

Caring

Headlines

June 14, 2007

Jones to Lead Nursing Research



You may have noticed that senior vice president for Patient Care, Jeanette Ives Erickson, RN, has a little more bounce in her step these days. That's because, as she announced during last month's Nurse Week celebration, "I'm giving myself a Nurse Week present. I'm giving myself the gift of Dottie Jones." With that, she announced that Dottie Jones, RN, senior nurse scientist, had been named the new director of The Yvonne L. Munn Center for Nursing Research.

Dr. Jones first enjoyed MGH privileges in 1998 as a clinical nurse specialist and later a nurse scientist in the department of Quality Assurance, Research & Staff Development. Since 2000, she has been a senior nurse scientist, continuing to cultivate and support nursing research throughout Patient Care Services. In October, 2006, Jones played an active role in leading the Munn Center through a transitional period, identifying the resources and infrastructure needed to support a robust nursing research program. She facilitated and implemented a variety of initiatives, including the Nurse Scientist Advancement Model for doctorally prepared nurses.

Jones has published and presented extensively, nationally and internationally. She is a professor of Adult Health Nursing at the Boston College William F. Connell School of Nursing, and on a recent sabbatical served as visiting professor at the University of Navarra School of Nursing in Pamplona, Spain. She is the recipient of numerous awards and honors, including the first Dorothy A. Jones Award for Knowledge-Development and Human-Becoming and the Boston College University 2005 Teaching Excellence Award; two *American Journal of Nursing* Book of the Year awards; the Dorothy Garrigus Adams Founders Award for Excellence in Fostering Professional Standards from Sigma Theta Tau International; and the Distin-

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Dottie Jones, RN, director, The Yvonne L. Munn Center for Nursing Research

PCS support staff, a key pillar of MGH infrastructure



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

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Every MGH employee performs an important service in the operation of this hospital. Every employee has an impact on the success of the organization. Every employee's contributions are valued by patients and staff, and none more so than those of our Patient Care Services support staff. They are a pillar of the MGH infrastructure and play a pivotal part in our ability to provide safe, high-quality care.

Unit service associates (USAs) contribute to a safe and healing environment by ensuring patient care units are clean and well stocked with supplies and equipment. They provide hospitality to patients and visitors, transport supplies, equipment, and specimens, and perform a myriad of other duties as required. They are responsible for room-turnover and discharge cleaning, directly affecting hospital efficiency and throughput.

Under the direction of a registered nurse, patient care associates (PCAs) assist the healthcare team in promoting a safe, compassionate environment, provide comfort, document certain assigned tasks, assist with food delivery, and perform many other unit-specific tasks and activities.

Operations associates (OAs) are vital to the effective functioning of patient care units. A key source of information, they interact with patients, families, visitors, and staff from departments throughout the hospital. They transcribe physician orders and monitor the completeness and integrity of patients' medical records.

OAs play a vital role in capacity-management using the CBEDS application to communicate bed availability to key areas in the hospital. They are on the front lines every day ensuring responsive customer service, effective communication, and patient- and family-satisfaction.

As with all role groups, it's important for employees to be well informed about events and initiatives occurring throughout the hospital. It's equally important to *hear* from all role groups to get their perspective on patient care, operations, safety, and other matters affecting the success of the organization. Toward that end, I attended a recent session of the OA/PCA/USA Connections program to make sure those lines of communication were open.

The session was very well attended with more than 140 support staff, and we had a *great* dialogue. Questions and comments touched on Joint Commission survey results, hand hygiene, patient confidentiality, changing technologies, merit raises, tuition reimbursement, opportunities for advancement within the organization, the importance of a professional dress code, and many other relevant topics. I was thrilled to see so many in attendance and to have an opportunity to hear what's on the minds of our front-line support staff.

Customer service is everyone's responsibility. And the best ideas for service-improvements come from those who provide these important services. This OA/PCA/USA Connections session was a chance to exchange ideas and the beginning of what I hope will be an ongoing dialogue with support staff about key issues

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affecting patients, employees, and the hospital.

Hopefully, we'll have many more opportunities to share ideas and brainstorm about ways to improve the hospital experience for patients and families. I know many of the topics discussed during this session will be the subject of future Connections programs, such as, The Journey from Job to Career (July 11, 2007). Other sessions will focus on Magnet re-certification, service issues, medical records, and other important topics. For more information about upcoming OA/PCA/USA Connections programs, contact Stephanie Cooper, training development specialist, at 4-7841.

We are fortunate to have such a caring, devoted, and capable support staff. It is a source of great pride and peace of mind to know that our patients and families receive the best possible care from the moment they walk through our doors until the moment they leave, from every member of our healthcare team.

Updates

I'm pleased to announce that Corey Mullen, RN, has accepted the position of clinical nurse specialist for the Ellison 7 Surgical Unit. Many thanks to Ann Martin, RN, who has covered the unit for several years. Ann will continue to cover the White 7 Surgical Unit.

As we continue to re-organize nursing leadership in the surgical services to keep pace with unprecedented

growth in these areas, I'm happy to announce that Scott Ciesielski, RN, has assumed the position of nursing director for all adult and pediatric post-anesthesia care areas. Marion Freehan, RN, and Lisa Morrissey, RN (new to MGH), will share nursing-director responsibilities for the Main Operating Room; and Janet Quigley, RN, will continue to oversee the Same Day Surgical Unit operating rooms and adult pre-op areas.

Clinical Recognition Program

The following clinicians were recognized February– May 1, 2007.

Advanced Clinicians:

- Kara A. Connor, RN, Orthopaedics
- Kathryn Sabo, RN, Medicine
- Robyn Bigelow, RN, Oncology
- Tara Stadelman-Cohen, SLP, Voice Center
- Tracey Carroll, RN, Cardiology
- Jacqueline Emond, RN, Oncology
- Patricia Tammaro, RN, Endoscopy
- Donna Stamatis, RN, Radiation Oncology
- Van Abreu, RN, Cardiology

Clinical Scholars:

- Kathleen Boyle, RN, Medicine
- Joy Williams, RN, Radiology
- Marybeth Bronson, LICSW, Social Services
- Jean Baker, RN, Newborn ICU

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Visiting scholar comes to MGH Heart Center

— Diane L. Carroll, RN, Yvonne L. Munn nurse researcher

In recognition of the unique contributions of cardiac nurses, on April 26, 2007, the MGH Nursing Service welcomed Dr. Barbara Riegel, RN, the second cardiac nursing visiting scholar. Her two-day visit encompassed activities that focused on cardiac nursing practice and scholarship, including oral presentations, a panel discussion, a moderated poster session, and unit rounds.

Riegel is an associate professor at the University of Pennsylvania with a well-developed program of research addressing self-care needs in heart-failure patients. More than 550,000 Americans have been diagnosed with heart failure. At MGH, heart failure is one of the primary reasons for admission among older adults. With a focus on heart-failure patients, Riegel

Cardiac nursing visiting scholar, Dr. Barbara Riegel, RN, shares her expertise with MGH cardiac nurses

had something to offer all nurses, as heart-failure patients are admitted to almost all patient care units.

In her morning presentation, Riegel focused on improving health outcomes through alternative health-care designs that might better address the self-care needs of heart-failure patients across the continuum. During Nursing Grand Rounds, Riegel presented her research on self-care management for heart-failure patients highlighting treatment delays that often accompany this vulnerable population due to cognitive, physical, and literacy barriers. These barriers influence strategies used to manage heart failure.

A well-attended panel discussion focused on a particularly complex heart-failure patient. The panel included staff nurses from Ellison 9 and 10 and Blake 8, and members of the multi-disciplinary team, including a social worker and physical therapist. Each nurse presented his/her challenges in caring for this patient and a moderator posed specific questions to Riegel.

During a moderated session, posters were displayed outside O'Keeffe Auditorium highlighting the innovative clinical practice in various cardiac settings. The Cardiac Practice Committee, advanced clinicians, and clinical scholars engaged Riegel in a discussion about clinical issues faced by heart-failure patients.


On the second day of her visit, Riegel visited cardiac units where nurses presented clinical narratives for discussion. Each unit focused on a different aspect of nursing care with discussion centering on how to foster an interdisciplinary approach, how to motivate and educate patients and families, and the challenges posed by chronically, critically ill patients.

The Cardiac Nursing Visiting Scholar Program provided an opportunity for cardiac nurses to discuss the clinical needs of heart-failure patients with an expert. Riegel's visit was an enriching experience for clinicians throughout MGH. For more information about the Cardiac Nursing Visiting Scholar Program, contact Sioban Haldeman, at 4-1375.



Magnet re-designation: the forces of magnetism

— by Suzanne Cassidy, senior project specialist

n October 31, 2007, MGH will submit evidence to the American Nurses Credentialing Center (ANCC) to become re-designated as a Magnet hospital. The ANCC has established 14 'Forces of Magnetism,' or characteristics of exemplary nursing practice. These forces define what it means to be a Magnet hospital and represent the highest standards for the nursing profession.

Force #1: Quality of nursing leadership

Nursing leaders are perceived as knowledgeable risk-takers who follow an articulated philosophy in the day-to-day operations of the Nursing Service. Nursing leaders convey a strong sense of advocacy and support on behalf of staff.

Force #1 describes an environment where nurses at all levels are supported through adequate allocation of resources, opportunities to advance, and the ability to be involved in decision-making throughout the organization. These characteristics reflect a strategic philosophy that is carried out in day-to-day operations and in the superior care received by patients and families.

You don't have to look far to see the quality of nursing leadership at MGH. It starts with the Patient Care Services vision statement, "Our every action is guided by knowledge, enabled by skill and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day." It is carried out through our professional practice model, and it's measured annually through the Staff Perceptions of the Professional Practice Environment Survey.

Force #2: Organizational structure

The ANCC describes organizational structure as flat, rather than tall, and unit-based decision-making prevails. Nursing departments are decentralized, with strong nursing representation on organizational com-

mittees. Nursing leaders serve at the executive level of the organization, and the chief nursing officer reports to the executive level.

Flat organizational structures bring key decision-making to the bedside. Since 1997, our collaborative governance model has been the core mechanism for supporting nursing practice and the framework for staff-nurse involvement. The Diversity, Ethics, Practice, Patient Education, Quality, Research, and Staff Nurse Advisory committees exemplify the characteristics of a Magnet-caliber organization where authority, responsibility, and accountability for patient care rest with the practicing clinicians.

Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse, has structured her management team to optimize operational relationships throughout the organization and support decision-making by nurses at all levels. She has the authority and responsibility for hospital-wide development, implementation, and evaluation of plans for providing nursing care. Several key groups support and carry out this work. Associate chief nurses, nursing directors, and other nursing leaders are key members of the clinical management team.

At the patient-care level, unit-based triad leadership teams oversee clinical operations, keeping clinical decision-making close to those caring for patients. The triad is comprised of a nursing director, clinical nurse specialist, and operations coordinator. The latter report directly to the nursing director, and together they support unit-based staff and clinical decision-making.

Strong nursing leadership and an organizational structure where effective decision-making prevails are just two characteristics that make MGH a Magnet hospital.

Watch future issues of *Caring Headlines* for more on the Forces of Magnetism. For information, contact Suzanne Cassidy, senior project specialist, at 6-0368.

The 14 Forces of Magnetism

- 1) Quality of nursing leadership
- 2) Organizational structure
- 3) Management style
- 4) Personnel policies and programs
- 5) Professional models of care
- 6) Quality of care
- 7) Quality improvement
- 8) Consultation and Resources
- 9) Autonomy
- 10) Community and the healthcare organization
- 11) Nurses as teachers
- 12) The image of nursing
- 13) Interdisciplinary relationships
- 14) Professional development

4th annual McEachern Award, a proud and poignant occasion

— by Julie Goldman, RN, professional development coordinator

“Danny... is
caring, sensitive,
empathetic, and
understands that
science alone
does not cure
a disease.”

On April 19, 2007, the 4th annual Brian M. McEachern Extraordinary Care Award was presented to speech-language pathologist, Danuza ‘Danny’ Nunn, SLP, in an emotional, standing-room only ceremony in the MGH Ether Dome. In her welcoming comments, senior vice president for Patient Care, Jeanette Ives Erickson, RN, recalled, “Time has flown since 2004 when representatives from Patient Care Services joined Brian’s sisters, Geri and Diane, and friends to discuss establishing an award in Brian’s memory to recognize extraordinary care and patient advocacy.”

“For the last four years,” said Ives Erickson, “family, friends, and colleagues have gathered to pay tribute to Brian McEachern, a quite hero, an ordinary man who performed extraordinary deeds during the course of his thirty-one years as a Boston firefighter.”

During the ceremony, stories about McEachern and his accomplishments were shared by Thomas Lynch, MD; Paul Christian, retired fire commissioner, McEachern family members; and Mary Manning, RN, a family friend. Stories reflected McEachern’s giving nature, endearing qualities, and heroic spirit.

Carmen Vega-Barachowitz, SLP, director of Speech, Language & Swallowing Disorders and Reading Disabilities, introduced Nunn, saying, “It was an honor and a privilege to serve on the selection committee for this award.” Criteria were based on personal attributes, patient-advocacy, empowerment, commitment to extraordinary patient care, compassion, and caring.

Four of Nunn’s speech-language colleagues, Allison Holman, SLP; Jennifer Mello, SLP; Stacey Rhoads, SLP; and June Williams, SLP, nominated her for the award. In their letter of nomination, they wrote, “Danny is passionate about collaboration between disciplines and feels it is the cornerstone of good patient care. She always goes the extra mile for her patients and family members.”

In her letter of support, Vega-Barachowitz wrote, “Danny has been indispensable to clinical operations as a member of the inpatient Speech, Language and Swallowing Team. She is caring, sensitive, empathetic, and understands that science alone does not cure a disease.” Nunn gave a moving acceptance speech that included an impassioned thank-you to the McEachern family,

her colleagues, and her family in Brazil for supporting her dream to come to the United States.

Ives Erickson thanked all MGH clinicians for honoring the memory of Brian McEachern with their extraordinary care and patient advocacy.

For more information about the Brian M. McEachern Extraordinary Care Award, call Julie Goldman, RN, at 617-724-2295.

Award recipient, Danny Nunn, SLP (center), with Ives Erickson (left), Vega-Barachowitz (second from right), and friends and family of Brian McEachern



Emergency preparedness: feeding patients in the event of a catastrophic disaster

— by Susan Doyle, RD, senior manager, Patient Food Services

We have a plan
to feed 1,200
patients for five days
in the event of an
emergency and a
system to store
and rotate all
supplies on-site.

How would you feed 1,200 patients in the event of an extreme disaster? Assume that MGH is cut off from a safe food supply. There is no drinkable water, there are no supplies being delivered, and only emergency power is available. Assume there is limited staff to distribute meals, and the entire service must be delivered on paper products (plates, cups, etc.)

That means no microwave ovens, no dishwashers, no refrigeration.

This was the challenge faced by Sarah Estabrook, RD, manager of Patient Food Services, when she and her team were charged with developing Nutrition & Food Services' Emergency Preparedness Plan. Together, with Nancy Craveiro (Nutrition & Food Purchasing); Al McPhee (Production); Kristyn Lantagne (Patient Menu and Data Systems); John Delvecchio (Tray Line); and Sharon Darak (Clinical Nutrition), the team designed a plan to feed 1,200 patients (200 more than maximum census) a diet of 1,500 calories per day with 60 grams of protein.

The plan provides a half-gallon of drinking water per patient per day.

After studying inpatient dietary needs and restrictions, clinical dietitians determined what foods would be essential in meeting dietary compliance and nutritional needs. Simulating an emergency situation, it became clear which foods would be considered critical and which would not be feasible in the event of a disaster.

The plan calls for portion-controlled and primarily shelf-stable food items to protect against contamination and maximize safety. One hurdle was deciding how to store all these items in-house, along with the necessary paper supplies. The water supply for a five-day survival situation, 3,000 gallons, requires ten industrial-size pallets over and above what's already in stock. Also, a plan needed to be implemented to rotate these stored items. It wouldn't do to have a storeroom full of expired food. The team made provisions for these and other essential items: head lamps, batteries, Cal Stat, manual can openers, etc. We are happy to report that we have a plan to feed 1,200 patients for five days in the event of an emergency and a system to store and rotate all supplies on-site.

Another consideration, which is equally important, is having the means to communicate during an emergency. The team outlined the chain of command, revised job responsibilities for essential personnel, and clarified what is expected of support staff.

Emergencies or disasters can happen at any time. Ideally, we'll never need to use our emergency back-up plan. We will hope for the best, but always be prepared for the worst.

For more information about Nutrition & Food Services' Emergency Preparedness Plan, please contact Susan Doyle at 6-2579.

Back row (l-r): John Delvecchio, Sharon Darak, Kristyn Lantagne, and Al McPhee.
Front row: Nancy Craveiro and Sarah Estabrook



Quality of life guides practice for medical nurse



Kathryn Sabo, RN, advanced clinician staff nurse, White 10 Medical Unit



My name is Kathryn Sabo, and I am a nurse on the White 10 Medical Unit. As a nurse, my practice has been influenced by many events, one of which was the difficult decision my family and I made to place my grandmother in a nursing

home. Despite our original trepidations, it turned out to be a positive experience. And in the end, when my grandmother passed away surrounded by her family, her death was not viewed as a failure to cure, but as part of a natural process. My grandmother's death provided a new perspective to me. Promoting the highest quality of life now guides my clinical practice and shapes my nursing interventions.

As a nurse I have the responsibility of advocating for my patients to ensure their needs are met. The time I spent caring for 'Joan' exemplifies this ideal and demonstrates the importance of the nurse-patient relationship.

Joan was admitted with congestive heart failure and pneumonia, which had resulted in changes to her mental status and physical weakness. Recently independent, Joan was now dependent on others for her care. Her admission was complicated by chronic obstructive pulmonary disease, newly diagnosed lung cancer, anxiety, and obesity. It was clear, listening to report, that Joan would be a challenging patient. She was very sick, but I had cared for complex patients before and felt ready for the challenge. The initial plan of care involved medically managing the congestive heart failure, treating the infection, and with the assistance of physical therapy, building her strength in order to discharge her to a rehabilitation facility. Unfortunately, it wasn't that easy.

Joan's admission could best be described as a roller-coaster ride. She had good days and bad days with episodes of respiratory distress and intermittent confusion. Despite many interventions, Joan was not improving. I realized her stay on White 10 would be longer than I thought.

In reviewing her medical record, I discovered Joan had had multiple admissions over the past year for congestive heart-failure exacerbations. This was an indication of declining heart function. The pneumonia created an additional stress to the heart as an increased workload was necessary to help her fight the infection. With each passing day, I observed a steady decline in Joan's condition. A scan of her chest revealed a significant mass encompassing her right bronchus. This, together with the chronic obstructive pulmonary disease, explained her poor respiratory rate and labored, pursed-lip breathing. Arterial blood gases verified increased levels of carbon dioxide, common in end-stage chronic obstructive pulmonary disease. She was hypoxic, which explained her poor ventilation, mental status changes, and weakness.

Joan tired quickly. Lab results revealed a poor nutritional status that, despite intravenous repletion, was not improving. Although Joan was obese, she was beginning to exhibit signs of failing to thrive. Her eyes were becoming sunken, and she was losing weight in her face. She would experience episodes of hypotension. Her frequent respiratory distress indicated a failing cardiovascular system. She had poor circulation that manifested itself in pitting lower-extremity edema. She said she felt as if she had 'elephant legs.'

I enjoyed caring for Joan because she challenged my clinical skills. Though she demanded much of my time

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and required constant reassurance and emotional support, I was rewarded with a smile and, “I’m glad you’re my nurse today.” Joan was committed to getting better. She was aware of her multiple diagnoses, but I wondered if she understood the severity of her prognosis.

As I continued to care for Joan, I began to wonder if she had a support system. She’d been in the hospital for a few days with no visitors. Her daughter eventually came to visit, but the dynamic between them seemed less than ideal, often resulting in hostility. It appeared Joan’s daughter was in denial about her mother’s illness. “Mom your breathing is going to get better once the doctors remove that tumor,” she’d say. Or, “I’m going to speak to the doctor about giving you stronger medications.” She didn’t understand why medical and nursing interventions weren’t helping. Joan was a different person when her daughter visited. Usually talkative and somewhat opinionated, she became quiet and ambiguous. To me, the daughter’s presence seemed to instill fear in Joan — fear of disappointing her daughter if she was unable to recover from her illness.

Joan’s condition continued to decline, and soon she needed a high-flow oxygen mask. Her mental status fluctuated, which combined with her weakened physical condition resulted in falls despite preventative measures. When lucid, Joan confirmed with the healthcare team that she wanted all measures taken to save her life. As a primary healthcare provider, I needed to respect her wishes, but I questioned if they truly were her wishes and what her quality of life would be with aggressive treatment.

I was seeing a daughter who loved her mother but who, I felt, was in denial. I believed she needed to be educated about the diseases her mother was facing and how they contributed to Joan’s prognosis. I recognized that Joan’s daughter was suffering, too. She needed someone to tell her it was okay to choose palliative measures.

I approached the case manager and social worker with my concerns. We called a family meeting with Joan’s daughter, physician, case manager, social worker, and myself. Together, we educated the daughter on her mother’s prognosis. We emphasized that her status would not improve, and most likely would get considerably worse. I took the opportunity to share my observations with her daughter, but she admitted she was having a hard time letting her go. I assured her those feelings were normal and told her I’d be there to help with whatever she needed. The daughter thanked us and said that pursuing aggressive treatment might be disrespecting her mother’s wishes.

The daughter left the meeting fully informed and

expressed a better understanding of her mother’s condition. After the meeting, I encouraged her to spend some time with her mother. I told her I’d accompany her to Joan’s room and help initiate the discussion. She declined. She said it was up to her to initiate the conversation with her mother. I was pleased to see her take an active role in her mother’s care. After a long talk, Joan and her daughter came to an understanding. Although it was difficult, the daughter realized that aggressive treatment could prolong her mother’s life, but at what cost? She wanted to remember her mother as a sassy, loving person and not a body connected to a machine. Joan admitted she was tired and not able to fight anymore. They decided together to be less aggressive with treatment. Quality instead of quantity was their priority. They decided to discontinue the high-flow oxygen and begin intravenous morphine. Joan died the following day, on my day off. I was told it was peaceful.

As a nurse, I strive to provide excellent care and maintain the highest quality of life for every patient. Quality of life is different for everyone. And sometimes, though it can be a difficult decision, allowing a loved one to die can be a way of preserving quality of life. I have learned to encourage patients and their loved ones to openly discuss their emotions. I’ve discovered they need time to make those important decisions. Effective communication and educating patients and families empowers them to make informed decisions.

Nurses are privileged to participate in end-of-life care. Though dealing with these situations isn’t easy, it’s important to help provide a positive experience. As an experienced nurse with a strong knowledge base, I was able to make clinical decisions and advocate for Joan.

My grandmother’s passing gave me insight. I was able to help Joan and her daughter see death as dignified. The wisdom I gained from this experience allowed me to grow and develop as a nurse.

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

Kathryn’s gentle but focused interventions helped Joan and her daughter come to grips with the terminal nature of Joan’s illness. Kathryn brought the care team together to begin the dialogue that ultimately allowed Joan and her daughter to face the truth together. Kathryn’s experience with her own grandmother helped inform her decision-making. And her experience with Joan and her daughter will inform her future practice. End-of-life care is never easy, but when delivered with openness and compassion, it can be rewarding for everyone involved.

Thank-you, Kathryn.

As a nurse, I strive to provide excellent care and maintain the highest quality of life for every patient. Quality of life is different for everyone. And sometimes, though it can be a difficult decision, allowing a loved one to die can be a way of preserving quality of life.

Scholarships fund the future

— by Paul Bartush, assistant director, Volunteer Services,
Medical Interpreters, and Information Associates

Every summer, the MGH Volunteer Department hosts high-school juniors and seniors from across the country as part of a collaborative relationship with the National

Youth Leadership Forum (NYLF). While visiting MGH, students attend educa-



(L-r): Stephen Hughes, principal of BC High School; Bohan Liu (class of '08), John DeLeon ('07), Jonathan Truong ('08), Lloyd Rolles ('08) and Paul Bartush, assistant director, Volunteer Services, Medical Interpreters, and Information Associates

tional lectures, tour various departments, and visit area hospitals and research facilities during their ten-day, interactive experience.

The mission of the NYLF is to empower promising students to make well-informed career choices by exposing them to a variety of professions in cities throughout the United States, including Boston.

Students are nominated by teachers and mentors. Participants must have a grade point average of B+ or better, and tuition is approximately \$2,200.

MGH is honored to provide scholarships to four students each year who might not otherwise be able to attend. This year's recipients: Bohan Liu, John R. DeLeon, Jonathan Truong, and Lloyd Rolles are all students at BC High School. For more information about the NYLF scholarship, call 617-643-3993.

Bidding farewell to Annabel Edwards

— submitted by Paul Amstein, RN, clinical nurse specialist

Annabel Edwards, RN, became an advanced practice nurse at the MGH Institute of Health Professions in June, 1985. She worked as a staff nurse at MGH on the Surgical Service until 1991 when she became a clinical nurse specialist in the MGH Pain Center. Edwards was memorialized at a national meeting of the American Society for Pain Management Nursing (ASPMN) last month. Edwards was a nurse practitioner at MGH and the sitting president of ASPMN when she passed away, November 18, 2006.

Edwards' personal and professional accomplishments were shared in stories about her respect for all people, her love of nature, and her penchant for singing and dancing. Personal testimonials about her mentorship, companionship, and knack for making challenging situations upbeat and memorable captured the essence of Edwards' spirit. Edwards' sister, Sue Frank, and MGH colleague, Elizabeth Ryder, RN, coordinated the memorial service, which included an audiotape of Edwards teaching colleagues a Quaker song called, "How can

I keep from singing." Edwards was recorded earlier, teaching the song in preparation for a memorial service to honor past ASPMN president and MGH nurse, Jeannie Guveyan, RN.

Edwards' contributions to MGH Nursing and the Pain Center will long be remembered, and her caring presence will be missed by all who knew her.

Edwards' sister, Sue Frank (left) and Liz Ryder, RN, MGH Pain Service nurse at memorial service



My vision for The
Yvonne L. Munn
Center for Nursing
Research is to
involve all nurses
in the conduct,
utilization, and
translation of
research
into clinical
practice.

guished Alumni Award from Indiana University. She has received a variety of grants from specialty organizations and foundations. Most recently, she was the principal investigator on a research study funded by the National Institutes of Health (NIH) and the National Institute for Nursing Research (NINR) to study the efficacy of a nurse-coached intervention and recovery at home following same-day surgery. Several nurses in our Same Day Surgical Unit participated in the research.

Jones has served as president of the Eastern Nursing Research Society and the North American Nursing Diagnoses Association International, on editorial boards, and was recently appointed a member of the editorial advisory board for *Nursing Research*. She has been a fellow in the American Academy of Nursing since 1980.

Says Jones, "It's an honor and a privilege to assume the role of director for The Yvonne L. Munn Center for Nursing Research. I'd like to thank Jeanette for this recognition and for her vision, continued support, and dedication to developing

the nursing research program at MGH. As a result of her foresight and commitment, we have created an environment where research is valued and encouraged.

"I am passionate about the discipline of nursing. As nurses, we need to be visionary and visible in our efforts to give voice to nursing knowledge and its impact on patient care. Research is one way to make our impact realized by others. The work being done at MGH to advance patient care from multiple perspectives is impressive. My vision for The Yvonne L. Munn Center for Nursing Research is to involve *all* nurses in the conduct, utilization, and translation of research into clinical practice. I think research should be part of everyone's practice in all settings throughout the hospital. Knowledge comes from questions raised by clinicians in practice, and the knowledge gained through research and clinical investigation should be used to guide and inform care.

"I look forward to working with all MGH nurses and other disciplines as we continue to improve patient outcomes and further distinguish the excellent work being done here to enhance high-quality, cost-effective, safe care for all."

New pathway to access Mass. Eye and Ear Infirmary

In preparation for the demolition of the Clinics and Vincent Burnham Kennedy buildings in the fall, the passageway between MGH and the Massachusetts Eye and Ear Infirmary (MEEI) in the Clinics Building will be closed to all traffic beginning in July. Travel between the two hospitals via

In preparation for the demolition of the Clinics and Vincent Burnham Kennedy buildings in the fall, the passageway between MGH and the Massachusetts Eye and Ear Infirmary (MEEI) in the Clinics Building will be closed to all traffic beginning in July.

this route will be strictly prohibited. Ambulatory outpatients and hospital staff will be asked to use alternate routes to access the MEEI.

A new MGH-MEEI bridge is being constructed that will connect the second floor of the Founders

Building with the MEEI. This bridge is intended for: inpatient transportation, clinical staff access to the MEEI, MEEI code responses, and transportation of patients in wheelchairs by members of MGH Volunteer Services.

The bridge is *not* intended for: general foot traffic, as a pathway for ambulatory outpatients, or as an alternate exit. The doors leading from the second floor of the Ellison Building to the Founders Building will be closed, and a sign will be posted indicating that the bridge is for clinical use only.

Employees who use the bridge frequently such as members of the MGH Code Team, Materials Management, Patient Transport, Police, Security & Outside Services, volunteers, speech-language pathologists, nurses, chief residents, and operations coordinators will be asked to take part in a training session to acclimate themselves to the access system and emergency procedures.

For more information, contact Denise Palumbo, RN, executive director of Radiology and director of Operations for the Building for the Third Century, at 617-726-1667.

Professional Achievements

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, presented, "Brain Freeze: Normothermia and Hypothermia in the ICU," at the Neuroscience Update Conference, in Washington, DC, March 16, 2007.

Ives Erickson appointed

Jeanette Ives Erickson, RN, senior vice president for Patient Care, was appointed Secretary of Health and Human Services for the National Advisory Council on Nurse Education and Practice. She will serve from March, 2007, through September, 2011.

Manley presents

Bessie Manley, RN, nursing director; Phillips House 22 Surgical Unit, presented, "Luxury Medicine: When is Health Care not Health Care?" at the HealthCare 2007 Excellence, Efficiency and Economics Conference at Yale School of Management, in New Haven, March 30, 2007.

Bonnanno and Heislein present

Physical therapists, Andrea Bonnanno, PT, and Diane Heislein, PT, presented their poster, "The Effect of Exercise on Quality of Life and Functional Performance for Patients Undergoing Treatment for Gastrointestinal Cancer," at the combined sections meeting of the American Physical Therapy Association, February, 2007.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, presented, "Optimizing Opioid Therapy: Practice and Risk-Management Techniques," at the annual meeting of the American Society for Pain Management Nursing in Dallas, March 27, 2007. Arnstein was also the chair of the symposium.

Neuro ICU recognized

The Neuroscience Intensive Care Unit received the American Association of Neuroscience Nurses' Outstanding Chapter of the Year Award, at the Annual Meeting of the American Association of Neuroscience Nurses in Orlando, Florida, April 29 – May 2, 2007.

Durkin, Lavieri and Wood publish

Tracey Durkin, RN; Mary C. Lavieri, RN; and Susan Wood, RN, co-authored the article, "What You Need to Know about Sepsis," in Volume 37, Number 3 of *Nursing* 2007.

Carroll presents

Diane L. Carroll, RN, nurse researcher, presented, "Collaborative Intervention Improves Adherence in Cardiac Elders," at the National Association of Clinical Nurse Specialists' National Conference, in Phoenix, March 1, 2007.

Carroll also presented, "The Clinical Indications and Evidence for Counseling Implanted Cardioverter Defibrillator Recipients," at the 17th Annual American Heart Association's Conference on Cardiovascular Nursing, in Newton, March 19, 2007.

Levin featured

Barbara Levin, RN, was featured in the article, "Introducing Barbara Levin BSN, RN, ONC, LNCC," in the National Association of Orthopaedic Nurses' NAON News winter edition. The column informs members about unique accomplishments and contributions of members to the areas of orthopaedics and nursing.

Levin presents

Barbara Levin, RN, presented her two posters, "Can You Hear What I Hear?" and, "Untangling Charlotte's Web," at the 4th Annual Patient Safety Conference: Surveillance through Nursing's Eyes, at the University of Pennsylvania, March 29 – 30, 2007.

Physical therapists present

Physical therapists, Maura Ament, PT; Frances Behar, PT; Danielle Bushey, PT; Diana Czulada, PT; Jessica Jacavage, PT; Benjamin Maschke, PT; Heather Markham, PT; Karen McKenna, PT; Jennifer Miraglia, PT; Christine O'Donnell, PT; Sheila Pallotta, PT; Poonam Pardasaney, PT; Angela Perrozzi, PT; Kristen Quagliarello, PT; Zoya Reznik, PT; Kiley Steinriede, PT; and Lesia Wilson, PT, presented, "Clinical Instructor Training and Certification Workshop," at the American Physical Therapy Association conference in Boston, March 10 – 11, 2007.

Burke broadcasts

Associate chief nurse, Debra Burke, RN, was a guest on *Baystate Forum* (a radio show) in a discussion with Gay Vernon on the nursing shortage, Sunday, March 25, 2007.

Macauley and Mulgrew present

Physical therapists, Kelly Macauley, PT, and Jacqueline Mulgrew, PT, presented their poster, "Implications in Managing Patients with a Ventricular Assist Device," at the combined sections meeting of the American Physical Therapy Association, February 16, 2007.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, presented, "Challenging Aspects of Evidence-Based Pain Management Nursing," and "Revisiting Guidelines for Arthritis Pain: Safe Use of COX-2, Selective and Non-Selective NSAIDs," at the American Pain Society's 2007 meeting, in Washington, DC, May 3 – 4, 2007.

Carroll and Gonzalez present

Diane L. Carroll, RN, nurse researcher, and Colleen Gonzalez, RN, clinical nurse specialist, presented their poster, "Visiting Preferences of Cardiovascular Patients," at the 7th Annual Meeting of the Council of Cardiovascular Nurses and Allied Professionals, European Society of Cardiology, in Manchester, England, March 23, 2007.

Tenney presents

Dawn Tenney RN, associate chief nurse, presented, "OR of the Future: Implications for Now," and "Fixing the Problem of Scarce Personnel," at the American Association of Clinical Directors meeting in Phoenix, March 9 and 10, 2007.

Tenney also presented, "Interventional Collaboration: One Organization's Collaboration Between the OR, Cath Lab and Interventional Radiology Service to Support the Growth of Interventional Vascular Surgery," at the UHC Perioperative Services Council Meeting in Chicago, March 27, 2007.

Pazola publishes

Kathryn Pazola, RN, pediatric staff nurse, published her poem, "Reflections on a Day in Room 400," in *Oncology Times*, March 10, 2007.

Jacavage honored

Jessica Jacavage, PT, physical therapist, received the MassGeneral Hospital for Children's Family-Centered Care Award, April 25, 2007.

Farrer and Murray certified

Karla Farrer, RN, and Jennifer Murray, RN, were certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in December, 2006.

Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, was appointed a member of the Education Advisory Committee for the American Pain Society for a two-year term, effective, May 1, 2007.

Johnson elected

Elizabeth Johnson, RN, clinical nurse specialist, GYN Oncology, was elected to the Nominating Committee of the Oncology Nursing Society for a three-year term in the 2007 elections.

Michel appointed

Theresa Michel, PT, physical therapist, was appointed a member of the American Physical Therapy Association in Alexandria, Virginia, in March, 2007.

Nurses and doctors publish

Kathryn Brush, RN, clinical nurse specialist, Surgical Intensive Care Unit; Elise Gettings, RN, research nurse coordinator, Anesthesia/Critical Care Unit; Elizabeth Van Cott, MD; and William Hurford, MD, authored the article, "Outcome of Post-Operative Critically Ill Patients with Heparin-Induced Thrombocytopenia: an Observational Retrospective Case-Controlled Study," in *Critical Care*.

Responsible Physician Project: making it easier to identify accountable caregivers

— by Keneth Honeck, Information Systems project specialist

When caring for patients at MGH, where multiple providers are involved, it's important to know which doctor or clinician is responsible for their care. The Responsible Physician Project, under the direction of chief medical officer, Brit Nicholson, MD, and led by Debbie Adair, HIS director, and Cy Hopkins, MD, director of the Office of Quality & Safety, will help clarify that information. The purpose of the Responsible Physician Project is to promote patient safety by making it easier to identify the responsible physician or responding clinician for every inpatient. Says staff nurse, Ann Eastman, RN, "This is a wonderful idea. As a staff nurse, I'm grateful this has been brought forward both for my sake as a professional and, more importantly, for the sake of my patients."

Phase I of the project focuses on providing the capability to easily access the responding clinician. Phase II will focus on accessing the responsible physician. For the purposes of this project, the term, 'responsible physician' refers to the one physician ultimately responsible for the patient at any point in time. The 'responding clinician' is the clinician accountable for the minute-to-minute care of the patient (resident, fellow, nurse practitioner, or physician's assistant). It's important for every member of the care team to be able to identify these individuals quickly and easily.

With input from many clinicians, some new features have been added to the Partners Enterprise Patient Lists (PEPL) in the Clinical Application System (CAS).

From the Care Tm button in the CAS shell, you can:

- identify these providers and click on their name to go to the Partners Phone Directory where you can easily send a page
- click on the 'e-mail' button and send the care team an e-mail. You might use this function to notify the entire care team of a family meeting
- click on the Responding Clinician History button to see who the responding clinician was during a specific time period

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- click on the Responding Clinician History button to see who the responding clinician was during a specific time period

For more information about the Responsible Physician Project, contact Ken Honeck at 617-724-9606.

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The screenshot shows a web application interface for MGH Inpatient Care Team. At the top, there's a header with the date and time (4.4.33 Thursday Mar 1, 2007 7:26 AM) and the user (Jodi MacLeod). Below this is a patient selection area with a dropdown menu showing 'CLAUS, SANTA C, JR' and a patient ID 'MGH 0000004'. The patient's age (27y), sex (M), and insurance (MEDICARE PART A B) are displayed. The primary care provider is listed as 'PCP: UNKNOWN, PHYSICIAN'. The main content area is titled 'Care Team Detail for MGH:5600583 RP-TEST, PATIENT-E - Microsoft Internet Explorer provided by Partners HealthCare System'. It shows the patient's name 'RP-TEST, PATIENT-E', MGH number 'MGH:5600583', DOB '05/16/1954', sex 'M', location 'W07 16 B', service 'Surgery Private', and primary team 'Surgery-Churchill Blue'. There are buttons for 'Add', 'Remove', 'E-mail', 'Print Report', and 'Responding Clinician History'. Below these is a table titled 'MGH Inpatient Care Team' with columns for Name, Department, Role, and Date/Time Added. The table lists several team members: Hutter, Matthew M., MD (Attending Physician), Hutter, Matthew M., MD (Primary Care Physician), Evans, Nathaniel R., MD (Responding Clinician, dated 05/17/2007 3:33 PM), Grady, Gail (Case Manager), and Hopkins, Cyrus C., MD (Consulting Physician). A note at the bottom states: 'The Responding Clinician is the clinician (doctor, nurse practitioner or physician's assistant) responsible for the day-to-day care of the patient. The Responding Clinicians rotate by shift.'

Name	Department	Role	Date/Time Added
<input type="checkbox"/> Hutter, Matthew M., MD	Surgery, Department of	Attending Physician	
<input type="checkbox"/> Hutter, Matthew M., MD	Surgery, Department of	Primary Care Physician	
<input type="checkbox"/> Evans, Nathaniel R., MD	Surgery, Department of	Responding Clinician	05/17/2007 3:33 PM
<input type="checkbox"/> Grady, Gail	Case Management	Case Manager	
<input type="checkbox"/> Hopkins, Cyrus C., MD	Infectious Disease	Consulting Physician	

Announcements

Clinical Pastoral Education fellowships for healthcare providers

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

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

Blum Center goes wireless

The Maxwell & Eleanor Blum Patient and Family Learning Center now has a wireless signal available for MGH patients and visitors. The joint project between the Blum Center, Patient Care Services Information Systems, and Partners Information Systems gives patients and families direct Internet access separate from the Partners network. The service comes in response to numerous requests from families and visitors who need to be in contact with work and others while visiting loved ones in the hospital.

The signal can be accessed from the Blum Center, on the first floor of the White Building. Patients and families are given instructions on how to access the Internet from their laptops. We are pleased to be able to provide this service to MGH patients and families.

The Blum Center is open Monday–Friday, 9:30am–6:30pm; Saturday, 11:00am–3:00pm.

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.

Choose a slogan; win a football

The MGH STOP (Stop Transmission of Pathogens) Task Force is sponsoring a contest to come up with a slogan to remind employees to practice good hand hygiene, and they need your help! The person who comes up with the winning slogan will receive a football autographed by Richard Seymour of the New England Patriots.

Only MGH employees are eligible:

- The slogan can be a single word, phrase, or complete sentence
- It should be distinct and not easily confused with other common terms or medical phrases
- It should be thoughtful and discreet, so as not to cause embarrassment or concern

Deadline for submissions is July 1, 2007.

All entries must include the employee's name, ID number, department, phone number and/or e-mail address.

Ideas can be sent to Infection Control, Bulfinch 330; or e-mail jtarselli@partners.org or hscleicher@partners.org; or drop submissions in the "Hand Hygiene Slogan Contest" box at the information desk across from Coffee Central.

The MGH Blood Donor Center

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

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

Employee Access Center moves

The Employee Access Center (EAC) is moving 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.

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Please contact Ursula Hoehl at 726-9057

Submissions

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

Next Publication

July 5, 2007

Educational Offerings – 2007

June

18

Managing Medical Emergencies
Related to Cancer

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

June

19

BLS Heartsaver Certification

Founders 325
8:00am – 12:30pm
Contact hours: TBA

June

19

Ovid/Medline: Searching for
Journal Articles

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

June

20

Advanced Wound Care Education:
Phase II (Day 2)

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: TBA

June

21

Preceptor Development: Learning
to Teach, Teaching to Learn

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: TBA

June

25

Management of the High-Acuity
Trauma Patient

O'Keefe Auditorium
8:00am – 4:30pm
Contact hours: 6.5

June

27

New Graduate RN
Development Seminar II

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

June

27

BLS Certification for Healthcare
Providers

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

June

28

Nursing Grand Rounds

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

July

2

CPR Re-Certification

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

July

9

CPR Mannequin Demonstration

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

July

9

Assessment & Management of
Patients at Risk for Injury

O'Keefe 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

Systems-improvement update

Question: I was on Ellison 11 recently and noticed they have some new signs and art work. Are all units going to get new art and signage?

Jeanette: I'm glad you noticed! Work is underway to replace pictures and art work in patient rooms and public corridors on all inpatient units. We're also replacing internal unit signs and signs at the entrance to patient care units. To date, new art has been installed in 90% of the Ellison building, with selection in progress for White, Blake, and Bigelow. Unit signage has been replaced in 90% of the Ellison building, and orders have been placed for White and Bigelow.

A team is developing a consistent, patient- and visitor-friendly 'look' for signage at unit entrances. And work is underway to improve way-finding between units and elevators on each floor.

Question: Can you update us on where the PCS departments currently located in Clinics and Vincent Burnham will be going?

Jeanette: The MGH Backfill Project to re-locate departments housed in Clinics and Vincent Burnham to make way for construction of the Building for the Third Century is almost complete. By mid-June all of the following moves will be complete:

- Pediatric Intensive Care Unit to Bigelow 6
- Volunteer and Interpreter Services to the Gray Basement
- Chaplaincy and (some of) Social Services to Founders 6
- PCS Systems Improvement to Founders 6
- Perioperative Administration (staff specialists and clinical nurse specialists) to Founders 6.

Question: At your open forum in April, you mentioned Joint Commission requirements around oxygen storage. Can you give us an update?

Jeanette: Great question. Soon you'll receive information about a process-improvement initiative led by Nursing, Materials Management, and Respiratory Care. The goals of the initiative are: 1) to ensure oxygen storage meets Joint Commission requirements, 2) replace existing oxygen tanks with new, lighter, MRI-compatible tanks, and 3) improve the storage and cleaning process.

New tanks have already been selected, and details on the process for separate storage of full and used tanks are being finalized along with the communication and education plan.

Question: When will we be getting new infusion pumps?

Jeanette: MGH has purchased 2,000 new, large-volume, smart pumps, which will be put into circulation in August following extensive in-service training, which will start in July. The Sigma large-volume smart pumps were trialed and selected by nurses. The goal is ultimately to convert all MGH infusion pumps to smart technology. We have already converted critical care syringe pumps to Medex smart pumps, and we'll select and implement a new smart PCA/epidural pump in early 2008. Future upgrades to all smart pumps will include wireless support and bar-code capability for drug recognition.

For more information about PCS service-improvement initiatives, contact your operations coordinator, nursing director, or George Reardon, director, PCS Systems Improvement, at 6-5392.



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