, is that correct?"

This clarification of language is one small step in guaranteeing patient safety and ensuing there's no confusion when confirming a procedure site. We need to use the word '*correct*' when verifying and confirming all elements of a procedure. To be clear and accurate, we should only use the word, '*right*' to indicate the side of the body or a side-specific element of the procedure to be performed.

The basis of the new Universal Protocol: Correct Patient-Correct Procedure-Correct Site, is a team time-out prior to

the start of any invasive or surgical procedure. The policy covers invasive procedures across hospital settings (radiology procedures, endoscopic procedures, cardiac catheterization, and electrophysiology studies), procedures performed in ICUs and on medical-surgical units. This policy and our practice of using time-outs reinforce our commitment to a culture of safety and quality patient care.

The four requirements of the Universal Protocol: Correct Patient, Correct Procedure, Correct Site policy begin with patient identification using the two required patient identifiers. The other steps are procedure-verification, marking the procedure site, and performing the time-out. Every member of the procedure team (nurse, technologist, physician, other health-care providers participating in the procedure, and the patient) has a role in the time-out. Keeping safety as the focus, once patient-identification has been verified, each team member is asked to verify the correct procedure, the correct site, and the correct side (if applicable).

The JCAHO has excluded a few procedures from the Universal Protocol: Correct Patient,



Ruth J. Bryan, RN
clinical nurse specialist

Correct Procedure, Correct Site policy. They are: venipuncture, peripheral IV insertion (including PICC lines), and insertion of NG tubes and foley catheters.

Some of the procedures that *will* require a time-out and completion of the Universal Protocol checklist are: percutaneous aspirations, chest-tube insertions, peritoneal taps, arterial line and central line placement, angiograms, and thoracentesis.

As a nurse involved in one of these procedures, what do you need to know to be in compliance with this new policy and JCAHO standard? You need to read the new Universal Protocol: Correct Patient, Correct Procedure, Correct Site Policy, which can be found in the *Clinical Policy and Procedure Manual*. There is also a two-page educational document about the Universal Protocol and check-

list, which should be read. Take the time to familiarize yourself with the checklist and expectations for completion.

Each health provider plays an essential role in this policy. Your role is to ensure the checklist is completed if the physician performing the procedure is otherwise engaged, or complete it yourself if you're involved in the procedure. The time-out checklist can be found in the medical record in the Special/Operative Procedures section once it has been completed.

Patient safety is our primary concern. Our compliance to this policy ensures that the correct procedure will be performed on the correct patient at the correct site and on the correct side.

For more information about the new Universal Protocol: Correct Patient, Correct Procedure, Correct Site policy, call Ruth Bryan, RN, at 6-8945.

Lessons about life, homelessness, dignity, and respect

—by Maryjo Cappuccilli, RN, clinical nurse specialist

Despite the best efforts of those in the city who work with people who are homeless, a man well known to many of us in the MGH community died over the Christmas holiday due to hypothermia. Days before his death, on Christmas Eve, 'Michael' was visiting with a staff nurse on White 9 as was his habit. She gave him what was to be his last Christmas dinner. He enjoyed it outside the White 9 elevators under her caring supervision.

Michael's death profoundly saddened many who knew him. His passing also adds to the urgency felt by many caregivers to redouble our efforts to work with this population of patients.

In the past few years, the Emergency Department has coordinated a High-Risk Patient Task Force in collaboration with Healthcare for the Homeless to increase continuity of care for Michael and others like him. The task force is facilitated by an Emergency Department psychiatric clinical nurse specialist and is expanding to include White 9 in this partnership. Any inpatient unit that would like to participate is welcome.

Recently, the Emergency Department held a memorial service for Michael. Individuals from MGH, BMC, The BEST Team, The Shattock Shelter, Boston Healthcare for the Homeless, and other agencies gathered to remember him at St. An-

thony's Shrine near Downtown Crossing.

The following words were spoken:

"Clients come to us because they are physically ill, mentally ill, or have special social needs. Some of our clients are alone and unconnected in the world. For these individuals, for the time they are with us, we become their families... and it is a privilege.

"Michael faced internal obstacles that even he may not have fully understood. These obstacles were sometimes interpreted by others through careful listening and observation and dialogue... skills that require entering into a relationship with another person.

"Michael taught people how to enter into a relationship with him. He guided us in how to support him. He helped us manage our feelings of discomfort and guilt and confusion about homelessness. He crossed over the divide, extended a compassionate hand, and brought us to where we could sometimes help. By assisting him, we benefitted.

"In addition to showing our respect for Michael, we are here today for all our clients who face harsh obstacles imposed from within themselves and from our larger society. When we take a risk and get to know a person like Michael, we are refusing to give in to our feelings of discomfort and guilt and confusion. We each trust the other to collaborate in good faith.

"There are many ways that Michael's life, and death, will have meaning. In part, it will be up to us to determine what that meaning will be."

For more information about the High-Risk Patient Task Force, contact Maryjo Cappuccilli, RN, in the Emergency Department at 4-4100.



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Clinical Narrative (Holman)

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she reflexively swallowed followed by overt choking, gasping for air, increased secretion production, and desaturation. I had seen this response in Tammy before, and each time I feared the worst. I explained to the family that this was her body's response to liquid going into her airway and she didn't appear comfortable. They seemed fearful and said they didn't want to feed her anymore if it was going to make her more sick and uncomfortable.

After about two weeks of daily monitoring and a few attempts to feed Tammy safely with her family, I realized that this was no longer about an HD patient and dysphagia; this was about end-of-life care and comfort. I felt I could no longer discuss with Tammy's family the possibility of her eating and drinking safely. I needed to communicate the importance of changing our focus to what would be best for her in terms of safety and comfort.

I spoke with my colleagues, Tammy's primary nurse, and the Neurology team. They all agreed that it was appropriate to consult Palliative Care. Once Palliative Care was consulted, I felt relief that Tammy would be made comfortable. Unfortunately, eating is an important part of quality of life, and it's hard for anyone to come to terms

with eliminating all hope of eating, even for pleasure. For many days to come, the impending question still remained—could Tammy take anything by mouth?

I was starting to feel like the bearer of bad news; the roadblock in her care. The Neurology attending physician, the Palliative Care team, and I had a discussion, and we agreed on a clear-cut plan.

Palliative Care took over Tammy's care and she was put on comfort measures only. She passed away a week later with her family by her side. I stopped by several times during that week to say hello and see if they needed anything, even though my role as speech pathologist was no longer required. I often find comfort in providing support to families even after my job of assessing/treating has been completed. I still think of Tammy to this day and how her family, the team, and I struggled to make the right decisions.

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

In this timely narrative, Allison's, skill, knowledge, advocacy, and moral agency play a pivotal role in Tammy's care. In her thoughtful assessment of Tammy's ability to swallow, her collaboration with her fellow speech-language pathologist, and the time she took with Tammy's hopeful family, Allison came to know Tammy in a unique and intimate way.

Allison took the time to build trust; she listened to Tammy's family and understood their concerns about her quality of life. She took a clinical risk in allowing the family to feed Tammy, wanting to support them for as long as it was safely possible.

In the end, Allison convened the team and helped this family come to terms with the reality of Tammy's condition so they could seek the appropriate palliative care. End-of-life care is never easy, but it is always a privilege.

Thank-you, Allison.

Durant Fellowship Call for applications

Thomas S. Durant, MD, spent his life chasing chaos and human suffering in some of the world's most forsaken locations. Seizing every opportunity to call attention to these abject conditions, he brought victims more than just medical care—he brought hope, compassion, humor and advocacy. With his stories, he encouraged others to become involved in international relief efforts and community programs closer to home.

To honor and celebrate the life of Dr. Durant, in 2001, MGH established the Thomas S. Durant, MD, Fellowship in Refugee Medicine. The fellowship supports healthcare professionals who deliver care, services and hope to people ravaged by war, disease, drought, poverty, or political strife. The duration of the fellowship and follow-up activities are defined in large part by the fellows, as well as current available assignments and needs.

To apply, submit by May 15, 2005:

- a one-page, single-spaced essay explaining your interest in refugee medicine, what you hope to accomplish and learn through the experience, and how it fits with your career goals
- a current curriculum vitae
- two letters of recommendation

Applications should be sent to:

Laurence J. Ronan, MD
director, Thomas S. Durant, MD Fellowship
in Refugee Medicine
Bartlett 917

Final candidates will be invited to interview with the Durant Fellowship Selection Committee. The 2006 Durant fellow will be selected by July 1, 2005.

For more information about the Thomas S. Durant, MD, Fellowship in Refugee Medicine, call 4-3874

New all-white patient wristbands

New all-white patient wristbands will be introduced starting June 1, 2005. Blue and red bands will no longer be issued.

Allergy status must be checked in the medical record

For more information, call Arjun Rao
at 4-7632

Educational Offerings

May 5, 2005

When/Where	Description	Contact Hours
May 19 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza	7.2
May 20 and May 23 8:00am–4:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
May 20 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
May 24 8:00am–12:00pm	BLS Certification—Heartsaver VBK 601	---
May 25 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
May 25 8:00am–4:00pm	Creating a Therapeutic and Healing Environment Wellman conference Room	TBA
May 26 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
May 26 1:30–2:30pm	Nursing Grand Rounds “Patient Education.” O’Keeffe Auditorium	1.2
May 27 12:00–3:30pm	Basic Respiratory Nursing Care Ellison 19 Conference Room (1919)	---
June 2 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
June 2 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
June 6 8:00–4:30pm	Cancer Nursing: Maintaining a Healing Environment amid a Technology Explosion O’Keeffe Auditorium	TBA
June 8 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
June 8 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
June 8 12:15–4:30pm	Pacing Concepts Haber Conference Room	4.5
June 8 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
June 8 11:00am–12:00pm	Nursing Grand Rounds “Reducing Fall Rates in Neurologically Compromised Patients.” Sweet Conference Room GRB 432	1.2
June 9 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
June 13 and 22 7:30am–4:30pm	Pediatric Advanced Life Support (PALS) Certification Program Day 1: Wellman Conference Room. Day 2: Training Department, Charles River Plaza	---
June 15 8:00am–4:30pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
June 16 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza	7.2

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111. For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

New Graduate in Critical Care Program

—by Laura Mylott RN, program manager

On Monday, March 28, 2005, 13 registered nurses were recognized for completing the intensive MGH-IHP New Graduate in Critical Care Program. The integration of these new professionals into MGH and North Shore Hospital's critical care nursing staff brings the total number of graduates of this program to 69. Certificates of completion went to:

- Julia Zelixon, RN
 - Jenna Smith, RN
 - Caitlin McManus, RN
 - Amy LoVetere, RN
 - Trisha Kelley, RN
 - Joaeph Antonowicz, RN
 - Andrea Piazza, RN
 - Susan Ironfield, RN
 - Pamela Muller, RN
 - Phyllis Packer, RN
 - Laura Nephew, RN
 - Jill McFarland, RN
 - Corie Damato, RN
- Associate chief nurse,

Theresa Gallivan, RN; director of the Graduate Program in Nursing at the IHP, Marjorie Chisholm RN; and manager and faculty of the New Graduate in Critical Care program, Laura Mylott, RN, spoke about the rigorous and demanding challenges of the program, the invaluable support and expertise of the preceptors, and the generosity of MGH clinicians

who teach in the program.

Implementation of the program is guided by a team of critical care nurse managers and clinical nurse specialists who meet regularly under Mylott's leadership to address

opportunities for program-development. Representing the graduating class, Amy LoVetere, RN, read a narrative describing the nursing care she provided to an elderly gentleman dying from end-stage chronic lung disease. LoVetere's narrative was particularly noteworthy for its depiction of dying as a unique and personal process that is defined

response to this patient's particular needs required 'knowing the patient.' Over time, she came to understand the needs of this patient and family. This knowledge enabled her to follow their lead, and she gently supported them through the uncertainty and emotionality of dying.

LoVetere's practice developed under the expert guidance of preceptors, Katherine Cosgrove, RN, and Elizabeth Goodwin, RN. They spoke about the unique partnership preceptors and new graduates form during the six-month program and how critical that relationship is to a successful and satisfying experience for all involved.

For more information about the New Graduate in Critical Care Program, contact the nurse manager or clinical nurse specialist in any ICU, or call Laura Mylott at 4-7468. For application information, call Sarah Welch in Human Resources at 6-5593.

(Photos by Paul Batista)



Clockwise from top left: Elizabeth Goodwin, RN, MICU; Katherine Cosgrove, RN, MICU; Laura Mylott, RN, manager and faculty of the New Graduate in Critical Care program; Amy LoVetere, RN, MICU; and Margery Chisholm, RN, director, Graduate Nursing Program at the IHP

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