Caring Headlines
February 7, 2008

# The Anthony Kirvilaitis Jr. Partnership in Caring Awards

*See story on page 4*

Kirvilaitis award recipients, Chung Wah (Patrick) Wong and Sheila Provencher, center, with senior vice president for Patient Care, Jeanette Ives Erickson, RN (left), and other award nominees (l-r): Vanessa Evans, Bernida Washington, and Domingas Gomes.

The newsletter for Patient Care Services
Massachusetts General Hospital

# An interview with Gregg Meyer, MD

In January, 2007, Gregg Meyer, MD, was named senior vice president for the MGH Center for Quality & Safety. In that role, Gregg is responsible for developing and coordinating our many quality and safety programs and initiatives, a formidable challenge as you well know. Recently, I had an opportunity to speak with Gregg about this important work, and I'd like to share some of that interview with you.

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

*Jeanette*: Gregg, welcome. It's hard to believe a year has passed since your appointment as senior vice president for the Center for Quality & Safety.

*Gregg*: It is hard to believe. But we've accomplished a lot in the past year. We've made some excellent progress in the areas of hand hygiene and medication reconciliation. We still have a lot of work to do, but I think we've come a long way in terms of developing the structure and processes that will allow us to address many of our quality and safety issues.

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>
> —Gregg Meyer, MD

*Jeanette*: I understand the Center for Quality & Safety has established its goals for 2008. Can you share those with us?

*Gregg*: Of course. I want everyone to be aware of our goals as we move forward together with this work. After a systematic review of our quality and safety challenges, we identified what we consider to be our highest-priority goals for 2008. They include:

- Reduce healthcare-associated infections: maintain hand hygiene gains and reduce catheter-associated blood-stream infections in all ICUs
- Reduce the rate of patient falls with injury
- Reduce the incidence of hospital-acquired pressure ulcers
- Improve select, inpatient, service-related metrics: reduce complaints about noise, improve staff responsiveness, nurse communication, and physician communication
- Improve the quality of hand-offs through analysis, implementation of new policies, new IT tools, and research
- Evolve the Patient Care Assessment Committee by developing a coordinated plan for departmental quality measurement and improvement
- Expand the use of our Safety Reporting System by increasing the rate of reporting and demonstrating safety improvements resulting from reports
- Develop a strategy for engaging patients and families and increasing awareness of the patient experience
- Increase presence in quality and safety research, including quality measurement-development

*Jeanette*: That's an impressive list. How can we help you?

*Gregg*: Your appointment of Keith Perleberg as the new director for Patient Care Services' Office of Quality & Safety is an enormous help. Keith is part of the

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leadership team I meet with every month to chart institutional strategies. Having that access, that open dialogue between us, is vital as we address issues and challenges that affect the entire hospital.

Also, I want the Center for Quality & Safety to operate on a de-centralized model. For that, I need all the chiefs, vice presidents, and leadership throughout the organization to really *own* quality and safety. Whenever anyone asks me how big my staff is, I have a very clear answer: I have a staff of twenty thousand. The only way to effect real change is with a de-centralized model where there's local ownership working in concert with centralized support and coordination.

*Jeanette*: Integrating quality and safety throughout the whole organization is a big challenge. Where do you begin?

*Gregg*: The key is communication—relationship-based communication. It's essential to share information. How many times have clinicians at MGH worked long and hard to solve a problem only to discover that someone else had solved it a year ago? We don't want to discourage innovation or creativity, but we need to share those solutions, coordinate our efforts, make the best use of our time and resources as we address the issues and concerns that affect us all. We want to make sure we're all pulling together in the same direction at the same time.

A perfect example of that is the upcoming Magnet re-certification site visit. Magnet is this year's Joint Commission. If you ask me what's foremost on my mind right now, it's Magnet. We're fortunate to have a capable, committed staff in Patient Care Services preparing us for their visit, but it's important that my office be available to support those efforts, too. Magnet re-certification is an institutional priority.

*Jeanette*: What do you need from PCS staff?

*Gregg*: Staff can help in three important ways. One: communicate with us about what you're seeing at the bedside. Continue to use the safety reporting system. Continue to participate in walk-rounds when you're able. Continue to participate in adverse-event reviews when it's appropriate. We can't make progress unless we hear from direct-care providers about the challenges they're facing.

Two: attitude is everything. Everyone needs to internalize the quality and safety message. That means participating in measurement activities, enthusiastically supporting Magnet re-certification, engaging with one another to maintain a culture of quality and safety.

And three: be vigorous participants in improvement initiatives. We've done great work in quality and safety in the past, and the most important ingredient in our success has been our multi-disciplinary approach. Our ability to work together to solve problems and improve systems is key. We have a rich history of positive quality and safety outcomes—we're just trying to bring that success to a new level.

*Jeanette*: Gregg, thank-you. This is helpful. I know staff are committed to a culture of quality and safety. We're eager to participate as we move forward with this important work.

We've done great work in quality and safety in the past, and the most important ingredient in our success has been our multi-disciplinary approach. Our ability to work together to solve problems and improve systems is key. We have a rich history of positive quality and safety outcomes—we're just trying to bring that success to a new level.

## In this Issue



(Cover photo by Abram Bekker)

# Wong, Provencher, recipients of 2008 Kirvilaitis awards

—by Thomas Drake, training specialist

On January 17, 2008, Jeanette Ives Erickson, RN, senior vice president for Patient Care, welcomed an electrified audience to O'Keeffe Auditorium for the sixth presentation of the Anthony Kirvilaitis Jr. Partnership in Caring Awards to operations associate, Sheila Provencher, and unit service associate, Chung Wah (Patrick) Wong. Said Ives Erickson, "Through this event, we come together to honor the legacy of Tony Kirvilaitis. Tony had a tremendous impact on many of us and continues to influence the way support staff are oriented and welcomed into Patient Care Services."

The Anthony Kirvilaitis Jr. Partnership in Caring Award was created in 2002 to recognize support staff who demonstrate reliability, responsiveness, assurance, collaboration, flexibility, creativity, and support in their daily work.

In her nomination letter for Patrick Wong, Amy Levine, RN, USA team leader in the Same Day Surgical Unit (SDSU), wrote, "Patrick is able to step in and help wherever it's needed. Because of his strong work ethic, staff respect and admire him."

Janet Dauphinee Quigley, RN, nursing director, wrote, "Patrick single-handedly created a stretcher system to respond to patients' needs, while taking into account the unit's challenging space demands. Patrick quickly understood the importance of having clean, made-up stretchers for our patients. He used every available space to store stretchers recovered from all areas of MGH. I recall stopping and exclaiming my pleasure with his hard work and ingenuity. He quietly said "Thank-you" and seemed genuinely surprised at the fuss I was making. He has surpassed my expectations with his ability to assess situations and create new systems without being asked. No wonder nurses always want him assigned to their areas!

"I'd like to close by quoting Patrick himself. He said, 'I work hard to keep patients and families safe. I value the opportunities MGH provides to meet new people and learn new things.' "

Hilary Levinson, RN, staff nurse in the Emergency Department, in her nomination letter for Sheila Provencher wrote, "Sheila seems to bring with her a serene sense of being that helps the entire unit reach a level of calm. Sheila's entire focus is one of helping patients get what they need and she'll go to great lengths to help. She'll get a newspaper for a family member, turn on a television for a patient, seek out a nurse to address a patient-care need, or sometimes just be a friendly ear for patients to talk to. She is an exceptional operations associate. There has never been a time that I've had to ask Sheila to do something… she's always one step ahead of me. It is almost as if she has a second set of eyes and ears to anticipate the needs of staff and patients."

James McCarthy, operations coordinator in the Emergency Department Observation Unit, wrote, "As a testament to Sheila's compassion and concern for patients, she has made several suggestions related to patients' comfort including sleep masks, ear plugs, and television headphones. Her calm demeanor and helpful nature contributed to the development, opening, and successful operation of this unit during its first year."

By chance, Provencher had been invited to speak at the award ceremony prior to being named a recipient. Excerpts from her inspiring talk follow:

### The Calm in the Storm

The phone rings.

You, the operations associate, answer it to hear, "Hi. It's the Core Lab. I've got a critical result . . ." The patient call-button sounds. Sixteen lab slips sit waiting to be filled out. Someone says, "We're all out of normal saline, can you call for more?" Dinner trays have arrived, it's time to check the meal orders. Two admis-

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sions just appeared on the screen, and you've got to prepare the charts. The case manager informs you that the chair car will be here soon to pick up patient X. The phone rings again. A distressed family member is wondering how her loved one is doing, but the nurse is with another patient, so you ask her to hold. You turn to see a transport worker with a new patient. All three phone lines ring at once, and you try to remember which flashing light is which!

Meanwhile, you, the unit service associate, are cleaning up a spill in room 36. You return to the desk to find three new rooms need to be cleaned, and, "When you get a chance can you re-stock the paper towels in the bathroom?" The operations associate has a look of panic on her face. "They sent a new patient, but room 42 isn't clean yet! Can you do it right now!" "Don't worry," you say to the patient as you pass him in the hall, "your room will be nice and clean for you!" You strip the bed, prepare fresh linens and hope no more patients will arrive until you've had a chance to clean their rooms.

The fast pace can seem like chaos. We all work in the midst of multiple and sometimes simultaneous duties, requests, alarms, phones, and (most importantly) people needing care and attention.

But, can I really call this chaos?

In fact, patients, families, and friends are facing a much deeper chaos, the severe storm of illness. With one phone call, in one moment, their lives have been turned upside-down. In the midst of illness, life has lost its security, its moorings. They are tossed in the storm, with neither anchor nor compass.

At such times, we all yearn for order and calm. Order from chaos. Calm in the storm.

What does all this have to do with cleaning toilets and answering phones?

Everything.

When we gently shape order from chaos—whether we're organizing medication forms, cleaning a room, or smiling at an anxious patient—we participate in the work of healing. We create a place of calm in the midst of the storm.

Anthony Kirvilaitis knew this. He knew that the smallest gestures—a joke, a smile, a visit—could make the biggest difference. Someone who knew Tony told me, in all things he, "just made people feel good about themselves and the work that they did."

I wish I had known Tony. But in hearing about him from his many friends and performing some of the same tasks, I feel I do know him. And I want to remember and practice his unique gift of presence.

It's impossible to impose perfect order, perfect healing. Disorder is the law of the universe. Medical charts will not arrange themselves neatly on the rack; rooms won't clean themselves; illness does not often spontaneously remedy itself.

But our presence, even in the midst of chaos, can make all the difference.

From 2003–2005, I lived and worked in Iraq with a small group seeking peace and human rights. The chaos of war, the storm of violence, often made me feel paralyzed and helpless. But one day an Iraqi friend told me, "You are here with us in our suffering."

*You are here with us in our suffering.*

This is the invitation and privilege of our work. In every task, in every moment, we can *be* there among people facing the chaos of illness. We can *be* the calm in the midst of the storm. And as Tony taught us, the calm in the storm can also be a place of humor and joy.

*

Other support staff nominated for the Kirvilaitis award include: Jean Donadio; Vanessa Evans; Domingas Gomes; Mariquinhas Rosa; Nettie Shaddock; and Bernida Washington.

For more information about the Anthony Kirvilaitis Jr. Partnership in Caring Awards, contact Tom Drake, training specialist, at 6-9148.

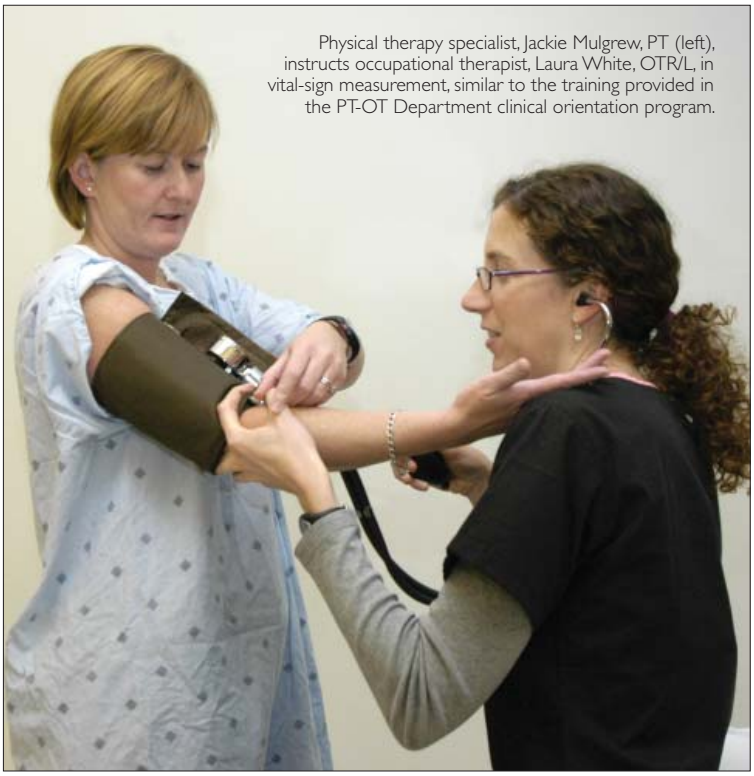
Sheila Provencher and Chung Wah (Patrick) Wong at award ceremony in O'Keeffe Auditorium

(Photo by Abram Bekker)

# Following in-flight emergency, OT pens thank-you note to colleagues

Dear Jane (Evans), Jessica (Ranford), Lauren (Spencer), and Jackie (Mulgrew),

I want to thank each of you for your efforts in the last two years enthusiastically instructing me in CPR, assessment of vital signs, cognition, sensory, and visual field testing. Because of the commitment of MGH to train its employees over and above basic, cursory certification, I was able to respond to a medical emergency on my return flight from the west coast a few days ago. Even though I had been an occupational therapist for five years prior to coming to MGH, I would never before have felt confident, or even capable, of handling some aspects of this emergency situation. I recently participated in a vital-signs measurement module as part of the new PT-OT Department orientation program. Thank-you, Jane, for encouraging me to take that course!



Physical therapy specialist, Jackie Mulgrew, PT (left), instructs occupational therapist, Laura White, OTR/L, in vital-sign measurement, similar to the training provided in the PT-OT Department clinical orientation program.

Mid-flight, a young man fell in the aisle, hitting his head. I was the only person to respond when flight attendants called for a doctor or nurse. When I went to him, he was diaphoretic and lethargic. Apparently he had been acting strangely in the 15 minutes prior to his fall. I stayed with him in the aisle for about 30 minutes, assessing his cognition (intact but delayed responses), obtaining his medical history (ADHD), occupational profile (student), and recent events (drinking heavily until the wee hours with no food or water all day (the flight had left at 5:00pm). When I felt he was stable enough to sit and drink, I encouraged him to drink orange juice with sugar, meanwhile putting an ice pack on his head.

I went back to my seat. Five minutes later, the flight attendants shouted for me. The young man had momentarily lost his vision (but was conscious), and both his legs were numb. The only equipment they had was a blood pressure cuff and stethoscope, so I was able to take his blood pressure. Thank-you, Jackie, for those skills! I did visual-field, cognitive, and sensory testing. Thank-you, Jessica, for those skills! The attendants brought out a plethora of emergency equipment, and I recognized the defibrillator controls. I was visualizing CPR steps in my head. Thank-you, Lauren! Fortunately, I didn't need to do anything except fit an oxygen mask over his face. He recovered without further incident. He was met by EMTs when we landed and was brought, I believe, to MGH for head imaging and observation, which I had recommended.

I really didn't do anything special or earth-shattering. But I know if it hadn't been for my input, the plane would have landed mid-country as flight attendants weren't trained in observation and vital signs. Because of these simple skills, the medical team in telephone communication with us could visualize what was occurring and agreed with my determination that he was stable enough to make the journey to Boston.

I received a lot of thank-yous from grateful fellow passengers, but what I really think is that *you* deserve the thanks. You instilled these skills in me. It's a nice reminder that OTs and PTs have valuable talents in many areas and can make a huge difference in the lives of others.

Enjoy your day,

Laura White

# Washington recognized as 'Leader by Example' by *Unity First News*

In the January-February, 2008, issue of *Unity First News*, director of Patient Care Services' Diversity Program, Deborah Washington, RN, was recognized as a 'Leader by Example' in the special Black History Month edition, which also paid tribute to Dr. Martin Luther King. *Unity First News* is an African American newswire that gears its coverage of current events to diverse communities and media. Publishers, Janine and Tom Fondon, wrote in their letter of notification to Washington, "We want you to know that your leadership is truly appreciated, not only by us, but by our readers and the communities across the Commonwealth. We appreciate your work to advance our communities, corporations and businesses and your initiatives to advance the value of diversity and inclusiveness in our communities and workplaces. We have always admired you for your efforts and leadership."

The article in *Unity First News* begins, "Over the span of her career, Washington has made a difference in the work and lives of many people. Her heart has cared. Her hands have worked to help others, and her mind continues to align people and projects that make a difference in our communities, and above all, the hospital where she works. Recently, Washington was selected by *Nursing Spectrum* as its National Nurse of the Year in the category of Advancing and Leading the Profession. The annual award recognizes the extraordinary contributions nurses make to their patients, to one another, and to the profession of nursing."

Patient Care Services and the entire MGH community congratulate Washington on this well deserved honor.

Her heart has cared. Her hands have worked to help others, and her mind continues to align people and projects that make a difference in our communities, and above all, the hospital where she works.


Legacy

In honor of Mary Eliza Mahoney, the first Black graduate from an American school of nursing and first professional Black nurse in the United States, we salute Deborah Washington. (Photo credit: below)

Deborah Washington

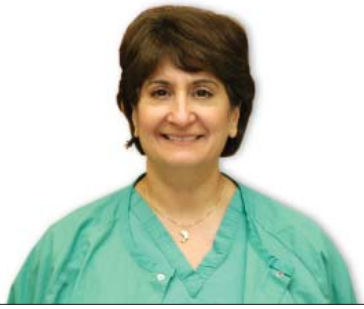
Leadership should be born out of the understanding of the needs of those who would be affected by it.
Marian Anderson

# Veteran PACU nurse helps patient find peace with end-of-life decisions

MGH is celebrating National Peri-Anesthesia Nurse Awareness Week, February 4–10, 2008.

My name is Jeanne Giovino, and I have been a nurse in the Post Anesthesia Care Unit (PACU) for 24 years. At 2:00am one Saturday night shift, I received a call from the operating room about a patient undergoing emergency abdominal surgery. Ms. M had come to the Emergency Department earlier that evening complaining of abdominal pain (of several weeks duration), a 50-pound weight loss, nausea, and vomiting. She was undergoing an exploratory laparotomy, colostomy, ovarian and fallopian tube removal, and a cystoscopy due to metastatic cancer.

Ms. M arrived in the PACU with low blood pressure, an elevated heart rate, and minimal urine output. Fluid deficit causes the heart to pump harder and faster in an attempt to compensate, so I treated Ms. M with several fluid boluses after consulting with Anesthesia. Typically, the anesthesiologist deals with these issues while the patient is in the PACU, but in this case, I felt it was important to involve the surgeon, as well. The surgeon agreed with my assessment and ordered additional volume. Ms. M's blood pressure began to improve, but her urine output remained low. This could still be an indication of dehydration, but I was concerned about a possible obstruction due to the extent of her metastatic cancer. I contacted the surgeon again and administered additional fluids. The surgeon said he would be down later to see Ms. M.



Jeanne Giovino, RN
staff nurse, Post Anesthesia Care Unit

Ms. M was sleepy when she arrived in the PACU. This gave me an opportunity to focus on stabilizing her vital signs. However, when she became more alert, she began to look worried. She told me she hadn't been to a doctor in more than 20 years. I was careful not to overwhelm Ms. M with information, but answered her questions frankly and honestly. She asked about her surgery, and I told her she had experienced no complications in the operating room, and her vital signs were stable. I explained that surgeons often prefer to talk to patients when they are more fully awake back on the unit. I asked Ms. M if she was having pain and she said she was comfortable.

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I was so grateful that night to have had the time to spend with Ms. M. I was able to give her my undivided attention. My initial goal of care was focused on correcting her physiological needs, but as the night progressed her psychological needs became more important.

Ms. M began to open up about her life. She was a retired publisher and had never married. Her life was devoted to the care of her 95-year-old mother. Her sister was caring for her mother while she was in the hospital. Although it was 4:00am, I asked if she wanted to speak with her sister on the telephone. I knew she needed to connect with someone so she could be reassured her mother was being well cared for and focus on her own recovery. She seemed relieved by my suggestion, and I made the call to her sister.

While Ms. M spoke with her sister, I reviewed the results of her CT scan. Ms. M had numerous lung nodules, lesions in her liver and spleen, a colon mass with partial obstruction, and ureteral obstruction. In looking over the notes from the ED, it appeared that someone had spoken to her about her diagnosis, but they weren't sure how much she had absorbed.

Ms. M was asking questions, and I knew that not telling her was going to make her more anxious. I called the surgeon and asked him to come to the PACU to examine Ms. M and speak with her about her diagnosis. The surgeon told Ms. M that her disease was very serious. He told her she had cancer and that it had spread to several organs. He explained her options. Ms. M could continue to seek aggressive treatment that might prolong her life but wouldn't cure her, or she could make comfort measure the focus her care. Ms. M looked at me with a bewildered expression, and I knew it was too big a decision for her to make on her own. I told Ms. M I'd call her sister and she could speak with her. Before I handed the phone to Ms. M, I spoke with her sister and explained the situation. Her sister was very quiet. She told me she'd had a feeling her sister was not going to receive good news. I knew Ms. M had a good relationship with her sister, and I knew getting her involved was the right thing to do.

Ms. M decided, due to the extensive spread of her cancer, to forego aggressive treatment. After the surgeon left, I sat by her side and we talked about her decision. She told me she wanted to die at home. I asked if she was scared. She said her main concern was companionship for her mother. She was also concerned about her mother seeing her die. But she felt she was making the right decision.

I told her what a good daughter she was to have cared for her mother for so long. It was obvious she had put her own health on the back burner. I told her how lucky she was to have a sister who would take over her mother's care and she could feel at peace with her decision. I asked if she'd like to see a chaplain, but she declined. I'm always amazed how patients find the strength to deal with such difficult situations. Ms. M seemed very much at peace; there was a calmness about her.

My shift was coming to an end and I told Ms. M I'd visit her when I returned to work in two days. She thanked me for my care and kindness and said she looked forward to my visit. I called the nurse who would be caring for Ms. M on the unit. I asked her to consult Palliative Care to assist Ms. M with end-of-life planning, and she assured me she would. I was so grateful that night to have had the time to spend with Ms. M. I was able to give her my undivided attention. My initial goal of care was focused on correcting her physiological needs, but as the night progressed her psychological needs became more important.

I don't think I'd ever been in this situation before. Usually when a patient is deteriorating, or despite our best efforts symptoms continue, we send them to the Surgical Intensive Care Unit. I wanted to write this narrative to show a side of the PACU that is rarely seen. We don't often have an opportunity to discuss life-and-death issues with patients because their stay with us is so brief.

When I went to visit Ms. M two days later, I was told she had died just a few hours before. It made me sad to think she never made it home to see her mother one last time. I hope, if nothing else, I was able to help Ms. M deal with a difficult situation and make it a little easier for her. After receiving the news that Ms. M had passed away, I couldn't help thinking of that old Frank Sinatra song—she did it her way.

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

Jeanne's presence and compassion are visible in every paragraph of this narrative. Jeanne recognized that Ms. M needed her sister to be involved in her decision-making process; she reassured Ms. M that her mother was being well cared for. In a very short period of time, Jeanne came to know Ms. M, earned her trust, and helped her through one of the most intimate, difficult times in her life. When Ms. M decided to forgo aggressive treatment, Jeanne stayed with her and helped her process that decision. What a wonderful, poignant story.

Thank-you, Jeanne.

# Save money, save power, save time: win, win, win!

Beginning March 10, 2008, MGH will roll out SavePower!, an initiative designed to conserve energy and reduce costs. Under the new inititiative, monitors at private computer workstations will automatically go into sleep mode when left inactive for 30 minutes or more. (Monitors on workstations in clinical areas will not be affected.) In sleep mode, monitors will display a black screen with an orange status light; touching the mouse or keyboard will return the monitor to active status.

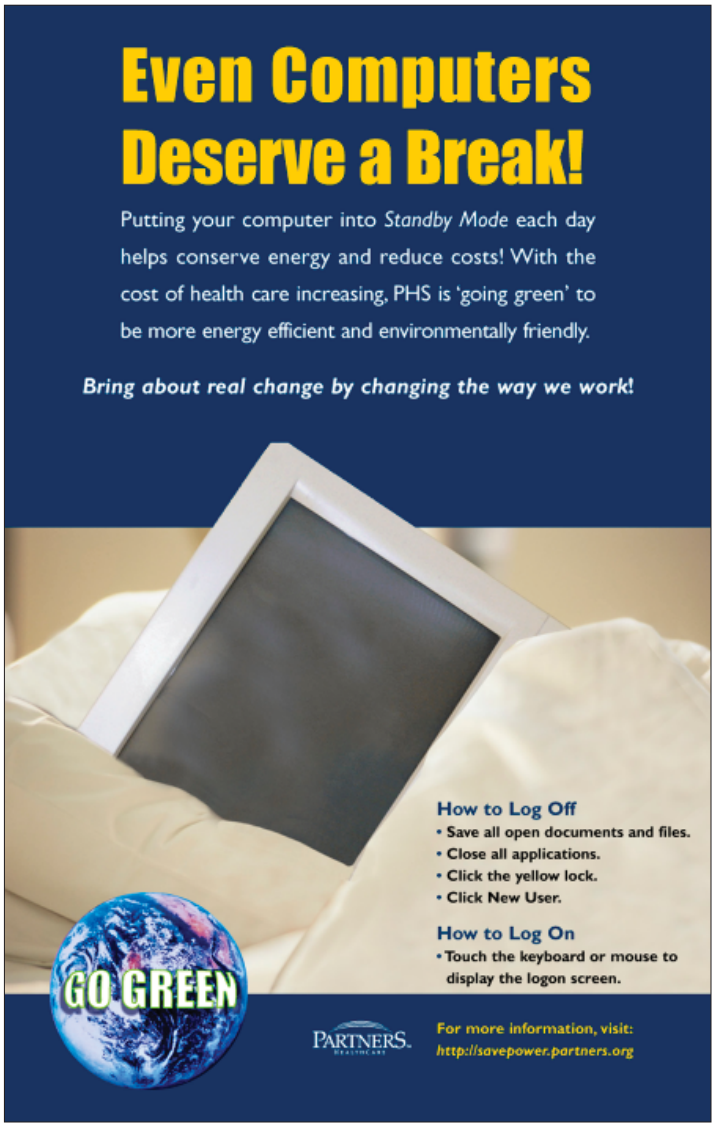
Later in the year, computers will also be put into sleep mode, reducing Partners-wide energy costs by more than a million dollars. Once operational, the SavePower! initiative will reduce greenhouse-gas emissions the equivalent of removing 2,000 cars from our roads each year.

Properly logging off computers will be key. At the end of the work day, employees should:

- save all open files and documents
- close all applications
- click the yellow lock icon at the bottom of the screen
- click the New User button.

By setting your your computer to sleep mode, you will continue to receive nightly network updates and minimize the time required to power up the following morning.

For more information about the SavePower! initiative, visit: http://savepower.partners.org.



# MGH celebrates National IV Nurse Day

—by Deb Guthrie, RN, IV nurse

January 25, 2008, was National IV Nurse Day. MGH observed the occasion with educational display tables outside Eat Street Café staffed by members of the IV Therapy Department. "SAVE that Line," the theme of this year's campaign, was chosen in cooperation with the Association of Vascular Access to promote patient safety and help reduce complications from vascular-access devices. (S=Scrupulous hand hygiene; A=Aseptic technique; V=Vigorous friction to hubs; and E=Ensure patency.) Educational models and materials shed light on the latest technology in peripheral IV catheters and peripherally inserted central catheters (PICCs). A variety of posters shared site-assessment tips, information on how to prevent complications, and descriptions of peripheral IV catheters and PICCs. IV staff were on hand to provide skills labs allowing interested visitors to practice proper flushing techniques.

The event was well attended and provided an opportunity for collaboration across disciplines. The most popular attractions were the new Nexiva peripheral IV catheters (specifically used for power injections in CT scans) and the soon-to-be-available PICC patient and family teaching booklet.

For more information about the work of the IV Therapy Team, contact the IV Therapy Department at 6-3631.

**Left:** Deb Guthrie, RN, describes placement of peripherally inserted central catheter. **Right:** Patricia Awbrey, RN, demonstrates how to assess a peripheral IV for possible complication.

# Magnet... and beyond!

—by Clare Swan, RN, Yawkey 8 Infusion Unit

Magnet recognition tells patients that MGH is a place where they can come for safe, high-quality care. And in the face of looming shortages of healthcare workers, Magnet hospitals are better able to withstand national shortfalls in nursing and other healthcare professions.

John Shaw Billings, the famed designer of Johns Hopkins Hospital got it right more than 100 years ago when he said, "A hospital is a living organism, made of many different parts, having different functions, but all these must be in due proportion and relation to each other, and to the environment, to produce the desired general results. The stream of life which runs through it is incessantly changing; patients and nurses and doctors come and go; today it has to deal with the results of an epidemic, tomorrow with those of an explosion or fire; the reputation of its physicians or surgeons attracts those suffering from a particular form of disease, and as the one changes so do the others. Its work is never done; its equipment is never complete; it is always in need of new means of diagnosis, of new instruments and medicines; it is to try all things and hold fast to that which is good."

The dynamic organism called Massachusetts General Hospital has thrived for more than a century with the creativity, innovation, and hard work of its nurses, doctors, staff, and administrators. We adapt to the rapidly changing environment in which we work, and we have earned the trust of our patients and the communities from which they come.

But change of this magnitude doesn't come easily. As professional nurses we didn't magically merge into a splendid synchronicity. The words of the late, great Sam Cooke sum it up perfectly: "It's been a long time comin'… but change is gonna come."

Jeannette Ives Erickson, RN, senior vice president for Patient Care, nurtured us to where we are today. In 1996, she set us on a course toward becoming a Magnet hospital with the creation of a patient-focused, clinical nurse-driven vision and value statement. Magnet recognition is about the exquisite work of professional nurses in an environment that supports the integrity of the nurse-patient relationship. Magnet hospital recognition tells patients that MGH is a place where they can come for safe, high-quality care. And in the face of looming shortages of healthcare workers, Magnet hospitals are better able to withstand national shortfalls in nursing and other healthcare professions.

Clare Swan, RN, staff nurse,
Yawkey 8 Infusion Unit

The truth is, it doesn't matter how far we've come; what matters is how much farther we have to go. If I had to choose one word to describe how many of us feel today, it would be 'breathless.' It used to be that change occurred in discrete increments, and we had a period of months—even years—to adapt. Now, change comes faster, like a treadmill stuck in high gear.

But there is a silver lining. MGH has made *US News and World Report*'s top-five list for achieving excellence and adhering to standards of the highest quality. Yes, our work is never done. And yes, we will, "try all things and hold fast to that which is good." Our culture of individual initiative and dedication to excellence is the X factor that helps us run faster and jump higher. No words capture our competitive spirit better than: "Good, better, best... never let it rest.. til our good is better, and our better... best."

In the race to create the most effective, most efficient medical facility of the future, I'm confident we will come out ahead. We may be a bit short of breath when we get there. But we'll be long on teamwork and satisfaction.

# Magnet re-designation site visit

*On October 26, 2007, MGH submitted written evidence to the American Nurses Credentialing Center (ANCC) to become re-designated as a Magnet hospital. In 2003, MGH was the first hospital in Massachusetts to achieve this prestigious honor. Currently, only 275, or approximately 5% of all healthcare organizations in the United States, have achieved Magnet designation.*
*On February 20–22, 2008, four Magnet appraisers and one appraiser fellow will visit MGH, giving us an opportunity to demonstrate how our written evidence is embedded in our every-day practice.*

*Question:* What is the purpose of the Magnet site visit?

*Jeanette:* Magnet appraisers will evaluate our overall performance and ability to develop programs and initiatives that become part of the MGH culture. It's an opportunity to showcase the excellent care we provide to patients and families.

*Question:* Who will be involved in the site visit?

*Jeanette:* Staff from throughout MGH will have an opportunity to interact with appraisers in a number of forums. Appraisers may speak with any member of the MGH community, so it's important for every employee to have a basic understanding of the Magnet designation process and be able to describe how their departments work in collaboration with Nursing. Appraisers will want to meet with members of the inter-disciplinary team to hear how collaborative clinical practice is delivered and supported. They may speak with patients, families, and visitors.

*Question:* What will appraisers look for during the site visit?

*Jeanette:* Appraisers will look for:

- inter-disciplinary, patient- and family-centered care
- evidence that MGH values, supports, recognizes, and rewards its employees
- a commitment to culturally competent and sensitive care
- strong and visible leaders at every level aligned with institutional strategic goals
- staff voice in decision-making regarding practice and quality of work life
- quality, safety, and performance-improvement initiatives
- robust employee-education and development programs
- strong community presence outside of MGH—locally, statewide, and nationally

*Question:* Why is being a Magnet hospital important?

*Jeanette:* More than 20 years of research demonstrates that Magnet hospitals have lower mortality and morbidity rates; shorter lengths of stay; higher patient- and staff-satisfaction scores; improved patient outcomes; and inter-disciplinary patient- and family-centered care.

It is a sign that outstanding care is delivered here; that we honor our commitment to quality and safety; that patients and prospective staff view us as an organization with a strong nursing service—we are an employer of choice.

It is a way to let the public know that MGH offers a practice environment that emphasizes autonomy, control over practice, and professional development; encourages interdisciplinary working relationships; fosters collaborative decision-making; provides opportunities for staff to participate in quality and safety initiatives; and reduces turnover and vacancy rates.

*Question:* How is the final decision made to award Magnet designation?

*Jeanette:* After conducting the site visit and reviewing written documentation, appraisers will submit a report to the ANCC's Commission on the Magnet Recognition Program. Word of the decision will come after the Commission reviews our report at its next meeting.

# Announcements

## Peri-Anesthesia Nurse Awareness Week

February 4–10, 2008

Maureen McLaughlin, RN, past president of the Massachusetts Chapter of the American Society of Peri-Anesthesia Nurses will present,

"Medication Safety in the Peri-Anesthesia Setting"

February 7, 2008
9:00–10:00am
Potts Conference Room
Bigelow 856

For more information, call Teresa MacDonald, RN at 6-6658

## The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

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

## A Celebration of Black History

Thursday, February 7, 2008
5:30–7:30pm
At the Museum of African American History
46 Joy Street (at the corner of Smith Court on Beacon Hill)

Hear a brief introduction of the pioneering African-American community on Beacon Hill and view a short film on Beacon Hill's black community in 1800.

Light refreshments will be served.
For more information, call 6-5741

## Cancer Center Seminars

MGH Cancer Center seminars are held in Isselbacher Auditorium, Building 149 at the Charlestown Navy Yard. Talks begin at 12:15pm and are video-conferenced to the Simches Research Building.

Wednesday, February 6, 2008
"Genetic Analysis of the Cellular Response to DNA Double-Strand Breaks"

Friday, February 8, 2008
"Small Molecule Regulators of SIRT1 in Health and Longevity"

Wednesday, February 13, 2008
"Argonaute Proteins in MicroRNA Biogenesis and RNA Interference"

Wednesday, February 20, 2008
"Mechanisms Regulating Epithelial Growth and Plasitcity"

Wednesday, February 27, 2008
"Targeting Tumor Microenvironment to Treat Cancer: Bench-to-Bedside and Back"

## Celebrating the Life and Accomplishments of Katie Brush

*February 13, 2008*
*11:00am–12:00pm*
*O'Keeffe Auditorium*

*Video-conferenced to Haber Conference Room and BWH*

*Reception to follow*

## African American Pinning Ceremony

February 12, 2008
10:30–11:30am
O'Keeffe Auditorium

This year's keynote speaker is Rhea McCauley, niece of Rosa Parks, who will discuss "Transformative Leadership." McCauley will share paintings and prints highlighting her family history and other scenes from the Civil Rights era.

Reception to follow.

## Bi-Monthly Venous Vascular Conferences

Announcing the first bi-monthly multi-disciplinary Venous Vascular Conference

February 13, 2008
7:00–8:00am
Bigelow Amphitheatre

Topics will include:

- Routine evaluation of patients with venous disease
- Criteria and proper technique for performing a venous duplex examination
- Case presentations

For more information call 6-4464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**Next Publication**
February 21, 2008

# Educational Offerings – 2008

## February 12

Ovid/Medline: Searching for Journal Articles

Founders 334
10:00am – 12:00pm
Contact hours: 2

## February 12

Chaplaincy Grand Rounds: "Interfaith Perspectives on Environmental Issues"

Yawkey 2-220
11:00am – 12:00pm
No contact hours

## February 13

New Graduate RN Development Seminar I

Training Department
8:00am – 12:00pm
Contact hours: TBA

## February 13

OA/PCA/USA Connections

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

## February 13

Simulated Critical-Care Emergencies

POB 448
1:00am – 3:00pm
Contact hours: TBA

## February 21

Preceptor Development: Learning to Teach, Teaching to Learn

Training Department
8:00am – 4:30pm
Contact hours: 6.5

## February 21

CVVH Review for the Experienced CVVH Provider

Founders 311
8:00am – 2:00pm
or 4:00–10:00pm
No contact hours

## February 22

Pain Relief Champion: State of the Art and Science Day II

O'Keeffe Auditorium
8:00am – 4:30pm
No contact hours

## February 27

New Graduate RN Development Seminar II

Training Department
8:00am – 12:00pm
Contact hours: TBA

## February 27

Pediatric Simulation Program

Founders 335
12:30 – 2:30pm
Contact hours: TBA

## February 28 & 29

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2220
8:00am – 4:30pm
Contact hours: TBA

## February 28

Intermediate Arrhythmia

SRC 3120
8:00 – 11:30am
Contact hours: 3.5

## February 28

Pacing Concepts

SRC 3120
12:15 – 4:30pm
Contact hours: 3.75

## February 28

Nursing Grand Rounds

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

## February 29

Heart Failure: What Healthcare Providers Need to Know

O'Keeffe Auditorium
7:30am – 3:30pm
Contact hours: TBA

## March 3

BLS/CPR Certification for Healthcare Providers

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

## March 3 & 17

ACLS Provider Course

Day 1: 8:00am – 4:30pm
O'Keeffe Auditorium
Day 2: 8:00am – 3:00pm
Thier Conference Room
No contact hours

## March 4

BLS/CPR Re-Certification

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

## March 5

Simulated Bedside Emergencies for New Nurses

POB 448
7:00am – 2:30pm
Contact hours: TBA

## March 5

Cardiac/Vascular Nursing Certification Preparation Course

Training Department
8:00am – 4:00pm
Contact hours: TBA

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

# Making way for B3C

The goal during construction is to minimize disruption to MGH patients and staff. Throughout construction, new signage and volunteer guides will be available to help direct traffic and alert people to changes.

Demolition of existing buildings to prepare for construction of the Building for the Third Century (B3C) has begun. B3C will be home to five floors of single, inpatient rooms. Services will include Neuroscience Acute Care, Neuroscience Intensive Care, and Medical Oncology. Scheduled to open in 2011 with full occupancy by 2012, the new building will house 29 new operating rooms, a new Sterile Processing Department, the Shipping and Receiving Division of Materials Management, a portion of the Radiation Department, and allow the Emergency Department to expand its services.

The goal during construction is to minimize disruption to MGH patients and staff. Departments and offices located in the Clinics, Vincent Burnham Kennedy, and Tilton Buildings have been re-located to various areas within the hospital. Throughout construction, new signage and volunteer guides will be available to help direct traffic and alert people to changes.

(Photo provided by staff)

Concrete slabs, masonry, steel, and other materials rendered from the demolition of the Clinics, Vincent Burnham Kennedy, and Tilton buildings will be recycled, including approximately 500 tons of steel and approximately 13,000 cubic yards of brick and concrete.

Caring Headlines
February 7, 2008

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