Caring Headlines
July 5, 2007

New Norman Knight Nursing Center unveiled

It's official! The long-time vision of senior vice president for Patient Care, Jeanette Ives Erickson, RN, was formally realized Tuesday, June 5, 2007, with the dedication of new space for The Norman Knight Nursing Center for Clinical & Professional Development. Attending an intimate ribbon-cutting ceremony on Founders 3 were special guest and benefactor, Mr. Norman Knight; Ives Erickson; MGH president, Peter Slavin, MD; and a small group of staff and dignitaries. The formal dedication, held on the Bulfinch terrace, brought scores of well-wishers and celebrants including local politicians, MGH trustees, college deans, MGH Nursing School alumnae, and many others.

In his comments, Jack Connors, Jr., chairman of the Partners Board of Trustees, spoke about his long-time friendship with Mr. Knight and his respect for Mr. Knight's business acumen and philanthropic endeavors.

Dr. Slavin shared some personal observations about nurses, and MGH nurses in particular, saying, "I did my medical residency at MGH. I was a practicing physician here. Many of my family members have received care here. So I've had ample opportunity to see MGH nurses in action.

"Nurses play an incredibly important role in both inpatient and outpatient care. Physicians rely heavily on nurses to monitor patients' conditions, alert them to changes, alleviate pain, and support and educate patients and families.

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(L-r): Senior vice president for Patient Care, Jeanette Ives Erickson, RN; Mr. Norman Knight; and MGH president, Peter Slavin, MD, cut ribbon at dedication ceremony for The Norman Knight Nursing Center for Clinical & Professional Development.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Honoring a special man for a special deed on a special day

Senior vice president for Patient Care, Jeanette Ives Erickson, RN with Mr. Knight in one of the simulation labs in The Norman Knight Nursing Center for Clinical & Professional Development. A state-of-the-art simulation center gives staff an opportunity to train on life-like, computer-operated mannequins, simulating actual medical events and crisis situations.

If you were unable to attend the dedication ceremony for The Norman Knight Nursing Center for Clinical & Professional Development, June 5, 2007, you missed a landmark day in the history of MGH Nursing. The occasion was made possible by the foresight, commitment, and generosity of benefactor, Mr. Norman Knight, whose vision and values echo those of Florence Nightingale. I like to think of Mr. Knight as walking in Florence Nightingale's footsteps; he is this century's visionary, a man of great wisdom and generosity.

Florence Nightingale once said, "On the surface, things were unaltered; but across the apparently immutable state of society, there flowed the searchlight of the philanthropic movement, and this illumination left behind it not only a movement to improve the social and material condition of people, but also a great awakening of conscience."

(Photo by Paul Batista)

Like Nightingale, Mr. Knight wants to improve the social and material condition of people.

During my initial meetings with Mr. Knight, we talked about the challenges facing the nursing profession — the aging population, the nursing shortage, new technology, the accelerating pace of the healthcare environment, issues around access to care, and the importance of addressing healthcare disparities.

We talked about what a wonderful and rewarding profession nursing is. Nightingale once said "Wherever there are people, nursing has the opportunity to support health and well-being in partnership with others... Alone, nursing cannot do it, without nursing, it cannot be done." Mr. Knight believes these words, which is why he understands the need to support the young of our profession who, fortunately, are entering the workforce in growing numbers. But we face significant challenges in facilitating their transition from academia to the practice setting.

Mr. Knight and I talked about the need for creating a culture of life-long learning.

We talked about the importance of sharing our clinical expertise, not only within the walls of MGH but around the world.

We talked about how nurses touch the lives of patients, families, and the community in a unique and significant way.

We talked about the importance of inspiring those considering nursing as a career and sharing with them opportunities to make a difference in people's lives.

Together, Mr. Knight and I realized that we could create something very special. With the hard work of past and present leaders of the center, we could give nurses and support staff the resources they need to provide the best possible care to our patients and families.

Exquisite design and planning resulted in a state-of-the-art learning center that houses not one, but two,

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We are embarking on an exciting new journey of discovery. The Norman Knight Nursing Center on Founders 3 gives us the space, the technology, the talent, and the resources we need to give new meaning to nursing education.

simulation labs where nurses and other members of the healthcare team can learn. It houses fully-equipped classrooms and conference rooms where a growing number of orientation, training, and continuing-education programs are offered to promote the continuum of care and support professional development.

We are embarking on an exciting new journey of discovery. The Norman Knight Nursing Center on Founders 3 gives us the space, the technology, the talent, and the resources we need to give new meaning to nursing education.

As we move forward, we hope that new partnerships with colleges and universities will help us advance the goals of The Norman Knight Nursing Center for Clinical & Professional Development. Through carefully chosen partnerships, we'll set new standards for nursing education and professional development.

Irish writer, Frank O'Connor, in one of his books, tells of a boy and his friends making their way across the countryside. When they come to a wall that seems too high to climb, they take off their hats and toss them over the wall. Then, they have no choice but to go after them. With the creation of this state-of-the-art education center, Mr. Knight has tossed his infamous cap over the wall, and we have no choice but to follow. Thank-you, Mr. Knight, for your generosity and support. We will climb that wall and look forward to exploring the wonders and opportunities that lie ahead.

For more information about The Norman Knight Nursing Center for Clinical & Professional Development, call 6-3111.

Mr. Knight celebrates with local businessman and radio personality, Peter Smyth, (center) and popular entertainer, Livingston Taylor

In this Issue

(Cover photo by Paul Batista)

Adjan-Vallen receives 3rd annual Jean M. Nardini, RN, Nurse of Distinction Award

— by Julie Goldman, RN, professional development coordinator

On June 13, 2007, in a packed Haber Conference Room, this year's Jean M. Nardini, RN, Nurse of Distinction Award was presented to Emergency Department staff nurse, Theresa Adjan-Vallen, RN. The Nardini award recognizes excellence in clinical practice, leadership, and a strong dedication to the nursing profession. Named in honor of former nursing director and nationally recognized dialysis nursing expert, Jean Nardini, RN, the award is a lasting tribute to her caring leadership, patient advocacy, compassion, and mentorship. Nardini was the first recipient of the award in 2005.

Adjan-Vallen has practiced at MGH for more than 30 years. Said ED nursing director, Maryfran Hughes, RN, who nominated Adjan-Vallen for this award, "I feel privileged to celebrate two outstanding nurses whom I've had the honor of working with.

"Jean was a colleague, a mentor, and a friend who was always ready to advocate for her patients and staff no matter how daunting the challenge. She was a source of support and encouragement to many, and when all else failed, she would cheer us up with one of her famous 'Alfred stories.'

"Terry is also a colleague and friend, who has been a role model to hundreds of nurses over the years. When I first came to the ED, Terry shared her knowledge and wisdom in emergency nursing and helped me become an ED nurse. She continues to share her expertise with new nurses today. Her patients and families are the focus of her practice no matter how chaotic the unit may be. She goes the extra mile for each and every one.

"Terry values collaboration and works with colleagues to promote a positive work environment. She shares her knowledge and skill calmly and confidently with staff of all disciplines."

Hughes shared a poem Adjan-Vallen had written many years ago, set to the rhythm of, *'Twas*

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Nardini award recipient, Theresa Adjan-Vallen, RN (center), with associate chief nurse, Theresa Gallivan, RN (front left); Emergency Department nursing director, Maryfran Hughes, RN (right); senior vice president for Patient Care, Jeanette Ives Erickson, RN (second from right); and members of the Nardini family (l-r): husband, Al, and sons, Trevor and Bret

Summer construction:
how will it affect you?

To ensure safety, foot traffic will be diverted away from the ED and main-entrance ramp with a series of new sidewalks and walkways.

Employees can expect to see a number of changes in the months leading up to the demolition of the Clinics, Tilton, and Vincent Burnham Kennedy (VBK) buildings in preparation for construction of the Building for the Third Century (B3C).

Throughout July, the Clinics, Tilton and VBK buildings will be vacated. Interior corridors between the three buildings, the White and Ellison buildings, and the corridor connecting the Clinics building to the Massachusetts Eye and Ear Infirmary (MEEI) will be closed. Prior to this closing, the MGH-MEEI bridge connecting the Founders Building to MEEI will be opened for clinical transportation only.

The Emergency Department (ED) entrance and a portion of the adjacent ambulance drop-off area will become part of the B3C construction site. Creation of a temporary entrance in the Main Lobby has already begun. In late September, a fence will be installed around the entire construction site.

To ensure safety, foot traffic will be diverted away from the ED and main-entrance ramp with a series of new sidewalks and walkways. Employees should be aware of the following changes:

- In July, the Partners shuttle bus stop will relocate from the WACC to the Jackson building entrance
- In August, the taxi stand will move to North Grove Street adjacent to the Parkman Street Garage
  - Inpatient discharges will move from the main entrance to the WACC lobby
- In September, non-emergent ambulance pick-ups and drop-offs will move from the main entrance to the Cox building entrance
  - The main-entrance driveway will be restricted to urgent ambulance use only
  - The main entrance patient drop-off area will move to the area where the current taxi stand is located
  - Safer crossings and covered routes will be available from the main campus to the Yawkey Building, the Proton Therapy Center, and the MEEI

For more information about upcoming changes related to construction of B3C, contact Brad Seamans at 6-2442.

Terry values collaboration and works with colleagues to promote a positive work environment.

the Night Before Christmas. The last few stanzas of the poem, *Reflections on a Clinical Narrative* are included below:

So as I lay nestled, all snug in my bed,
I labor to tell what I think should be said.

Of the sorrows I've seen, what story be told?
How to show you the courage I daily behold.

We care for so many, we take it in stride.
Did we make a difference, while at the bedside?

No matter how expert, our technical skills,
IVs, assessments, and dosing of pills.

That's all well and good, and gives us great pride.
But always remember, the person inside.

So deep in my heart, what matters to me,
Are the patients and nurses, and all that they see.

That each day in my care, I hope they would tell,
By my words and my actions, I served them all well.

In his heartfelt comments, Nardini's husband, Alfred, thanked friends and colleagues for their continued support and recognition of Nardini's accomplishments. He congratulated Adjan-Vallen on receiving the award this year.

For more information about the Jean M. Nardini, RN, Nurse of Distinction Award, contact Julie Goldman, RN, professional development coordinator at 4-2295.

Effective pain-management: a long-standing MGH tradition

Re-assessment by nurses after administering analgesics and routinely monitoring patients with patient-controlled analgesia (PCA) are key steps in preventing undesired outcomes.

Question: Why is pain-assessment and re-assessment important?

Jeanette: Pain is an important quality and safety issue; and pain-management requires timely, on-going attention. Untreated, pain can cause physical and mental harm and intensify, making it more difficult to treat. Pain interferes with a patient's ability to participate in activities necessary for recovery and disrupts relationships and quality of life.

Question: What do regulatory organizations say about pain-assessment and management?

Jeanette: The Food and Drug Administration requests that all prescription pain medication carry a black-box warning. Opioid analgesics are listed (by the Institute for Safe Medical Practices) as 'high-alert' medications. Patients treated with medications for pain need vigilant assessment and documentation. Re-assessment by nurses after administering analgesics and routinely monitoring patients with patient-controlled analgesia (PCA) are key steps in preventing undesired outcomes. The Joint Commission echoes the importance of documenting pain-assessment and evaluating response to treatment as essential quality and safety standards.

Question: What are the expectations for pain-assessment and management?

Jeanette: In a complex practice environment, it's important to document the assessment and evaluation of pain-management even as busy clinicians struggle to prioritize competing demands. To ensure safe, effective care, pain must be assessed and documented accurately and consistently for every patient upon admission, when transferred to a different unit, and following procedures requiring heavy sedation or anesthesia. When patients receive interventions to alleviate pain, they must be re-assessed in a timely fashion to determine the safety and efficacy of treatment.

Question: What are the documentation requirements for pain-assessment and management?

Jeanette: When a patient is admitted, the presence and intensity of pain is noted on the admission sheet with additional details included in the narrative note. All other assessments of pain are indicated on the patient care flowsheet with a number indicating the intensity of pain or a letter indicating that pain was assessed but a number could not be assigned (U=unable to quantify; APP=assume pain is present). Other details about the assessment (pain character, location, adverse drug effects, improvement in functioning) are noted in the progress notes. Re-assessment after a pain-relieving intervention is documented in a timely manner with a number or letter on the flowsheet and other details as indicated in the progress note. Re-assessments are needed every four hours for patients on continuous infusions, using sustained-release analgesics (such as a fentanyl patch) and those using PCAs. Re-assessments are done every two hours for patients receiving epidural analgesia and within an hour after other analgesics (oral or IV) are administered. These re-assessments are documented on the patient care flowsheet.

Question: What resources are available at MGH in the area of pain-management?

Jeanette: We are very proud of our accomplishments in the area of pain-management. MGH has a long history of understanding and alleviating pain, dating back to the first use of ether within our walls. Through cutting-edge research, we continue to advance the understanding and treatment of pain. We pledge to all patients that their pain will be carefully assessed, treated, and re-assessed to ensure that treatment is working and that patients are able to rest as comfortably as possible.

For more information about pain-assessment and pain-management, call Paul Arnstein, pain clinical nurse specialist, at 4-8517.

Knight Dedication (continued from front cover)

"This is an enormous responsibility and speaks to the important and sophisticated role nurses play in today's healthcare setting. Not only do they require clinical knowledge but an understanding of the emotional needs of patients and families and the ability to respond with care and compassion.

"I would like to thank Mr. Knight for recognizing the important role nurses play and for actively supporting their education and development through his funding of The Norman Knight Nursing Center for Clinical & Professional Development and other initiatives. Norman, with your visionary leadership and philanthropy, you are facilitating the knowledgeable, compassionate care so essential for nurses. My sincerest thanks to you for your belief in, and support of, MGH nurses."

Ives Erickson added her comments of appreciation, comparing Mr. Knight to Florence Nightingale, saying he is, 'this century's visionary.' (See Jeanette Ives Erickson's column on page 2.)

A humble Mr. Knight took the podium before a standing-room-only crowd. He spoke eloquently about the importance of strong leadership and an effective infrastructure in supporting nurses. With great expectations for the center that bears his name, he said, "This is not just a center for MGH nurses, but for nurses everywhere as we advance the skill, education, and practice of nurses around the world."

In closing, Mr. Knight paraphrased renowned philanthropist, Andrew Carnegie, saying, "No man can become rich without enriching others. To amass wealth is a remarkable thing; to die wealthy is to squander a great opportunity."

If you haven't already done so, visit The Norman Knight Nursing Center for Clinical & Professional Development on Founders 3. For more information, call 6-3111.

Top: guest of honor, Mr. Knight with long-time friend, Mario DiCarlo; **At right:** Ives Erickson with MGH Nursing School alumnae, Linda Lass Orrell, RN (left), and Elva Proctor; **Far right:** Mr. Knight with (l-r) Ives Erickson, Jack Connors, Jr., chairman of the Partners Board of Trustees, and MGH president, Peter Slavin, MD; **Below left:** Brian French, RN, simulation program manager, applauds; **Below right:** Mr. Knight and Ives Erickson with Mr. Knight's sons, Scott (left) and Robert.

(Photo by Paul Batista)

What you should know about health care proxy forms

— submitted by the Advance Care Planning Task Force, a sub-group of the Ethics in Clinical Practice Committee

The MGH Advance Directives Policy provides a mechanism for asking every adult patient whether he or she has an advance directive in place. An advance directive is a statement that provides information about a person's healthcare choices and appoints a healthcare agent to make decisions about care should the patient become unable to do so due to illness or injury.

By asking about advance directives during the admission process, we provide an opportunity for patients to learn about advance care planning and complete an advance directive if they so desire. The MGH Health Care Questionnaire helps staff document these efforts. MGH uses a form recognized by the state of Massachusetts to record advance directives, a simple legal document called a health care proxy form. Patients do not need a lawyer to complete this simple form, which has instructions attached. It is important for patients to understand the process for identifying the person who will act as their healthcare agent and execute their advance directive. This can be a challenge when the patient's primary language is not English.

MGH uses a form recognized by the state of Massachusetts to record advance directives, a simple legal document called a health care proxy form.

The health care proxy form can be ordered in English or Spanish from Standard Register. The form can be printed from the Patient Care Services website in English, Spanish, large-print English, and in 11 other languages, including: Portuguese, Arabic, traditional Chinese, French, Greek, Haitian, Creole, Italian, Khmer, Russian, and Vietnamese. The website offers guidance for clinicians conversing with patients who don't speak English.

Recently, Donna Slicis, RN, of the Pre-Admission Testing Area, asked colleague, Regis MacDonald, RN, about her experience providing health care proxy forms to patients whose preferred language is something other than English.

Slicis: Regis, how does having health care proxy forms available in many languages support your clinical practice?

MacDonald: Advance-care-planning discussions aren't easy. Patients tend to worry when you talk about health care proxies before an operation. They think it might mean something bad is going to happen. A language barrier adds to the complexity of those patient-education conversations about their right to complete a health care proxy form.

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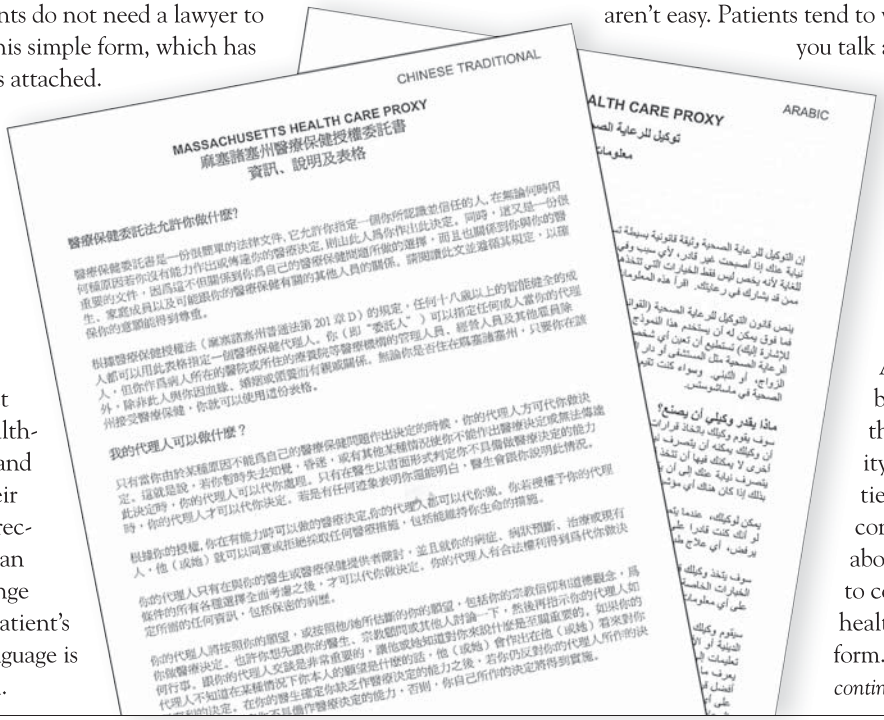

MGH to participate in AONE/ RWJF Transforming Care Project

MGH will participate in a national, two-year project called, Transforming Care at the Bedside.

MGH has been selected by the American Organization of Nurse Executives (AONE) and the Robert Wood Johnson Foundation (RWJF) to participate in a national, two-year project called, Transforming Care at the Bedside (TCAB). In January, RWJF awarded almost $1 million to AONE to work with 50 hospitals across the country to share lessons learned from TCAB, a project originally launched in 2003 by RWJF and the Institute for Healthcare Improvement. Six Massachusetts hospitals were selected to participate in this phase of the project; MGH was the only adult academic medical center in the state to be chosen.

The White 10 General Medical Unit will serve as the project site at MGH, with White 9 serving as the control unit. The TCAB leadership team will consist of:

- Barbara Blakeney, RN
- Eileen Flaherty, RN
- Theresa Gallivan, RN
- Christina Graf, RN
- Susan Kilroy, RN
- Sara Macchiano, RN
- Nancy McCarthy, RN
- Sally Millar, RN
- Amanda Stefancyk, RN

For more information about the Transforming Care at the Bedside project, call Barbara Blakeney, RN, at 4-7468.

Print health care proxy forms from the PCS or PCOI website in English, large-type English, Braille, and 11 other languages. Health care proxy forms can be ordered from Standard Register: English: (#70013) Spanish: (#84443).

Although a medical interpreter is present to interpret what I'm saying and the patient's questions, I find patients really relax when they see a document in their own language. It helps them understand this is a right afforded to *all* patients. Having the form available in many languages reinforces their comfort and willingness to listen.

Slicis: Is it easy to access and print health care proxy forms?

MacDonald: Yes. All clinicians should be familiar with the process. From the Patient Care Services website, select Clinical Resources, then select Health Care Proxy Forms and the desired language.

Slicis: Does it cost money to print Health Care Proxy forms?

MacDonald: At a certain point in the process, a pop-up window advises that MGH is charged for each form. This is only to discourage *unnecessary* printing. Individuals are not charged for Health Care Proxy forms.

Slicis: How do you assist patients who want to complete a form?

MacDonald: Medical interpreters explain my comments to patients and families and interpret their questions to me. If a patient decides to complete a Health Care Proxy form, we fill out an English form and a form in the patient's native language for inclusion in the patient's record. Either form by itself is not helpful.

I follow these steps when talking about advance directives with patients who don't speak English:

- Work with a medical interpreter to ensure patients understand what is being discussed and have an opportunity to ask questions
- Verify the patient's preferred language for reading printed materials
- Review the health care proxy form with patients using both the English *and* the preferred-language form
- Provide the preferred-language and English-language forms to patients if/when they choose to complete them
- If patients complete the forms, obtain copies of both versions for inclusion in the medical record
- Document the presence of the health care proxy in the record
- Give patients the original forms for their records so they can review them and share them with their healthcare agent, family members, and other healthcare providers

For more information about advance care planning and health care proxy forms, contact Donna Slicis, RN, at 4-1668.

Life lessons learned by entry-level physical therapist

Erin Greenler, PT, entry-level clinician
inpatient physical therapist

My name is Erin Greeler, and I am an inpatient physical therapist. When people learn I work in a hospital, they often say, "I'll bet that gives you a greater appreciation for life." But truly, what working at MGH has helped me appreciate are the values, family, and friends that make my life so full. Caring for 'John' over the course of four weeks reinforced that appreciation and taught me many valuable lessons to add to my PT practice. My experience with John also made me appreciate how much a team of dedicated professionals and a loving family can accomplish. And along the way, I learned the importance of not being afraid of the unknown, the importance of mentors, and the importance of preserving a person's dignity at every stage of care.

My experience with John made me appreciate how much a team of dedicated professionals and a loving family can accomplish.

John is a 58-year-old man who owns two successful businesses. He is part of a large and loving family. His sister describes him as extremely dedicated to his work and having a sense of humor that, "just won't quit." John did the right thing in going for a routine colonoscopy at his local hospital. Unfortunately, this simple procedure that has helped save the lives of so many people, drastically changed John's life and the lives of his family members. John unknowingly sustained a grade-three laceration to his spleen during the procedure and returned to the hospital one day later with a stomach ache. Before they had a chance to examine him further, John went into cardiac arrest, suffering a major anoxic (lack of oxygen) brain injury during the ten-minute resuscitation period. His condition was complicated by respiratory failure at which time he was transferred to MGH for further management.

I first met John when he was a patient in the Respiratory Acute Care Unit (RACU). I had been contacted to evaluate and treat him. The consult came when I was working a weekend shift and, having never treated a patient with anoxic brain injury, I was very nervous and began to feel unprepared. I worried that I had no past experience to guide me, that I wouldn't know how to correctly categorize his impairments, and I wondered what I could add to this patient's care.

During my brief time at MGH, I have learned to approach each patient armed with a screening template in my mind and the words, 'movement expert.' I reminded myself that I could initiate care based on pertinent data gathered during my screening examination and I could consult my clinical specialist as a resource to further guide my examination and treatment if necessary. Beginning each examination, no matter the patient, with the minimum data-set for a PT examination in my mind, a framework of impairments easily comes to mind. Rather than walking into John's room already 'knowing' what I was going to find, I relied on

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past experience and instead walked in thinking, 'Okay, arousal, attention, cognition… Let's see where that gets me.'

Armed with this inner reinforcement, I screened John and found other issues. Confronted with this new information, how would I use it in such a manner as to be useful and accurately prognosticate John's return to function? I began by referring to information I had gathered at a recent PT conference (another invaluable asset of the MGH experience). While the conference didn't specifically focus on anoxic brain injury (it focused on traumatic brain injury and how to successfully prognosticate), it did provide me with a starting place, familiar terminology, and some key tests commonly used in these situations.

One patient visit and many questions later, I found myself seeking out Lily, my clinical specialist (another invaluable asset). I reviewed my findings with her, and she helped me develop questions and explore tests and measures I'd never used before (such as the JFK Coma Recovery Scale), and she showed me specific interventions that could be used as sensory stimuli. Lily directed me to several landmark studies that helped me develop my plan of care and gave me a more accurate, well rounded picture of John's final outcome.

Rather than walking into John's room already 'knowing' what I was going to find, I relied on past experience and instead walked in thinking, 'Okay, arousal, attention, cognition… Let's see where that gets me.'

I learned all this and more during the month I treated John. But when I think about John, that's not what I remember.

I remember his gracious, loving family who stayed at his bedside every day. I remember their faces when they told me about the man they knew. I remember the hope they had that that man would come back to them. I remember the thankfulness they expressed to all their caregivers, and how thankful they made me feel to have my own family. They truly were a model of kindness, support, and advocacy.

Unfortunately, in addition to the devastating injury John suffered, his family had to deal with his insurance company to ensure John was given the best chance of recovery. Throughout each trial and obstacle, John's family actively advocated for him without resorting to anger or blame. They worked with MGH staff members every day to get John the coverage he deserved.

I remember the dedication of staff who worked tirelessly writing letters of appeal to his insurance company and answering John's families' many questions. The entire team — therapists, nurses, physicians, and case managers — provided coordinated care as a unified team. We advocated for acute-level rehabilitation for John and provided on-going therapy while we awaited authorization so he wouldn't lose the early-intervention gains he'd made that are so important to neurological recovery.

Slowly but surely, John did make some gains, emerging from a vegetative state into the beginnings of minimal consciousness. After several weeks of appeals, letters, and strongly written progress notes, John's insurance company agreed to pay for acute rehabilitation. John's story will likely not have a fairy-tale ending. He will probably remain severely functionally impaired, needing assistance for all mobility and activities of daily living. But he has a chance to better recognize and interact with his environment and family and enjoy a better quality of life. This is the chance John's family wanted, and because of the entire team, it's the chance he's going to get.

I learned so many lessons from John and his family. Lessons about evaluation, treatment, and prognosis. Lessons about working with colleagues and patient-advocacy, all of which I will be able to apply to other patients. But mostly, I'm thankful for having been part of John's recovery and helping him to have the best possible chance for further recovery.

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

Erin's narrative reflects the excellence found at all levels of practice, including the novice level. Erin demonstrates a strong grasp of how to approach her assessment, set goals, and seek consultation when necessary in caring for and treating John. She tapped into her past experience caring for patients with similar diagnoses and looked to the literature and established knowledge gained from attendance at a professional conference. But Erin's immersion in gaining knowledge and experience didn't blind her to what John and his family were going through. She remained sensitive, alert and responsive to all their needs throughout John's extended hospitalization.

Thank-you, Erin.

Clinical Pastoral Education for Healthcare Professionals

— by Angelika Zolllfrank, director, Clinical Pastoral Education

The MGH Chapel was the setting for a celebration when five Kenneth B. Schwartz fellows and two spiritual caregiver fellows graduated from the Clinical Pastoral Education (CPE) Program for Healthcare Professionals on Thursday, May 24, 2007. Three nurses, a nurse practitioner, a nurse anesthetist, a social worker, and a fourth-year medical student shared their experiences as participants in this unique training program.

Anne Marie Kaune, RN, nurse practitioner, recalled praying with a homeless, schizophrenic man as his foot infection was treated. Marion Parker, RN, staff nurse, Phillips House 20, remembered sharing Psalm 23 with a patient; he prayed in Hebrew, she spoke English.

The goal of the Clinical Pastoral Education Program for Healthcare Professionals is to create an educational environment that allows clinicians to integrate their and their patients' spirituality into clinical practice. Says Heather Carlson, RN, "We each came here seeking different things. None of us realized how our lives, both professionally and personally, would be changed by our involvement in this program." Reflecting on the five-month program that offers insight into the beliefs of a variety of religious communities, Carlson observed, "The care we give has become more sacred; we've been able to have deeper, more meaningful connections with our patients. And in learning how to assess our patients' spirituality, we began to explore our own, as well."

Another goal of the program is to help clinicians excel in the art of, "comforting and holding patients in deeper, more meaningful ways," said Reverend Angelika Zollfrank, director, Clinical Pastoral Education.

All graduates felt the program made a difference in the way they care for others and themselves. Says Virginia Jones, RN, "I have slowed down so I can assess all aspects of my patients' care, including their spiritual risk. I've found that by being more present, I have a greater connection to their spirits; perhaps it's because I give myself totally to my patients even if for only a brief time."

The next MGH Clinical Pastoral Education Program for Healthcare Providers is scheduled for January 7–May 22, 2008. For more information about the program, the Kenneth B. Schwartz Fellowship in Pastoral Care, or the Spiritual Caregiver Fellowship, contact Reverend Angelika Zollfrank, in the MGH Chaplaincy at 4-3227.

Applications are due by September 1, 2007.

(Back row, l-r): Lynda Gillan, RN, nurse anesthetist; Marion Parker, RN, staff nurse; Alyssa Rosen, medical student; Heather Carlson, RN, staff nurse; and Reverend Angelika Zollfrank (Front row): Nancy Strong, LICSW, social worker; Virginia Jones, RN; and Anne Marie Kaune, RN, nurse practitioner

(Photo by Paul Batista)

Oncology Nursing Career Development Award

— by Julie Goldman, RN, professional development coordinator

On May 30, 2007, the Oncology Nursing Career Development Award was presented to Jane Miller, RN, staff nurse in the Yawkey 8, Infusion Unit. The award, established in 1989, recognizes staff nurses who consistently demonstrate excellence in caring for cancer patients, serve as role models to others, and a show a genuine commitment to professional development. The $1,000 award, intended to be used to advance professional development, is funded by the Friends of the MGH Cancer Center.

Miller was nominated by Infusion Unit clinical nurse specialist, Susan Finn, RN, who said of Miller, "Jane sets an example with her clear and compassionate style of communication. She routinely invites clinicians from other disciplines into her practice to be sure all the patients' needs are being met." In letters of support, Miller was consistently described as, "passionate about her patients and her education. She is a caring, dedicated role model and friend."

Miller has held various clinical positions, starting as a nurse on a gynecological surgical unit, then in an outpatient chemotherapy unit that focused on gynecological and breast cancers.

Miller came to the Yawkey 8 Infusion Unit two years ago and says, "It's the best decision I ever made." An oncology nurse for 18 years, her passion for oncology nursing has never faded.

When asked what she likes about oncology nursing, Miller quickly replies, "The patients. It is a privilege to be allowed into the lives of patients and families who struggle each day with cancer. Being able to help them on their journey is both humbling and rewarding."

For more information about the Oncology Nursing Career Development Award, contact Julie Goldman, RN, professional development coordinator in the Knight Nursing Center, at 4-2295.

(L-r): Ginny Durfee, president, Friends of the MGH Cancer Center; award recipient, Jane Miller, RN; her husband and mother; Judy Feingold, and Joanne LaFrancesca, RN

(Photo by Abram Bekker)

The three Bs: babies, bees, and botulism

is there a connection?

— by Kathryn A. Beauchamp, RN, pediatric critical care clinical nurse specialist

Kathryn Beauchamp, RN, pediatric critical care clinical nurse specialist

Unlike adult intensive care units that separate patients according to diagnosis, the Pediatric Intensive Care Unit (PICU) admits children of all ages and all diagnoses. The PICU is like a patchwork quilt where no two fabric swatches are the same. Ask any PICU nurse what it's like to work in this type of environment and you'll probably hear, "You have to be prepared, because you never know how the next patient will present," or, "Every day is different, interesting, challenging," or, "We see some very unique patients."

One of those unique patients arrived a week before Thanksgiving in 2006, when eight-month old, 'Kevin,' was brought to the MGH Emergency Department.

Infantile botulism is caused by Clostridium botulinum spores, which are found in soil, dust, and honey (that's where bees come in)... Approximately 80–110 cases are diagnosed in the United States each year, most commonly in California, Utah, and Pennsylvania.

Kevin had become constipated ten days prior to admission, and his parents had noticed he'd experienced progressive weakness, lethargy, poor oral intake, and looked like he was losing weight. On the morning of his admission, when his mother went to get Kevin from his crib, she said he felt 'like a rag doll.' Concerned and frightened, she called 911.

In the Emergency Department, Kevin presented with hypotonia (weak muscle tone), hypoglycemia (low blood sugar), and was acidotic (had excessive acidity in his body fluids). The pediatric team began treatment with intravenous fluids, glucose, and an extensive array of tests and procedures to determine the diagnosis. With Kevin's history of constipation, loss of muscle tone and low blood sugar, the leading diagnosis was infantile botulism.

Infantile botulism is caused by Clostridium botulinum spores, which are found in soil, dust, and honey (that's where the bees come in). Spores swallowed by adults rarely cause problems, but in the immature gastrointestinal tract of an infant the spores can germinate and colonize in the large intestine. Botulinum neurotoxin, one of the most poisonous substances known, is produced and passes into the bloodstream where it binds irreversibly with muscle tissue at the neuromuscular junction. Approximately 80–110 cases are diagnosed in the United States each year, most commonly in California, Utah, and Pennsylvania.

continued on next page

Baby Kevin developed the initial symptom of infantile botulism when he became constipated, the result of his gastrointestinal-tract muscles becoming paralyzed. This usually occurs three to 30 days after ingesting the harmful spores. The next symptoms to appear were listlessness, decreased appetite, and then the classic 'rag-doll' syndrome. During the next five days in the general pediatric unit, baby Kevin's symptoms began to worsen. He developed ptosis (drooping of the upper eye lid), difficulty breast-feeding, trouble swallowing, and an inability to move his facial muscles. The decision was made to transfer baby Kevin to the PICU for closer monitoring of his respiratory status and swallowing issues. Over the next 24 hours, his symptoms continued to deteriorate, especially his breathing as the neurotoxins began to paralyze his respiratory muscles. Within 36 hours of being admitted to the PICU baby Kevin's respiratory distress worsened, he lost his gag reflex and the ability to swallow secretions. A test performed that morning was consistent with pre-synaptic neuromuscular junction disorder (infantile botulism). The medical team decided to intubate Kevin and use mechanical ventilation to protect his airway.

Twenty days after being admitted to MGH, baby Kevin was discharged home with his parents... I'm happy to report that baby Kevin made a full recovery and continues to reach his developmental milestones.

Having seen only two other cases of infantile botulism in my 26 years of pediatric critical care nursing, I knew the PICU staff and Kevin's family would need as much information as possible to care for this critically ill infant. Working with other members of the pediatric multi-disciplinary team, we obtained information about the Infant Botulism Treatment and Prevention Program from the California Department of Health Services (CDHS).

In a joint effort of the CDHS, National Botulism Surveillance and Reference Laboratory, Center of Disease Control and Prevention and the division of Biostatistics, University of California at Berkeley, an antidote for infantile botulism has been developed. After five years of clinical studies in California (1992-1997) and a six-year national study (1997-2003), Human Botulism Immune Globulin Intravenous (BabyBIG®) was approved by the Federal Drug Administration for treatment of infantile botulism in infants less than one year old. Prior to the availability of this immunoglobulin we were only able to treat the symptoms, and with the long life of botulism neurotoxins, infants were often hospitalized for weeks requiring mechanical ventilation and tube feedings.

Throughout his admission baby Kevin's mother slept at his bedside and provided as much of his care as possible. When the decision was made to place Kevin on mechanical ventilation she was devastated and found it difficult to look at him attached to all the monitoring equipment. Supporting this family through this difficult situation was a high priority. We downloaded information on infantile botulism from the CDHS website for Kevin's parents. They were included in every decision, and several family meetings were held to discuss the plan around administering immunoglobulin BabyBIG®.

The PICU medical team made arrangements to have BabyBIG® delivered to the hospital. To prepare the nursing staff to administer this unfamiliar immunoglobulin, I compiled a packet of information on prehydration, dosage, administration, monitoring parameters, adverse reactions, and emergency medications to keep at the bedside. On Thanksgiving Day, baby Kevin received a single infusion of BabyBIG® over several hours in an attempt to neutralize the botulinum toxins in his gastrointestinal tract.

Baby Kevin responded rapidly to the infusion, regaining enough control of his respiratory muscles to be extubated four days later. Over the next two weeks, baby Kevin slowly showed further improvement, first moving his head, then holding his head independently, opening his eyes, reaching for his favorite toys, and finally to the joy of his mother, resuming breast-feeding. During our last visit, I saw baby Kevin as he was before he became ill and was rewarded with the most heart-warming smile. Twenty days after being admitted to MGH, baby Kevin was discharged home with his parents. During the next month he was followed by Early Intervention and Physical Therapy. I'm happy to report that baby Kevin made a full recovery and continues to reach his developmental milestones.

For more information on infantile botulism and the immunoglobulin, BabyBIG®, visit the CDHS Infant Botulism Treatment and Prevention Program website at www.infantbotulism.org.

Professional Achievements

Blakeney presents

Barbara Blakeney, RN, innovation specialist, presented, "When the Future Gets Here, Will We be Ready?" to the MGH Alumni Association, April 20, 2007.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Management of the Burned Hand," at the National Burn Conference in San Diego, March 21, 2007.

Capasso presents

Virginia Capasso, RN, clinical nurse specialist, co-presented, "Theory Panel: a Dialogue on Creating a Community of Scholars in Relation to Health as Expanding Consciousness," at the Eastern Nursing Research Society conference in Providence, April 13, 2007.

Clair-Hayes presents

Kathy Clair-Hayes, LICSW, Social Services, presented, "The Heart of the Matter: a Child's Experience and the Developmental Impact of Cancer," at the Strengthening the School's Response When a Parent has Cancer Conference (sponsored by Hurricane Voices and the Wellness Community), in Waltham, April 9, 2007.

Corveleyn and Berrett present

Amy Corveleyn, LCSW, and Julie Berrett, LICSW, Social Services, presented, "Being on your Own with Cancer," at the Young Adults Living with Cancer, I'm Too Young for This conference, at the Massachusetts College of Art in Boston, March 31, 2007.

Whall-Strojas and Hathaway present

Denise Whall-Strojas, RN, staff nurse, and Jeanne Hathaway, MD, Social Services, presented, "Facing Cancer and Partner Abuse: Patients' Experiences and Recommendations for Healthcare Providers," at the Family Violence Prevention Fund's national conference on Health Care and Domestic Violence in San Francisco, March 15–17, 2007.

Cole and Hagan present

Elizabeth Cole, PT, and Casey Hagan, PT, physical therapists, presented, "Lymphedema Etiology: Signs, Symptoms and Treatment," at Partners Home Health Care in Waltham, April 17, 2007.

Griffith presents

Catherine Griffith, RN, Cardiac ICU, presented, "Developing a Community of Scholars and its Impact on Clinical Practice," at the Eastern Nurses Research Society, in Providence, April 13, 2007.

Johnson presents

Elizabeth Johnson, RN, clinical nurse specialist, presented, "Intraperitoneal Chemotherapy and Ovarian Cancer," at the Oncology Nursing Society's 32nd Annual Congress, in Las Vegas, April 23, 2007.

Pardasaney co-authors

Poonam Pardasaney, PT, physical therapist, co-authored the chapter, "Rehabilitation Program-Development: Clinical Decision-Making Prioritization and Program Integration," in *Scientific Foundation and Principles of Practice in Musculoskeletal Rehabilitation*, in February, 2007.

Hathaway presents

Jeanne Hathaway, MD, Social Services, presented, "Does Participation in Healthcare-Based Domestic Violence Advocacy Programs Make a Difference? Positive and Negative Perceptions of an Ethnically Diverse Sample of Clients," at the Family Violence Prevention Fund's national conference on Health Care and Domestic Violence in San Francisco, March 15 – 17, 2007.

Robinson presents

Ellen Robinson, RN, clinical nurse specialist, The Institute for Patient Care, presented, "Sustaining Care of the Patient in the Context of Moral Distress/ Futile Treatment," and, "Complexities in Decision-Making for Persons with Disabilities Nearing the End of Life," at the 14th annual Collaborative Ethics Conference at UCLA, March 23, 2007.

Keeley presents

Adele Keeley, RN, nursing director, presented, "Merging Palliative Care in the Critical Care Unit," at the Institute for Family-Centered Care Conference, in Portland, Maine, April 23 – 26, 2007.

Lee presents

Susan Lee, RN, clinical nurse specialist, presented, "Collaborative Governance Evaluation: Strategies to Improve Understanding," at the Eastern Nursing Research Society conference in Providence, April 12, 2007.

Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Sensation and Sensibility," at Tufts University in Medford, March 26, 2007.

Madigan presents

Janet Madigan, RN, presented, "Policy or Politics: Will Reason Prevail? The Massachusetts Staffing Ratio Debate," at the American Organization of Nurse Executives' 40th anniversary annual meeting in Washington, DC, April 14, 2007.

Michel presents

Theresa Michel, PT, physical therapist, presented, "Task Force for Development of Exercise and Physical Activity Guidelines Based on the Best Available Evidence for Individuals with Type II Diabetes and Pre-Diabetes," at the American Physical Therapy Association conference in Alexandria, Virginia, March, 2007.

Connors and Jeffries present

Marian Jeffries RN, clinical nurse specialist, and Patricia Connors, RN, presented, "Communicating Nursing Practice: Common Problems Identified by MGH Staff Nurses and Clinical Nurse Specialists with Comparisons to CNSs throughout the United States," at the European conference of the Association for Common European Nursing Diagnoses, Interventions and Outcomes, in Amsterdam, in April, 2007.

Russo presents

Katherine Russo, OTR/L, occupational therapist, presented, "Splint Lab," at Tufts University in Medford, April 23, 2007.

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, Neuroscience Intensive Care Unit, presented, "Hyperglycemia: Concerns for the Neuroscience Patient," at the Hershey Pennsylvania Medical Center, April 2, 2007.

Letendre and McKenna Guanci present

Mary McKenna Guanci, RN, clinical nurse specialist, and Ann Letendre, RN, staff nurse, Neuroscience Intensive Care Unit, presented, "Conversations at End of Life and Organ Donation," at the American Association of Neuroscience Nurses' Conference in Orlando, Florida, April 30, 2007.

Pardasaney teaches

Poonam Pardasaney, PT, physical therapist, co-instructed the, "Strong for Life Program for Community-Dwelling Senior Citizens," at the Roybal Center for Enhancing Late Life Function at the University of Illinois, in Decatur Illinois, March, 2007.

Roche presents

Joseph Roche, RN, staff nurse, Surgical Intensive Care Unit, was a guest speaker for the MGH International Trauma and Disaster Institute, presenting on various clinical topics for the Institute's educational program in South Dakota, April 24 – 26, 2007, and in San Antonio, Texas, April 30.

Mulgrew and Squadrito present

Jackie Mulgrew, PT, and Alison Squadrito, PT, physical therapists, presented, "Management of the Acute Care Patient," at the Englewood Hospital, in Englewood, New Jersey, April 21–22, 2007.
They also presented, "Management of the Acute Care Patient," at St. Francis Hospital in Hartford, Connecticut, March 10-11, 2007.

Continueded on next page.

Professional Achievements (continued)

Orroth and Pessina co-author

Occupational therapists, Amy Orroth, OTR/L, and Monica Pessina, OTR/L, co-authored the chapter, "Burn Injuries," in *Occupational Therapy for Physical Dysfunction*, 2007.

Rosell presents

Patricia Rosell, MSW, and Elizabeth Miller, MD, presented, "Feasibility of a Clinic-Based Adolescent-Partner Violence Intervention," at the Family Violence Prevention Fund's National Conference on Health Care and Domestic Violence, in San Francisco, March 15 – 17, 2007.

Johnson prresents

Elizabeth Johnson, RN, clinical nurse specialist, GYN Oncology, presented her poster, "Oncology Nurses' Perceptions of Patient Problems Encountered in Care," at the Oncology Nursing Society's 32nd annual congress, in Las Vegas, April 24 – 27, 2007.

Perry presents

Donna Perry, RN, professional development coordinator, The Institute for Patient Care and co-director of the Durant Fellowship Program, presented, "Transcendent Pluralism and the Transcendental Method: a Progressive Method for Nursing Research," and, "Lonergan and Human Understanding in the Socio-Political Realm," at the Eastern Nursing Research Society Scientific Sessions in Providence, April 12 – 13, 2007.

Nurses present

Catherine Griffith, RN, Cardiac Intensive Care Unit; Mary E. Larkin, RN, clinical research manager; Diabetes Center; Chelby L. Cierpial, RN, Ellison 11 Medical Unit; Victoria J. Morrison, RN; Catherine O'Malley, RN, staff nurse, Operating Room; and Virginia Capasso, RN, clinical nurse specialist, The Norman Knight Nursing Center for Clinical & Professional Development, presented their poster, "MGH Nursing Research Committee Develops Innovative Subcommittee Structure for Succession Planning," at the Eastern Nurses Research Society meeting Magnet Session in Providence, April 12, 2007.

Egan co-authors

Marie T. Egan RN, and Warren S. Sandberg, MD, co-authored the article, "Auto Identification Technology and its Impact on Patient Safety in the Operating Room of the Future," in *Surgical Innovation*, 2007.

Brown and Stamatis present

Sheila Brown, RN, and Donna Stamatis, RN, Radiation Oncology, presented their poster, "Development of a Teaching Tool for Patients Receiving Brachytherapy and Non-Radiation Nurses," at the Oncology Nursing Society Congress, in Las Vegas, April 25, 2007.

LaSala presents

Cynthia Ann LaSala, RN, clinical nurse specialist for the White 9 General Medical Unit, presented her poster, "Impacting Patient-Care Outcomes and the Role of the Clinical Nurse Specialist: Evaluation of Staff Nurse Perceptions of High-Frequency Patient Problems," at the Massachusetts Organization of Nurse Executives 2007 spring quarterly meeting in Natick, March 9, 2007.

Zimmer, Speakman and Heffernan present

Bonnie Zimmer, MSW, director of the HAVEN Program, Elizabeth Speakman, MSW, social worker, and James Heffernan, treasurer of the MGPO, presented, "What about the Men? Opportunities and Challenges of Engaging Men as Allies in the Health Care Setting," at the Family Violence Prevention Fund's National Conference on Health Care and Domestic Violence, in San Francisco, March 15-17, 2007.

Radwin presents

Laurel Radwin, RN, nurse researcher, The Yvonne L. Munn Center for Nursing Research, presented the keynote speech, "Understanding Patient-Centered Nursing Care," at Boston Medical Center's Nursing Research and Evidence-Based Practice Day, April 4, 2007. Radwin also presented, "Testing the Quality Health Outcomes Model in Cancer Care," at the University of Massachusetts in Boston, April 18, 2007.

Carroll appointed

Diane Carroll, RN, Yvonne L. Munn Center for Nursing Research, was appointed adjunct associate professor at Northeastern University in May, 2007.

Pessina presents

Monica Pessina, OTR/L, occupational therapist, presented, "Introduction to Splinting" lecture and workshop at Boston University's, Sargent College of Health and Rehab Sciences, in February, 2007

OTs certified

Occupational therapists, Jennifer Cardella, OTR/L, Lauren Cosgrove, OTR/L, Jane Evans, OTR/L, and Laura Spencer, OTR/L, received the A-One Certification, from Columbia University, in March, 2007.

Capasso presents

Virginia Capasso, RN, clinical nurse specialist, presented her poster, "MGH Nursing Research Committee Develops Innovative Subcommittee Structure for Succession Planning to Ensure Leadership-Development and Sustain Initiatives," at the Eastern Nursing Research Society meeting in Providence, April 13, 2007.

Carroll and Mahoney honored

Diane Carroll, RN, and Ellen Mahoney, RN, received the Clinical Research Award for their study, "Selected Antecedents to the Process of Integration to the Patients and Their Older Spouse After a Cardiac Event," from the Alpha Chi chapter of Sigma Theta Tau International in May, 2007.

Jones, Washington recognized

Dorothy Jones, RN, director, Yvonne L. Munn Center for Nursing Research, and Deborah Washington, RN, director of Diversity, were named the New England regional recipients of the annual *Nursing Spectrum* Excellence Awards, May 15, 2007. Jones was recognized for teaching, Washington for advancing the profession.

Thayer elected

Julie Thayer, RN, Cardiac Access Unit, was elected chair of the Governance Committee for the Theta at Large chapter of Sigma Theta Tau, in May, 2007.

Moran appointed

Peter Moran, RN, Emergency Department case manager, was appointed president of the Case Management Society of America for the 2007–2008 term.

O'Malley-Simmler recognized

Norine O'Malley-Simmler, RN, received the 2007 Circle of Excellence Award, from the American Association of Critical-Care Nurses, (AACN), at the AACN's National Teaching Institute and Critical Care Exposition in Atlanta, May 19 – 24, 2007.

Perry recognized

Donna Perry, RN, professional development coordinator and co-director of the Durant Fellowship Program, received the Distinguished Dissertation Award from Boston College's William F. Connell School of Nursing, May 20, 2007.

Quinn appointed

Thomas E. Quinn, RN, project director, MGH Cares About Pain Relief, was appointed to the Editorial Board of *Pain Management Nursing*, the official journal of the American Society for Pain Management Nursing in March, 2007.

Nurses present

Jane Miller, RN, staff nurse, Hematology; Joanne LaFrancesca, RN, Cancer Center Infusion Unit; and Susan Lee, RN, associate nurse scientist, The Institute for Patient Care; and the Yawkey 8 Infusion Team, presented their poster, "Relationship-Based Nursing, Quality, and Outcomes Among Ambulatory Oncology Patients: Preliminary Findings," at the Eastern Nursing Research Society meeting in Providence, April 13, 2007.

Announcements

The MGH Blood Donor Center

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

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

Employee Access Center moves

The Employee Access Center (EAC) has moved from Clinics 117 to Bulfinch 107 effective June 11, 2007.

The full-service Employee Access Center is a central resource offering employees access to computer terminals and technical support for PeopleSoft Employee Self Service. Employees can view paychecks on-line, access benefits information, enroll in the MBTA commuter pass program, change personal information, update emergency contacts, list education and professional training, and change direct-deposit deductions.

The Employee Access Center is home to pay advice and commuter rail T-pass distribution, and staff are on-hand to answer questions and guide employees through PeopleSoft Employee Self Service.

For more information, call: 617-726-6338, or e-mail ibridge@partners.org.

Joint Commission Laboratory Survey

Reminder to MGH staff that an unannounced Joint Commission laboratory survey is expected to take place some time before January 1, 2008. This survey is independent of the recent hospital survey that took place in December and centers on the processes and environments involved with lab testing from point-of-care testing to laboratory work with a focus on the 2007 Laboratory Services National Patient Safety Goals.

For more information, contact Donna MacMillan, at 6-8887.

Nominations now being accepted for McGovern Clinical Excellence Award

In 2004, the Massachusetts General Physicians Organization (MGPO) created an award to honor the memory of Brian A. McGovern, MD, a dedicated and beloved MGH physician. Physicians in good standing in every clinical department are eligible. Ideal candidates:

- spend much of their time focused on patient care and are viewed by colleagues as the 'go-to' person for their clinical acumen, skill, and responsiveness
- are compassionate and make the extra effort to ensure patient needs are met, whether through direct care or the accurate and timely delivery of other services
- are often the 'unsung hero' whose contributions make our community a better place to work and receive care.

To nominate a physician, go to: http://is.partners.org/mgpoonline/mcgovernaward/. Nominations are due by Friday, July 20, 2007, and must be submitted on-line. For more information, contact Cary Shaw at 617-643-3985.

Volunteer & Interpreter Services relocates

The office of Volunteer & Interpreter Services has moved from the first floor of the Clinics Building to the Gray basement, suite GRB 015. Phone numbers are unchanged:
Volunteer Services: 6-8540
Interpreter Services: 6-6966

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Clinical Pastoral Education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the Nursing Service are offering fellowships for the 2008 MGH Clinical Pastoral Education Program for Healthcare Providers.

Fellowship is open to clinicians from any discipline who work directly with patients and families and who wish to integrate spiritual caregiving into their professional practice.

This is a part-time program, Mondays from 8:30am–5:00pm. Additional hours are negotiated for the clinical component. Deadline for application is September 1, 2007.

For more information, call the Chaplaincy at 726-4774.

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Susan Sabia

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Submissions

All stories should be submitted to: ssabia@partners.org
For more information, call: 617-724-1746

Next Publication

July 19, 2007

Educational Offerings – 2007

July 9

CPR Mannequin Demonstration

Founders 335
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

July 9

Assessment & Management of Patients at Risk for Injury

O'Keeffe Auditorium
8:00am – 4:30pm
Contact hours: TBA

July 10

CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

July 10

Chaplaincy Grand Rounds: "Addressing Existential Issues in Patient Care"

Call for location (6-2220)
11:00am – 12:30pm
No contact hours

July 11

New Graduate RN Development Seminar I

Training Department
Charles River Plaza
8:00am – 2:00pm
Contact hours: TBA
(for mentors only)

July 11

Nursing Grand Rounds

Haber Conference Room
11:00 – 12:00pm
Contact hours: 1

July 11

OA/PCA/USA Connections

Bigelow 4 Amphitheater
1:30 – 2:30pm
No contact hours

July 11

Nursing Research Committee's Journal Club

Yawkey 2210
4:00 – 5:00pm
Contact hours: 1

July 12, 16, 17, 23, 30 & 31

Greater Boston ICU Consortium Core Program

VABHS
7:30am – 4:30pm
Contact hours: TBA

July 16

BLS Certification for Healthcare Providers

Founders 325
8:00am – 12:30pm
No contact hours

July 24

Ovid/Medline: Searching for Journal Articles

Founders 334
11:00am – 12:00pm
Contact hours: 1

July 25

New Graduate RN Development Seminar II

Training Department
Charles River Plaza
8:00am – 2:30pm
Contact hours: TBA
(for mentors only)

July 26

Nursing Grand Rounds

O'Keeffe Auditorium
1:30 – 2:30pm
Contact hours: 1

July 26

Basic Respiratory Nursing Care

Bigelow Amphitheater
12:00 – 4:00pm
No contact hours

July 30 & 31

Intra-Aortic Balloon Pump

Day 1: CSEMC
Day 2: Founders 325
7:30am – 4:30pm
Contact hours: TBA

August 1

CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

August 2

BLS Certification for Healthcare Providers

Founders 325
8:00am – 12:30pm
No contact hours

August 3

On-Line Electronic Resources for Patient Education

Founders 334
9:00am – 12:00pm
Contact hours: 2.5

August 6

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

August 7

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2220
8:00am – 4:00pm
Contact hours: TBA

For more information about educational offerings, go to: http//mghnursing.org, or call 6-3111

GLBT pride at MGH

The PCS Diversity Committee embraces a broad definition of diversity. MGH has a strong diversity program that is fully supported by hospital leadership.

Question: I know June is Gay Pride Month. Was anything done to celebrate this important occasion in the GLBT (gay, lesbian, bisexual, transgender) community.

Jeanette: The PCS Diversity Committee embraces a broad definition of diversity. On June 15, 2007, the committee sponsored an educational session with guest speaker, Stewart Landers, senior consultant and activist on issues related to HIV/AIDS, gay rights, and health issues affecting the GLBT community.

Question: I worry I might inadvertently say something insensitive because I don't know the language or terminology used in the gay community.

Jeanette: You might find these explanations helpful:

- GLBT: an acronym for gay, lesbian, bisexual and transgender
- Sexual minority: people who identify as gay, lesbian, bisexual, transgender, or intersex
- Sexual orientation: the preferred term used when referring to an individual's physical, spiritual, and/or emotional attraction
- Transgender: a broad term used to describe anyone whose identity or behavior falls outside of stereotypical gender norms. Includes transsexuals, cross-dressers, transvestites, and intersex individuals
- Queer: a re-claimed derogatory expression for the sexual-minority community (not accepted by all members of the sexual-minority community)
- Outing: the act of publicly revealing another person's sexual orientation, considered inappropriate in the current political and social climate
- Intersex: one whose external genitalia at birth do not match the standards for male or female; one whose sex glands do not totally match the sex assigned at birth; or one whose sexual development does not match the sex assigned at birth
- Gender identity: the psychological gender of a person, regardless of what gender the person was at birth
- Coming out: a sometimes difficult and/or long-term process of self-acceptance and revelation of one's sexual orientation
- Domestic partnership: a long-term commitment between two adults who reside together and are financially and emotionally interdependent

Question: Will my manager support me if I want to attend GLBT educational sessions?

Jeanette: MGH has a strong diversity program that is fully supported by hospital leadership. For more information, contact Human Resources or Deborah Washington, RN, director of Diversity for Patient Care Service (4-7469).

Caring Headlines
July 5, 2007

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