

# Caring

Headlines

March 27, 2008

## The Norman Knight Preceptor of Distinction Award



*See story on page 4*

Preceptor of Distinction award recipient, Joann Burke, RN (second from left), with (l-r): nursing director; John Murphy, RN; Mr. Norman Knight; senior vice president for Patient Care, Jeanette Ives Erickson, RN; and clinical nurse specialist, Mary Guanci, RN.

# Test of change: transforming care at the bedside

The goal is to empower nurses and other front-line staff to have a voice in unit-based systems—to tap into the knowledge and experience of direct caregivers and use that knowledge to re-design care-delivery models.

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s many of you know, since May of 2007, MGH has been participating in a unique and innovative project jointly sponsored by the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement, and the American Organization of Nurse Executives called, Transforming Care at the Bedside (TCAB). TCAB was originally conceived in response to the Institute of Medicine's landmark report, *Crossing the Quality Chasm*, to help make care safer, more effective, timely, efficient, equitable, and patient-centered.

TCAB embraces a new way of thinking about care-delivery. The goal is to empower nurses and other front-line staff to have a voice in unit-based systems—to tap into the knowledge and experience of direct caregivers and use that knowledge to re-design care-delivery models. In that respect, according to the Institute for Healthcare Improvement, TCAB “does not simply fine-tune the status quo, but rather transforms the elements that affect care, including: care-delivery processes, nursing care models, the physical environment, organizational culture and norms, collaboration, and performance.” In short, TCAB encourages nurses and other team members to quickly identify, test, and then implement new ideas based on their perceptions and observations at the bedside. And who better to make those important decisions than direct-care providers?

At MGH, the TCAB project is being conducted on two units: the 20-bed White 10 General Medical



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

Unit, which is serving as the pilot unit; and the 24-bed White 9 General Medical Unit, which is the control unit. Both units see patients with a wide array of diagnoses, social and psychological issues, acuity levels, and co-morbidities. Both have multi-disciplinary staff with varying levels of experience from new clinicians to experienced practitioners. Staff on both units are excited about participating in this ground-breaking study to advance patient care, improve quality and safety, and hopefully, afford clinicians more time at the bedside.

Early on in our journey, representatives from our TCAB Steering Committee attended a two-day meeting in Philadelphia to network with staff from other hospitals participating in the study and to gain an understanding of the background, principles, and processes guiding the TCAB initiative.

Upon our return from Philadelphia, White 10 nursing director, Amanda Stefancyk, RN, and clinical nurse specialist, Susan Kilroy, RN, planned two retreats to share what they'd learned with staff. Bringing together nurses, patient care associates, unit service associates, operations associates, and the operations coordi-

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By sharing our experiences with the TCAB project, we add to the body of knowledge that allows us to truly transform care at the bedside. Hopefully, our participation in this important initiative will give us and others the tools to quickly, efficiently, and safely improve our care-delivery models.

nator, they began to lay the foundation for a unit-wide shift to a TCAB culture. They talked about barriers, obstacles, challenges, and potential pitfalls. They took a good, long look at the “status quo,” before beginning the real work of developing solutions.

Common themes emerged from their discussions: How could they be more present to patients? How could they improve quality, communication, safety, morale? How could they improve the overall experience for patients and staff?

The wonderful thing about the TCAB approach is that staff are encouraged to try new processes, new systems, new ideas in an attempt to weed out ideas that don't work and hone in on the ones that do. It's a rapid-cycle, trial-and-error approach that staff on White 10 call, “Adapt, Adopt, Abandon.” Essentially... implementing a change, evaluating whether it works to improve care, and either adopting the change as new practice or abandoning it.

The White 10 retreats generated more than 500 potential ideas. Suggestions ranged from very simple (adding more glucometer machines) to more complex (having nurses participate in presenting patients at morning rounds; putting medication-dispensers in every room) to more alternative (offering music and massage therapy; implementing designated quiet times on the unit).

Staff introduced the TCAB approach gradually, one idea, one nurse, one patient at a time until the entire unit was fully engaged. Ideas were tried and tested. Those that met with staff approval were adopted. Others were adapted, re-tried, and either adopted or aban-

doned depending on the results. Once staff became accustomed to the process, the approach took on momentum. Weekly TCAB meetings once facilitated by Amanda and Susan are now primarily run by staff.

One ‘test of change’ that met with overwhelming approval was the idea to move frequently used supplies closer to the bedside, eliminating the need for clinicians to de-glove or de-gown to retrieve centrally stored supplies. Now, in collaboration with Infection Control, items such as saline flushes, alcohol preps, band-aids, oxygen tubing, etc., are kept in readily accessible cabinets in each patient's room.

Another idea that surfaced as a result of TCAB is the newly adopted practice of nurses taking lunch breaks off the unit, providing a chance to get away for a brief time and return to their patients refreshed and renewed. This may seem unimportant, but staff report feeling more productive and present to their patients.

Theoretically (and it seems that practice on White 10 supports this theory) the TCAB approach allows clinicians to spend more time in direct-care activities, more time with patients at the bedside, more time in meaningful patient-clinician interactions. By sharing our experiences with the TCAB project, we add to the body of knowledge that allows us to truly transform care at the bedside. Hopefully, our participation in this important initiative will give us and others the tools to quickly, efficiently, and safely improve our care-delivery models.

I'll keep you informed as we begin to see definitive results from the TCAB study both here at MGH and in hospitals across the country.

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(Cover photo by Abram Bekker)

# The Norman Knight Preceptor of Distinction Award

—by Julie Goldman, RN, professional development coordinator

In O’Keeffe Auditorium, on February 28, 2008, staff nurse, Joann Burke, RN, of the Blake 12 Neuroscience ICU, became the fifth recipient of the prestigious Norman Knight Preceptor of Distinction Award. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed attendees to the award ceremony, saying, “It is important to celebrate the role of nurse preceptors. Preceptors guide new clinicians on their journey of growth and discovery as they role-model excellence in patient- and family-centered care. A preceptor of distinction is recognized by colleagues as someone who consistently demonstrates excellence in educating, precepting, mentoring, and coaching other nurses.”

Burke began her nursing career on a Neurology/Orthopaedic unit in a community hospital. Since coming to MGH in 2001, she has mentored and precepted

many new graduate and newly hired, experienced nurses. In a letter of nomination, Mary O’Meara, RN, staff nurse, said of Burke, “Each time Joann orients a new nurse to our ICU, I am impressed by how well she prepares them to succeed. She takes the time to understand how they learn. By thinking of all the variables in advance, she creates a safe environment for orientees to be successful in the Neuro ICU.”

Nursing director, John Murphy, RN, and clinical nurse specialist, Mary Guanci, RN, wrote, “Joann brings to the bedside a wealth of knowledge, a tireless spirit of inquiry, and an ability to ensure that the appropriate care is being provided for patients and families. She is flexible and builds confidence by employing the right balance of freedom and supervision. She puts her whole self into precepting new nurses.”

Perhaps Burke’s own words best describe her commitment to precepting: “I remember what was like to be new to a unit and how scary it can be. I try to help new nurses integrate themselves into the culture and grow their practice.”

As part of the ceremony, Burke read a clinical narrative in which she described the end-of-life care she and her preceptee provided during their preceptorship. Murphy then engaged Burke in a dialogue to unbundle and reveal the lessons gained by the experience.

Ives Erickson thanked benefactor, Mr. Norman Knight for his continued support and generosity. She acknowledged all the nominees, presenting them with copies of Florence Nightingale’s, *Notes on Nursing*. “Just as Florence Nightingale charted a course for the nurses who followed her,” said Ives Erickson, “today’s nominees are charting a course for the nurses of tomorrow.”

For more information about The Norman Knight Preceptor of Distinction Award, contact Julie Goldman, RN, at 4-2295

Award recipient, Joann Burke, RN (fourth from left), with fellow nominees (l-r): Cynthia Meglio, RN; Richard Piccuito, RN; Laurie Miller, RN; Courtney Craig, RN; Cara Taylor, RN; Linda Richards, RN; and Gregory Conklin, RN.



# Ellison 7: new Dedicated Education Unit

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

**O**n January 31, 2008, a dozen nursing students from the University of Massachusetts, Boston (UMass), arrived at MGH to begin their clinical placement in the new Dedicated Education Unit (DEU) on Ellison 7. The DEU is an innovative model of clinical nursing education wherein the entire patient care unit is transformed into an optimal learning/teaching environment through the collaborative efforts of staff nurses, unit leadership, students, and faculty. The underlying concept of the DEU is the belief that staff nurses play a vital role in developing the knowledge and professional skills of nursing students. In the DEU, staff nurses are the clinical instructors, supported by university faculty, hospital leadership, and nursing colleagues.

Staff and leadership celebrate the opening of the new Dedicated Education Unit on Ellison 7.



(Photo by Paul Batista)

This clinical partnership is designed to foster a collaborative relationship that allows nursing practice to inform nursing education and, in turn, nursing education to influence nursing practice and the delivery of care. With six staff-nurse instructors and 12 UMass students, each instructor is assigned two students and supported by a faculty coordinator at UMass who provides orientation to the UMass curriculum, as well as support and coaching throughout the semester.

The goals for this clinical partnership include:

- providing a solid, functional foundation for evidence-based nursing practice
- creating a teaching partnership that enables students to integrate critical thinking, communication, assessment, and technical skills into nursing practice
- mentoring students in their transition from students to entry-level practitioners
- promoting the development of faculty and clinical partners through collaborative teaching, practice, service, and scholarship
- providing a model for clinical nursing education that addresses the nursing faculty shortage, the nursing workforce shortage, and the need for increased enrollment in nursing programs
- addressing the education and practice gap by integrating quality and safety competencies into teaching and learning experiences for students and clinical faculty

The Dedicated Education Unit was made possible through a partnership with MGH, Brigham & Women's Hospital, and the UMass College of Nursing & Health Sciences.

For more information, contact Gaurdia Banister at 4-1266.

# Patient-centered care: everybody's getting into the act!

—by Daphne B. Noyes, interfaith chaplain

**F**or patients experiencing lengthy hospital stays, time can drag. This was true for Bob Deveau, a retired machinist who was at MGH awaiting a heart and kidney transplant. From his room on Ellison 8, Bob spent days gazing out his window at the demolition of the Clinics, Vincent Burnham Kennedy, and Tilton buildings, making way for the Building for the Third Century (B3C). He had a bird's-eye view of workers in their hard hats dismantling the buildings and the tall crane towering over the job site.

As Bob's chaplain, I knew that time weighed heavily on him as he waited and waited. I also saw how fascinated he was with the construction project going on just outside his window. Together, social worker, Kitty Craig-Comin, LICSW, and I brainstormed ways to connect Bob with that world outside.

Not long afterward, I met Kris Hutchins, clerk of the works for the B3C project and told him how much it would mean to Bob to have some connection with the project. Kris spoke with Allison Ferrari, the office manager for Turner Construction, and she spread the word among the construction workers.

A day or two later, a package arrived on Ellison 8 containing a carpenter's cap, a Big Dig sweatshirt, a Turner Construction fleece, and union decals with the message: "For Bob, from some of the men and women on the B3C Construction Project." A few days after that, another package arrived, this one containing a personalized Turner Construction hard hat identifying Bob as the project's, "window superintendent." Kris, Allison, and others from the project visited Bob every few days, updating him on the work and providing him with a much-needed sense of connection. In big letters, Kitty taped Bob's name to his window, so workers could identify his room from the construction site below.

Bob got his new heart on February 2, 2008, and his new kidney the following day. After being transferred from the Cardiac Surgical ICU to the Transplant Unit, Bob was visited by Kris, Allison, and the other construction workers who stopped by regularly with status reports, which always lifted Bob's spirits.

Bob went home in late February proudly wearing his hard hat out of the hospital. "That project saved my life," he said, remembering the long days of waiting.

When I originally approached Kris about making some kind of 'connection' with Bob, I had no idea the relationship would flourish the way that it did. Construction workers became part of the team caring for Bob, helping him maintain hope and motivation. As I observed the many ways they offered encouragement—including the placement of a large plywood valentine atop one of the adjacent hospital buildings—I realized that Bob was encouraging them, as well. He became a tangible representation of the MGH mission... to create a place dedicated to the healing of body, mind, and spirit.

Back row (l-r): Kris Hutchins, B3C project; Reverend Daphne Noyes, chaplain; Lissette Chao, physician assistant; Brian Chase, Turner Construction; and Mary Jean Winer, RN.

Seated: Allison Ferrari, Turner Construction; Kitty Craig-Comin, LICSW, social worker; patient, Bob Deveau; and Carol Blanchard, RN.



(Photo by Abram Bekker)

# MGH Center for Global Health hosts international health experts

—by Roy Ahn, ScD, senior administrative manager, MGH Center for Global Health

The Center for Global Health's seminar series runs through the spring. On April 10, 2008, Bruce Walker, MD, will be the featured speaker.

Charles MacCormack, president and CEO of the nonprofit organization, Save the Children, speaks as part of Center for Global Health's on-going seminar series.

Recently, as part of its on-going seminar series, the MGH Center for Global Health (CGH) held seminars exploring two major health topics: international disaster response and global child health. The January 10, 2008, seminar, entitled, "International Humanitarian Emergencies," was a panel discussion headed by Frederick 'Skip' Burkle, Jr., MD, director of

the Asia-Pacific Center for Biosecurity, Disaster and Conflict Research at the University of Hawaii. Burkle, drawing on his extensive experience as former deputy assistant administrator for the Bureau for Global Health, US Agency for International Development, and interim health minister of Iraq, described the "direct effects" and "indirect effects" of disasters on the health of affected populations over time. Burkle's talk was followed by a panel discussion on improving responses to international disasters. Discussion was moderated by Thomas Burke, MD, director of the CGH. The panel was composed of Burkle, Susan Briggs, MD, Lydia Mann-Bondat, MPH, and from the Harvard Humanitarian Initiative, Michael VanRooyen, MD.

On February 25th, Charles MacCormack, president and CEO of the nonprofit organization, Save the Children, shared the history of Save the Children's global health programs and spoke of the current "balkanization" of the international child health field. He explained that nongovernmental organizations focusing on specific diseases (e.g., AIDS, malaria, etc.) are competing against each other for limited dollars rather than collaborating on a comprehensive strategy to improve global child health. MacCormack called on universities to use their convening power to bring these groups together to make the most effective use of existing child-health funding.

The Center for Global Health's seminar series runs from fall through spring. On Thursday, April 10th, from 5:00pm to 6:30pm, in O'Keefe Auditorium, Bruce Walker, MD, professor of Medicine, Harvard Medical School, and director of the Partners AIDS Research Center, will be the featured speaker. For more information, contact Roy Ahn at 3-0067.



(Photo by Abram Bekker)

# Kindness and respect guide social worker's care of dying patient



Claudine Riley, LICSW, oncology clinical social worker

March is National Social Work Month. This year's theme, building on strengths, focuses on the connections social workers provide between home, health, family, friends, and communities.

**M**y name is Claudine Riley. Two years ago, I began working at MGH as a social work intern from Smith College. After obtaining my MSW, I was hired as a clinical social worker to work with women with gynecologic cancers. During the past 18 months, I have enjoyed working with patients and families throughout the continuum of care, from newly diagnosed patients on the Bigelow 7 Gynecology/Oncology Unit and in the outpatient treatment areas in the Yawkey and Cox buildings.

Ms. L, a 42-year-old woman, was referred to me by her case manager to assess her ability to cope with the progression of her cancer. Ms. L's medical history included HIV, diabetes, and recurrent metastatic cervical cancer. She was struggling with several psychosocial issues, including a history of domestic violence, drug use, homelessness, financial concerns, and emotional distress (most recently related to the fact that her boyfriend had been murdered). Ms. L was single and identified members of her church as her family. She reported having relatives nearby but had minimal contact with them. She worked three jobs.

When I met Ms. L, she expressed her expectation to proceed with chemo- and radiation therapy. She deemed this an inconvenience to get through in or-

der to return to work. But due to the progression of her cancer, this was not going to be possible.

Ms. L was informed that no further treatments were available. She was understandably devastated by this news. She was discharged home, but returned two days later complaining of pain. At that time, she had no recollection of having received the news of her poor prognosis. She told me I must be "mistaken" when I mentioned our conversation to her. I soon learned this was how Ms. L responded to distressing information.

Ms. L, who was well known to staff on the Gynecology/Oncology Unit, was notorious for 'doing things her way.' To the consternation and concern of her health-care providers, Ms. L would often refuse procedures saying she was tired or physically uncomfortable. Her caregivers believed Ms. L didn't fully understand the gravity of her illness as demonstrated by her refusal of treatments intended to alleviate her symptoms. Team members asked me to assess her understanding, try to reason with her, and emphasize that the tests were intended to help her.

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Ms. L's story is reflective of many patients' experiences in the sense that each person finds her own way of coping with disease and treatment. It might not be the way healthcare providers would choose, but I try to support my patients while making sure that appropriate steps are taken to ensure their well-being.

In addition to Ms. L's other medical conditions, she had an infection that required staff to wear gloves and gowns when entering her room, which intensified her sense of isolation. She often commented that due to her dietary restrictions and limited contact, she felt as if she was 'in prison.' When I would meet with Ms. L, she would cordially invite me to have a seat then ask the nurse for two lemonades as if we were in a restaurant. It became apparent that her protests regarding medical procedures and her quirky 'waitressing' requests gave her a sense of normalcy and control. As I learned more about Ms. L, I realized she was doing as much as she could, including what she could or couldn't discuss about her prognosis.

Although Ms. L was told on several occasions about her poor prognosis, she continued to express her hope for a complete recovery and a desire to go home. She insisted she wanted to be 'full-code' status. When staff attempted to explain what this would entail and the possible complications, Ms. L would tell them to leave, shouting, "You don't know me or my beliefs!"

As Ms. L's health continued to deteriorate, it became clear that a healthcare agent needed to be designated. During weeks of daily visits, Ms. L began to confide in me, disclosing her history and requesting that I stay with her for longer periods of time. Though Ms. L typically denied her impending death, I hoped this foundation would allow me to broach the topic of end-of-life wishes. Incredibly, when I introduced the subject of a healthcare proxy, Ms. L listened then solemnly indicated whom she wanted her agents to be. She said she had discussed her care preferences with them and they both knew what she wanted. Together, we spoke with her agents on the phone, and Ms. L explained that they would be responsible for making decisions if she was unable to do so for herself.

This window of clarity was brief, and later in the day, Ms. L again engaged in conversations about returning to work. That brief discussion told me she understood her prognosis but found it intolerable to consider the harsh reality of her condition. She therefore took control of when she would address these issues. She chose to focus on a more hopeful, albeit less realistic world where she could cling to her dream of being a professional horse rider. Even with Ms. L's physical discomfort, the muscles in her face would soften when she spoke of the horses she rode as a child.

In an effort to find ways to comfort Ms. L in her final days, I gathered several horseback-riding magazines and read articles to her as she stroked the pictures. Although Ms. L sometimes shared pieces of her fragment-

ed history and childhood with me, I only explored areas where she felt comfortable. It wasn't a time to address past traumas, but rather a time to provide comfort and a sense of peace. I had hoped to explore end-of-life wishes with her. But she seemed to prefer putting her energy into more nurturing topics. It became apparent that Ms. L had spent her life fighting unfavorable, unfair odds and had managed to endure many hardships. In a sense, it seemed Ms. L was hard-wired to survive, never considering the possibility of giving up, regardless of the circumstances.

As Ms. L became more ill, a family meeting was called to discuss end-of-life planning. Ms. L was alert, and although just the day before she had spoken of riding horses again in the fall, she was able to focus on the discussion and share her final wishes in minute detail. Later in the week, Ms. L's room was filled with visitors, and she smiled as she made plans with them for the future. Three days later, Ms. L died in her sleep.

Ms. L's story is reflective of many patients' experiences in the sense that each person finds her own way of coping with disease and treatment. It might not be the way healthcare providers would choose, but I try to support my patients while making sure that appropriate steps are taken to ensure their well-being. Ms. L helped me see that one's definition of 'appropriate steps' is subjective, especially in terms of acknowledging one's imminent mortality. Though many people questioned whether Ms. L comprehended the gravity of her prognosis, I believe she understood and chose not to address it. I relayed this to the team and advocated for Ms. L's wishes. Together, we worked to make Ms. L's hospitalization as comfortable as possible.

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

This is a wonderful example of the need for clinicians to carefully guide patients and families through the unfamiliar territory of personal illness. Claudine recognized Ms. L's need to control and filter information based on what she was equipped to handle. She gently immersed herself in Ms. L's world, genuinely gaining her trust and confidence. Then delicately balancing Ms. L's need for denial with her own need to keep Ms. L safe, she took advantage of those brief windows of opportunity to ensure Ms. L's final wishes were known and respected. Thanks to Claudine, Ms. L was able to hold on to her childhood dreams and still participate in her own care decisions.

Thank-you, Claudine.

# A day in the life of a social worker at a community health center

—by Dinah Gilburd, LICSW, clinical social worker

Because medical and clinical social services are located in the same building, I often run into clients and families as they come and go from other appointments. It's an informal setting that affords me ample opportunity to stay connected to my clients.



As I walk past the Bunker Hill Mall and up the hill to work, I pause to cross Main Street. I'm greeted by a parent of one of my clients. She stops to tell me how pleased she is that her son keeps his afternoon appointments with me at the clinic. He attends middle school less than a block away. One of the advantages of a neighborhood health clinic is the close proximity for people in the community. As I continue up the hill, a horn honks, and a woman waves to me. "Hi," she calls and reminds me we have a family meeting later that day. By the time I reach the top of the hill, my day has already begun as a clinical social worker in a community health center.

Nestled at the top of the hill among stately old homes is the MGH Charlestown HealthCare Center. Built in the 1920s, the red, brick building was once converted from a public health building to the Bunker Hill Health Center, and in 1968, it was acquired by MGH as its first community health center. The Charlestown HealthCare Center offers comprehensive medical services with Internal Medicine on the first floor, Pediatric/Adolescent Medicine on the second floor, and Counseling and Behavioral Services for children, adults, and families on the third floor. Because medical and clinical social services are located in

the same building, I often run into clients and families as they come and go from other appointments. It's an informal setting that affords me ample opportunity to stay connected to my clients.

An important aspect of my job is understanding the 'culture' of the population. Charlestown is a diverse community with many ethnicities and a wide variety of health issues.

Like many urban communities, Charlestown struggles with substance-abuse, crime, and poverty. Though progress has been made in some of these areas, many of my clients still deal with the effects of parents suffering from overdoses or incarceration. As a result, some children are being raised by single parents, extended family members, or they have become part of the foster-care system.

During one family session, a grandfather asked me what he should tell his six-year-old grandson who continually asks, "When is my mother coming home?" Parental guidance for these caretakers becomes one of the primary goals of treatment. Because these issues are so complex, community resources are available to our families.

As a member of the Child and Family Team, I work with a multi-disciplinary group of social workers, psychologists, psychiatrists, and trainees. We each provide clinical services to children and families, and we provide outreach and consultation to neighborhood schools. Our weekly team meetings are an invaluable

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As I reflect on my career as a social worker in a community health setting and my passion for helping clients navigate life's challenges, it is tremendously gratifying to know there is no other work I'd rather be doing.

Dinah Gilburd, LICSW, in the neighborhood where she practices as a clinical social worker at the MGH Charlestown HealthCare Center.

opportunity to share, coordinate care, and learn from one another. The Child and Family Team collaborates monthly with the Adult Team to discuss cases.

In this community setting, outreach to children and teens in neighborhood schools is a crucial part of my job. Visiting schools allows me to see children who otherwise might not receive therapeutic services. In addition to providing clinical services as part of the Headstart program, I observe and evaluate classrooms for credentialing requirements. I work closely with staff to identify high-risk children and families for counseling.

When I visit a classroom or observe a child for diagnostic purposes, I'm reminded of the resilience of children and the safe and nurturing environment provided by staff at their schools. Dr. Robert Brooks, in his book, *The Self Esteem Teacher*, uses a powerful metaphor to describe how he locates a child or adolescent's area of strength. He writes, "Many of my patients are swimming or drowning in an ocean of self-perceived inadequacy. To counteract this image of drowning, I contend that every person possesses at least one small island of



(Photo by Paul Batista)

competence, one area that is, or has, the potential to be a source of pride and achievement."

When I consult with teachers, we try to identify a child's area of strength. In one classroom, a nine-year-old boy with significant learning problems and suffering from low self-esteem was proficient with a musical instrument. He was asked by his music teacher to play for his class. The expression of pure joy on his face as he played and the positive response of his classmates helped him locate his 'island of competence.'

I help facilitate a camp scholarship program for children and teens who would otherwise remain at home for the summer. Some local organizations provide summer programs for youth in the community. Perhaps I can explain my deep feeling of satisfaction by sharing a comment made to me by a 9-year-old client. He had just finished his first session at camp after a difficult year at school. Because of learning problems, he was going to have to repeat the grade. As he entered my office, he exclaimed, "Dinah! Guess what! I made friends for the first time and everyone was so nice to me! I can't wait to go back next summer!"

Presently, I'm participating in an innovative research project. The MGH Community Health Associates and the MGH Benson-Henry Institute for Mind-Body Medicine are collaborating on a project to provide, "easily accessible, behavioral-medicine interventions to patients served by the MGH community health centers." The outcome of their collaboration is a pilot study entitled, "Effectiveness of a Behavioral Medicine Intervention with Depressed Patients in a Community Health Center Setting." My role is to teach stress-reduction techniques to patients who want to become more actively involved in their own health care. The response from participants has been extremely positive. Once they learn to elicit the relaxation response on their own, they begin to feel the benefits. A group member with chronic shoulder pain shared with me, "The pain has not gone away, but I am different. I feel peaceful. I've learned to drift off to a place of quiet, a little break from my daily crazy stuff."

I have found so much meaning in my work. At the end of the day, I leave the building and amble back down the hill. I pass the Boys and Girls Club and wave to some of my clients who are waiting for a ride home. As I reflect on my career as a social worker in a community health setting and my passion for helping clients navigate life's challenges, it is tremendously gratifying to know there is no other work I'd rather be doing.

# Mahoney retires after long, distinguished career

—by Eileen Flaherty, RN, director, PCS Management Systems

**O**n January 31, 2008, Patient Care Services and the MGH community bid farewell to nursing resource coordinator, Barbara Mahoney, RN, as friends and colleagues gathered to celebrate her 43 years of distinguished service. A graduate of the MGH School of Nursing, Mahoney began her nursing career in 1964 as a staff nurse in the Medical Intensive Care Unit. After two years, she was made head nurse of the unit where she provided outstanding leadership for the next ten years.

In 1976, Mahoney became a clinical leader providing clinical and administrative support to a 25-bed medical unit as well as the ICU. In 1986, when Mahoney became nursing resource co-

ordinator for PCS Management Systems, she began training, coaching, and supporting nursing leaders in the management of staff resources. Said one colleague, “Whenever you went to Barbara for help, you could always count on her willingness to share her tremendous knowledge and experience. With Barbara, no question was too small, no mistake too big to be fixed.”

Mahoney was well known for her contributions to the MGH Optimum Care Committee (OCC). Partnering with Ned Cassem, MD, former chief of Psychiatry, Mahoney was an influential member of the committee helping countless nurses and physicians engage in the consultation process and helping countless patients and families deal with end-of-life issues.

Speaking at her retirement party, many of Mahoney’s colleagues came forward to express their admiration and respect for her years of mentoring, wisdom, and friendship. Cassem; Honor Keegan, RN; Mary Connaughton, RN; and Chris Graf, RN, shared stories of Mahoney’s invaluable influence and support during their careers as clinicians and healthcare leaders.

MGH president, Peter Slavin, MD, acknowledged Mahoney’s many accomplishments and offered his personal thanks for her contributions to his own professional development and to the ongoing success of the hospital.

The entire MGH community wishes Mahoney well as she embarks on her well-deserved retirement.

Nursing resource coordinator and long-time veteran of MGH, Barbara Mahoney, RN (below), is congratulated by (clockwise from top):

senior vice president for Patient Care, Jeanette Ives Erickson, RN; former chief of Psychiatry, Ned Cassem, MD; one of many colleagues who came to wish Mahoney farewell; and MGH president, Peter Slavin, MD.



# What's 'up' with all the ceiling lifts?

*Question:* I've noticed a lot more ceiling lifts throughout the hospital. Can you provide an update on the status of this project?

*Jeanette:* We made the decision to install ceiling lifts in all patient care units as a way to reduce staff injuries. This is an evidence-based measure that supports both our quality and safety goals and the goals of Patient Care Services' strategic plan.

*Question:* What is the current status of the installation plan?

*Jeanette:* Lifts have already been installed in 12 patient care units. An additional 12 units will have lifts by the end of September, 2008, with all units completed by 2009.

*Question:* Is it possible to complete installation any sooner?

*Jeanette:* An important factor in our ability to complete installation is capacity. Each installation involves closing a patient room for a certain amount of time. Completing installation sooner would require closing more rooms, and we just can't do that. At any given time, lifts are being installed in two patient care units. We were careful to select units with different patient populations to avoid admission/access issues. (For example, we wouldn't install lifts on two medical units at the same time.)

*Question:* Would it be better to install a few lifts on all units, as opposed to installing lifts in every room, one unit at a time?

*Jeanette:* We considered proceeding that way, but decided a unit-based approach would support a quicker, more effective, more seamless change in clinical practice. And we're taking advantage of the time during which rooms are closed for lift installation to make other changes, as well, such as installing nurse call systems and monitoring equipment. It has proven to be a very successful approach.

*Question:* How are staff responding?

*Jeanette:* Nurses report great satisfaction at being able to mobilize patients while minimizing their own risk of injury. Ceiling lifts are contributing to positive outcomes for patients and staff alike.

*Question:* Is there training on how to use these new lifts?

*Jeanette:* Education and training are important aspects of this project. We've created a task force, under the direction of Gaurdia Banister, RN, executive director for The Institute for Patient Care, to develop a training program to ensure a successful transition. We've installed lifts in The Knight Nursing Center for Clinical & Professional Development, and soon in POB4, so caregivers who aren't part of unit-based staffing can receive training.

For more information about ceiling lifts, contact Dan Kerls, project manager, at 4-3085.

Lifts have already been installed in 12 patient care units. An additional 12 units will have lifts by the end of September, 2008, with all units completed by 2009.

# Professional Achievements

## Beauchamp certified

Kathryn Beauchamp, RN, pediatric clinical nurse specialist, became certified as a pediatric critical care nurse specialist by the American Association of Critical Care Nurses, in January, 2008.

## Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Hand Rehabilitation Course: Flexor Tendon Management," at Tufts University, February 4, 2008.

## Mulgrew and Squadrito present

Physical therapists, Jackie Mulgrew, PT, and Alison Squadrito, PT, presented, "Management of the Acute Care Patient," at the Metro West Medical Center in Framingham, January 11-12, 2008.

## O'Connor presents

Catherine O'Connor, SLP, speech-language pathologist, presented the, "Lee Silverman Voice Treatment Program," for the Parkinson Disease Support Group at the Jewish Community Center in Waltham, December 6, 2007.

## Pazola and Stakes present

Kathryn Pazola, RN, and Kathleen Stakes, RN, presented, "Dancing Around the Truth: Cultural Differences Regarding Full Disclosure in the Treatment of Cancer Patients," at the Dana Farber Cancer Institute, January 17, 2008.

## Townsend presents poster

Elise Townsend, PT, physical therapist, presented her poster, "Physical Therapy Management of Patients with Duchene Muscular Dystrophy: a Systematic Review," at the American Physical Therapy Association Combined Sections Meeting in Nashville, February, 2008.

## Triggs certified

Cara Triggs, OTR/L, occupational therapist, became certified in Hand and Upper Extremity Rehabilitation by Tufts University in January, 2008.

## Meglio presents

Cynthia Meglio, RN, presented, "Left Atrial Appendage Occlusion Devices," at the 2nd annual Atrial Fibrillation Symposium for Allied Health Professionals, January 17, 2008.

## Giacalone presents

Maryjane Giacalone RN, presented, "Pharmacological Treatment Options for Patients with Atrial Fibrillation," at the 2nd annual Atrial Fibrillation Symposium for Allied Health Professionals, January 17, 2008.

## Orencole presents

Mary Orencole, RN, presented, "Usefulness of Cardiac Resynchronization Therapy for Patients with Atrial Fibrillation," at the Second Annual Atrial Fibrillation Symposium for Allied Health Professionals, January 17, 2008.

## Huggins interviewed

Nancy Huggins, RN, was interviewed in a telecast on January 21, 2008, by Mallika Marshall, MD, medical reporter for WBZ-TV, about a program that helps Parkinson's patients gain strength.

## Garlick appointed

Martha Garlick, PT, physical therapist, was appointed a representative of the Northern Metropolitan District Chief Assembly of the American Physical Therapy Association of Massachusetts, from January to December, 2008. She was also appointed a member of the Legislative Committee of the American Physical Therapy Association of Massachusetts from January, 2008, to December, 2010; and elected delegate for the American Physical Therapy Association House of Delegates from January to December, 2008.

## Konner appointed

Social worker; Karon Konner, LICSW, was appointed a member of the Simmons Graduate School of Social Work Alumni Board, in January, 2008.

## Parlman appointed

Kristin Parlman, PT, physical therapist, was appointed a member of the Awards Committee for the American Physical Therapy Association, Neurology Section, from 2007-2010.

## Bonanno appointed

Andrea Bonanno, PT, physical therapist, was appointed a member of the Nominations Committee for the Massachusetts Chapter of the American Physical Therapy Association of Massachusetts in February, 2008.

## Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Managing Extensor Tendons: Anatomy," at Tufts University, February 10, 2008, and, "Managing Extensor Tendons: Injuries and Splint Lab," on February 25, 2008.

## Mulgrew and Squadrito present

Physical therapists, Jackie Mulgrew, PT, and Alison Squadrito, PT, presented the two-day course, "Management of the Acute Care Patient," at Vanderbilt Medical Center in Nashville, February 16-17, 2008.

## Parlman presents

Kristin Parlman, PT, physical therapist, presented, "Neurology Section Practice Issues Forum: Defining Autonomous Practice Across Various Neurological Practice Settings," at the American Physical Therapy Association, Combined Sections Meeting in Nashville, February 10, 2008.

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## Next Publication

April 17, 2008

# Educational Offerings – 2008

April

**1**

BLS Heartsaver Certification

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

April

**2**

BLS/CPR Re-Certification

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

April

**2**

Simulated Bedside Emergencies  
for New Nurses

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

April

**3**

BLS/CPR Certification for  
Healthcare Providers

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

April

**7**

Building Relationships in the  
Diverse Hospital Community:  
Understanding our Patients,  
Ourselves, and Each Other

Founders 325  
8:00am–4:30pm  
Contact hours: 6.8

April

**7 & 14**

ACLS Provider Course

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

April

**8**

Simulated Critical-Care  
Emergencies

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

April

**8**

Chaplaincy Grand Rounds:

Yawkey 4-930  
11:00am–12:00pm  
No contact hours

April

**9**

New Graduate RN  
Development Seminar I

Charles River Plaza  
8:00am–12:00pm  
Contact hours: TBA

April

**9**

Pediatric Simulation Program

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

April

**9**

OAP/PCA/USA Connections

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

April

**10**

Ovid/Medline: Searching for  
Journal Articles

Founders 334  
1:00–3:00pm  
Contact hours: 2

April

**11**

Basic Respiratory Nursing Care

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

April

**11**

Assessment and Management  
of Psychiatric Problems  
in Patients at Risk

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

April

**14**

BLS/CPR Re-Certification

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

April

**16**

Simulated Bedside Emergencies  
for New Nurses

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

April

**16**

Nursing Grand Rounds

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

April

**17 & 18**

Oncology Nursing Society  
Chemotherapy Biotherapy  
Course

Day 1: 8:00am–4:30pm  
Yawkey 2-220  
Day 2: 8:00am–4:00pm  
Yawkey 2-210  
Contact hours: TBA

April

**17**

Management of Patients with  
Complex Renal Dysfunction

Yawkey 4-810  
8:00am–4:30pm  
Contact hours: TBA

April

**18**

PALS Re-Certification

Simches Conference Room 3110  
8:00am–4:30pm  
No contact hours

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

# Announcements

## GLBT Health Awareness Week April 7-11

Join the MGH gay, lesbian, bisexual, and transgender community for a variety of programs aimed at promoting and improving the health of our community.

- Monday, April 7th, 4:00pm  
GLBT Aging Panel  
Thier Conference Room
- Tuesday, April 8th, 8:00am  
*Cancer in Two Voices* (a video)  
Davison Lecture Hall  
6:00pm (repeat screening)  
Haber Conference Room
- Wednesday, April 9th  
GLBT Health Awareness  
Information Table  
Main Corridor
- Thursday, April 10th, 4:00pm  
Transgender Health Issues  
Thier Conference Room
- Friday, April 11th  
Health & Wellness at the Clubs  
at Charles River Park  
Free workout for MGH  
employees

For more information, visit,  
[lgbtmgh@partners.org](mailto:lgbtmgh@partners.org).

## 2008 MGH College Fair

Please join us at the 2008  
MGH College Fair

April 16, 2008  
12:00–4:00pm  
Charles River Plaza, Suite 200

The fair is an opportunity for  
MGH employees to evaluate and  
compare courses geared toward  
advancing careers in health care.

Colleges and universities  
scheduled to attend:

- Bay State College
- Bunker Hill Community  
College
- Cambridge College
- Emmanuel College
- Fisher College
- Harvard Extension School
- Mass Bay Community  
College
- Massasoit Community  
College
- Mass College of Pharmacy
- MGH Institute of Health  
Professions
- Northeastern University
- Roxbury Community  
College
- Salem State College
- Springfield College  
(Charlestown campus)
- Suffolk University
- UMass, Boston

For more information,  
contact John Coco at 4-3368  
or visit: [http://is.partners.org/hr/  
New\\_Web/mgh/mgh\\_training.  
htm](http://is.partners.org/hr/New_Web/mgh/mgh_training.htm).

## EAP Work-Life Seminar

"What to do with Your  
Next \$100"

April 23, 2008  
12:00–1:00pm  
Thier Conference Room

What is more important, paying  
down debt or building up savings?

Presented by Amy Perry,  
consumer finance educator,  
this seminar looks at saving and  
investment strategies, financial  
choices, and debt-mangement.

For more information,  
call 6-6976.

## Make your practice visible: submit a clinical narrative

*Caring Headlines* is always  
interested in receiving clinical  
narratives that highlight the  
exceptional care provided by  
clinicians throughout  
Patient Care Services.  
Make your practice visible.  
Submit your narrative for  
publication in *Caring Headlines*.  
All submissions should be sent via  
e-mail to: [ssabia@partners.org](mailto:ssabia@partners.org).

For more information,  
call 4-1746.

## Career Information Day

Come hear healthcare  
practitioners provide insight into  
their professions at the 5th Annual  
Career Information Day

March 27, 2008  
10:30am–2:00pm  
Thier Conference Room

Learn about various careers  
in 30-minute presentations  
designed to help employees make  
informed decisions about career-  
development:

Nursing: 10:30  
Financial Aid: 11:00  
Medical Technology: 11:30  
Surgical Technology: 12:00  
PBO Medical Coding: 12:30  
Electrodiagnostic Technology: 1:00  
Medical Imaging (Radiography):  
1:30

For more information,  
contact John Coco at 4-3368 or  
visit the Training & Workforce  
Development website at: [http://  
is.partners.org/hr/New\\_Web](http://is.partners.org/hr/New_Web)



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