

# Caring

Headlines

December 3, 2009



MGH  
community  
rallies to  
make Jewish  
holiday  
meaningful  
for patient  
hospitalized  
during  
Sukkot

*See story on  
back cover*

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Rabbi Ben Lanckton, (left) Jewish chaplain,  
and Yoseph Ciment beside temporary Sukkah  
erected on the terrace outside White 8

# There's more to patient care than clinical outcomes

*Excellence Every Day means owning the patient experience*

We're known the world over for our clinical expertise, cutting-edge research, and patient outcomes. But there's more to patient care than clinical excellence.

The name Massachusetts General Hospital is synonymous with exceptional patient care. We're known the world over for our clinical expertise, cutting-edge research, and patient outcomes. As a Magnet hospital, our systems, infrastructure, and practice model are the very hallmark of excellence. But there's more to patient care than clinical excellence. A simple conversation with any patient or family member will tell you—there's more to patient care than clinical outcomes.

As we work to ensure that every patient who comes through our doors experiences the full meaning of Excellence Every Day, our efforts must extend to the *whole* patient experience. Comfort, respect, courtesy, cleanliness, and basic human consideration are as essential to patient care as pain-management and fall-prevention. And as with every aspect of Excellence Every Day, we all play a part.

Leading us in our efforts to perpetually improve service and raise awareness about the issues affecting the patient experience are director of PCS Clinical Support Services, George Reardon; senior director of Service for MGH, Richard Corder; and process improvement program director, Mary Cramer. Working together, and with all of us, George, Richard, and Mary are helping us focus our attention where it's needed most.



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

At MGH, we have a number of ways to measure service and patients' perceptions of care. Feedback from patient and family advisory councils, quality dashboards, and of course, our Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data all inform our work. Based on these indicators and our own observations and interactions, we have identified three areas of priority. They are: communication, responsiveness, and cleanliness.

One strategy that's already been adopted on several units is hourly rounding. Studies show that frequent rounding not only improves communication and responsiveness but has a positive impact on preventing patient falls and reducing hospital-acquired pressure ulcers. The best tip for effective rounding is, 'Be yourself.' When you enter a patient's room, let your genuine concern for the patient guide your interaction. Avoid 'scripted' questions, engage in pleasant conversation as you assess their needs. Make sure patients know who

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Our demeanor in answering telephones, the way we carry ourselves as we accommodate unorthodox requests, the way we react when asked to do something outside of our job description—these all contribute to the way patients perceive responsiveness. As we go about our daily practice, does our attitude convey kindness, compassion, and concern?

you are, why you're there, and when you'll be back. Ask if there's anything you can do for them while you're there. If every employee adopted this approach, patients would feel perpetually safe and supported.

Attitude may be the most important aspect of responsiveness. Attitude affects every interaction we have with every patient, family member, and colleague. Our demeanor in answering telephones, the way we carry ourselves as we accommodate unorthodox requests, the way we react when asked to do something outside of our job description—these all contribute to the way patients perceive responsiveness. As we go about our daily practice, does our attitude convey kindness, compassion, and concern?

Responsiveness isn't limited to patient care units. The Patient Care Services Greeter Program enlists volunteers in the Main Lobby to greet patients and visitors as they arrive and offer assistance in finding their way. Feedback from patients and visitors has been overwhelmingly positive. They appreciate the personal touch and unsolicited offer of assistance. The program has been especially well received by non-English-speaking visitors who may require a little extra help.

You can volunteer to become a greeter by committing as little as one hour per month. For information about the Greeter Program call Mike Stone, manager of the Information Desks, at 4-6596.

Over the past few months, operations managers and unit service associates have been exploring ways to im-

prove the processes around cleaning patients' rooms, including strategies for letting patients know we're committed to a clean environment. Soon, bedside tent-cards and bathroom check-sheets will let patients know if their rooms were cleaned while they were away from the unit. Maintaining a clean environment is everyone's responsibility. Picking up litter, calling to report a spill (6-2445), or just noticing when something isn't right and taking action to fix it can make a big difference.

Process improvement plays an important role in enhancing the patient experience. Through interdisciplinary training and workshops, staff and leadership are learning about change-management and a variety of tools necessary to support process-improvement projects. Always looking for ways to eliminate waste and improve efficiency, staff are involved in a number of initiatives geared toward improving quality and safety, service, and efficiency. Projects have been chartered to identify opportunities for improvement in areas such as access to care, patient safety, patient flow, supply management, space utilization, cleanliness, and much more.

These are just some of the ways we're working to improve the patient experience. We're thankful to George and Richard and Mary for leading this effort, but it's not their responsibility alone. We're all leaders in the effort to improve service and make MGH a safe and welcoming place.

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# Beckles looks back on half-century of neonatal nursing

—by Patricia Beckles, RN

Pat Beckles, RN (center), with cousins who graduated from the same hospital in the 1940s and 1950s.

**H**ow time flies when you're having fun. 1959. What a wonderful year. Five years after becoming a registered nurse, I had a wonderful husband, a beautiful 4-year-old daughter, and a new house. I decided to go to work to help buy furniture for our new home. I had worked on the pediatric unit at MGH as a ward helper

the year I graduated from high school and had enjoyed taking care of babies and toddlers, so I applied for a job as a night nurse. A wonderful old, white-haired woman named, Miss Grady, hired me. That's how it all began.

At that time, there was no such thing as a newborn intensive care unit. Most parents brought their children to the hospital by car or taxi. Sometimes, by the time they arrived, it was too late. Neonatal transport teams going out in ambulances or helicopters to accompany babies back to the hospital was unheard of. There were no ventilators for infants. What seems routine today had not yet even been imagined.

Today's isolettes are a far cry from the incubators we used back then—rectangular boxes with hinged covers that swung open to put the baby inside (the same kind of incubators used by the famed Dionne quintuplets). To provide moisture for babies we poured water into a reservoir in the bottom of the incubator. We soon learned that unless we added vinegar to the water, it rapidly became a breeding ground for bacteria. It was a time of learning by trial and error.

There were no monitors to observe vital signs. We relied on our instincts to tell us when something was wrong. And we depended on the babies to let us know when they needed interventions. The introduction of pumps to administer intravenous fluids instead of regulating fluids with a screw-clamp on the IV tubing was a great advancement.

I remember the first time I went in an ambulance to pick up a sick infant. We took a paper bag, a couple of syringes, and a few meds. We taped the stethoscope to the baby's chest to monitor his heart. There were no endo tubes, laryngoscopes, Ambu bags, or masks. I

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(Photo provided by Beckles)

## A Nursing Reflection (continued)

shudder when I think how confident we were. But we always managed to get the baby safely back to MGH. Today it's like traveling with a miniature hospital. We have ventilators, a physician, a respiratory technician— we can intubate and start treatment as soon as we arrive.

I was on duty the first time we used a positive-pressure tube to keep a baby's lungs inflated. It was a cylinder of water on the wall with oxygen blown through it. The water had to be kept at a certain level to keep the pressure constant and not blow out the baby's lungs. One of my jobs was to monitor the water level in the cylinder and not let it drop. That was a scary night.

After that came an adult ventilator, a huge machine about the size of a washer or dryer. It was a volume ventilator, so the danger, of course, was that too much volume could blow out the baby's lungs. Fortunately, that never happened, but it made for some very nerve-wracking nights. I was so grateful for the team of respiratory technicians we had. Whenever I paged them, they came right over. I learned so much from them about ventilators and how to keep my babies safe. After many trials with machines such as the 'dog ventilator' and 'puffer machines,' we now have ventilators designed specifically for babies. We used to have to jury-rig endo tubes to get the right size. Now, we have equipment that's just the right size for our tiny patients. Technology has improved so much, and many babies have benefitted from these advancements.

When I started working at MGH, nurses wore white uniforms, white shoes, and white stockings. We all wore caps representing the schools from which we graduated. It was always interesting to talk to nurses and hear about their experiences in different parts of the world.

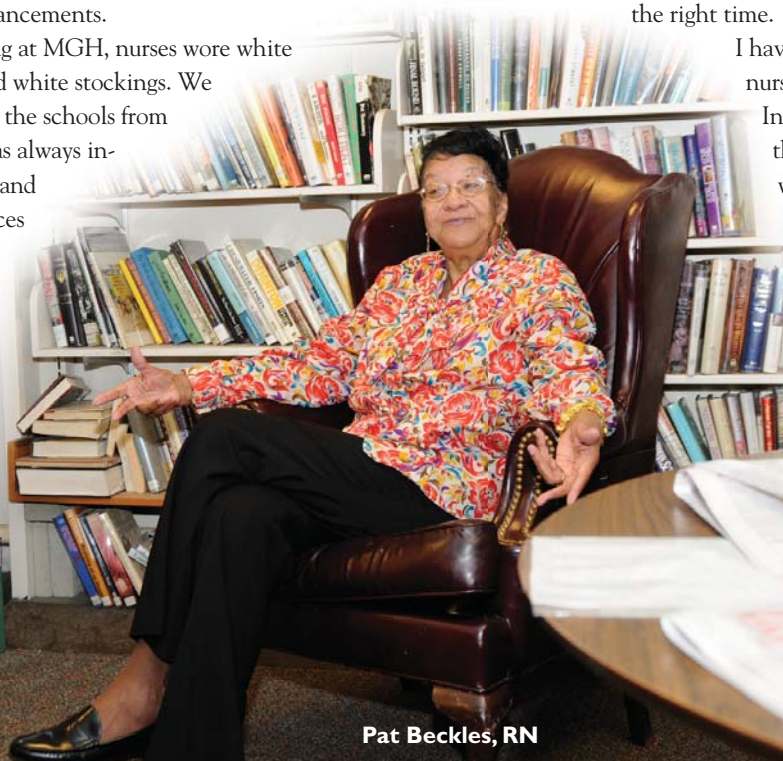
We had a night supervisor named, Miss Smith. Her shoes were always freshly polished, and her MGH cap was always straight on top of her head. She wore a navy-blue sweater around her shoulders because

she covered the Bulfinch Building as well as Pediatrics, and those corridors were always drafty. She would come around at midnight and check every patient, check their intake and output sheets to make sure they'd received the correct amount of fluids and were putting out sufficient urine. She stood up for her nurses. In those days, nurses had a more subservient role. Miss Smith taught me that as long as I was doing the right thing for my patients and followed MGH protocols, (and she knew them all!) she would always stand up for me. What a comforting feeling for a young nurse. Under her guidance, I developed the confidence to advocate for my small charges. The director of Nursing, Miss MacDonald, let it be known that her door was open every morning and nurses could stop in to say Hi or discuss a problem. I took advantage of that open-door policy on many occasions, and she always had some wise advice to help make me a better nurse.

When I first started at MGH, we were still dissolving tablets of morphine in a spoonful of saline over an ether lamp. The thought of that reminds me how far we've come. In the "old days," intravenous fluids came in glass bottles and were heavy and cumbersome to handle. Thermometers were glass and often broke. (Have you ever tried picking up mercury? It's not easy!) Now everything is plastic. IV fluids come in easy-to-carry plastic bags. Most medications are computerized and we use scanning technology to ensure the right patient gets the right medicine at the right time.

I have seen the evolution of a nursery into a Neonatal Intensive Care Unit. What a thrill to know how many lives we've saved. I have met wonderful people and made lifelong friends. I've seen doctors show their emotions and not be ashamed or diminished by it.

Now I can see how the time flew by. I wouldn't have missed this journey for anything. I have seen so many changes and improvements throughout my long career. I'm so glad I decided to stay at MGH.



**Pat Beckles, RN**

# MGH celebrates 75th anniversary of pastoral care

—by Reverend Angelika Zollfrank, manager, Clinical Pastoral Education

Reverend Russell L. Dicks provides pastoral care to young patient in the 1930s

In 1936, MGH physician, Richard Clarke Cabot, MD, wrote, “The sick need the chaplain because the sick do not live by bread alone, nor by the most appropriate diet, medication, surgery, nursing, and hygiene that can be brought to their aid. The chaplain needs education and training to be able to effectively help our sickest patients and families to move towards spiritual health and an overall

sense of peace and satisfaction with their stay at the hospital.”

Home to many pioneers of modern medicine, MGH not surprisingly also played a part in the development of hospital-based training in pastoral care. This year, we celebrate the 75th anniversary of Clinical Pastoral Education (CPE) at MGH. In 1934, under the leadership of Cabot and Reverend Russell L. Dicks, MGH became the first general hospital in the nation to offer a program to train religious lead-

ers in the art of pastoral care. Cabot and Dicks, together with other local clergy, developed training methods on how to provide compassionate spiritual care to patients and families in crisis.

In 1944, MGH hosted a meeting of a forerunner of the national Association for Clinical Pastoral Education (ACPE). Today, the ACPE is the accrediting agency for more than 250 CPE programs, including those offered at MGH. In 1998 a new program was introduced: CPE for Healthcare Professionals. With funding from the Kenneth B. Schwartz Center and the department of Nursing, healthcare providers are given an opportunity to participate in the CPE program, learning to support patients and families by recognizing and honoring spiritual values in the context of care-delivery. The CPE for Healthcare Professionals fellowship is available to six care providers each year.

One participant of the program wrote, “I am now able to ask questions about faith and spirituality. A caring connection—that’s what it is all about.”

Generations of religious leaders have completed rotations at MGH during their ministerial training. Today, a career in healthcare chaplaincy requires a master’s degree, a year of clinical pastoral education, board-certification, ongoing peer review, and continuing education.

Clinical Pastoral Education at MGH provides a solid educational foundation. Those who wish to become professional healthcare chaplains can enroll in advanced CPE. Said one recent graduate, “I learned to be centered and present with families in crisis. I have a clearer sense of purpose, determination and passion, which I bring to my religious life as well.”

For more information about CPE opportunities at MGH, call 4-3227.



(Photo provided by staff)

# Good and Keeley selected *Nursing Spectrum* 'Nurses of the Year'

Below (l-r): associate chief nurse, Theresa Gallivan, RN; Grace Good, RN; Adele Keeley, RN; senior vice president for Patient Care, Jeanette Ives Erickson, RN; and Judith Mitiguy, RN, representing *Nursing Spectrum*.

**O**n November 12, 2009, friends, family members, and colleagues of Grace Good, RN, and Adele Keeley, RN, gathered in the Trustees Room to celebrate their selection by *Nursing Spectrum* as this year's Nurses of the Year. Good, a nurse practitioner and leader of Team 5, was recognized for Clinical Care, while Keeley, nursing director for the Blake 7 Medical Intensive Care Unit, was recognized for Management. Judith Mitiguy, RN, executive vice president for Nursing Communications and Initiatives

at *Nursing Spectrum*, shared that both Good and Keeley were chosen unanimously in their categories in a 'blinded' selection process.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, was on hand to offer her congratulations. Said Ives Erickson, "This is a great honor, both for Grace and Adele, and for MGH. Their work and influence as nursing leaders is impressive and far-reaching. We're very fortunate to have them on our team."

Associate chief nurse, Theresa Gallivan, RN, introduced each honoree saying of Good, "Grace is a uniquely strong model in her dedication to patient advocacy and personalized care through collaboration with others. She reminds us that patient care is about patients—their whole being, life, lifestyle, and life circumstances. And that delivering care means doing whatever it takes to work with what is presented by the patient."

Of Keeley, Gallivan said, "Adele's leadership is guided by two key beliefs: that the well-being of patients and families and the satisfaction of nurses go hand in hand; and that advances can only be made by focusing on the possibilities rather than the limitations." Sharing a passage written by a patient's wife, Gallivan read, "While my husband remembers nothing of his experience in the MICU, I have vivid memories of your attentive, professional care. It was an oasis of calm and trust during a harrowing time. I am very grateful."

Patient Care Services joins the entire MGH community in congratulating Grace Good and Adele Keeley for this well-deserved recognition.



# Narrative culture contributes to seamless transition of care

I wanted to give them every chance to 'hit the ground running' with their new care team. I decided to write a narrative and add it to the standard paperwork that would accompany Sally to rehab.

**M**y name is Debbie Cupp, and I am a nurse on the Ellison 10 Cardiac Step Down Unit. Recently, I cared for 'Sally,' a 50-year-old woman who had been transferred from Neurology following an acute stroke. After being stabilized neurologically, she needed further treatment for an infected heart valve before she could be safely transferred to rehab. I was assigned to her care on her first day on our unit.

Prior to entering her room, I familiarized myself with Sally's medical record. She had a known structural abnormality in her aortic valve that had put her at increased risk for infection. She also had a history of breast cancer.

Sally and her husband, 'Don,' were newlyweds. They had celebrated their first anniversary just weeks before. Don awoke the morning after their anniversary to find Sally struggling to get out of bed. She appeared confused by her inability to do what she wanted to do. Don immediately called 911.

As I entered Sally's room to conduct my initial assessment, I imagined the fear and uncertainty she must be feeling. I recognized the impact of the sudden loss of control over her surroundings. I wanted her to know I was sensitive to the anxiety she was experiencing, so I promised to keep her involved and aware of all plans regarding her care. In addition to providing good nursing care, I wanted to reduce any apprehension she was feeling so she'd be ready to engage with her other caregivers: the speech-language pathologists and physical



Debbie Cupp, RN, MGH staff nurse (left) and Donna Carpenter, RN, case manager, Spaulding Rehabilitation Hospital

and occupational therapists who would eventually play a key role in her recovery.

I asked Sally if she knew anyone else who'd ever had a stroke. That's when I learned how her husband had recognized her symptoms so quickly—her father-in-law, Don's father, had had a stroke just a month ago. I was concerned about her ability to remain optimistic in light of this information. To make matters worse, he had been placed in a long-term care facility and wasn't doing well.

I wanted Sally to stay mentally and emotionally linked to the self she was before the stroke. I met her family and friends and learned of their significance in her life. I wanted her to remember the strength she had possessed as she had faced breast cancer less than five years earlier. The story she told was full of sophisticated self-reflection, inner strength, and a healthy sense of self-worth.

Don split his attention between his father's care and keeping a vigilant eye on Sally. He was mindful that caregivers might view him as intrusive, so he always

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sought approval or informed us of his plans to assist her. This strengthened our inclination to include him as an active partner in her care. He reveled in each little victory she made.

Don was unaffected by Sally's altered physical appearance, her disheveled hair, or the mess she made at mealtimes. She in turn, unconditionally accepted his assistance in all aspects of her care. They were living examples of the, 'for better or for worse, in sickness and in health' portion of their recent vows. As he assisted her in transferring from bed to chair, they would often steal a quick kiss.

It was rewarding to see how well they worked together and with us. Knowing she'd have to start over with a new care team when she transferred to rehab was a concern for Sally and for me. As her discharge date grew near, I wondered how I might be able to support her on the next leg of her journey. While the standard forms would provide all the relevant clinical information, they wouldn't capture all I had come to know about Sally as an individual and about Sally and Don as a highly effective team. I wanted to give them every chance to 'hit the ground running' with their new care team.

I decided to write a narrative and add it to the standard paperwork that would accompany Sally to rehab. I called Spaulding and was told that Donna Carpenter, RN, would be her case manager. I e-mailed Donna and introduced myself. I explained my concerns and let her know I was sending a narrative along with Sally's paperwork. I asked her to read it and use it in whatever way she felt it would promote a smooth transition and continuity of care for Sally. I asked her to let me know if she found it helpful. This story in *Caring Headlines* is the result of the communication that was initiated by my narrative between Donna and me on behalf of our mutual patient.

**M**y name is Donna Carpenter and I am a case manager for the Young Stroke Program at Spaulding Rehabilitation Hospital. As a case manager, I review every patient's medical record prior to meeting them. The day I met Sally, I received the narrative from Deb. Narratives are not a typical part of the medical record in the transfer process from acute care to the rehabilitation setting. I eagerly read Deb's narrative before meeting Sally and her husband.

The narrative was a valuable tool as I began to understand the difficulties Sally and Don had experienced. Sally had arrived at MGH on Christmas Day, after suffering a serious stroke due to an underlying cardiac defect. She had had a long and complex acute-care stay. I was assigned to Sally's case and would be responsible for coordinating her care as she began her long recovery.

In reading Deb's narrative, I came to know Sally as a person, a new wife, and a business executive. I came to understand that her husband was eager, willing, and capable of participating in all aspects of his wife's care. I knew it would be important to involve both of them in the rehabilitative process. At our weekly team rounds with Sally's primary nurse, physician, and therapists, we agreed that Sally's husband would be present for all therapy sessions and nursing interventions. I advocated for the maximum insurance coverage for Sally in response to her desire to be discharged directly home avoiding a stay in a sub-acute-care facility.

Sally recovered slowly, with Don always by her side. He was often at his laptop communicating Sally's progress to their family, friends, and primary care physician. Because of Don's willingness and ability to learn, he was able to assist in safely transferring Sally in and out of bed, a necessary prerequisite for returning home. Initially, the rehab team was concerned that a home discharge might not be possible. But going back to the motivation Deb had described in her narrative, it became clear that with the appropriate time and teaching, Sally would be able to return home.

For this couple, Deb's narrative helped provide a seamless transition of care. The communication and teamwork between clinicians in different settings and different hospitals allowed Sally's care team to focus on her goals and ultimately help her return home.

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

It's all about relationships. Relationships between patients and caregivers, and relationships between members of the care team. Debbie knew Sally and her husband. She knew the dynamics of their relationship and how that affected Sally's recovery. Debbie's narrative allowed Donna and the team at Spaulding to know Sally beyond what they could learn in her medical record. What a wonderful example of the success and importance of the narrative culture.

Thank-you, Debbie and Donna.

In reading Deb's narrative, I came to know Sally as a person, a new wife, and a business executive. I came to understand that her husband was eager, willing, and capable of participating in all aspects of his wife's care. I knew it would be important to involve both of them in the rehabilitative process.

# Nursing license renewal begins January 1st

—by Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

**I**n Massachusetts, nurses are required to renew their nursing licenses on or before their birthdays in all even-numbered years. January 1, 2010, is the start of the next license-renewal cycle. Nurses must renew their licenses on or before their birthdays, or the license will expire. In Massachusetts, it is illegal to practice as a nurse without a current license. The good news is that license-renewal is easier than ever with on-line renewal through the Board of Nursing website.

Typically, 45-60 days before your birthday, you'll receive a renewal notice in the mail (if the Board of Nursing has your current address). The Post Office will not deliver a license-renewal notice to a forwarding address. When the renewal notice arrives, you're

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Regulations regarding continuing education are designed to ensure that all nurses in the state of Massachusetts possess current knowledge and competencies to deliver safe patient care.

required to sign and date the renewal form, which is a legal attestation of your compliance with the regulations governing nursing in this state. To complete the transaction, the form and renewal fee must be mailed to the Board of Nursing before the expiration date (one minute past midnight on your birthday).

Completing the renewal process by mail can take two to three weeks. To save time and ensure your license doesn't expire, you can renew your license on-line at: [www.mass.gov/dph/boards/rn](http://www.mass.gov/dph/boards/rn).

To maintain an active license, the Board of Nursing also requires 15 contact hours of continuing education every two years to be completed before your license-renewal date. The Board of Nursing does not require you to include your continuing-education certificates with your license renewal form unless directed to do so by an official audit. Regulations regarding continuing education are designed to ensure that all nurses in the state of Massachusetts possess current knowledge and competencies to deliver safe patient care.

Continuing education for nursing license renewal must be in an area of professional nursing practice. Currently, The Norman Knight Nursing Center for Clinical & Professional Development offers more than 200 approved continuing-education courses through HealthStream. They are available 24 hours a day, seven days a week, from any computer with Internet access. In collaboration with the Clinical Nurse Specialists Group and others, The Knight Nursing Center offers approximately 100 programs per year.

In 2010, new programs will be offered that combine HealthStream with an instructor-led component. New topics are being added, including: Promoting Innovations in Nursing Practice, Building Evidence-Based Practice, and Creating Richer More Meaningful Relationships with your Patients and Families, and others.

If there is a topic of interest you'd like to suggest, please e-mail Gino Chisari, RN, director, The Knight Nursing Center for Clinical & Professional Development, or call 6-3111.

# Comfort and Support after Loss Memorial Service

—submitted by the Comfort and Support After Loss Committee

Comfort and Support After Loss Committee (back row, l-r): Janet Madden, RN; Lisa Scheck, LICSW; Kathryn Beauchamp, RN; Clorinda Bancroft, LICSW; Leslie Kerzner, MD; and Genevieve Gonzalez, LICSW. (Seated): Brenda Miller, RN; Fredda Zuckerman, LICSW; and Kathleen Stakes, RN. (Not pictured: Denise DuChaine, LICSW; Ann Haywood-Baxter, MDiv; Heather Peach, CCLS; and Eileen White.

The 18th annual MassGeneral Hospital for Children's Pediatric, Neonatal and Obstetric Memorial Service was held November 1, 2009. The service is dedicated to the MGH families who have experienced the death of a child from infancy through adolescence, including miscarriage and stillbirth. Families and staff return year after year to participate in what continues to be an important and meaningful event.

"The loss of a child is forever."

"Be patient with your grief."

"Keep supportive people close to you."

These are just some of the comments heard at this year's service in O'Keeffe Auditorium.

Clinical social worker, Fredda Zuckerman, LICSW, moderated the service. Speakers included: Ronald Kleinman, MD, chief of Pediatrics; Howard Weinstein, MD, chief of Pediatric Hematology-Oncology; Kathleen Stakes, RN, pediatric oncology clinical nurse specialist; and Elyse Levin-Russman, LICSW, pediatric social worker. Elliot Melendez, MD, former PICU attending physician, welcomed Spanish-speaking attendees, and Reverend Daphne Noyes was on hand to offer prayers. Family members and loved ones shared stories and poems in remembrance of their beloved children and offered words of comfort to other families.

Music therapist, Lorrie Kubicek, along with Kimberly Khare and Stephanie Johnson, provided a backdrop of inspirational music for the occasion. Their carefully chosen songs filled the room with familiar, poignant joy. A moment of silence and a candle-lighting ceremony followed the traditional naming ceremony where each family was given a pewter heart and daffodil bulb to plant in remembrance. Families hung decorative memorials to their loved ones, which will be placed in the 2009 memorial scrapbook. A photo slide show set to *Somewhere over the Rainbow* ended the ceremony.

Brenda Miller, RN and a team of volunteers provided fun activities for younger attendees in the MGH Back-up Child Care Center.

Following the service, a reception was held in the East Garden Room. Families had a chance to re-connect with caregivers and meet other families. Memorial quilts and scrapbooks from past years were on display.

For more information about the work of the Comfort and Support After Loss Committee or the annual memorial service, contact Fredda Zuckerman, LICSW, at 4-3177.



# Research opportunities for nurses

—submitted by the Nursing Research Committee

**T**he Nursing Research Committee is already looking ahead to Nurse Recognition Week 2010. Have you been involved in a research study or clinical inquiry on your unit that has shed light on a best practice or led to a solution to a clinical problem. Would you like to share your findings with others? Perhaps you should consider submitting an abstract for a poster presentation to be included in next year's Nursing Research Expo. The experience is fulfilling and will leave you with an indelible sense of satisfaction at having contributed knowledge to improve the delivery of patient care.

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One of the many advantages of working at MGH is having access to experts in so many fields of study. The Yvonne L. Munn Center for Nursing Research and the PCS Nursing Research Committee are excellent resources for nurses looking for research opportunities.

Two prerequisites to becoming involved in nursing research are an inquiring mind and a heightened interest in improving patient care. One of the most important roles of a nurse is to question what is happening to patients, describe patients' responses to care, and explore care alternatives to address patients' needs.

If you're interested in becoming involved in the research process, consider the following:

- The first step in developing a researchable question is recognizing patterns or problems that inspire you to ask, How can this be changed or improved? The prospect of developing a research study may be intimidating if you haven't been involved in the process. But the best research is often initiated by clinicians closest to the bedside.
- The next step is to identify colleagues with whom you can talk about what you have observed. Look for those who have an interest in your topic and those who have expertise and experience in conducting research.

One of the many advantages of working at MGH is having access to experts in so many fields of study. The Yvonne L. Munn Center for Nursing Research and the PCS Nursing Research Committee are excellent resources for nurses looking for research opportunities. Finding Help:

- For ideas on getting started, contact your clinical nurse specialist. The co-chairs of the Nursing Research Expo Subcommittee (Laura Naismith, RN, or Teresa Vanderboom, RN) can also offer assistance.
- A class in abstract-writing will be offered on December 4, 2009, from 12:00–1:00pm in the Buckley Conference Room on Blake 8.
- For abstract templates and exemplars, visit the Nursing Research Committee website at: [http://www2.massgeneral.org/PCS/The\\_Institute\\_for\\_Patient\\_Care/NR/abt\\_research.asp](http://www2.massgeneral.org/PCS/The_Institute_for_Patient_Care/NR/abt_research.asp).

Poster Categories:

- Original Research
- Research Utilization
- Performance Improvement

The deadline for submitting abstracts is January 15, 2010.

# The facts about blood transfusion

*Question:* Why is there so much emphasis on safety related to administering blood and blood products?

*Jeanette:* Serious complications and even death can occur if a patient is given the wrong blood or blood product. Having systems in place to ensure safe practices related to blood-administration is a priority, not just at MGH, but across the country.

*Question:* How do we prevent the wrong blood from being administered at MGH?

*Jeanette:* Safety steps are built into the process from the time a patient's initial blood specimen is obtained to the time a blood product is administered. These steps ensure that the blood has been individually matched to the patient receiving the blood product. Every nurse authorized to transfuse blood products has completed training specific to the administration of blood products.

*Question:* Who is qualified to obtain the blood specimen that's used to identify the patient's blood type?

*Jeanette:* All MGH staff trained in phlebotomy can draw the initial blood specimen to determine type and cross-matching.

*Question:* Are there other safety measures?

*Jeanette:* There are three distinct steps in the blood-transfusion process. The first is to draw a blood specimen using two patient identifiers and send it to the Blood Bank. This sample is used to determine the patient's blood type. The second step is to request the blood product once the physician has ordered it. And the third is for two nurses to verify the patient and the patient's blood type prior to transfusing any blood product. These built-in redundancies help prevent errors.

The Blood Bank has its own system of checks when matching a patient's blood type with available blood products. They don't release any blood products until the patient is ready to receive the transfusion and they've verified the match using two patient identifiers.

*Question:* Who is qualified to initiate transfusion of blood and blood products?

*Jeanette:* Transfusions must be administered by a physician, a registered nurse, a nurse practitioner, or a physician's assistant who has completed transfusion-therapy training and demonstrated competence. Respiratory therapists certified in ECMO who have completed transfusion-therapy training may administer transfusions during ECMO procedures.

*Question:* Who is qualified to participate in the verification process prior to initiating a transfusion?

*Jeanette:* Verification must be performed by:

- two registered nurses, one of whom must have completed the MGH educational program and competency process for blood administration, and another who has completed the verification education program
- a physician and a registered nurse who has completed the verification education program

Verification must be performed at the patient's bedside. The patient's name and patient ID number are checked against the blood product. The blood product itself is checked by two clinicians for blood type, blood component number, and expiration date. Finally, the patient's blood type is verified with the blood product, and the physician's order for the blood is reviewed to confirm the ordering information matches the product.

*Question:* Where can I find more information about blood transfusion protocols?

*Jeanette:* See "Blood Transfusion," in the *Clinical Policy and Procedure Manual*, and "Transfusion Therapy Overview," in the *Nursing Procedure Manual*.

For more information, contact the PCS Office of Quality & Safety at 3-0140.

# Announcements

## Eldercare monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscovitz, LICSW, geriatric social worker for the Eldercare monthly discussion group, sponsored by the Employee Assistance Program. Come and discuss subjects relevant to eldercare.

Next session:  
December 8, 2009  
12:00–1:00pm  
Doerr Conference Room  
Yawkey 10-650

Old friends and new members are welcome  
Feel free to bring your lunch  
For more information, call 6-6976  
or visit [www.eap.partners.org](http://www.eap.partners.org)

## Invitation to registered nurses

winter/spring 2010 Program

The RN Residency: Transitioning to Geriatrics and Palliative Care Program is now accepting applications for the winter/spring 2010 sessions.

The RN Residency Program provides registered nurses an opportunity to learn and apply current, evidence-based geriatric and palliative nursing knowledge and innovative patient-care delivery models. A combination of didactic teaching and clinical experience, the program aims to strengthen the nursing workforce and improve the quality of nursing care to older adults and their families.

All registered nurses interested in geriatrics and palliative care are invited to apply.

January 19–21, 2010  
(plus one day per month through June, 2010)  
Classes held at  
Simches Research Center

For more information, call Ed Coakley, RN, at 4-7677

## 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.

## 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.

## Holiday Songfest

The MGH Chaplaincy invites you to join in its annual holiday songfest

Thursday, December 17, 2009  
12:00–1:00pm  
in the Main Corridor  
near the Blum Patient & Family Learning Center

Holiday attire is encouraged  
Special prize for “best dressed”

All are welcome

## Call for Abstracts Nursing Research Expo 2010

Do you have data that could be presented via a poster? The PCS Nursing Research Committee will be offering classes in abstract-writing. Look for information in future issues of *Caring Headlines*.

Prepare now to submit your abstract to display a poster during the 2010 Nursing Research Expo

Categories:

- Original Research
- Research Utilization
- Performance Improvement

For ideas on getting started, contact your clinical nurse specialist. Co-chairs of the Nursing Research Expo Sub-Committee (Laura Naismith, RN, or Teresa Vanderboom, RN) can also offer assistance.

For abstract templates and exemplars, visit the Nursing Research Committee website at: [www2.massgeneral.org/pcs/The\\_Institute\\_for\\_Patient\\_Care/NR/abt\\_research.asp](http://www2.massgeneral.org/pcs/The_Institute_for_Patient_Care/NR/abt_research.asp)

(Note corrected website)

The deadline for submission of abstracts is January 15, 2010.

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### Submissions

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For more information, call: 617-724-1746

Next Publication  
December 17, 2009

# Educational Offerings – 2009

December

**7&8**

Oncology Nursing Society  
Chemotherapy Biotherapy  
Course

Day 1: Yawkey 2-220  
Day 2: Yawkey 4-820  
8:00am–4:30pm  
Contact hours: TBA

December

**8**

New Graduate RN  
Development Program

Founders 311  
8:00am–4:30pm  
No contact hours

December

**9**

Code Blue: Simulated Cardiac  
Arrest for the Experienced Nurse

POB 448  
7:00–11:00am  
Contact hours: TBA

December

**9**

Nursing Grand Rounds

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

December

**14**

Cancer-Related Emergencies: a  
Symposium for Nurses

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

December

**14**

BLS/CPR Re-Certification

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

December

**15**

Pediatric Simulation Program

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

December

**15**

Simulated Critical-Care  
Emergencies

POB 448  
7:00–11:00am  
Contact hours: TBA

December

**17**

Preceptor Development: Learning  
to Teach, Teaching to Learn

Charles River Plaza  
8:00am–4:30pm  
Contact hours: 6.5

December

**17**

Intermediate Arrhythmia

Simches Conference Room 3-120  
8:00–11:30am  
Contact hours: 3.5

December

**17**

Pacing Concepts

Simches Conference Room 3-120  
12:15–4:30pm  
Contact hours: 3.75

December

**18**

PCA Educational Series

Founders 325  
1:30–2:30pm  
No contact hours

December

**21**

CPR Mannequin Demonstration

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

January

**4**

Oncology Nursing Concepts

Yawkey 2-220  
8:00am–4:00pm  
Contact hours: TBA

January

**5**

BLS/CPR Certification for  
Healthcare Providers

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

January

**5**

Pediatric Simulation Program

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

January

**6**

PALS Instructor Class

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

January

**7**

Intermediate Arrhythmia

Haber Conference Room  
8:00–11:30am  
Contact hours: 3.5

January

**7**

Pacing Concepts

Haber Conference Room  
12:15–4:30pm  
Contact hours: 3.75

January

**13**

Simulated Bedside Emergencies  
for New Nurses

POB 419  
7:00am–2:30pm  
Contact hours: TBA

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

# The power of the sukkah

—by Rabbi Ben Lanckton, staff Jewish chaplain

Being hospitalized can be disorienting, confusing, even frightening. For patients unable to engage in religious or cultural practices because they're confined to a hospital, it can be particularly disheartening. It was with that awareness that I received a phone call from Rabbi Ciment recently, regarding a seriously ill patient on Phillips House 21.

Several years ago, Rabbi Ciment's octogenarian father was a patient at MGH. His stay required him to be in the hospital during the first few days of the week-long Jewish holiday of Sukkot. The central observance of Sukkot is sitting, eating, and reciting blessings in a sukkah, a small outdoor booth, traditionally made with a thatched roof, specially constructed for this fall harvest holiday. When Rabbi Ciment asked if he could construct a sukkah for his father on the terrace adjacent to his patient-care unit, I balked. I didn't know if it would be logistically feasible. I wondered if it was medically advisable for the patient to visit a sukkah. But with the cooperation of the entire healthcare team, Buildings & Grounds, and Police & Security, Rabbi Ciment's father was able to participate in his life-long practice of sitting in a sukkah on Sukkot.

Once again, this year, I received a call from Rabbi Ciment two days before Sukkot. Another patient was requesting a sukkah. This

time, the patient was on Phillips House 21. And this time, I was prepared. Knowing that Phillips 21 doesn't have an outdoor terrace, I arranged to have the sukkah erected in the same place as last time, on the terrace outside White 8. I obtained medical clearance for the patient. I explained the situation and religious significance to the nursing directors on Phillips 21 and White 8. I spoke with the director of Police & Security and other key players. Every MGH employee with whom I spoke wanted to do everything they could to help this patient.

This year, Sukkot fell on a rainy weekend, so special precautions

had to be taken to secure the sukkah and ensure that access to the terrace was safe. Visits to the sukkah were timed to make sure they were long enough to fulfill religious tradition but short enough not to over-tax the patient.

For weeks afterward, the patient and her family were effusive in their gratitude. One daughter told me I would earn 'zechus' (special merit) for coordinating construction of the sukkah. Her

son shook my hand, once in greeting, and a second time in gratitude.

Sadly, the patient did not survive. She died in the company of her family and community weeks later. Her passing made our efforts to fulfill her wish to observe Sukkot in accordance with her faith that much more special. Before she passed, she asked me to tell her healthcare team: "Todah rabah." "Thank-you very much."

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The central observance of Sukkot is sitting, eating, and reciting blessings in a sukkah, a small outdoor booth, traditionally made with a thatched roof, specially constructed for this fall harvest holiday.

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