

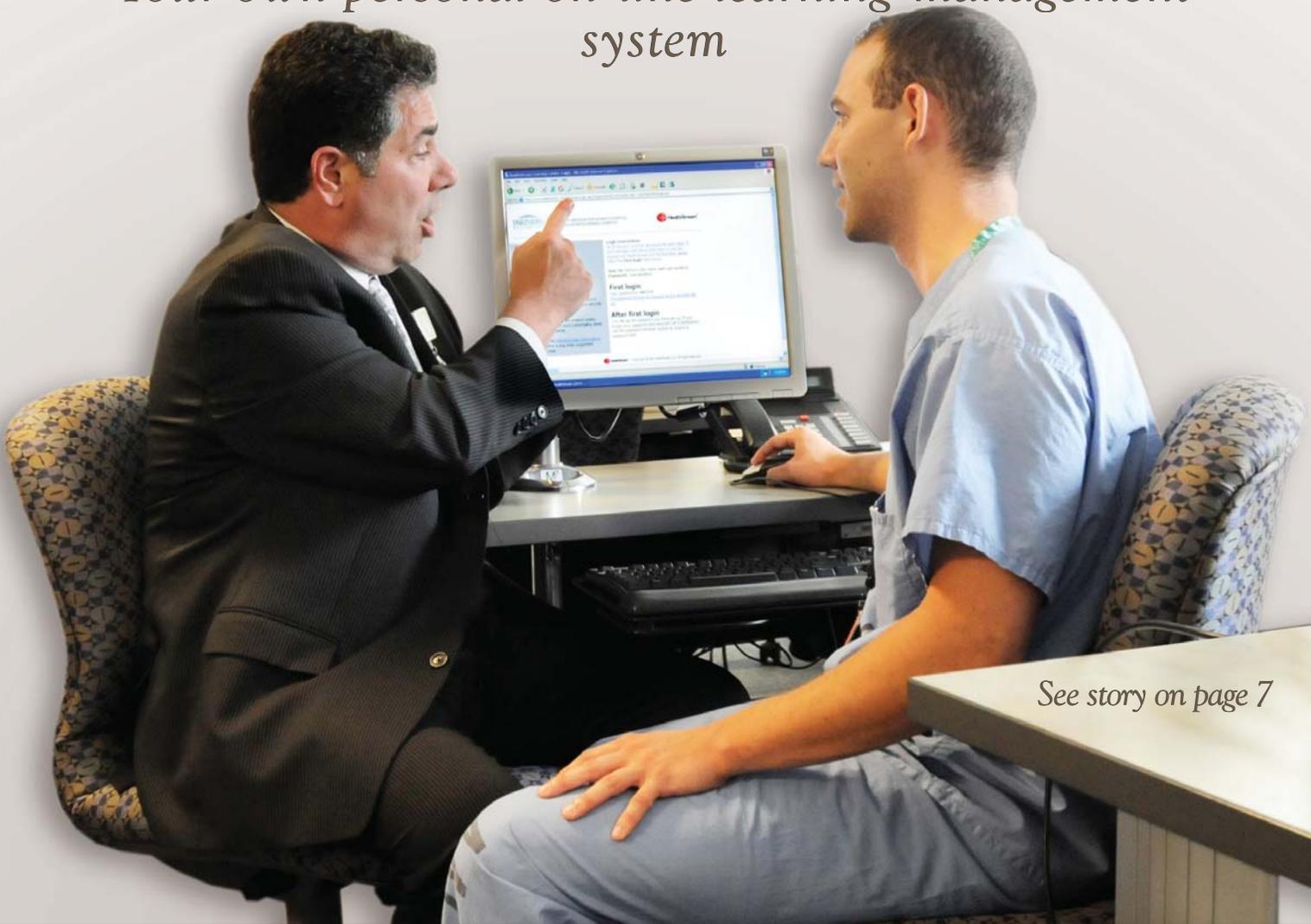
Caring

Headlines

July 30, 2009

HealthStream

Your own personal on-line learning-management system



See story on page 7

Gino Chisari, RN, director of The Knight Center for Clinical & Professional Development (left), introduces Zachary Fang, operations associate in the Post Anesthesia Care Unit, to HealthStream, the new on-line, healthcare learning program.

HIPAA: *it's about more than just privacy*

We enter into a trusting relationship every time we meet a patient for the first time. And that trust is the core, the foundation, on which every caring profession is built.

When we talk about the Health Insurance Portability and Accountability Act, or HIPAA as we more commonly call it, most healthcare professionals think it's about privacy. And it is. Partly. But to me, the larger issue, the more important issue, is trust—trust and respect for our patients and the intimate information they share with us. We enter into a trusting relationship every time we meet a patient for the first time. And that trust is the core, the foundation, on which every caring profession is built.

Enacted in 1996, HIPAA was the first national legislation to formally protect a patient's right to the confidentiality of his/her medical information. As healthcare professionals, we have a moral, ethical, and now a legal obligation to preserve that right. As we well know, in an environment of constantly evolving, sophisticated, electronic communication, complying with this mandate is increasingly challenging. Which is why we need to re-commit ourselves to the task every day.

In thinking about how to protect health information, we must always consider the worst-case scenario. No one can predict the countless ways in which information can inadvertently find its way into the wrong hands. But we must plan for it just the same. We don't



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

know what happens to written materials once they're out of our hands. But we must take every precaution to prevent private information from being read, intercepted, overheard, found, or otherwise unintentionally disclosed.

Confidential information should be torn or shredded when no longer needed. (On inpatient units, it should be placed in blue confidential bins for shredding later.) Health information stored on personal computers and devices should be password-protected. It is unlawful to fax certain documents outside the hospital without specific written authorization. Patient information should never be discussed in public areas (elevators, hallways, subways, or on cell phones within earshot of others). Even if the patient's name isn't specifically mentioned, it creates the impression that we're violating confidentiality, that we're dishonoring a sacred trust. And that is *not* okay.

continued on next page

As we begin to think more consciously about our commitment to protect health information, two simple questions should guide our actions: “What would I want done if it were *my* medical information in question?” And, “Do I really need to know this information in order to do my job?” Pretty simple.

I know there are occasions when employees want to find the birth date, marital status, or some other personal information about a co-worker. This may seem innocent, even thoughtful. But this, too, is a violation of privacy if that information is obtained by looking at the person’s medical record or personal health information. All MGH employees have the ability to see who has accessed their electronic medical records by performing a self audit. Simply go to any Partners workstation, click on Start, Partners Applications, Utilities, PHS Self Audit. I urge employees to do this periodically and report any violations to your supervisor or director, or call Health Information Services (Medical Records) at 4-4555.

Remember:

- Keep all patient information confidential including: patient’s name, physical or psychological condition, emotional status, financial situation, and demographic information
- Share patient information on a need-to-know basis according to medical necessity
- Keep all confidential information (from hastily scribbled notes to electronic data) secure

- Be mindful of your surroundings when discussing patient information. Avoid discussing patients in public places such as elevators, hallways, shuttle buses, public transportation, or at social events
- Retrieve confidential papers from fax machines, copiers, mailboxes, conference rooms, and other publicly accessible locations as quickly as possible
- Use technology such as fax machines and e-mail only to support patient-care activities. Do not fax information to attorneys, employers, or patients without the appropriate consent
- Always tear or shred paper copies of documents containing patient information
- It is the responsibility of all staff to keep patient and hospital information confidential

It is our duty to protect the health information of patients in our care. We need to hold ourselves and our colleagues accountable to the highest standards of confidentiality. Yes, we do it because it’s the law. But more importantly, we do it to preserve the integrity of the clinician-patient relationship. And we do it to uphold the trust that patients place in us every day.

Update

I am pleased to announce that Lucy Milton, RN, has accepted the position of clinical nurse specialist for the Wang Post Anesthesia Care Unit.

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Celebrating the achievement of learning English as a second language

—by Stephanie Cooper, educational development and project specialist

Gathering under the Bulfinch tent, June 5, 2009, colleagues and friends from throughout the MGH community came together for the 14th annual celebration of the English for Speakers of Other Languages program (ESOL). Helen

Witherspoon, operations manager for Training & Workforce Development, commended students, senior leadership, managers, family members, and colleagues whose commitment, and often sacrifice, make the program a success year after year. Eight employees in the program received US citizenship this year, three were promoted in their jobs, and three received Partners in Excellence Awards.

Below, keynote speaker, Richard Chacon, addresses the gathering and presents diploma to student, Rashida Housney, image service representative in Radiology. At right, instructor, Wendy Strauss, presents diploma to Bigelow 14 unit service associate, Halima Singri.

Jerry Ruben, president and CEO of Jewish Vocational Services, compared the celebration to another event that took place at the same time. “Given the effort required to work, raise a family, and go to school,” he said, “this graduation is as inspiring if not more so than Harvard’s graduation taking place right across the river.”

Lead instructor, Beth Butterfoss, welcomed student speakers to the stage to share their experiences in the program. Said occupational therapy assistant, Elizabeth Caraballo, “Because of this class, I am able to communicate better and help more patients. I understand therapists when they need something. I can talk with my boss and learn my duties more easily.”

Keynote speaker, Richard Chacon, executive director of the Massachusetts Office for Refugees and Immigrants, congratulated students, saying, “We all benefit from your commitment. Not only are you helping your co-workers, but also you families and communities. You are the future of the Commonwealth. I hope you see that future with the confidence that comes from new achievement. We need your voice and your commitment.”

Since 1995, MGH has provided English for Speakers of Other Languages classes to employees in all departments, making it the longest running program of its kind in the city of Boston. Offered through a partnership with Jewish Vocational Services, the program has inspired other similar hospital-based programs throughout the city. This year, Mayor Thomas Menino presented MGH with a certificate of recognition acknowledging our civic leadership in offering on-site English classes to our workforce. Said Carlyene Prince-Erickson, director of Employee Education and Leadership Development, “The award reminds us that our ESOL program is one of many ways the hospital fulfills its mission of teaching and supporting the community.”



(Photos by Abram Bekker)

The Carol A. Ghiloni, RN, Oncology Nursing Fellowship

—by Mandi Coakley, RN, staff specialist

For the ninth consecutive year, the Carol A. Ghiloni, RN, Oncology Nursing Fellowship program sponsored two student nurses for a ten-week fellowship in the Oncology Nursing Service at MGH. The fellowship, funded through the Hahnemann Hospital Foundation, gives students an opportunity to learn and observe the varied roles of nurses and the numerous opportunities available to them upon graduation. The Ghiloni Oncology Nursing Fellowship program was developed in 2001 to provide student nurses with insight into the specialty of oncol-



ogy nursing with the hope that fellows would assume oncology nursing positions at MGH upon graduation.

This year's fellows, Liz Johnson, a nursing student at Boston College, and Jane D'Addario, a student at Thomas Jefferson University School of Nursing, began their fellowship on an inpatient unit. For the first five weeks, Johnson worked with preceptor, Molly Lyttle, RN, on Phillips 21, while D'Addario worked with her preceptor, Michelle Howard, RN, on Bigelow 7.

Half-way through the program, they switched units to round out their education. Fellows had an opportunity to observe practice in Radiation Oncology, the Infusion Unit, and the outpatient disease centers in the Yawkey Center. When not working with their preceptors, Johnson and D'Addario attended Schwartz Center Rounds, HOPES programs, spent time in the Blood Transfusion Service, Interventional Radiology, and took advantage of a number of other learning opportunities in the Cancer Center.

For more information about the fellowship, call Mandi Coakley, RN, staff specialist, at 6-5334.

Above right: (l-r): Carol Ghiloni, RN; Todd Hultman, RN, palliative care nurse practitioner; Liz Johnson, RN, oncology clinical nurse specialist (front); and Ghiloni fellows, Jane D'Addario and Liz Johnson.
Below: Hultman reviews medical record with Johnson and D'Addario.



There's more than one way to warm a patient's soul

—by Teri-Ann Aylward, RN, and Sarah Purcell, RN

Blanket bearers (back row, l-r): Jen Brock RN; Rachel Jacobson RN; Beata Renehan; Jacki Emond, RN; Tina Cruz, RN; Lawren White, RN; Teri-Ann Aylward, RN. (Seated): patient, Christina Mendes; Kaitlin Morton, RN; and Katie Gustafson.

Recently, nurses on the Ellison 14 Medical Oncology and Bone Marrow Transplant Unit adopted a change in their scope of practice. Working with an organization that distributes hand-made blankets and afghans to seriously ill or traumatized children, they have started to incorporate this practice into their care. Though Ellison 14 is not a pediatric unit, many of the patients they care for have children who are affected by the illness of their parents. Says staff nurse, Teri-Ann Aylward, RN, “As nurses, we see families living with the pain and sorrow

of cancer every day. When we heard about this organization, we thought it would be a great way to help the children of our patients. We thought giving a child a beautiful, comforting blanket would help provide a sense of protection at a difficult time.”

The non-profit, volunteer-based organization they work with is comprised of hundreds of local chapters across the country. Blankets are collected and distributed to children in hospitals, shelters, social service agencies, and other outlets where children can benefit from the gift of a warm blanket.

Says staff nurse, Sarah Purcell, RN, “Many patients are admitted to our unit for cancer treatment, bone marrow transplant, and at times, end-of-life or palliative care. The offering of a blanket from our family of nurses on Ellison 14 gives their children a sense of trust and comfort. Sometimes it's given as a gift from a parent who is ill. It gives the child a sense that he or she is ‘taking home a little piece of daddy’ while daddy stays in the hospital. A blanket is a tangible reminder when times got tough. We all know how small children sometimes cling to a security blanket. You'd be surprised how these blankets help a child cope with the illness of a parent.”

Since December of 2008, Ellison 14 has distributed more than 113 blankets to 55 families. Their goal is to keep this project going and continue to share love and compassion by providing their patients' children with comforting blankets.

For more information about the organization that provides this generous service, contact Teri-Ann Aylward or Sarah Purcell at 4-5410.



(Photo provided by staff)

Managing change through HealthStream

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

Perhaps the most exciting news is that by September 30, 2009, all members of Patient Care Services will have access to HealthStream. This will allow us to deliver targeted educational programs to specific role groups and disciplines.

We've all heard it said: "The only thing that stays the same is change." Nowhere is that more true than in health care today. Change occurs daily in a wide array of forms and settings. Financial, clinical, and regulatory requirements have us more keenly focused on our environment of care. Technology designed to make our work easier sometimes feels as if it's slowing us down. Patients and families expect a safe, high-quality, patient-care experience. With so much going on, it can be daunting to manage all the information that invariably accompanies change.

The key to managing information is being able to sort and store it in 'nice-to-know' and 'need-to-know' categories. And once stored, we need a process by which to quickly retrieve it. Having the ability to manage, store, and retrieve information for professional development, clinical competency, compliance training, or self-enrichment is the purpose behind HealthStream. HealthStream is a kind of personal assistant for managing information related to change.

When HealthStream launched in January, it was received with great approval from staff, and feedback remains positive. HealthStream has been used to deliver mandatory information regarding Rapid Response, Universal Protocol, Heparin IV Bolus by Pump, the Essentials of PCA Therapy, and Central Line Placement and the Role of the RN Monitor. Much of the success of HealthStream is due to the ease with which staff can complete their annual required training. But HealthStream is far more than required training; it is a personal learning-management system.

Over the next few months you'll begin to see some enhancements in HealthStream. The most frequently requested enhancement by staff nurses and nursing leadership was the ability to be notified about new programs by e-mail. Beginning August 3, 2009, staff will be notified by HealthStream via e-mail alerts whenever a new course is assigned.

Another frequently requested enhancement was the ability to input classes taken outside of HealthStream. Beginning August 3rd, staff will be able to add courses, conferences, and continuing education credits to their personal transcript, and all this information will be neatly stored in one location so it can be submitted for annual performance appraisals.

Perhaps the most exciting news is that by September 30, 2009, all members of Patient Care Services will have access to HealthStream. This will allow us to deliver targeted educational programs to specific role groups and disciplines. In addition to required regulatory courses, HealthStream can augment new-employee orientation and on-going clinical competency development. To maximize the effectiveness of HealthStream, our HealthStream team has developed an application process, which is available by contacting The Norman Knight Nursing Center (at 6-3111). This process facilitates the transition of content previously only available in hard copy into the HealthStream system.

On the horizon is the development of blended learning programs, awarding continuing education credits for MGH/PCS-developed courses, and continuing to collaborate with the HealthStream organization to enhance the program's usability.

For more information, or to provide feedback about HealthStream, call Gino Chisari, RN, director of The Norman Knight Nursing Center, at 3-6530.

Case management intervention facilitates positive patient outcome

Among this population, patients are often seeking specialized care not available elsewhere. There are frequently challenges for the case manager around complex discharge plans and complicated insurance reimbursement issues.

My name is Denise Thibeault, and I am an experienced neurology nurse case manager. For the past year, I have worked on the fast-paced, complex, White 12 Neuroscience Unit. Among this population, patients are often seeking specialized care not available elsewhere. Frequently, there are challenges for the case manager around complex discharge plans and complicated insurance reimbursement issues.

‘Ellen’ was a 30-year-old woman with a complicated medical history of two craniotomies for a recurrent brain tumor that had left her with right-sided paralysis and deafness. She had a paralyzed vocal cord and a history of aspiration pneumonia. She had been admitted emergently from her MGH neurosurgeon’s office for treatment of acute lower-lobe pneumonia prior to another craniotomy for recurrence of her brain tumor.

In reviewing Ellen’s chart as part of my initial case management assessment, I noted that she met the criteria for acute hospital-level care. Since she was too ill to talk, I spoke with her mother who was also a nurse. Ellen’s mother told me that for two weeks prior to admission, Ellen had lived with her requiring moderate assistance with activities of daily living. Prior to that, Ellen had lived independently in a neighboring state in her own apartment on the second floor of a two-story



Denise Thibeault, RN, case manager

home. She worked as an art therapist. She had received prior home health services, but no inpatient rehabilitation care.

Ellen’s mother confirmed active primary insurance with an HMO in their home state as well as secondary insurance through Medicaid. I submitted the initial clinical review to Ellen’s insurer to establish medical necessity, a practice I would continue daily throughout her hospitalization. I predicted the trajectory of Ellen’s hospitalization and anticipated she would require acute, multi-disciplinary, inpatient rehabilitation following discharge. I knew I would need to identify an in-network provider that could meet her needs.

Ellen’s pneumonia was aggressively treated, and she was taken to the operating room for her scheduled craniotomy. However, a bronchoscopy in the OR showed a collapsed lung and thick, infected secretions. Her surgery was aborted, and Ellen returned to White 12 for continued IV antibiotics and PICC-line placement.

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Soon after, I was surprised to be notified that Ellen's insurer was denying payment for her entire stay at MGH saying it was an elective admission and MGH was outside of Ellen's network.

I contacted the Case Management clinical operations coordinator and learned that Ellen's insurance was a closed-network HMO plan, and that MGH was not in her network. I informed Ellen's neurosurgeon and the clinical team of the denial.

When I informed Ellen's mother of the situation, she explained she had chosen MGH because we offer a specialist in the kind of surgery Ellen needed to save her life. She had not been able to find the level of care Ellen required in her network. She had thought, albeit incorrectly, that if she went outside the network, Medicaid would automatically pick up the costs. Ellen's mother was adamant that Ellen remain at MGH. I assured her we would work with the insurer to find a solution but encouraged her to initiate an appeal.

I felt a sense of urgency to secure reimbursement so Ellen could continue being cared for by her MGH team. I wanted to facilitate a positive outcome and worried what would happen if Ellen were transferred to a facility that wasn't able to provide the same level of care and expertise as her MGH caregivers.

I worked with our clinical operations coordinator to facilitate a conversation between the HMO medical director and our neurosurgeon to try to obtain an out-of-network benefit exception. The insurer needed to understand the acute nature of Ellen's condition and the level of care and expertise that couldn't be replicated within their network. This conversation never took place despite numerous attempts.

Ellen soon required a tracheostomy and insertion of a percutaneous gastrostomy tube. I continued to provide the insurer with daily clinical updates, participated in daily inter-disciplinary rounds, and kept Ellen's mother aware of the status of the insurance issues. It was very important that Ellen's needs be the primary focus, and I continued to advocate for this in support of a positive outcome.

I saw my role not only as an advocate for Ellen, but as a facilitator of reimbursement. I needed to provide Ellen's mother with accurate information, but it required tact and sensitivity not to exacerbate her already high stress level around her daughter's condition.

While awaiting a decision as to whether we would have to transfer Ellen to an in-network provider, the team explored the idea of discharging Ellen home on

IV antibiotics to return to MGH in two weeks for the craniotomy. Ellen's mother agreed to provide around-the-clock care, so I developed a comprehensive home discharge plan using in-network providers. But because Ellen still required frequent tracheostomy suctioning, the home discharge plan was postponed.

Since payment was still being denied, I alerted key members of our leadership team to bolster our appeal. On the morning of Ellen's surgery, we finally received authorization for an out-of-network benefit exception for Ellen's entire hospital stay.

As predicted, after Ellen's surgery, the team recommended an inpatient rehabilitation stay. An in-network stay at a rehabilitation facility near Ellen's home was approved, and I worked with the director of Admissions to facilitate her transfer. Ellen was discharged, medically stable, and transported by ambulance to the rehab hospital with her very happy mother at her side.

This story highlights the intricate work of case managers in advocating for complex medical patients. I was able to facilitate interventions by key stakeholders, collaborate with Ellen's mother and treatment team in daily inter-disciplinary rounds, provide regular clinical reviews to the insurer, and anticipate and arrange for post-acute care. Ellen's needs were met—she received the specialized medical care and surgery she needed without having to be transferred from MGH against her mother's wishes. This is a true success story, and I'm proud that comprehensive case management intervention was able to make a difference.

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

This narrative is a study in patience and perseverance. In trying to do what was best for her daughter, Ellen's mother inadvertently created a potentially catastrophic situation. Denise dealt with this situation by staying focused on Ellen's needs. As her case manager and advocate, Denise was committed to making sure Ellen received the specialized care she needed while exploring every avenue to secure financial reimbursement for her treatment. A success story, indeed.

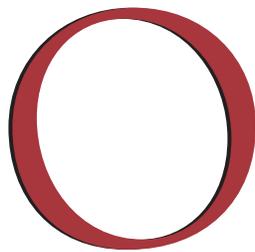
Thank-you, Ellen.

This story highlights the intricate work of case managers in advocating for complex medical patients... Ellen's needs were met—she received the specialized medical care and surgery she needed without having to be transferred from MGH against her mother's wishes.

Clinical pastoral education program opens ‘new avenues of healing’

—by Reverend Angelika Zollfrank

At a recent Clinical Pastoral Education program graduation ceremony are (l-r): Joanie Rosenbaum, MD; Dorothy Weiss, MD; Reverend Angelika Zollfrank; Victor Presto, RN; Scot Bateman, MD; Soon-Il Song, MD; and Donna Clarke, LICSW.



On May 21, 2009, six participants completed the 2009 Clinical Pastoral Education Fellowship offered by the MGH Chaplaincy. The program, supported by the Kenneth B. Schwartz Center and the department of Nursing, is open to individuals from all disciplines. Participants learn to engage in meaningful relationships in a clinical context, perform individualized spiritual assessments, and learn about cultural, spiritual, and religious diversity.

Throughout the fellowship, under the guidance of Reverend Angelika Zollfrank, the group of four physicians, a nurse, and a social worker met weekly to discuss how spiritual care-giving can support patient outcomes. Says Victor Presto, RN, “I’ve been a psychiatric nurse on Blake 11 for ten years. I’ve had hundreds, maybe thousands, of encounters with patients from various cultural, social, and religious backgrounds. Though I’ve attempted to treat all my patients with dignity and respect, I felt something was ‘missing’ in my practice. The Clinical Pastoral Education Program has helped me find that missing element. Learning how to address patients’ spiritual needs has opened a new avenue of healing.”

Says Scot Bateman, MD, “Not only has the program given me confidence in broaching spiritual topics, I’ve already seen results. We cared for a young boy who had Vietnamese parents who were Buddhist. By engaging his mother in conversations about her belief system and how it impacts her care of her son, we bridged a huge divide. The success of that exchange will have repercussions for other families, as it was obvious how our team and this family bonded as a result of being open to listening and understanding.”

This year’s graduates were: Scot Bateman, MD; Donna Clarke, LICSW; Victor Presto, RN; Soon-Il Song, MD; Joan Rosenbaum, MD; and Dorothy Weiss, MD.

To apply for the MGH Clinical Pastoral Education Program for Healthcare Providers offered in the winter of 2010, or for more information about the program, contact Reverend Angelika Zollfrank at 4-3227.

Applications are due by September 1, 2009.



(Photo by Abram Bekker)

Signal detection supports quality and safety

Question: I'm hearing a lot of talk about safety reporting. And a recent issue of *Caring Headlines* carried a number of narratives that focused on quality and patient safety. Is this a new direction for MGH?

Jeanette: MGH has a long-standing practice of reporting adverse events. Our safety reporting system is intended to capture not only adverse events, but also near misses. Near-miss scenarios call attention to situations that have the potential to cause harm. Reporting these events provides an important warning system that allows us to intervene or improve systems before adverse events can occur. We encourage staff to report all situations they perceive to be unsafe to help prevent adverse events from occurring.

Question: And the narratives that were recently published in *Caring Headlines*?

Jeanette: Narratives are an excellent source of information and a powerful tool in helping us detect and understand issues related to quality and safety. Sharing stories with our colleagues gives us insight into the circumstances surrounding adverse events, knowledge about how and where systems break down, and awareness of details that might otherwise go unnoticed. Narratives make our experiences visible and can be used as important teaching opportunities.

Question: I read all those narratives and can't recall a time in the past when we've been so candid and open about our experiences.

Jeanette: In many ways those narratives represent an important evolution in our organization. Part of our work to enhance quality and safety is providing a receptive, blame-free environment where staff can speak openly about their experiences. To achieve the highest level of excellence, every employee must be comfortable talking about problems and errors in an atmosphere that values thoughtful discussion. The nurses who wrote those narratives were extremely brave. They took a risk. And their courage helped identify opportunities to improve patient care. I hope they serve as an example to every member of Patient Care Services.

Question: What other avenues are available to support patient safety?

Jeanette: I would remind everyone about the Office of Patient Advocacy. Receiving and documenting information about the experiences of patients and staff give us a wealth of data. When looked at in the aggregate, these are valuable indicators of issues affecting quality and safety in our environment.

Safety rounds, where issues and concerns are discussed at the unit level, is another option. This is an effective forum for identifying ways to improve patient care.

Question: If I'm unsure whether an event should be reported or not, what should I do?

Jeanette: Nursing directors and managers within Patient Care Services are always available to help staff resolve issues, but if you're unsure, it's better to err on the side of caution and file a safety report. The PCS Office of Quality & Safety can be reached at 3-0140.

Professional Achievements

Radwin presents

Laurel Radwin, RN, nurse researcher, presented, "A Research Program on Patient-Centered Nursing Care," at the Boston University School of Public Health, May 27, 2009.

Cronin recognized

Julie Cronin, RN, staff nurse, Gynecology, received the Oncology Nursing Career Development Award, June 26, 2009.

Russo presents

Katherine Russo, occupational therapist, presented, "Trauma in the Upper Extremity," at Tufts University, June 3, 2009.

Cole certified

Elizabeth Cole, PT, physical therapist, became certified as a women's health specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Silvius presents

Ellen Silvius, RN, endoscopy staff nurse, presented, "Chronic Pediatric Constipation," at the 36th annual Society of Gastroenterology Nurses and Associates meeting, in St. Louis, in May, 2009.

Brown recognized

Sarah Brown, RN, staff nurse, General Medicine, Phillips 21, received the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy, June 19, 2009.

Blakeney appointed

Barbara Blakeney, RN, innovation specialist, The Center for Innovations in Care Delivery, was appointed a member of the Board of Directors for Boston Health Care for the Homeless, in June, 2009.

Macauley certified

Kelly Macauley, PT, physical therapist, became certified as a cardiovascular and pulmonary specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Olson and Vai present

Gayle Olson, wellness coordinator, and Jillian Vai, PT, physical therapist, presented, "ACL Prevention Program," at the Brigham & Women's-Mass General Health Care Center, in Foxboro, May 6, 2009.

Johnson honored

Cynthia Johnson, RN, clinical nursing supervisor, received the 2009 Nursing Appreciation Award from the Internal Medicine Residency Program, at the Department of Medicine's Annual Teaching Awards ceremony, June 4, 2009.

Fitzgibbons elected

Meghan Fitzgibbons, project specialist, Volunteer Department, was elected to chair Area 4, (Boston), for the Massachusetts Association of Directors of Healthcare Volunteer Services, for 2009-2010.

Podesky certified

Jennifer Podesky, PT, physical therapist, became certified as a neurological specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Vanderboom presents

Teresa Vanderboom, RN, radiology nurse practitioner, presented, "Assessment, Treatment, and Prevention Strategies for Stroke," at the 16th annual Northeast Regional Nurse Practitioner Conference, in Newton, May 8, 2009.

Ament appointed

Maura Ament, PT, physical therapist, was appointed a member of the Neurology Section Stroke SIG Nominating Committee, of the American Physical Therapy Association, in Alexandria, Virginia, for a three-year term, starting in June, 2009.

Adeletti certified

Kate Adeletti, PT, physical therapist, became certified as a neurological specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Tikonoff certified

Laura Tikonoff, PT, physical therapist, became certified as a neurological specialist, by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Arnstein presents

Paul Arnstein, RN, pain clinical nurse specialist, presented, "Pain as Policy: Effect on Quality and Compliance," at the Annual Scientific Meeting of the American Pain Society in San Diego, May 8, 2009. Arnstein also presented, "The Pain Paradox: Providing Effective Relief while Mitigating Risk," on May 7, 2009.

Arnstein appointed

Paul Arnstein, RN, pain clinical nurse specialist, was appointed a member of the Scientific Program Committee of the American Pain Society, in May, 2009.

Arnstein was also appointed a member of the master faculty for the Geriatric Pain Management Resource Nurse Course of the American Society of Pain Management Nursing, in May, 2009.

Savidge presents

Edgar Savidge, PT, physical therapist, presented, "Rehabilitation of Femoroacetabular Impingement," at the Sports Medicine 2009: Advances in MRI and Orthopaedic Management" conference in Boston, June 15, 2009.

Savidge also presented, "Injury Prevention and Stretching Clinic," at the Leukemia and Lymphoma's Team Training, in Wakefield, June 20, 2009.

Manley and Parhiala present

Bessie Manley, RN, nursing director, General Medicine, Phillips 22, and Joanne Parhiala, RN, staff nurse, Psychiatry, presented, "Professional Practice, Our Journey Together," at the Exeter Hospital Nursing Symposium, Charting the Course Toward Excellence, in Exeter, New Hampshire, June 3, 2009.

Professional Achievements (continued)

Travers certified

Matthew Travers, PT, physical therapist, became certified as an orthopaedic specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Townsend certified

Elise Townsend, PT, physical therapist, became certified as a pediatric specialist by the American Physical Therapy Association, in Alexandria, Virginia, June 24, 2009.

Waak certified

Karen Waak, PT, physical therapist, became certified in Advanced Cardiac Life Support by Brigham and Women's Hospital, June 3, 2009.

Akladiss presents

Joanna Akladiss, OTR/L, occupational therapist, presented, "Splinting Lab and Lecture," at Tufts University, June 15, 2009.

Oertel publishes

Lynn Oertel, RN, clinical nurse specialist for Anticoagulation Management Service, authored the chapters: "Personnel Needs and Division of Labor"; "Nursing Issues"; "Logistical Management of Prothrombin Times and International Normalized Ratios"; "Management of Patient Information"; and "Education Curriculum for Patients and Teaching Methods," in *Managing Oral Anticoagulation Therapy: Clinical and Operational Guidelines*, 3rd edition, with Jack Ansell, MD, and Ann Wittkowsky.

Bartush elected

Paul Bartush, director of Volunteer Services, was elected president of the Massachusetts Association of Directors of Healthcare Volunteer Services, for a two-year term, starting in June, 2009.

Mulgrew presents

Jackie Mulgrew, PT, physical therapist, presented, "Management of the Acute Care Patient," at the Anne Arundel Medical Center, in Annapolis, Maryland, June 5–6, 2009.

O'Toole publishes

Jean O'Toole, PT, physical therapist, authored the article, "The Multidisciplinary Approach to Breast Cancer-Related Lymphedema: the Why, Whom and How of the Team," in *National Lymphedema Network Lymphlink*, in June, 2009.

Orencole presents

Mary Orencole, RN, Cardiac Resynchronization Therapy Program, presented, "Device Features for Information and Optimization," at the 31st annual meeting of the Heart Rhythm Society in Boston, May 12, 2009.

Orencole also presented the oral abstract, "Multidisciplinary Care of Patients Receiving Cardiac Resynchronization Therapy Significantly Improves Clinical Outcomes." Co-authors include Jagmeet Singh, MD; David McCarthy, MD; Kevin Heist, MD; Saumya Das, MD; William Dec, MD; Stephanie Moore, MD; Michael Picard, MD; Lindsay Riedl; Tanya Harrell; and Gregory Lewis, MD.

Amatangelo and Kistler present

Mary Amatangelo, RN, nurse practitioner, and J. Philip Kistler presented, "Stroke as a Traumatic Event," at the 41st annual American Association of Neuroscience Nurses Educational Meeting in Las Vegas, March 29, 2009.

Boehm presents

Martin Boehm, PT, physical therapist, presented his poster, "Lumbar Stabilization Training in a Professional Golfer Demonstrating Signs of Clinical Instability," at the annual conference of the American Physical Therapy Association, in Baltimore, June 11, 2009.

Michel presents

Theresa Michel, PT, physical therapist, presented her poster, "Perceived Benefits and Barriers to Physical Activity of HIV+ Patients with Metabolic Syndrome," at the annual conference of the American Physical Therapy Association, in Baltimore, June 11, 2009.

Moulaison and Oertel present

Walter Moulaison, Jr., RN, nursing director, and Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Services, presented their poster, "Developing a Nursing Workload Measurement System in the Anticoagulation Management Service," at the 10th national conference of the Anticoagulation Forum on Anticoagulation Therapy, in San Diego, May 7–9, 2009.

Zachazewski presents

James Zachazewski, PT, physical therapist, presented, "Foot and Ankle Disorders and Injuries," at the Foxboro Community Center, in Foxboro, June 25, 2009.

Researchers present

Laurel Radwin, RN, nurse researcher; Howard Cabral; Tiffany Siu Woodworth; and Gail Wilkes, RN, presented their poster, "Race and Language Effects on Patient-Centered Nursing Care, Trust, and Re-Admissions," at the 26th annual research meeting of the AcademyHealth, in Chicago, June 29, 2009.

Researchers present

Laurel Radwin, RN; Howard Cabral; Leslie Chen; and Bonnie Jennings, RN, presented their poster, "A Protocol for Capturing Daily Variability in Nursing Care at the Individual Patient Level," at the 26th annual research meeting of the AcademyHealth, in Chicago, June 29, 2009.

Interdisciplinary team publishes

Barbara Lakatos, RN; Virginia Capasso, RN; Monique Mitchell, RN; Susan M. Kilroy, RN; Mary Lussier-Cushing, RN; Laura Sumner, RN; Jennifer Repper-Delisi, RN; Erin Kelleher, RN; Leslie Delisle, RN; Constance Cruz, RN; and Theodore Stern, MD, authored the article, "Falls in the General Hospital: Association with Delirium, Advanced Age, and Specific Surgical Procedures," in the May/June, 2009 issue of *Psychosomatics* 50.

Announcements

New Perspectives on Mind and Body

2009 MGH Nurses Alumnae Fall Reunion Educational Program co-sponsored by the MGH Institute of Health Professions School of Nursing

Friday, September 25, 2009
Simches Auditorium
8:00am-4:30pm

\$20 before July 1, 2009
\$30 after July 1, 2009

6 nursing contact hours

Must register by
September 11, 2009

For more information,
call 6-3114.

Jeremy Knowles Nurse Preceptor Fellowship

Call for Applications

Applications are now being accepted for The Jeremy Knowles Nurse Preceptor Fellowship. The fellowship recognizes exceptional preceptors for their excellence in educating, inspiring and supporting new nurses or nursing students in their clinical and professional development.

The one-year fellowship provides financial support to pursue educational and professional opportunities.

Applications are due by September 8, 2009.

For more information, contact your clinical nurse specialist or Mary Ellin Smith, RN, at 4-5801.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Clinical pastoral education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2010 MGH Clinical Pastoral Education Program for Healthcare Providers

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

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 8:30am-5:00pm. Additional hours are negotiated for the clinical component.

Deadline for application is September 1, 2009.

For more information, call Angelika Zollfrank at 4-3227.

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.

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Submissions

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

Next Publication

August 20, 2009

Educational Offerings – 2009

August

7

PALS Re-Certification
Simches Conference Room 3-110
7:45am–4:00pm
No contact hours

August

10

Diabetic Odyssey
O'Keeffe Auditorium
8:00am–4:30pm
Contact hours:TBA

August

11

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

August

11

New Graduate RN
Development Program
Founders 311
8:00am–4:30pm
Contact hours:TBA

August

11

Pediatric Simulation Program
Founders 335
12:30–2:30pm
Contact hours:TBA

August

12

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

August

13

Building Relationships in the
Diverse Hospital Community:
Understanding our Patients,
Ourselves, and Each Other
Founders 325
8:00am–4:30pm
Contact hours: 6.8

August

14

PCA Educational Series
Founders 325
1:30–2:30pm
No contact hours

August

17

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

August

18

BLS Instructor Program
Founders 325
8:00am–4:30pm
No contact hours

August

19

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse
POB 448
7:00–11:00am
Contact hours:TBA

August

20

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

August

20

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

August

24 & 25

Oncology Nursing Society
Chemotherapy Biotherapy
Course
Day 1: Yawkey 2-220
Day 2: Yawkey 4-820
8:00am–4:30pm
Contact hours: TBA

August

24

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

August

27

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

September

1

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

September

3

CVVH Review and
Troubleshooting for the
Experienced CVVH Provider
Founders 311
8:00am–2:00pm
Repeated: 4:00–10:00pm
No contact hours

September

9

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

September

9

Pediatric Simulation Program
Founders 335
12:30–2:30pm
Contact hours:TBA

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

Patients' rights

Question: I know patients have rights and responsibilities. How does that affect my daily practice?

Jeanette: Patients' rights and responsibilities are intended to protect them and encourage them to take an active role in their health and well-being. Copies of "Patients' Rights and Responsibilities" are posted on units and included in the *Patient Information Guide*. More importantly, the actions we take every day tell patients we respect their rights and responsibilities. Some of these actions include:

- wearing name tags
- introducing ourselves to patients
- teaching patients and families
- listening to patients and families
- providing patient privacy
- treating patients in a caring manner
- evaluating and treating pain

All caregivers respect patients' rights as they care for patients every day. Sometimes we just don't realize the important impact it has.

Question: How does the hospital support patients' rights?

Jeanette: Posting patients' rights and responsibilities and providing this information in written form is a mandatory requirement. Creating an environment that fosters patients' rights is another matter. Fortunately, MGH understands the importance of this issue. Throughout the entire hospital, programs and initiatives are in place to educate, support, and foster an atmosphere that respects patients' rights. Some examples include:

- The Multicultural Education Program
- Cultural Rounds
- Community outreach
- Patient and family advisory councils
- Interviews with patients
- American Hospital Association Point-To-Talk booklets
- The Council on Disabilities Awareness
- Patient Care Services Diversity Program
- Diversity committees

Question: What resources are available if questions arise around patients' rights?

Jeanette: Many resources are available to staff. The relationship between patients and healthcare providers is strengthened when patients feel comfortable taking an active role in their care. Some resources include:

- The Office of Patient Advocacy
- Interpreters Department
- The Multicultural Affairs Office
- Chaplaincy

As always, staff may seek assistance from their directors or supervisors who can provide specific information for particular situations.

Every patient has a right to freedom of expression, decision-making, personal dignity, and human relationships. Ensuring these rights are respected is an extension of Excellence Every Day and 'business as usual' in every Magnet hospital.

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