

Caring

July 20, 2006

HEADLINES

Inside:

- Moving Patients with Ease 1
- Jeanette Ives Erickson 2
 - Omnicell
 - On-Line Safety Reporting
- Fielding the Issues 3
 - PCS Diversity Committee
- Workplace Education Program Graduation 4
- Robert W. Carey Lecture 5
- Caring for the Invisible Patient .. 6
- Recognition 8
 - Durante Award
 - Cronin and Raphael Award
- Clinical Narrative 10
 - Kathie Capeless, RN
- Quality & Safety 13
 - National Patient Safety Goals
- MGH Heart Center 14
- Food & Nutrition 15
 - Cardiac Patients
- Clinical Nurse Specialist 16
 - Lynn Oertel, RN
- Excellence in Action Award .. 17
- Educational Offerings 19
- Professional Achievements . 20

New lifts let clinicians move patients with ease

(see page 12)



Senior project specialist, Dan Kerls, demonstrates new portable lift with the help of patient care associates, Sandra Goodman (left), Bardha Plaku (right), and staff nurse, Ellen Roderick-Joseph, RN

Two new systems: two successful patient-safety initiatives

Strouble-shooting and problem-solving are big parts of our daily work. I think everyone would agree that when you find a solution that simultaneously promotes patient safety, improves systems, and encourages people to do the right thing... that's a good solution. And that's exactly what we have in two systems implemented recently, both of which help us track, identify, and prevent adverse events.

Omnicell, our automated medication distri-

bution system, has given us a greater level of efficiency and accountability in delivering and administering drugs throughout the hospital. Its built-in safety features, such as portable, locked drug cabinets; the physical separation of sound-alike look-alike drugs; and the ability to generate customized reports, has decreased our number of drug-related errors and improved patient safety.

Though incidents of drug diversion at MGH are very rare, Omnicell's electronic reporting system, which can be sorted

by patient, drug, nurse, time of day, etc., has made it quick and easy to reconcile drug consumption and utilization. And that ease of reconciling consumption translates to fewer errors, fewer opportunities to divert drugs, and fewer drug-related adverse events.

On those rare occasions when discrepancies do occur or unusual patterns emerge, they can be identified immediately, and appropriate actions can be taken to rectify or explain the inconsistencies. A number of factors can skew reports making

it seem as if there's been unusually high or low drug utilization on a given unit or by a particular clinician. Some factors that can skew reports include working part- or full-time; a higher number of patients per care-

giver; day- versus night-shift reports; the acuity of patients cared for; a change in a patient's condition, etc. When nurse managers and unit pharmacists review Omnicell reports, they take these factors into consideration.

In the near future, another layer of prevention will be added to the drug distribution system when Omnicell is connected electronically to Provider Order Entry (POE) and the MGH Pharmacy. More to come on that.

The other system I want to mention is the newly up-and-running on-line safety reporting system. This system allows any MGH employee to report an incident or safety concern directly to the Office of Quality & Safety via the computer,

continued on next page



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

PCS Diversity Committee focuses on broad definition of diversity

Question: I recently saw an article in the *MGH Hotline* about a leadership retreat focusing on diversity. What does that mean for Patient Care Service?

Jeanette: Patient Care Service continues to have a strong diversity program. The PCS Diversity Steering Committee is in the final stages of work to create a definition of health disparities that will serve as a reference point for issues related

to practice, cultural competence, and education. Patient Care Services is committed to a broad definition of diversity, which means you can expect to see more programs focusing on age, gender, and sexual orientation.

Question: I've started seeing a diversity logo in

various e-mail announcements and posters. How did that come about?

Jeanette: The Patient Care Service Diversity Steering Committee felt it was time for the program to have a distinctive 'look.' The logo you have seen will soon be presented for formal approval.

Question: I attended the recent presentation on the care of gay, lesbian, and transgender patients and thought the information was really relevant and important. Will there be more programs like this?

Jeanette: Yes. The response to that program has been very positive. Several people have suggested we reactivate the GLBT group for interested employees. If you'd like more information on this, please contact Deborah Washington, director of PCS Diversity at 4-7469.

Question: As we prepare for the upcoming JCAHO visit, is there anything we should know about diversity or culturally competent care?

Jeanette: Our commitment to provide culturally and linguistically appropriate care to all patients is in alignment with JCAHO standards. The standards are related to maintaining good communication between staff and patients, especially when there is need for an interpreter; and showing respect for the values and beliefs of patients and families at all times.



Jeanette Ives Erickson

continued from previous page

any time of day or night. Replacing our manual reporting system, on-line safety reporting is faster, easier, more reliable, and allows us to collect, store, and use data in a meaningful way to improve hospital systems.

The on-line safety reporting system can be accessed from any MGH computer by clicking on Start, Partners Applications, Safety Reporting MGH. The site is easy to navigate with straightforward cues that prompt you through each stage of the process. Each successive screen is generated based on information that

has already been provided, allowing for a greater level of detail and a more focused report. Reports are submitted immediately upon completion, or you can save an incomplete version of the report and return to it later at a more convenient time. If, as is the case with many clinicians, you get distracted while in the process of filing a report, there's an 'auto save' function that saves the report for you. When the report is submitted, it goes directly to the Office of Quality & Safety and your location manager. Alerting the location

manager allows immediate, unit-based concerns to be addressed in a more timely manner and promotes preventative interventions.

The on-line safety reporting system allows users to attach supporting documents such as pictures, files, letters, policies, procedures, or any other information that can be transmitted electronically.

One screen asks for suggestions on how we can 'avoid similar events in the future.' Joan Fitzmaurice, RN, director of the Office of Quality & Safety, tells me we've received some great suggestions from staff on how to prevent potential-

ly hazardous events and situations. The system is working!

One of the big advantages of an on-line reporting system is the ability to collect and compare data from all areas allowing us to identify trends and issues that may need to be addressed globally. Eventually, all Partners entities will have access to the system, giving us the added ability to look at and compare data among and between hospitals.

Though the on-line safety reporting system is highly user-friendly, all MGH employees are being trained via on-line tutorials, open forums, self-training packets, and

unit-based training sessions.

With patient safety ever at the forefront of our practice, the automated medication distribution system and the on-line safety reporting system are making a significant difference in our ability track, identify and prevent adverse events.

For more information on either of these systems, contact the Office of Quality & Safety at 6-9282.

Update

I'm happy to announce that Liz Johnson, RN, has accepted the position of oncology clinical nurse specialist for the Bigelow 7 GYN-Oncology Unit effective immediately.

Workplace Education Program graduation

—by Ruth Dempsey, RN, Stephanie Cooper, and Elaine Kwiecien

On June 23, 2006, the MGH Workplace Education Program held its 11th annual Celebration of Achievement for students who completed the English for Speakers of Other Languages Program. Throughout the ceremony, the themes of education, family, and community were stressed in comments by students and speakers alike.

Carlyene Prince-Erickson, director of Employee Education and Leadership Development, spoke of the 'exquisite grace' it takes to work, go to school, and care for your family at the same

time. She commended the commitment of employees who participate in this on-site program with the promise of a better future for themselves and their families. Prince-Erickson thanked the managers, instructors, members of the Planning and Evaluation Team, Jewish Vocational Services, friends, and family

members, without whose support the program would not be possible.

Students from each class section read excerpts from essays they'd written sharing details of their lives, native countries, families, friends, and cultures. Students thanked MGH for the opportunity to participate in the program.

Jeff Davis, senior vice president for Human Resources, introduced

keynote speaker, Sam Yoon, the first Asian American to serve on the Boston City Council. Yoon, who was born in Korea and emigrated to the United States when he was ten months old, congratulated the graduates, thanked them for their stories, and commended them for taking the time to learn English while working and caring for their families. Yoon's parents' belief in the importance of education was what brought them to this country. Said Yoon, "Education is the key to success. You can strive for higher goals

and still be proud of your native language, culture, and country. We have an obligation to promote education in our society, to help people achieve their dreams." Yoon praised MGH for recognizing the changes occurring in the community and in the workforce and for making the hospital a stronger, better place to work for everyone.

Certificates were presented to students by instructors, Beth Butterfoss, Diana Crane, and lead instructor Jane Ravid. Bill Banchiere, director of Environmental

continued on page 11



(Photo by Michelle Rose)

Robert W. Carey Lecture celebrates collaborative practice

—by Elizabeth Johnson, RN, clinical nurse specialist

Collaboration is one of the critical elements of quality patient care. So declared nurse scientist Laurel Radwin, RN, at the 2006 Robert W. Carey Lecture on June 15, 2006. “If collaboration is present,” said Radwin, “it’s invisible. If it’s not present, patients notice immediately and experience its absence as poor care, incompetence, and negligence on the part of all providers. Collaboration must be multi-disciplinary as well as intra-disciplinary. Nurses must have meaningful discussions with each other, with physicians,

and with other members of the team in order to deliver effective care.” Radwin identified eight elements of patient-centered care from extensive research with hundreds of patients. They are: respect, coordination, good communication, informed knowledge, emotional support, inclusion of significant others, attention to comfort, and continuity.

“Patient-centered care is compassionate care,” said Radwin, noting that patient-centered care is linked to one of the most cherished values of the nursing profession.

Radwin shared attri-

butes of quality nursing care based on feedback from patients. These attributes include using current professional knowledge; establishing a rapport with patients and families; actively acknowledging patients as partners in care; treating patients as individuals; being attentive to the diverse details of individual patients’ needs; promoting continuity; and coordinating care across the continuum. When these attributes are realized, the result is an enhanced sense of well-being on the part of pa-

tients who experience greater trust, optimism, a sense of authenticity, increased stamina, readiness to bear discomfort, and a willingness to participate in the challenges of illness and treatment.

Radwin, an assistant professor of Nursing at the University of Massachusetts, spoke from her extensive research on quality nursing care with an emphasis on the patients’ perspective. Her observations represent on-going research and scholarly articles on quality nursing care as defined by patients—a seminal perspective described in her paper, “Oncology Patients’ Perceptions of Quality Nursing Care,” published in *Research in Nursing and Health*. In a 1999 paper in *Scholarly Inquiry for Nursing Practice*, Rad-

win noted that while clinicians have established standards of quality care in their various disciplines, it is critically important to include the voice of patients.

Radwin has developed The Oncology Patients’ Perceptions of the Quality of Nursing Care Scale, a nursing research tool that’s been translated into a number of languages and utilized by nurse researchers on six continents.

Staff from the Oncology Infusion Unit established the Robert W. Carey, MD, Lectureship to honor Dr. Carey’s generosity in creating a fund upon his retirement in 2003, to recognize the contributions of nursing in the ambulatory infusion setting, and to acknowledge the spirit of collaborative practice.

Blood: there’s life in every drop

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building

The MGH Blood Donor Center is open for whole blood donations:
 Tuesday, Wednesday, Thursday,
 7:30am–5:30pm
 Friday, 8:30am–4:30pm
 (closed Monday)

Platelet donations:
 Monday, Tuesday, Wednesday, Thursday,
 7:30am–5:00pm
 Friday, 8:30am–3:00pm

Appointments are available for blood or platelet donations

Call the MGH Blood Donor Center to schedule an appointment
 6-8177



Clare Swan, RN (left), who worked closely with Dr. Carey in the ambulatory setting, introduced Laurel Radwin, RN, the 2006 Carey guest lecturer

(Photo provided by staff)

Caring for the invisible patient

—submitted by the PCS Diversity Committee

On June 14, 2006, the Patient Care Services Diversity Steering Committee sponsored an educational forum in O’Keeffe Auditorium entitled, “Caring for the Invisible Patient.” The forum focused on the care of gay, lesbian, bisexual, and transgendered patients.

Harvey Makadon, MD, associate professor of Medicine at Harvard Medical School, began with a presentation entitled, “Hearing all voices: better health care for the LGBT community.” Makadon reminded clinicians that stigma is still very much part of the healthcare experience for gay patients, which contributes to concerns about sharing sexual orientation with caregivers. Understandably, gay patients worry about

reactions that make them feel devalued and subsequently lead to a lower quality of care. Makadon identified barriers to open discussion, including: the knowledge and attitude of clinicians; patient attitudes; fear of disclosure; stigma; and the quality of communication between patient and caregiver.

Makadon stressed that it takes time to establish trusting relationships with all patients. Clinicians need to be careful not to lose sight of basic healthcare considerations while ensuring gay-friendly interac-

tions. For example, cancer screenings, reproductive counseling, parenting, aging, and marriage are topics of concern to the GLBT community just as they are in any other population. Stress associated with discrimination and social pressures often leads to poor health choices like tobacco, alcohol, and drug use. ‘Coming out’ can be especially psychologically and emotionally painful in a gay individual’s life. There is often confusion as loved ones hear, adapt to, accept, or reject the news.

Judith Bradford, PhD,

co-chair and director of Lesbian Health Research at the Fenway Community Health Center, shared information on research and the GLBT community. Health policy relies on a constant flow of new information. Since gay patients have historically represented a ‘hidden’ research population, innovative methods are needed to gain access to untapped GLBT-related research topics. Non-traditional ways of collecting data are necessary. A technique known as respondent-driven sampling has become a valuable source of information in increasing our knowledge about the needs of this distinct patient population. Respondent-driven sampling is similar to ‘snow-

ball sampling’ in that individuals participating in a research study recruit friends, who recruit other friends, and so on. Bradford observes that there are ways in which evidence-based interventions can be adapted to reflect populations not included in an original research design. For example, lesbians are an under-served patient population. They are estimated to be at greater risk of breast cancer due to a greater prevalence of risk factors such as obesity, alcohol use, never having been pregnant, and lower frequency of mammograms.

The care of transgendered patients is even more complex. The absence of insurance coverage, societal hostility, a lack of respect for transgendered

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Caring for the Invisible Patient panelists (l-r): staff nurse, Shean Marley, RN, of Internal Medical Associates; Judith Bradford, PhD, co-chair and director of Lesbian Health Research at Fenway Community Health Center; and Harvey Makadon, MD, associate professor of Medicine at Harvard Medical School, field questions from employees in O’Keeffe Auditorium



Caring for the Invisible Patient

continued from previous page

individuals, and employment discrimination make it especially challenging for this population to receive quality health care.

Following Bradford and Makadon's presentations, staff nurse, Shean Marley, RN, of Internal Medical Associates, joined them for a panel discussion and question-and-answer session. Marley emphasized the role of family in the health-care experience of GLBT patients. Sometimes, the conventional practice of including family in the patient's experience can lead to unexpected distress if interactions aren't handled appropriately. Caregivers need to make sure they know family

dynamics and avoid making assumptions.

The GLBT Health Access Project has published standards that can be used as a reference by healthcare organizations interested in providing a high standard of care to the gay community. These standards should cause us to think and renew our desire to learn. We have work to do in relation to our care of gay, lesbian, bisexual, and transgendered patients. Every person who comes to MGH is entitled to the best care we have to offer.

For more information about the care of GLBT patients or the work of the PCS Diversity Committee, call 4-7469.

Advanced practice clinician directory

- Do you know your colleagues?
- Are you looking for someone to consult about a challenging patient issue?
- Are you looking for someone who shares your area of expertise?

The on-line advanced practice clinician directory allows you to find nurse practitioners, nurse midwives, clinical nurse specialists, and physician assistants by name or specialty area

To access the on-line advanced practice clinician directory, go to the Patient Care Services website and click on Clinical Resources, then select Advanced Practice Directory or go to: http://www.massgeneral.org/pcs/secure/advance_practice/specialtylist.asp

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

Community Standards of Practice for the provision of quality health care to gay, lesbian, bisexual, and transgendered clients

Published by the GLBT Health Access Project

- Standard 1: Establish, promote and effectively communicate an inclusive, non-discriminatory work place environment for gay, lesbian, bisexual, and transgendered employees.
- Standard 2: Support and encourage visibility of gay, lesbian, bisexual, and transgendered employees.
- Standard 3: Work toward ensuring that gay, lesbian, bisexual, and transgendered employees of all ages are subject to the same terms and conditions of employment, including the same benefits and compensation, as all other employees.
- Standard 4: Ensure that comprehensive policies are implemented to prohibit discrimination in the delivery of services to gay, lesbian, bisexual, and transgendered clients and their families. Ensure that all staff use, and all written forms and policies employ, culturally appropriate language when dealing with gay, lesbian, bisexual, or transgendered clients and their families. For the purpose of these standards the term 'family' includes relatives by blood, adoption, marriage, or declaration of domestic partnership.
- Standard 5: Ensure that comprehensive and easily accessible procedures are in place for clients to resolve complaints alleging violations of these policies.
- Standard 6: Develop and implement intake and assessment procedures and ensure they meet the needs of gay, lesbian, bisexual, and transgendered clients of all ages and their families.
- Standard 7: Have a basic familiarity with gay, lesbian, bisexual, and transgender issues as they pertain to services provided by your organization.
- Standard 8: Routinely provide general care to gay, lesbian, bisexual, and transgendered clients; be competent to identify and address specific health problems and treatment issues; provide treatment accordingly and appropriate referrals when necessary.
- Standard 9: Ensure that case management and treatment plans include and address sexual orientation and gender identity where it is necessary and appropriate to care.
- Standard 10: Ensure confidentiality of client data, including information about sexual orientation and gender-identity issues.
- Standard 11: Provide appropriate, safe, and confidential treatment to gay, lesbian, bisexual, and transgendered minors. All clients who are minors shall be informed of their legal rights and advised of the possible consequences of any statutory or otherwise mandated reporting.
- Standard 12: Include gay lesbian, bisexual, and transgendered people and their families in outreach and health-promotion efforts.
- Standard 13: Encourage Board of Directors and other institutional bodies to have representation from GLBT communities.
- Standard 14: Include gay, lesbian, bisexual, and transgendered people in community benefits programs.

Durante Award for Exemplary Care and Service to Cancer Patients

—by Julie Goldman, RN, professional development coordinator

It was standing room only in the Maynard Conference Room on June 27, 2006, as Bruce Chabner, MD, welcomed attendees to the eighth annual Susan and Arthur Durante Award for Exemplary Care and Service to Cancer Patients, named in honor of benefactor, Arthur Durante, who passed away in August, 2000. This year's recipients were Cathleen Poliquin, RN, nurse practitioner for the Bone Marrow Transplant program; and Heather Baker, medical assistant for the Genitourinary Oncology Center.

The MGH Cancer Center has long recognized the compassion, enthusiasm, and commitment of healthcare professionals and support staff throughout MGH. Durante and his wife, Susan, witnessed this dedication on many occasions during his long illness. They established the \$1,000 award to be given annually to two MGH staff members for respite, relaxation, and renewal.

Poliquin was nominated by Thomas Spitzer, MD, who introduced her at the ceremony. Said Spitzer, "Cathleen is a truly compassionate and caring nurse who has always taken whatever steps were required to

ensure optimal care for her patients. Her calm and thoughtful approach is noteworthy. She has organized a comprehensive training session for staff nurses new to the Transplant Unit and enlists various experts to expand the curriculum."

In a letter of support, Kristen Bodnaruk, RN, wrote, "Cathleen has a unique manner as she eases patients' anxiety with her ability to listen and understand. She has been a mentor and teacher to all of us in the profession."

One patient wrote, "Cathleen took the time

to sit down with us and reassure us about my transplant. I've seen her interactions with other patients, and I know it's not just a job for her; it truly is her calling."

Poliquin, a nurse for more than 30 years, said, "I'm honored and humbled by the patients and families who have given me such a precious gift. It is very special to be given this award that honors a very special patient, Arthur Durante."

Donald Kaufman, MD, introduced Baker saying, "Heather has always been interested in working in the medical

field. She enrolled at the Bryman Institute to become a medical assistant. She started at the Cancer Center in 2003 as part of an externship and has been here ever since. Heather is the epitome of a team player. She leads by example. She is reliable, independent, and diligent."

In her letter of nomination, Erika Barrett, RN, wrote, "Heather is one of the first faces our patients see. I've heard from many patients that they always feel better once they see Heather."

In a letter of support, Barbara Cashavelly, RN, nurse manager, wrote, "Heather has impressed me since her first day as a medical assistant student. Her smile, compassion, and dedication to her work and patients are remarkable. Heather is a

role model and a team player."

Said Baker, "My time at the Cancer Center has taught me to value my family and friends. Family is the core unit; it's what makes coming to work more than just a job—it's a commitment."

We're fortunate that Susan and Arthur Durante established this award to recognize the contributions that clinical and support staff make every day in caring for cancer patients. Associate chief nurse, Jackie Somerville, RN, closed by acknowledging all those who were nominated. Said Somerville, "It's important to celebrate each other and our relationships with those who seek our care... not just once a year, but each and every day."



(L-r) are: Jackie Somerville, RN; Bruce Chabner, MD; Donald Kaufman, MD; award recipients, Heather Baker and Cathleen Poliquin, RN; and Thomas Spitzer, MD

(Photo by Michelle Rose)

Cronin and Raphael Award for Patient Advocacy

—by Julie Goldman, RN, professional development coordinator

The Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy was established in 1999 in memory of patients, Paul Cronin and Ellen Raphael, and to recognize the exemplary nursing care they received on Phillips House 21. The award is given to a clinical and/or support staff member who consistently demonstrates excellence in addressing the individual needs of patients and families. It was Cronin and Raphael's belief that empowering the people who care for patients allows them to grow,

flourish, and excel in the important work they do.

This year's recipient of the Cronin and Raphael Award for Patient Advocacy was patient care associate, Thi Duong.

Duong came to the United States from Vietnam in 1992 with her husband and two sons. When she arrived, she spoke no English. To help support her family, she worked as a seamstress and took English classes to earn her GED. She later enrolled in the Certified Nursing Assistant course at Bunker Hill Community College. Duong interned on Ellison 6 where she held her

first job as a patient care associate. Over time, Duong transferred to Bigelow 14 then Phillips House 21 in 2005.

Duong was nominated by a patient and colleagues on her unit. In his letter of nomination the patient wrote, "Thi made me feel as though my own family was looking over me. She is genuine, gentle, and skilled at her work."

Fellow patient care associate, Christina Georgoudis, wrote, "I witnessed first hand how flexible Thi is in her care of patients. I have learned so much from her creativity, enthusiasm, and

sense of self-empowerment, and I hope to learn a lot more."

Another colleague wrote, "Thi always treats her patients with great dignity."

When asked what Duong likes most about her job, she says, "I like the spirit of teamwork. I like giving patients something that money can't buy. I give them my heart. I treat them as I would want a member of my family treated."

Duong has expressed a desire to go to nursing school.

Others nominated for the Cronin and Raphael Award this year were:

- Sophia Niles, operations associate
- Susan Pierce-Chana, operations associate
- Solange Fils-Aime, patient care associate

Said associate chief nurse, Theresa Gallivan, RN, "Patient advocacy has many faces. It can be found in the search for solutions to a patient's problem. It can be found in partnering with clinicians from other disciplines and departments. It can be found in talking to patients and families and respecting their values and beliefs. It can be found in interventions and gestures that ensure the highest quality, individualized care for patients.

"As direct care providers and those who support direct care, we have the opportunity and responsibility to keep patients and their families front and center. We need to challenge others and ourselves to ensure our policies, procedures, and practice meet the needs of our patients and families, and when they don't, we need to do something about it!"

At left: Cronin and Raphael Award recipient, Thi Duong (back row; third from left); nurse manager, Keith Perleberg, RN (second from left); senior vice president for Patient Care, Jeanette Ives Erickson, RN (center back); associate chief nurse, Theresa Gallivan, RN (beside Ives Erickson); and members of the Cronin and Raphael families.



(Photo by Michelle Rose)

Case manager ensures quality care across state lines

My name is Kathie Capeless, and I have been a nurse at MGH for 27 years, the past six as a case manager. In the course of my nursing career, whether as a staff nurse or case manager, end-of-life issues have always tugged at my heart—but none more than the situation I'm about to relate.

Mary was a 54-year-old woman with metastatic ovarian cancer. She lived with her supportive husband, John, and two children, and had been admitted with intractable pain. In reviewing her medical record, I noted Mary was being followed by Palliative Care, had a history of home infusion, and had been cared for by visiting nurses. There was no mention of hospice care and no clear plan for the future.

When I met John and Mary, my plan was to review prior services, discuss goals and plans for treatment, and ultimately discharge. Mary was very comfortable as she had been started on morphine in the last 24 hours. As I entered her room, she was sitting in a chair gazing through the window at the Charles River. John was reading the paper; both seemed to

be miles away in thought.

After introducing myself and my role, Mary said very softly, "We were supposed to leave for Florida in two days for vacation. I know it'll be my last vacation with my children."

John began to comfort her as she started to cry. He said he needed to take care of her and that the vacation could be postponed.

Mary insisted that she was comfortable now, and that had been the medical goal. Her wish was to be able to take one last vacation with her family. Mary sobbed. I was overwhelmed with the sense of doom in the room. She told me her children (a son and daughter) were 9 and 11 years old. She went on to say how she'd been preparing them for her demise. In recent months she'd been feeling better, so they had planned this vacation. My heart went out to her. All I could think about was my own children and husband and how I would want to do the very same thing. To John and Mary this seemed like a fading dream. But I felt strongly that we could make this happen. I knew we had the resources to make it happen.

Both Mary and John were elated to hear I was going to tap all available resources and do my best to help make their vacation a reality. To my surprise, neither Mary nor John had mentioned their vacation plans to the team. John gave me their itinerary, and I started contacting the appropriate people.

I spoke first with members of the palliative care team who were very supportive of the plan.

I put Mary in touch with a national home-infusion service that had an office in Florida. They would be able to manage Mary's care. Mary had experience with home infusion, so she'd just need a refresher course.

John had given me the name of a neurologist in Florida who had come highly recommended, but Mary hadn't been seen by him yet. I wasn't sure if the neurologist would be willing to manage Mary since he hadn't assessed her. I spoke with him and a nurse practitioner, and after discussing the case, they agreed to follow Mary during her vacation in Florida. I was more than happy to fax the discharge summary to them.

I was told by Palliative Care that Mary would



Kathie Capeless, RN
case manager

need a PICC line placed. I spoke to her oncologist and he authorized the use of a port-a-cath (a less invasive, more portable access device for infusions). Everything was falling into place.

I ordered a wheelchair for Mary and oxygen so she'd have it in Florida. I spoke with the airline. Even though she would be traveling with oxygen, she wouldn't need it in flight, and she'd have doctor's orders with her in case there were any questions about her fanny pack. I tried to get her a seat in first class, but the airline they were flying didn't have a first-class option. The airline representative told me they would make every effort to make sure Mary was comfortable during her flight.

By the end of the day, everything was in place. I reviewed the plan with John and Mary. She smiled, and John called me their 'angel.' They thanked me for everything I'd

done to make this vacation possible. I felt such emotion. They hugged me, and I left wishing them a relaxing and pain-free vacation.

Mary left for Florida as planned with her family in early March. I checked in with the home infusion service and learned that all went well. She only needed to contact them once with a question regarding the infusion. She returned to Boston a week later.

Mary and John sent a postcard from Florida to the staff on Phillips 22. It was good to read that the family had enjoyed themselves. John and Mary thanked staff for their care. I was touched when I read, "Thanks especially to Kathy, who made the support from the infusion service happen, moving earth, if not heaven."

Eleven days after returning from Florida, Mary died peacefully at home with hospice.

continued on next page

Some portions of this text have been altered to make the story more accessible to non-clinicians.

Clinical Narrative

continued from page 10

Writing about this case made me realize the impact we have on the lives of others. In 'doing my job,' using familiar resources, I was able to make Mary's last wish come true. All I could think was, "How could I *not* make this happen." It was absolutely the right thing to do. If I had been Mary, I would have wanted the very same thing, and I would have appreciated the assistance just like she did.

We all get caught up in 'doing our jobs,' not realizing the impact we have on our patients and their families. As clinicians, we need to cherish those moments, because when I'm having one of those days, when I'm feeling unappreciated, I pull that postcard from my drawer and think—Yes, this is what

it's all about. Thanks, Mary.

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

"I knew I had the resources to make this happen." Aren't those wonderful words! With that one sentence, Kathie set in motion a comprehensive plan to help make this patient's last wish become a reality. Without hesitation, she called upon colleagues inside and outside the hospital to ensure that Mary and her family could enjoy a family vacation despite her significant healthcare needs. No detail was too big or too small.

All in a day's work? Perhaps. But Kathie's actions made a significant difference in the lives of this family.

Thank-you, Kathie.

Workplace Education

continued from page 4

Services, and program manager, Helen Witherspoon, recognized Amarilis Pina and Maria Cardoso, for receiving their graduate equivalency degrees (GEDs) this year.

Ravid, who's leaving MGH this month after eight years with the Workplace Education Program, called every student, 'a hero.' Said Ravid, "Each student is from another country, has adjusted to

our culture, met family obligations, and juggled responsibilities here and in their native countries. Many work two or three jobs but their classes are an important part of their lives."

Volunteers are essential to the continued success of the Workplace Education Program. For more information about the program, call Beth Butterfoss at 6-2230.

MGH community mourns loss of cherished friend and OR nurse



Patricia Hurst, RN

It is with great sadness that the perioperative nursing staff announces the untimely passing of their friend and colleague, Patricia Hurst, RN. Hurst was a private scrub nurse for Dr. Harris in the Main Operating Room for many years, later transferring to the Same Day Surgical Unit where she worked in the OR until her retirement. Friends remember Hurst as a dedicated MGH nurse who had a passion for gardening.

She will be missed.

Message from a Workplace Education Program graduate

My name is Amarilis Pina. I have been an employee at MGH since October 9, 1991.

My first job was in Environmental Services where I spent five years, and then I was promoted to unit service associate (USA). I was responsible for stocking the medicine room and making sure patients had the supplies they needed. My supervisor was Joanne Gringeri. She encouraged me to get a high school education.

Joanne helped me find a tutor to help me with my classes and homework. I was happy because she found the best tutor in the world. My tutor is Nancy Hiller and she has been helping me for four years. She's a wonderful person.

After working with Nancy, I took a Clinical Assistant Course and received my certificate. Joanne encouraged me to become a patient care associate so I could get experience drawing blood and perhaps become a phlebotomist.

I started taking classes to become a patient care associate. When I accomplished that, Joanne helped me find a job. I have been a patient care associate for almost two years, and I'm very happy with my job. Joanne helped guide me in the right direction for my career.

I want to thank all the people who helped me especially my tutor, Nancy Hiller. I will graduate on May 22nd and receive my high school diploma!

Moving patients with ease

—by Dan Kerls, OTR/L, senior project specialist,
and Tucker O’Day, PT, program manager, Ergonomics

In a 2002 paper, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) wrote, “With an aging nursing population and an increasingly corpulent [general] population, healthcare organizations will find it a basic necessity to acquire ergonomic technologies that reduce the risk of physical strain and injury in the delivery of patient care. Exposure to the risk for ergonomic or musculoskeletal injury occurs frequently in nursing while performing patient-handling tasks such as lifting and transferring, repositioning, and ambulating patients.”

Consistent with national statistics on nurses and ergonomic injuries, nurses at MGH sustained the greatest number of OSHA recordable musculoskeletal injuries of all MGH employees in 2004 and 2005 (with ergonomic injuries among nurses representing 30% of all ergonomic injuries).

The US Department of Labor’s Bureau of Labor Statistics has benchmarked the national injury and illness rate for hospitals at 8.3 injuries and illnesses per 100 full-time employees. At MGH, eight inpatient units exceeded that rate in 2005; seven inpatient units exceeded the rate in 2004.

Research supports eliminating the manual

handling of patients by nurses and using mechanical assistive devices instead. In an effort to eliminate or minimize the risk of injury to nurses, MGH is currently trialing a number of assistive devices with great success.

A subgroup of the MGH Safety Committee, the Worker Health and Safety Advisory Task Force, has been meeting over the past year, investigating the use of a variety of lifts on inpatient units. On January 31, 2006, a ceiling lift pilot program began on White 12 and Blake 7

with lifts installed in two rooms on each unit. Response from staff, patients, and families has been resoundingly positive. Nurses on both units gave the lifts a 9.7 (out of 10) rating on issues such as quality, safety, efficiency, effectiveness in reducing injury, and comfort in use. Some of their comments were:

“Lifts enable us to turn larger patients more frequently, improving their outcomes.”

“I’ve gotten patients out of bed whom, in the past, I wouldn’t have attempted to move, even with help.”

“We no longer have to call Security to help us move a patient.”

“I don’t know where nurses would be without these. Every unit should have one. My back thanks you!”

Feedback from patients and families has focused on how safe transfers feel with the use of the lifts. One clinician in the Medical Intensive Care Unit (MICU) notes that ceiling lifts have had a positive impact on patients in the MICU in terms of improved skin integrity and pulmonary function.

The pilot program has been beneficial in raising awareness around the need for this kind of technology at MGH. Funding is being requested to

install ceiling lifts in other high-risk units over the next year. Portable lifts are being piloted on Ellison 12 with an eye toward having portable lifts stored centrally. Quick and easy access to lifts is important, so housing them centrally may present a challenge. We’re currently looking at how other hospitals address this issue and whether it would be feasible to store portable lifts ‘regionally’ or on inpatient units for quick accessibility.

We invite all staff to visit White 12 and/or Blake 7 to see the lifts and talk with staff about their experience using them.

For more information, call 4-3085.



Kerls is returned to his chair by patient care associates, Erica Sanchez (left); Souad Mamdouh (center); and Bardha Plaku

How we're meeting JCAHO's National Patient Safety Goals

—by Katie Farraher, senior project specialist, Office of Quality & Safety

The JCAHO's National Patient Safety Goals highlight ways in which hospitals can promote patient safety, and MGH is working hard to ensure we meet those goals.

Goal: "Improve the accuracy of patient identification, using at least two patient identifiers when providing care, treatment or services." The purpose of this goal is to ensure that clinicians take the time to match the name and medical record number on a patient's wristband with the name and medical record number on the medication administration record or requisition. Patient Care Services will be launching a new campaign this month with posters and flyers emphasizing the importance of matching the patient with

the treatment despite how well you may know the patient.

Goal: "For verbal and telephone orders or telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and *read back* the complete order or test result." At MGH, all policies regarding this standard have been implemented and can be found in the *Clinical Policy and Procedure Manual* under, "Patient Order Policy."

Goal: "Standardize a list of abbreviations, acronyms, symbols, and dose designations *not to be used* throughout the organization." A list of unapproved abbreviations was distributed

throughout the organization in 2003. Since then, the list of unapproved abbreviations has been added to the bottom of progress notes and templates in Provider Order Entry so clinicians are unable to use unapproved abbreviations when writing orders.

Goal: "Measure, assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver, all critical test results and values." The turn-around time for critical test results at MGH is within the standard.

Goal: "Implement a standardized approach to hand-off communication, including the opportunity to ask and respond to

questions." This was a new safety goal in 2006. Several committees at MGH are working to develop procedures for hand-off communication. One element developed to meet this standard involves verbal reporting. When verbal reporting is not possible, the sending clinician will print his/her name and telephone (or pager) number so if questions arise, communication can occur in a timely manner. More to come.

Goal: "Improve the safety of using medications." MGH, specifically the Medication Education Safety and Approval Committee, has made significant changes to improve medication safety. Patient controlled analgesia (PCAs) and epidural drug concentrations have been narrowed so only certain concentrations can be used, and a drug library has been developed. A new policy has been developed for sound-alike/look-alike drugs. The policy can be found in the *Clinical Policy and Procedure Manual*. Laminated cards with the list of sound-alike/look-alike drugs have been distributed throughout the organization, and special lettering is being used in Omnicell. New labeling of all medications and medication containers has been implemented in perioperative areas and will soon be rolled out in procedural areas.

Goal: "Reduce the risk of healthcare associated

infections." Monitoring by infection control practitioners continues in patient care areas.

Goal: "Accurately and completely reconcile all medications across the continuum of care." MGH has developed a new policy that all patients admitted to MGH will have their medications reconciled at admission and discharge from the hospital. Clinicians responsible for patients who experience a change in the level of service shall review the pre-admission medication list when writing transfer medication orders. This new medication reconciliation procedure has been implemented on almost all inpatient units.

Goal: "Reduce the risk of patient harm resulting from falls." On November 1, 2005, MGH implemented the MORSE scale. It is a standardized assessment tool used to identify patients at high risk for falls. New online problem lists are available for staff, and MGH has introduced new beds with alarms to help reduce the risk of falls.

Patient safety is the highest priority at MGH. National Patient Safety Goals are guidelines to help ensure our systems are meeting and exceeding safety expectations set by the JCAHO and our own high standards.

For more information about JCAHO's National Patient Safety Goals, contact Katie Farraher at 6-4709.

August Vacation Club

August 21–September 2, 2005
MGH Backup Childcare Center
Camp Hours: 7:30am–5:45pm

Cost: \$275 for five-day week. Individual days: \$60 per child

Activities (subject to change)

August 21–25	August 28–September 2
USS Constitution/Navy Yard tour	Bowling
Paul Revere House	Fenway Park Tour
Day sail on the "Roseway"	Plaster Fun Time
Franklin Park Zoo	George's island
Movie at Boston Common Cinema	Cook-out

The program is for 6–12 year old children. The Backup Childcare Center will provide appropriate activities for younger children (15 months–5 years old). All programs must be pre-paid and are non-refundable.

Call 617-724-7100 or stop by to reserve space

MGH Heart Center celebrates nursing

—by Diane Carroll, RN, clinical nurse specialist

In recognition of the unique contributions of cardiac nurses, the MGH Heart Center celebrated nursing on June 22, 2006, with a full day of activities.

A poster display was held in the Main Corridor during the week of June 19th with posters from all cardiac units describing current initiatives and highlighting new therapies and unit-based activities. Posters were developed by staff in the Electrophysiology Laboratory, The Knight Center for Interventional Cardiovascular Therapy, the Cardiac Operating Room, cardiac units on Ellison 8, 9, 10, 11, and

Blake 8. One poster highlighted the Cardiovascular Certification Program and the review course offered for staff nurses; another, from the Cardiac Practice Committee, demonstrated the unique contributions to the care of cardiac patients resulting from the work of this committee.

On June 22nd, cardiac nurses presented a



(Photo by Abram Bekker)

moderated poster session in the Main Corridor with poster displays, information on risk factor, equipment used in the care of cardiac patients, and informative discussions about these specialized practice environments.

The first visiting cardiac nurse scholar, Jean McSweeney, RN, from the University of Arkansas, attended sessions throughout the day, one of which focused on Mc-

Sweeney's area of research: the prodromal and acute symptoms of myocardial infarction. McSweeney, who has published her research in nursing and medical journals, presented, "How Nurses can Identify Symptoms of Myocardial Infarction in Female Patients, Family Members, Friends, and Colleagues." Her research has identified unusual fatigue, sleep disturbances, and shortness of breath as early warning signs. Shortness of breath, weakness, and unusual fatigue are acute symptoms of women having a myocardial infarction.



Above: visiting cardiac nurse scholar, Jean McSweeney, RN, **Center:** Julie Norian, RN, fields questions during poster display session **At left (l-r):** From the Ellison 9 Cardiac Care Unit, Michael Fifer, MD, medical director; Erica Edwards, RN; Vivian Donahue, RN, clinical nurse specialist; Evangeline Jimenez, RN; Colleen Snyderman, RN, nurse manager; Danielle Holland, RN; and Norine O'Malley-Simmler, RN

Cardiac patients and their nutritional needs

—by Emily George, RD, and Laurie Danca, RD

According to the American Heart Association, more than 71 million Americans have some form of cardiovascular disease (CVD). It takes a team of highly trained individuals to prevent and treat CVD. Registered dietitians and nurses are key members of that team.

Dietitians assist the medical team in treating and reinforcing prevention for CVD patients. Dietitians evaluate cardiac risk factors and determine whether patients have other nutrition-related health issues (e.g., renal disease, cardiac cachexia, diabetes, etc.) Once this evaluation is complete, dietitians recommend an appropriate diet and educate patients and their families on why a proper diet is important.

Dietitians begin by looking at the whole patient—previous eating habits, economic limitations, life-style, and level of independence and functioning. The patient's educational level and preferred method of learning are important and taken into consideration. Patients learn how food choices relate to cardiac disease and how they can benefit from modifying their diet. Diet restrictions may include low-cholesterol foods,

low saturated fat, no added salt, and/or foods appropriate for diabetic patients. Dietitians help patients identify changes they can make and set goals for the future. Focusing on small, manageable, life-style changes helps patients comply with new diet restrictions once they leave the hospital.

Nurses play an important role in successfully treating nutritional problems and educating cardiac patients. The first step is screening. Nurses screen each patient upon admission to the unit. Responses on the nutrition section of the Nursing Assessment Form alert dietitians to those patients who need a clinical nutrition assessment. Dietitians assess these patients within 24 hours. Nurses provide valuable input enabling dietitians to develop a nutritional care plan that best meets the patient's needs. This collaboration results in the best possible outcome for patients.

Once patients have been educated, it's important to reinforce the newly learned information to ensure retention. Nurses' continual reinforcement of dietary guidelines with patients, families, and friends makes for an easier transition to a healthier life-style. It's important to

remind patients that education doesn't end at discharge. Following up with Outpatient Nutrition Services can increase patients' knowledge of, and commitment to, a heart-healthy diet and life-style.

For more information on the dietary considerations of cardiac patients, call 6-2579.



Registered dietitians, Laurie Danca, RD (left), and Emily George, RD

MGH is committed to improving hand hygiene

A note about C. diff

Alcohol-based hand-rubs are more effective than soap and water for routine hand hygiene, but hand *washing* (followed by Cal Stat use) is recommended if you're dealing with a pathogen called *Clostridium difficile*, more commonly known as, C. diff.

Like other pathogens, C. diff can cause infection and illness, but it can also form spores that can contaminate the patient's environment. Spores can survive for long periods of time on environmental surfaces; they can be spread to other people or places by contaminated hands or gloves; and they are resistant to many things, including alcohol, the disinfecting agent in Cal Stat.

As a result, hand-washing with soap and water is recommended after contact with a patient (or the patient's environment) who has a known C. diff infection, even after gloves are removed. Soap and the scrubbing action help physically remove any spores that may be present. After washing, dry hands thoroughly and apply Cal Stat to destroy any remaining germs.

Note: Careful daily cleaning of environmental surfaces will help reduce spore-forming opportunities of these organisms and physically remove spores that do develop.

Special cleaning, as described on the back of the Contact Precautions Plus sign, is recommended when a patient's C. diff infection resolves or when the patient is transferred or discharged.

Contact your nurse manager or call the Infection Control Unit (726-2036) for more information about C. diff.



Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131
726-2036

Anticoagulation management: a dedicated nurse clinic

—by Lynn B. Oertel, RN, clinical nurse specialist

My name is Lynn Oertel, and I have worked at MGH for more than 28 years. More than half that time has been devoted to anticoagulation management; primarily with patients in clinical research trials, but currently I'm the clinical nurse specialist for Anticoagulation Management Services (AMS).

Coumadin (warfarin) has been used for more than 50 years, and yet we continue to refine our base of clinical evidence to improve strategies for its use. Over the past ten years, we've observed a great deal of interest in establishing disease-management clinics dedicated to treatment with warfarin. MGH is home to one of the nation's largest and oldest specialty clinics dedicated to monitoring, managing, and educating patients who require anticoagulation therapy. When it was first established in 1969, the clinic specialized in Coumadin treatment and used paper documentation as was the practice at the time. A few years later, a computer-based system was developed to assist with the complicated monitoring and follow-up this patient population required. A computer-assisted dosing program was introduced to provide decision support for dosing in a uniform and consistent manner. This was an innovative approach at that time

as the hospital had yet to enter the world of computerized record-keeping.

The result has been exemplary care for MGH patients receiving warfarin therapy. Over time, the number of patients managed by the AMS has grown as has the number of staff. In response to research conducted at MGH and elsewhere, enhancements were made to the computer program. The greatest change experienced by AMS began about three years ago when we became part of Patient Care Services.

Today, we have a staff of nine nurses (four part time), two full-time patient service coordinators, a nursing co-director, and part-time clinical nurse specialist. Medical oversight is provided by a physician co-director. We manage more than 3,600 patients and that number is growing all the time. We recently implemented a primary nursing model of care whereby every patient has a primary nurse who assesses, plans, and executes the plan of care for his/her patients.

Our relatively new transitional discharge pathway provides consistent care across the continuum between inpatient and outpatient settings. These pathways incorporate other agents, which can be administered at home thereby minimizing patients' length of stay. AMS nurses are in frequent contact with pa-

tients, sometimes daily, to monitor and manage their anticoagulant drug therapies. These pathways facilitate optimal discharge planning and prevent gaps in follow-up care from the time of discharge to the patient's first outpatient appointment. AMS nurses work collaboratively with the medical team, case managers, home care providers, pharmacies, and inpatient staff nurses.

There are many challenges associated with anticoagulant therapy. Warfarin frequently appears on the top-ten list of drugs likely to cause harm. It is frequently involved in drug errors. As a relatively narrow therapeutic agent, there is little room for miscalculating dosages, and if this should happen, the potential is high for bleeding or thromboembolic complications. Therefore, frequent monitoring via blood tests is required to evaluate a patient's response to warfarin. AMS staff use a variety of tools to follow the progress of patients and can easily tell who is overdue for a blood test and institute an appropriate plan of action. Patient education is key to achieving successful outcomes and ensuring patient safety. AMS works closely with patients and their families to promote safety and compliance with this challenging therapy.



Lynn Oertel, RN
clinical nurse specialist

JCAHO's National Patient Safety Goals identify several areas relevant to patients receiving anticoagulants. One goal is to improve the effectiveness of communication among caregivers. AMS staff place progress notes in patients' records whenever one of our patients is admitted. In so doing, key information is shared with other members of the team. An AMS icon in CAS and LMR alerts caregivers that the patient is on warfarin and managed by AMS. These are just a few of the ways in which we help enhance communication between the inpatient and outpatient settings.

It's an exciting time in AMS. As the clinical nurse specialist, I'm not only involved with staff orientation and development, I'm instrumental in implementing changes in our model of care and discharge pathways. We are about to implement a new software program to replace the antiquated, 35-year-old system we've been using. These changes would not be possible if not for a

dedicated staff and collaboration with other disciplines throughout the hospital. Improving patient care is our number one goal, and I'm pleased to be part of that effort.

The clinic is open from 8:00am-4:30pm, seven days a week; off hours are covered by physician page. If you have a question or want to share information about an AMS patient, send e-mail to: mghams@partners.org. Page the transition pager at 3-0103 or the maintenance pager at 3-0104 to contact a patient's primary or associate nurse. To augment patient discharge teaching, several patient- and family-teaching tools are available online at: <http://ccmu.mass-general.org/pathways/> under the heading, "Patient Education." The MGH television channel offers videos on Fragmin and Arixtra. The MGH Clinical Guidelines and Pathways website has links to detailed information about anticoagulation and AMS under the headings, "Guidelines" and "Pathways."

For more information, call 6-2768.

Excellence in Action on Phillips House 20

On April 3, 2006, Phillips House 20 staff nurse, Stephanie Mahoney, RN, sent an e-mail to nurse manager, Keith Perleberg, RN. She wanted to commend senior resident, Rory Weiner, MD, for his presence and compassion during a recent patient-care situation. And Perleberg had heard similar reports from others.

Mahoney recounted the story of Mr. C, an older patient who'd been admitted from a local nursing home because of changes in his mental status. Just as Mr. C was returning to his baseline health status, he learned that his wife of many years who shared a room with him at the nursing home, had died. Mr. C

responded to the news of his wife's death with a rapid and dramatic physical decline. In the days that followed, Weiner spent a lot of time with Mr. C and his family. He thoughtfully, skillfully, and effectively guided them and staff (including a new graduate nurse still in orienta-



tion) to a place where Mr. C could die in comfort and with dignity.

Mahoney observed that Weiner's presence to Mr. C, his family, and staff wasn't unique to this case; it characterizes his entire practice. Said Mahoney, "The nursing staff on Phillips 20 has greatly admired Dr. Weiner during the few weeks he's spent with us. He's all about patient-centered care. His intellect, compassion, and appreciation for the unique contributions of nurses made the complexity of this patient situation far less stressful."

At the suggestion of associate chief nurse, Theresa Gallivan, RN, Perleberg forwarded Mahoney's e-mail to the Service Improvement Department for consideration of an Excellence in Action Award. On May 30, 2006, MGH president, Peter Slavin, MD, presented Weiner with the award during medical rounds.



(Photos by Paul Batista)

Above: Staff nurse, Stephanie Mahoney, RN

At left: MGH president, Peter Slavin, MD (left), presents senior resident, Rory Weiner, MD, with Excellence in Action Award during medical rounds. For more information about the Excellence in Action Program, contact project manager, Melanie Cassamas at 6-1816.

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Written contributions should be submitted directly to Susan Sabia as far in advance as possible. *Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas should be submitted by e-mail: ssabia@partners.org
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Educational Offerings

July 20, 2006

When/Where	Description	Contact Hours
August 3 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
August 7 and 14 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	16.8 for completing both days
August 9 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
August 9 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
August 9 12:15–4:30pm	Pacing Concepts Haber Conference Room	4.5
August 9 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
August 16 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
August 16 11:00am–12:00pm	Nursing Grand Rounds “Caring for Patients with Multiple Complex Needs,” Haber Conference Room	1.2
August 22 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
August 23 8:00am–2:00pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
August 24 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK401 (No BLS card given)	---
August 24 1:30–2:30pm	Nursing Grand Rounds “Provoking Ischemia; Risking Infarction,” O’Keeffe Auditorium	1.2
August 29 and 30 8:00am–4:30pm	BLS Instructor Program VBK601	---
September 7 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
September 7 8:00–4:00pm	Oncology Nursing Concepts: Advancing Clinical Practice Yawkey 2210	TBA
September 7 8:00am–12:00pm	CVVH Core Program Training Department, Charles River Plaza	TBA
September 8 and 13 8:00am–4:00pm	Phase II: Wound Care Education Training Department, Charles River Plaza	TBA
September 8 8:00–10:00am	On-Line Patient-Education Resources FND626	2.4
September 8 and 25 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	---
September 11, 13, 20, 22, 28, 29 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program (check for locations)	44.8 for completing all six days
September 13 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)

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>.

Levine appointed

Operating room nurse, Amy Levine, RN, was appointed nurse leader of Sigma Theta Tau's Gamma Epsilon Chapter in April, 2006.

Pardasaney publishes

Poonam Pardasaney, PT, physical therapist, authored the article, "Advantage of Limb Salvage Over Amputation for Proximal Lower Extremity Tumors," in *Clinical Orthopaedics and Related Research*, spring issue, 2006.

Kacmarek featured

Robert Kacmarek, RRT, director of Respiratory Care Services, was featured in the article, "Respiratory Care Researcher Robert Kacmarek Knows the Thrill of Scientific Discovery," in *AARC Times* in April, 2006.

Kilroy and Repper-DeLisi publish

Clinical nurse specialists, Susan Kilroy, RN, and Jennifer Repper-DeLisi, RN, co-authored the article, "We Need to Meet," in the *Journal of Clinical Ethics*, spring issue, 2006.

Burke and Robinson publish

Suzanne Burke, RN, and Ellen Robinson, RN, co-authored the article, "Talking with Lorraine's Mother and Sister, Five Months After her Death," in the *Journal of Clinical Ethics*, spring issue, 2006.

Lucas presents

Neurology nurse, Lori Lucas, RN, presented her poster, "Withdrawal of Care in a Neuroscience Setting: a Practice Guide for Nurses," at the American Association of Neuroscience Nurses' annual conference in San Diego April 23-26, 2006.

Levin-Russman presents

Elyse Levin-Russman, LICSW, clinical social worker, presented her poster, "Partnering with Families to Enhance Clinical Services: the Development of a Family Advisory Committee," at the Association of Pediatric Oncology Social Workers' annual conference in Toronto on May 5, 2006.

Social workers present

Social workers, Eileen Joyce, LICSW; Michelle Hazelwood, LICSW; and Stacy Chandle, LICSW, presented their poster, "It Takes a Village: a Group Approach to Individual Social Work Advancement," at the 22nd Annual AOSW conference in Minneapolis, May 3-6, 2006.

Physical therapists certified

Physical therapists, Morgan Cole, PT; Mary Del Olmo, PT; Lisa Duncombe, PT; Badia Eskandar, PT; Regina Flynn, PT; Abby Folger, PT; Amy Hanson, PT; Angela Hauber, PT; Suy-Sinh Law, PT; Matthew Nippins, PT; Matthew Travers, PT; and Anne Viser, PT, were certified as clinical instructors by the American Physical Therapy Services' Education and Credentialing Program.

Birkemose certified

Patrick Birkemose RN, passed the Cardiac Medical Certification Exam given by the American Association of Critical Care Nurses in May, 2006.

McKenna receives transitional doctorate

Physical therapist, Karen McKenna, PT, received the title, transitional doctor of Physical Therapy, from Sage Graduate School, in May, 2006.

Physical therapists certified

Physical therapists, Lilian Dayan-Cimadoro, PT; Kristin Parlman, PT; and Alison Squadrito, PT, received the Vestibular Rehabilitation Certification from Emory University in Atlanta in April, 2006.

Bryan and Empoliti present

Clinical nurse specialists, Ruth Bryan, RN, and Joanne Empoliti, RN, presented, "Make No Bones About it, Patient Safety is Important," at the National Association of Orthopedic Nurses Annual Congress, May 20-24, 2006.

Nurse researchers present

Kathleen Grinke, RN; Catherine Griffith, RN; Kathleen Walsh, RN; Mary Larkin, RN; and Virginia Capasso, RN, presented their poster, "Promoting Research Utilization: the Nursing Research Committee," at the 18th Annual Eastern Nursing Research Society meeting in Cherry Hill, New Jersey, April 20, 2006.

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