

March 15, 2007

Caring

HEADLINES

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High in the Andes, HAVEN advocates making a difference

(See story on page 6)



HAVEN advocates, Niza Troncoso (left) and Bonnie Zimmer, LICSW, on a humanitarian mission to Peru, stand before the ancient Incan city of Machu Picchu

Ensuring we have the right tools and resources to manage conflict

According to the Mediation Training Institute, a national organization providing conflict-management training to large corporations, preventable conflict in the workplace is a major factor in the rising cost of health care. The national average of voluntary resignations resulting from unresolved conflict is 65%, and that figure is higher in the healthcare arena. In 2005, a study in the *American Journal of Maternal/Child Nursing* reported the cost of replacing one specialty nurse is equivalent to 156% of that nurse's annual salary.

Whenever two or more people come together, there's potential for disagreement or conflict. And when those people are passionate about what they do and confident in their skills and abilities, the potential for discord is even greater. No wonder hospitals across the country are making a significant investment in conflict-management and interpersonal negotiation strategies for staff and leadership.

In the recent Staff Perceptions of the Professional Practice Environment Survey, staff

identified conflict-management as an area where we need improvement. If staff think we need help in this area... we need help in this area.

When you put as much time and energy into recruiting and retaining the best and the brightest as we do at MGH, losing even *one* clinician to unresolved conflict is *too many*.

As with any challenge, the best way to overcome conflict is to make sure we have the right tools. At MGH, we've committed a great deal of time, effort, and creativity to ensuring we have the tools and resources nec-

- decreased productivity
- an unwillingness to share information
- discomfort at work
- stress
- wasted time
- impaired decision-making

The same class suggests a number of approaches to conflict that may be appropriate at certain times in certain situations. Some situations may call for avoidance, while others require compromise, or collaboration, or accommodating another's point of view. This class provides a good overview of styles and strategies for managing conflict.

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essary to recognize, address, and manage conflict.

One class offered through The Norman Knight Nursing Center for Clinical & Professional Development, called, *Fighting Fires without Burning Bridges: Effective Strategies for Managing Conflict*, enumerates some of the negative outcomes associated with conflict:

Workforce Dynamics: Skills for Success, combines three separate classes into an intensive day-long seminar focusing on:

- working with a multi-generational workforce
- tips for skilled negotiating
- preparing for and engaging in difficult conversations

This is a comprehensive, interactive work-



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

shop that offers real-life strategies for dealing with conflict. Anyone struggling with discord or frustration in the workplace should sign up for this class (next scheduled for May 17, 2007).

We're fortunate that our department of Police, Security & Outdoor Services specializes in recognizing and diffusing volatile situations. They offer a number of opportunities for staff to learn and practice strategies for managing conflict.

Management of Aggressive Behavior (which encompasses both verbal and non-verbal strategies for handling conflict and aggression), Workplace Violence, and Understanding and Dealing with Conflict in the Workplace are some of the educational programs offered by Police, Security & Outdoor Services. These programs offer useful tips and information on how to recognize, prevent, and manage

difficult situations. And representatives from Police, Security & Outdoor Services are always happy to tailor presentations to the individual needs of units and departments. For more information, call 6-2121.

Two of our nursing directors (formerly called nurse managers), Adele Keeley, RN, and Susan Morash, RN, have earned master's degrees in Dispute Resolution and Conflict Negotiation. This specialized training and education makes them valuable resources on their respective units and to the hospital at large. Adele teaches Negotiation Skills in The Norman Knight Nursing Center, and Susan recently published the chapter, "Non-Events and Avoiding Reality," in the Dispute Resolution section of *The Negotiator's Fieldbook*. Both Adele and Susan should be considered sources of guidance and expertise in

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The MGH Cash Balance Retirement Plan

Question: I recently completed five years of service to MGH. Does that mean that I'm eligible for a pension?

Jeanette: MGH has a Cash Balance Retirement Plan. Employees are automatically vested in the plan after completing 1,000 hours of service in five consecutive years.

Question: Do I need to do anything to enroll in the Plan?

Jeanette: No. There are no forms to fill out and no enrollment process. You are automatically included in the plan upon meeting the service requirements.

Question: Do I need to contribute anything to the plan?

Jeanette: No. The hospital credits your account with an amount that's determined based on your age, annual pay, and length of service. The amount ranges from 5–15% of your pay. And I like the idea that the plan rewards you on a combination of your life experience and your years of service to MGH.

Question: Does the retirement-plan account earn interest?

Jeanette: Yes. The interest is guaranteed to be at least 6.5% per year.

Question: When do I receive the funds in my account?

Jeanette: Once you're vested, you can receive all or part of the money in your account in an immediate payment upon retirement or departure from MGH. Any monies not disbursed at that time will be used to provide a monthly benefit.

Question: My co-worker left MGH for a period of time, but she's been back for a few years. Is she enrolled in the plan?

Jeanette: That would depend on the length of time she worked at MGH before leaving and the duration of time she was

away. I suggest she call her Human Resources generalist who can help determine her status in the plan.

Question: Is the Cash Balance Retirement Plan different from my 403b account?

Jeanette: Yes. The Cash Balance Retirement Plan is different from the 403b, which is also known as a tax-sheltered annuity. Employees who elect to participate in a 403b account have pre-tax money withheld from

their paychecks to purchase mutual funds with Fidelity, TIAA-CREF, and/or Vanguard. This is a great way for employees to save money.

Question: Where can I get more information about the Cash Balance Retirement Plan?

Jeanette: Your Human Resources generalist can put you in touch with a benefits specialist who can provide you with more individualized information about your account.

Jeanette Ives Erickson

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dealing with sensitive situations and conflict-resolution.

And let's not forget the most important resource of all—ourselves. We're all professionals. We're all committed to the same higher purpose—helping people. While we may have strong feelings about our work and our patients, we are also possessed of kindness, tolerance, patience, intelligence, and understanding. And sometimes, those qualities can be the most effective

conflict-management tools at our disposal.

These are complex times. There are no simple solutions. But I can tell you this: tools are only as effective as the people who use them. No class can help; no person can help; no program can help until you take the initiative to use them.

If you are experiencing conflict in your current situation, I hope you consider the following resources:

- Employee Assistance Program (6-6976)

- Human Resources (3-2857)
- The Knight Nursing Center for Clinical & Professional Development (6-3111)
- Police, Security & Outside Services (6-2121)
- Occupational Health Services (6-2217)
- Your nursing or department director
- Chaplaincy (6-2220)

Update

I'm happy to announce that Charlene O'Connor RN, has accepted the position of clinical nurse specialist for the Blake and Gray Main Operating Rooms effective March 26, 2007.

Sexual Assault Awareness Month

Join the Employee Assistance Program, HAVEN, the Emergency Department Sexual Assault Program, and Police, Security & Outside Services to "Help Blow the Whistle on Sexual Assault"

**Thursday, April 5, 2007
11:00am–1:00pm
in the Central Lobby**

For more information, call 6-2121

Internet Safety

In this age of computer- and Internet-based information, many people fall victim to Internet-based crime. Please join Police, Security & Outside Services' senior investigator, Matt Thomas, for a free seminar, "Child and Adult Internet Safety"

**Wednesday, March 21, 2007
1:00–2:00pm
Thier Conference Room**

Topics of discussion will include: hacking, software-piracy, identity-theft, fraud, cyber-stalking, harassment, child-pornography, and Internet child abductions

Don't be a victim

Register via PeopleSoft Employee Self Service using course code PSISS

Refreshments will be served

For more information, call 6-2121

Black History Month: a call to action

—by Deborah Washington, RN, director of PCS Diversity

Black History Month was a little different this year at MGH. On February 7, 2007, there was a call to action in O’Keeffe Auditorium when black nurses, nursing students, and operations coordinators met with senior vice president for Patient Care, Jeanette Ives Erickson, RN, and director of PCS Diversity, Deborah Washington, RN.

This call to action was prompted by the significant amount of work that remains to be done in our commitment to diversity at MGH: recruiting a diverse work-

force; embracing cultural competence as part of clinical practice; and being vigilant to inconsistencies in the care and services we provide to patients and families.

A strong recruitment program has increased the number of nurses at MGH from diverse backgrounds. When we embarked on our formal diversity initiative more than a decade ago, we saw the value of having care providers who reflect the patients we serve. Our increasingly multi-ethnic patient population has proved that insight correct.

But there is unfinished business: inadequate

interpreter services for multi-lingual populations; unequal treatment of patients from diverse backgrounds; health education that doesn’t meet the needs of a multi-cultural community. Black History Month is a time to reflect and dialogue about issues that concern us.

The lively exchange of ideas in O’Keeffe Auditorium touched on such critical issues as academic degree-preparation for entry into practice; mentorships; and ensuring a respectful work environment.

There’s a cultural philosophy in the black community known as

‘giving back.’ It’s the concept of lending a hand to help others move forward. When someone achieves success, there’s a responsibility to help another move forward. Mentoring was a key topic at our meeting. Teaching and welcoming new employees was identified as one way to give back that requires participation from all.

Health statistics for African Americans in the United States are of great concern. Blacks live shorter lives and experience more chronic illnesses and diseases than whites. Access to care, the ability to afford care, and lifestyle are all contributing factors. Prejudice and discrimination also factor into the equation. Employing nurses from diverse backgrounds

is essential if we’re to foster broad-based change.

Talk of a welcoming work environment where everyone is accepted and respected spurred some thought-provoking discussion. One nurse asked, “How big does my name badge have to be before people believe I’m a nurse?”

Other quotes from attendees reflect the sentiment of the group.

Said Ines Jackson-Williams, RN, “The thing that strikes me the most is that in 2007, we’re still having these discussions. It saddens me, yet makes me determined to help bring about change.”

Leah Gordon-Rowe, RN, observed, “As a newly hired nurse, it’s nice to know you’re not

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“People have to feel needed. Frequently, we just offer a job and ‘perks.’ We don’t always offer people a purpose. When people feel there is a purpose and that they’re needed, there’s not much else to do except let them do the work.”

—Maya Angelou



At left: minority staff members dialogue with senior vice president for Patient Care, Jeanette Ives Erickson, RN, about recruitment and retention strategies
Opposite page: director of PCS Diversity, Deborah Washington, RN (above) facilitates a spirited and constructive question-and-answer session with staff

Black History Month

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alone. The fact that Jeanette met with us showed me her commitment to the future, to this community of nurses, and to the overall growth and enhancement of nursing at MGH. It's an honor to be a nurse here."

Said Mojisola Duval, RN, "Unity creates community."

"I was impressed by what I heard," said Ingrid Beckles, RN. "Too often we go about our day-to-day routine not thinking about how we can make a difference. I think there will be renewed energy

and support among black nurses at MGH. I'm convinced only great things can come from this."

"We can make a difference by working together," said Ron Greene, RN.

A number of black nurses from White 9 observed, "The meeting was great. We feel like we have a family at MGH and appreciate White 9's support of a diverse workforce. We have faced many challenges at MGH because of our race, but I'm happy to see that Jeanette

was so supportive, sharing her ideas on how we can be more effective in these efforts."

Fareeda Mahmoud, RN, said, "We need to achieve greater diversity throughout the hospital, and a crucial piece of that is making sure management not only verbally supports this effort, but physically supports it, as well."

"Together, we can move mountains and eradicate healthcare disparity," said Ivonny Niles, RN.

If this call to action showed us anything, it is that we will continue to ask the necessary questions. One day we will

reach the vision of Carter G. Woodson, the founder of Negro History Week, who said, "We should emphasize not Negro History, but the Negro in

history. What we need is not a history of selected races or nations, but the history of the world void of national bias, race, hate, and religious prejudice."



**"Have a vision.
Be demanding."**

— Colin Powell

**"Of all the forms of
inequality, injustice in
health care is the most
shocking and inhumane."**

— Reverend Martin Luther
King, Jr.

**"A little learning, indeed,
may be a dangerous thing,
but the want of learning is a
calamity to any people."**

— Frederick Douglass



HAVEN advocates making a difference

—by Niza Troncoso, domestic violence advocate, and Bonnie Zimmer, LICSW, director of the HAVEN program

In 2006, the MGH HAVEN program (Hospitals Helping Abuse and Violence End Now) entered into a partnership with the Harvard Program on Refugee Trauma (HPRT) and was invited to participate in a two-week training session at Harvard Medical School. The training introduced two groups of Peruvian healthcare providers to HPRT's Tool Kit for Healing the Wounds of Mass Violence. HAVEN's training sessions focused on domestic-violence screening in the healthcare setting and culturally relevant care for Latina survivors of intimate-partner violence.

HPRT's work in Peru began in 2003 after the Peruvian Truth Commission Report called for reparations to be made to those regions of the country that had been most affected by the 20 years of violence Peru had endured between 1980 and 2000. Their recommendations focused on healing and the mental-health consequences of that period of violence.

Six months after the HMS training, HAVEN was invited to travel to Peru to help trainees improve their healthcare response to patients who had survived political and gender-based violence.

On November 3, 2006,

Niza Troncoso, domestic violence advocate, and Bonnie Zimmer, LICSW, director of HAVEN, boarded a plane for a ten-day mission to Peru.

While in Peru, Troncoso and Zimmer met with representatives from the University of San Marcos School of Medicine, the Ministry of Women's Health, the Ministry of Health, nurses, physicians, psychologists, social workers, and outreach workers. With the help of Peruvian guides and hosts, Pedro Mendoza, a primary care physician, and Victoria Pareja, a psychologist, they visited the city of Lima and two villages in the Andes: Ayacucho and Cuzco. As

they traveled throughout the country, they were embraced by people who dubbed them, "Las chicas de Harvard."

Peru is a country of stark contrasts. Decimated by 20 years of violence that claimed the lives of 60,000 people, the citizens of Peru are nonetheless energized, passionate, and determined to do more than just survive. Troncoso and Zimmer visited the Andean village of Ayacucho, which was a hub of terrorism from 1980 to 2000. Literally 100% of the people of Ayacucho are primary or secondary victims of the violence that ended less than a decade ago. Despite the personal trauma they've endured, they have organized a number of creative, community-based programs to begin the healing process. And they've done this with very few resources.

During visits to health centers in the Ayacucho region, Troncoso and Zimmer heard about efforts to organize programs to help prevent child abuse, help physicians screen and respond appropriately to patients with histories of torture and violence, help women abused by their husbands, and help battered women living in impoverished areas. Troncoso and Zimmer shared ideas about training programs, support-group models, and the emerging research on the connection between trauma and mental-health issues. Healthcare providers in Ayacucho spoke about their own experiences with violence, torture, and loss, and the need to care for caregivers even as they learn to be better providers for their patients.

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At left: Hospital in Huaycan, an area of Lima where refugees from Andean villages fled during the Shining Path terrorist years

Opposite page top: Plaque reads: "To those Peruvian men and women, victims of the longest and most painful period of violence ever suffered in our nation. May the process we are initiating today bring us closer to justice and a true and lasting peace."

Opposite page bottom: Troncoso and Zimmer with their Peruvian hosts and some local healthcare providers.

Some of the major problems facing the people of Peru include:

- extreme poverty and lack of resources
- the impact of political violence on community and mental health
- the impact of political violence on healthcare providers. In Ayacucho, it is assumed that 100% of healthcare workers are themselves direct or indirect survivors of violence

Some efforts already underway in Peru include:

- ‘promotores de salud’ are hired from the community to provide outreach, health-education and support, working closely with medical providers to reach underserved areas of Peru

- teachers being trained to identify signs of depression, alcohol and drug abuse, and suicidality among the students they serve
- economic programs being integrated into domestic-violence support groups. Using native arts such as knitting, leather working, and painting, members of the group create crafts and organize other groups to do the same
- health fairs to provide information on child-safety and how to prevent child-abuse
- an integrated program for survivors of gender-based violence is designed to minimize barriers to resources and reduce secondary

- trauma to victims
- The Maternal Child Health hospital in Lima has developed specialized services for pregnant adolescents, including help with legal needs, psycho-social education, and support throughout the pregnancy and birth

Throughout the country, Troncoso and Zimmer observed many examples of how culturally diverse and inclusive messages were communicated to the public. Posters and billboards were used to promote good mental health and prevention. Some signs proclaimed: “Mental health begins with the first hug: express your feelings, thoughts and opinions with your child-



ren,” or, “Mental health is the ability to love, work, and play.”

Public-awareness campaigns focused on images of healthy families, posi-

tive child-rearing practices, and the beauty and resilience of the country and the people of Peru. In one specialized hospital that sees patients from remote, rural areas, special ‘picture signs’ were made to help non-Castilian speaking residents learn about the availability of medical care.

The HAVEN team was inspired by the passion and resourcefulness of a people struggling with their own trauma and painful memories, armed with few resources or educational opportunities. It is the hope of the HAVEN team to nurture a Peruvian sister program that would share resources, engage in meaningful cultural exchange, continue to provide technical assistance, and allow us to share our knowledge and skill with our new friends in Peru.

For more information about the HAVEN program at MGH, please call 724-0054



End-of-life care: one of the privileges of being a nurse

My name is Kellyann Jeffries, and I am a staff nurse on the Bigelow 9 Respiratory Acute Care Unit (RACU). 'Elle' truly inspired me to tell the story of how she accepted her fate with a grace and dignity that were unmatched in my experience. Elle was a retired nurse in her early 70s who was regarded by all who knew her as amazing. From staff, family, and friends, I heard how, when you were in her care, there was nothing to worry about; she was tough, but always an advocate. Staff told how she exuded a special kind of strength that made people want to follow her. And as her son said, "We did, because she was always right."

I saw that spark in her as I cared for her. Though she couldn't speak because she was on a ventilator for most time I cared for her, I was able to read her lips, and we 'spoke' often. This year, Elle began a fight with leukemia that was complicated by a series of events that left her ventilator-dependent and compromised her immune system with a lung infection. While frequently transfusing Elle, we vigilantly watched her blood counts and aggressively

treated the infection that was keeping her ill. At the same time, her multi-disciplinary RACU team continued to try to wean her off the ventilator. She would make some progress and then be set back by bleeding or an ongoing infective process.

In the RACU, our multi-complex patient population challenges the best of clinicians. Patients are often ventilator-dependent, tracheotomized, and are almost always unable to speak. We learn to read lips, ask closed-ended questions to hone in on what patients are trying to say, and work hard to make those connections nurses make. Often, in addition to these challenges, patients in the RACU have episodes of delirium or altered mental status, the result of fluctuations in their oxygenation, medications, ability to sleep, or changes in their neurological status related to their illness. With all that going on, connecting with patients can be extremely challenging.

In the RACU, we also deal with many end-of-life situations, where patients and families have received all the benefits of our medical interventions and have reached a clinical cross-

road triggering tough questions about how, or whether, to proceed with medical treatment. We talk about the kind of care that should be delivered, quality-of-life issues related to ventilator-dependence, and we help them come to terms with what the future will bring. Helping a terminally ill patient see the big picture and identify an end-point of care is a daunting experience for anyone. But we have a great team in the RACU. We support each other as well as our patients and families in coping with these difficult decisions. It's important to have that continuity in the physical and emotional support we provide to our patients.

Elle told us how she used to care for patients 'like her,' and never thought this would be 'how she would go.' She spoke frankly of the frustration of not being able to talk and how much it meant to her when someone responded quickly to her call bell. Though her body was failing, her mind was very much intact. She seemed very willing to share how it felt to be in her situation. She was very clear about the things she needed from her healthcare providers,

friends, and family. As someone who's worked with this patient population for two years, I was eager to hear the insights this compassionate and intelligent nurse could give me as she was on the receiving end of our care.

One night, Elle seemed particularly anxious so I asked if she might like to be bathed. The warm water and back-rub with her favorite apricot lotion and fresh bed linens seemed to ease her anxiety. As I left her room, she said, "Thank-you. That made all the difference. Not the medications, not the vital signs. To me, that made all the difference."

My relationship with Elle developed over several weeks. On the weekend before Christmas, I was with her when news came that her infection had spread to her heart, and there was nothing more we could do for her. She was told she could pass away at any time,

and we wanted to focus on her comfort. This devastating news was delivered by her long-time primary care doctor, who was visibly upset giving her such tragic news. Elle's reaction was acceptance. Always the nurse, she began making sure everyone around her was okay. Later, she quietly asked me to sit with her, saying "This is a lot to swallow. But what can I do?"

Elle talked about her children and her concern for them; she talked about her grandchildren and how she'd only seen the youngest one once. She reiterated how frustrating it was not to be able to talk. She asked if it would be okay for her sisters to spend the night. On Christmas Eve, Elle and her sisters spent the night together, much as they had as children, but with an added 'preciousness' to every moment. The strength of their bond was evident.

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Kellyann Jeffries, RN
staff nurse, Respiratory Acute Care Unit

Clinical Narrative

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As Elle communicated with the many family members and friends who visited, I often acted as translator, reading her lips. She'd tell them, "Don't be afraid to talk about it, my death. I'm okay. This is why family is so important. Please stay close to each other. It's so important."

Elle was a woman of faith, and this was very evident when she knew her death was imminent. We discussed her death. She said that, "God would call her when it was her time," and she expressed understandable doubt saying, "Who really knows what's next?"

Elle remained strong.

And although sad to be leaving her life and family, right up until the end, she had a peace and dignity that continues to overwhelm me.

This experience reminds me of the anonymous quotation: "Life lives, life dies. Life laughs, life cries. Life gives up and life tries. But life looks different through everyone's eyes."

Working with people at the end of their lives

and seeing life through their eyes is a gift. People choose to spend their lives in their own ways. Helping them make sense of it; helping families reflect on it; comforting them through the sadness of having to leave the lives they've built for themselves is one of the true privileges of being a nurse.

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

What a beautiful story. With all the clinical concerns, technological interventions, and medical setbacks surrounding Elle's care, Kellyann was fully present to her during the last weeks of her

life. She made sure compassion and humanity were part of Elle's last days. Kellyann's concern for Elle's comfort and peace of mind established a sense of trust between them. And the fact that Kellyann was able to read her lips and help her communicate with her family and friends only strengthened that bond.

As much as Kellyann was an integral part of Elle's end-of-life care, Elle (always the nurse!) gave Kellyann something, as well. Kellyann will carry this experience with her and incorporate these lessons into her future practice. It really is a privilege to care for patients at the end of life.

Thank-you, Kellyann.

Occupational Therapy Month at MGH

Captain Kathleen Yancosek, OTR/L, of the Walter Reed Army Medical Center, will present, "Care of the Military Upper Extremity Amputee Patient" and speak about her work with functional prosthetic training and returning veterans of the Iraqi war. Please attend this inspiring, relevant presentation. All are welcome.

April 12, 2007 at 5:30pm
Simches Research Building, Conference Room 3110
Reception to follow

Join us for this Occupational Therapy Month event
 For more information, call 4-0147

April Vacation Club MGH Backup Childcare Center

April 16-20, 2007
Hours: 7:30am-5:45pm
Cost: \$275 for five-day week
individual days: \$60 per child

Reservations can be made starting March 5, 2007

The program is intended for 6-12 year-olds and will include: a juggling performance and lessons with Dave the juggler; "Mirrors and Kaleidoscopes" with Steve Lechner; an Omni Theater presentation; The Big Apple Circus; face-painting and circus activities at the center

The Backup Childcare Center will provide care and activities for younger children (aged 15 months-5 years old). Call or stop by to make a reservation. A non-refundable pre-payment is required for all Vacation Week slots

For more information, call 617-724-7100

MGH College Fair

Come explore your options
 at the MGH College Fair

March 28, 2007
165 Cambridge Street, Suite 200
11:30am-4:00pm

The Fair will help you explore opportunities to advance your education and learn more about careers in healthcare

Colleges and universities featured will be:

- Bunker Hill Community College
- Cambridge College
- Emmanuel College
- Fisher College
- Mass Bay Community College
- Massachusetts College of Pharmacy
- MGH Institute for Health Professions
- Northeastern University
- Quincy College
- Roxbury Community College
- Suffolk University
- University of Massachusetts, Boston

For more information, visit our website at: http://is.partners.org/hr/New_Web/mgh/mgh_training.htm

New Graduate Nurse in Critical Care Program graduation

—by Gail Alexander, RN, program coordinator

On February 8, 2007, 17 nurses from MGH and the North Shore Medical Center were recognized for successfully completing the New Graduate Nurse in Critical Care Program. This is the 11th class of graduates from this six-month orientation program designed to give new nurses extended knowledge in critical-care nursing.

Certificates of completion were awarded to the following MGH nurses:

- Jennifer Campbell, RN (Cardiac Surgical Intensive Care Unit)
- Jennifer Kurtz, RN (Cardiac Surgical Intensive Care Unit)
- Megan Connors, RN (Coronary Care Unit)
- Rosalind Trent, RN (Coronary Care Unit)
- Leah Gamello, RN (Medical Intensive Care Unit)
- Amber Orłowski, RN (Medical Intensive Care Unit)
- Jessica Holigan, RN (Neuroscience Intensive Care Unit)
- Elizabeth O'Neil, RN (Neuroscience Intensive Care Unit)
- Nicole Blanch, RN (Pediatric Intensive Care Unit)
- Danielle Roberge, RN (Pediatric Intensive Care Unit)

- Kathryn Slattery, RN (Surgical Intensive Care Unit)
- Alison Smith, RN (Surgical Intensive Care Unit)

North Shore Medical Center nurses receiving certificates of completion were:

- Janina Gymziak, RN (Cardiac Surgery Unit)
- Lesley Yamaki, RN (Cardiac Surgery Unit)
- Deborah Bronstein, RN (Intensive Care Unit)
- Valerie Hattersley, RN (Intensive Care Unit)
- Lauren Nadeau, RN (Intensive Care Unit)

The ceremony was moderated by associate

chief nurse, Jackie Somerville, RN, who recalled the inception of the program in 2001, to help prepare for the impending nursing shortage, particularly in critical care. Since that time, 93 MGH nurses have completed the program.

Senior vice president for Patient Care, Jeanette Ives Erikson, RN, congratulated the graduates and noted that five of the 29 preceptors who participated in the program were themselves graduates of the program. Ives Erikson commended them for 'giving back' to the hospital and enhancing their own professional development.

John Murphy, RN, nurse manager of the Neuroscience Intensive Care Unit, shared his observations about the changing technology in the critical care setting, noting one thing that hasn't changed is the importance of the nurse in this highly specialized area of care.

New graduate, Elizabeth O'Neil, RN, and her preceptor, Joann Burke, RN, read narratives they wrote describing their respective experiences caring for a young, critically ill mother and her family. The patient ultimately became an organ donor following cardiac death. Though caring for a donor after cardiac death was a new experience for both nurses, Burke was able to provide wisdom and emotional support for O'Neil and the patient's family throughout the process.

Mary McKenna Guanci, RN, clinical nurse specialist in the Neuroscience ICU spoke of the special relationship that develops between preceptor and novice nurse and the evolution of that relationship as the new nurse gains experience and begins to practice independently.

Gail Alexander, RN, program coordinator, thanked unit leadership, program faculty, and preceptors for contributing to the success of the program.

For more information about the New Graduate Nurse in Critical Care Program, contact the nurse manager or clinical nurse specialist in any ICU, Gail Alexander, at 617-726-0359, or visit the Knight Nursing Center for Clinical & Professional Development website at: www.mghnursing.org.



New Graduate Nurse in Critical Care Program graduates (back row, l-r): Deborah Bronstein, RN; Valerie Hattersley, RN; Leah Gamello, RN; Elizabeth O'Neil, RN; Amber Orłowski, RN; Jessica Holigan, RN; Jennifer Kurtz, RN; Rosalind Trent, RN; Jennifer Campbell, RN; Megan Connors, RN; and Leslie Yamaki, RN (Seated, l-r): Lauren Nadeau, RN; Kathryn Slattery, RN; Nicole Blanch, RN; Alison Smith, RN; and Danielle Roberge, RN (Not pictured: Janina Gymziak, RN)

Chastain certified

Patricia Chastain, PT, physical therapist, became a pediatric certified specialist by the American Physical Therapy Association, in February, 2007.

Johnson appointed

Elizabeth Johnson, RN, clinical nurse specialist, was appointed a member of the Advanced Oncology Nursing Certification Committee in February, 2007.

Quinn appointed

Thomas Quinn, RN, project director, MGH Cares About Pain Relief, was appointed trainer for the End-of-Life Nursing Education Curriculum in Oncology, in November, 2006, and trainer for the Hospice and Palliative Nurses Association Generalist Clinical Review in February, 2007.

Parlman presents

Kristin Parlman, PT, physical therapist, presented, "The Use of Case Discussions to Facilitate Evidence-Based Practice in Acute Neurologic Physical Therapy," at the combined sections meeting of the American Physical Therapy Association, February 17, 2007.

Radwin appointed

Laurel Radwin, RN, nurse researcher, was appointed a member of the abstract review panel of the Academy Health Interdisciplinary Research Group on Nursing Issues Program in February, 2007.

Zachazewski presents

James Zachazewski, PT, physical therapist, presented, "Rehabilitation of the Adolescent Athlete's Shoulder," at the combined sections meeting of the American Physical Therapy Association on February 15, 2007.

Zachazewski also presented, "Rehabilitation of Knee and Leg Injuries," "Hip and Groin Injuries," "Functional Anatomy and Examination of the Lumbar Spine," and, "Core Instability and Stabilization Training," in San Diego, February 28–March 2, 2007.

Fallon certified

Katie Fallon, RN, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in October, 2006.

Kracher certified

Jean Kracher, RN, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center, in January, 2007.

Bardzik certified

Susan Bardzik, RN, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in October, 2006.

Drapek certified

Lorraine Drapek, RN, became certified in Radiation Oncology, by the Oncology Nursing Certification Corporation in November, 2006.

Jampel presents

Ann Jampel, PT, physical therapist, presented, "Transforming Clinical Education: Creating Academic and Clinical Partnerships," at the American Physical Therapy Association in Alexandria, Virginia, in February, 2007.

Carroll presents

Diane Carroll, RN, nurse researcher, presented, "Quality of Life in Implanted Cardioverter Defibrillator Recipients: the Impact of a Device Shock," at the sixth Annual Cardiovascular Nursing Conference, at the North Shore Medical Center, February 8, 2007.

Nurses, physician, publish

Patricia Mian, RN; Susan Warchal, RN; Susan Whitney, RN; Joan Fitzmaurice, RN; and, David Tancredi, MD, authored the article, "Impact of a Multi-Faceted Intervention on Nurses' and Physicians' Attitudes and Behaviors Toward Family Presence During Resuscitation," in *Critical Care Nurse*, in February, 2007.

McCorkle appointed

Charles McCorkle, LICSW, clinical social worker, was appointed, honorary clinical instructor, Smith College School for Social Work, for the academic year, 2006–2007.

Mulgrew and Squadrito present

Physical therapists, Jacqueline Mulgrew, PT, and Alison Squadrito, PT, presented, "Management of the Acute Care Patient," at St. Peters Hospital in Albany, New York, February 3–4, 2007.

Arnstein publishes

Paul Arnstein, RN, clinical nurse specialist, authored the chapter, "Pain Management," in *Fundamentals of Nursing: Concepts, Process and Practice*, 8th edition.

Zachazewski publishes

James Zachazewski, PT, physical therapist, authored several chapters in the textbook, *Scientific Foundations and Principles of Practice in Musculoskeletal Rehabilitation*.

Burchill and Curley present

Occupational therapists, Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, presented, "Flexor/Extensors: Management of Common Injuries," and "Splinting for Flexor and Extensor Injuries," at Tufts University in February 2007. Curley also presented, "Extensor Tendons: Management of Injuries."

Multi-disciplinary team presents

Kate Barba, RN; Andrea Bonnanno, PT; Diane Carroll, RN; Sheila Golden-Baker, RN; Grace Good, RN; Mary Ellen Heike, RN; Jennifer Lassonde; Barbara Moscovitz, LICSW; and Alison Squadrito, PT, presented their poster, "Staff Survey Using Geriatric Institutional Assessment Profile, (GIAP)," at the 10th Annual NICHE Leadership and Users Conference, in New York, February 5–8, 2007.

The Tracheostomy Quality Team

Ensuring quality care for tracheostomized patients throughout the hospital

—by Marian Jeffries, RN, and Susan Gavaghan, RN

The Tracheostomy Quality Team was established in 2005 when it became clear that caring for more than 600 tracheostomy patients per year on general care units was the new reality. Working with the Surgical Clinical Practice Management team, ensuring safe, high-quality airway-management for patients on all units became our goal. Advocating for collaboration and coordination of care became our mission. The Tracheostomy Quality Team is comprised of two advanced practice nurses (Susan Gavaghan, RN, of the Respiratory Acute Care Unit; and Marian Jeffries, RN, of the Thoracic Surgery Unit), a respiratory therapist (Neila Altobelli, RRT) and a speech language pathologist (June Williams, SLP).

Tracheostomy algorithms for ventilated and non-ventilated patients were developed and provide a framework for our multi-disciplinary team. The algorithms identify steps to help patients move toward tracheal decannulation while assessing key indicators such as, secretion clearance, adequate gas exchange, aspiration potential, swallowing issues,

vocal strength and wound concerns. The algorithm guides our care, but input from all disciplines is essential to ensure positive outcomes for tracheostomized patients throughout the hospital. Our goal is to support the care team in providing safe, high-quality care for this specialized patient population.

A pilot study of 100 patients with new tracheostomies demonstrated the need for education around many bedside-care and technology issues. While the Tracheostomy Quality Team initiated the effort to improve the quality of care for these patients, a core team of dedicated respiratory therapists currently follows this population on a daily basis and has made significant improvements in the trajectory from placement to decannulation.

A daily e-mail communication tool was developed to inform clinical leadership of the identity and location of airway-management (tracheostomized) patients on their respective units. Included in the e-mails are attachments and links to resources and materials that focus on optimizing care for this population. Our goal is to improve the quality

of life for these patients through education and multi-disciplinary contributions.

Mr. H was an active 76-year-old man who had been involved in a motor vehicle accident that resulted in facial fractures, a loss of teeth, and a loss of vision in his left eye. In addition to limited vision, Mr. H was hard of hearing, unable to speak, smell, taste, or eat. Now hospitalized for oral surgery to correct his facial injuries, he had a tracheostomy tube fitted to his hearing aids and was placed in a private room on a general care unit for pain and airway-management.

When the Tracheostomy Quality Team first encountered Mr. H, he was in bed, mildly discouraged about his condition, and frustrated with his lack of ability to communicate clearly. Mrs. H was supportive but concerned about her husband's condition and declining optimism. Mr. H wasn't able to swallow his saliva; he was suctioning his mouth with a suction wand he clutched in his hand. His nurse was trying to meet his needs, but having cared for only one trached patient previously, she was overwhelmed by the complexity of his situation.



Clinical nurse specialists, Marian Jeffries, RN (left), and Susan Gavaghan, RN

After introducing ourselves to the nurse, Mr. H, and his wife, we assessed Mr. H, suctioned him, evaluated his trach pressure, obtained a replacement cannula for his appliance, and made sure all the necessary equipment was at his bedside. We assured Mr. H that his oxygen needs were being met, but his secretions were too copious to alter his care at that time. Our goal was to help mobilize him, expand his lung volumes, prevent atelectasis and hopefully help him cough up secretions independently. We suggested that staff assess Mr. H's suctioning needs more frequently, monitor his pain, and increase the frequency of his mouth care. These measures seemed to comfort him. After conveying this information to the nurse and the unit respiratory therapist and documenting our findings in Mr. H's record, we moved on to our next patient.

A few days later when we returned to Mr. H's

room to assess his progress, he was experiencing some distress. His temperature was 100°, and he had been started on antibiotics for an apparent infiltrate. He was wheezing audibly with each deep breath, and his breath sounds were decreased markedly on the left side.

The unit clinical nurse specialist and the Tracheostomy Quality Team worked together to develop a plan of care to address the increased acuity of Mr. H's condition. We reviewed bedside practices and reinforced airway-management with unit staff, and the clinical nurse specialist was now engaged to follow up with staff and Mr. H.

Mr. H was reassured by the presence of the team, and we immediately started him on a nebulizer treatment. Sitting with him at eye level and speaking to him about his care and the plan to remove his trach tube before being discharged

continued on next page

Clinical Nurse Specialists

continued from previous page

was a pivotal point for Mr. H. He needed that hope that the airway tube wasn't going to be necessary forever. He grabbed our hands individually and mouthed the words, "Thank-you."

Following the nebulizer treatment, Mr. H was suctioned for secretions and his oxygen mask put back on. We reminded him that keeping the oxygen mask on helped keep his secretions less viscous. Having more fluid secretions enabled him to have a clear airway and stronger cough. Our speech-language pathologist assessed Mr. H's ability to swallow, and realized that with some exercises and support he'd be able to regain this ability quickly. Essentially, he had forgotten how to swallow. Once we re-established his ability to swallow and cough effectively, he became a candidate for a smaller tracheostomy tube. A surgical consult was

arranged to down-size his tracheostomy tube to facilitate secretion-clearance.

We reviewed care of the tracheal opening with his nurse, and an official speech-language consult was requested to begin strengthening the muscles in his neck. A physical therapy consult was requested to address Mr. H's fear of mobilization.

It was wonderful to see Mr. H's vitality return the very next day. He literally turned around overnight. He was able to communicate that his fear of moving was really a fear of occluding his airway and suffocating.

Mr. H's tracheostomy was down-sized, and his secretions were more controlled after the speech-language consult. He was able to swallow his saliva once again. The skin around his trach site improved, and he was able to ambulate in the hallway with assistance. After a brief,

but successful speaking-valve trial, Mr. H was decannulated and able to go to a rehabilitation facility before being discharged home.

It is a privilege to care for patients who literally have no voice and help them move forward in their recovery. We will continue to assess practice, improve quality, and monitor the care of tracheostomized patients to improve outcomes. Tracheal down-sizing and decannulation, the use of speaking valves, preventing aspiration, and the early placement or discharge of tracheostomized patients are realistic goals of the Tracheostomy Quality Team. By reviewing each case individually, assessing options, implementing a realistic care plan, and involving the patient and family in the multi-disciplinary team, we will continue to improve outcomes and 'give voice' to this silent population.

For more information about the Tracheostomy Quality Team, contact Marian Jeffries, RN, at 4-4031.

National Patient Safety Week

In recognition of National Patient Safety Week, March 4-10, 2007, the Office of Quality & Safety gave Nutrition & Food Services gift certificates to a random number of staff who submitted reports during that week. Teresa MacDonald, RN, commented on how user-friendly the system was. "It's a great way to identify issues and prevent accidents."

Cathy Griffith, RN, likes the immediacy of the reporting. "You can file a report as soon as you notice something. It's a very useful tool for highlighting system issues and improving processes."

Since its inception in March, 2006, the electronic Safety Reporting System has received more than 9,000 reports from employees, providing important and timely information to help ensure a safe and hazard-free environment for patients, families, staff, and visitors.



MacDonald (left) and Griffith

Joan Fitzmaurice, RN, director of the Office of Quality & Safety thanks staff for their participation and attention to detail when sharing suggestions.

For more information about the electronic Safety Reporting System, call 6-9282.

Published by:

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

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

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Articles/ideas should be submitted by e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

Next Publication Date:

April 5, 2007



Job Shadow Day gives students a reason to get excited about careers in health care

—by Galia Wise, manager, MGH-East Boston High School Partnership

Said one high-school student who participated in the 12th annual city-wide Groundhog-Job Shadow Day program, “I didn’t know MGH had such a good reputation and helped so many people.” On February 2, 2007, Groundhog Day, 41 Boston Public High School students, the largest group ever, visited MGH to learn more about careers in health care by ‘shadowing’ staff for part of the day. Through the Job Shadow Program, students learn about the professional work environment and the world of health care from the perspective of healthcare professionals. Students spend part of the day observing, asking questions and assisting their work-experience host whenever appropriate, while getting first-hand experience in the dynamic healthcare setting.

Students are exposed to a wide variety of educational and clinical experiences. One student observed surgery in the operating room, another saw cancer cells through a microscope, while another observed patient exams and dialogued with MGH nurses. This

was a mutually beneficial day for students and staff as they shared stories and learned from one another.

Joining East Boston High School students to explore the world of health care were ten students from Health Careers Academy, a Boston Public School located in the Fenway area. Health Careers Academy has

entered into a new partnership with MGH, spearheaded by Patient Care Services and the MGPO. Job Shadow Day is a school partnership initiative coordinated through the MGH Community Benefit Program.

More than 40 staff members volunteered to participate in Job Shadow day, including staff

from Patient Care Services, Radiology, Pharmacy, Medicine, and Pathology. For many of the students, this was their first glimpse at the inner workings of a major teaching hospital.

One student observed, “I never knew how big MGH was and how many positions there were in just one department.”

Another said, “I can see that people here work really hard to help the patients.”

Job Shadow Day was about learning outside the classroom and seeing what it takes to have a career in health care.

In Boston, Job Shadow Day is a partnership of the Boston Public School system, the Boston Private Industry Council, and the Massachusetts Department of Education and Junior Achievement.

For more information, about the Job Shadow program, contact Galia Wise at 4-8326.



Educational Offerings

March 1, 2007

<i>When</i>	<i>Description</i>	<i>Contact Hours</i>
March 22 1:30–2:30pm	Nursing Grand Rounds O'Keeffe Auditorium	1
March 22 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	6.5
March 26 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other FND 325	6.8
March 27 8:00am–4:00pm	Medical-Surgical Nursing Certification Prep Course (Day 2) Yawkey 10-660	TBA
March 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	3.6
March 28 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification FND325	---
March 29 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills FND325 (No BLS card given)	---
March 30 8:00am–12:00pm	BLS Certification—Heartsaver FND325	---
March 30 8:00am–4:30pm	Coronary Syndrome O'Keeffe Auditorium	TBA
March 30 12:00–3:30pm	Basic Respiratory Nursing Care Bigelow Amphitheatre	---
April 2 8:00am–12:30pm	BLS Certification for Healthcare Providers FND325	---
April 3 and 4 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	TBA
April 3 7:30–10:30am/12:00–3:00pm	CPR—American Heart Association BLS Re-Certification FND325	---
April 6 8:00am–4:30pm	End-of-Life Nursing Education Program O'Keeffe Auditorium	TBA
April 10 8:00am–4:30pm	BLS Instructor Program FND325	---
April 11 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	3.6 (for mentors only)
April 11 8:00–11:30am	Intermediate Arrhythmias Yawkey 10-660	3.5
April 11 12:15–4:30pm	Pacing Concepts Haber Conference Room	4
April 11 11:00am–12:00pm	Nursing Grand Rounds Haber Conference Room	1
April 11 1:30–2:30pm	OA/PCA/USA Connections “Preparing for your Doctor’s Visit.” Bigelow 4 Amphitheater	---
April 13 and 30 8:00am–3:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	---

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

DVT Awareness Month: making education fun

—by Lynn Oertel, RN, clinical nurse specialist

DVT Awareness Month is designed to raise public awareness about the risks and treatment of deep-vein thrombosis (DVT), a condition that kills more people in the

United States than AIDS and breast cancer combined.

A deep-vein thrombosis (DVT) is a blood clot in an upper or lower extremity. Serious compli-

cations can occur when a blood clot travels to the lungs, blocks a pulmonary artery or one of its branches and causes a pulmonary embolism. Every year, nearly 300,000 peo-

ple in the United States die from DVT-related conditions, and approximately 600,000 are hospitalized for complications.

During the month of March, staff of MGH Anticoagulation Management Services are embarking on a special project to help raise awareness about DVT. They're

creating colorful 'DVT socks,' highlighting the importance of DVT risk-assessment. If you think you, a friend, or family member may be at risk, talk to your doctor about ways to protect against DVT.

For more information about DVT, go to: www.preventdvt.org, or call Anticoagulation Management Services at 6-2768.



At left: Staff of the Anti-Coagulation Unit (l-r): Palmi Riposa, RN; Barbara Mahoney, RN; Vivine Wilson, patient service coordinator; and Lynn Oertel, RN, clinical nurse specialist, show some of the festive socks created by staff for DVT Awareness Month. The project combines fun, creativity, and patient-education to bring important information to the public

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