

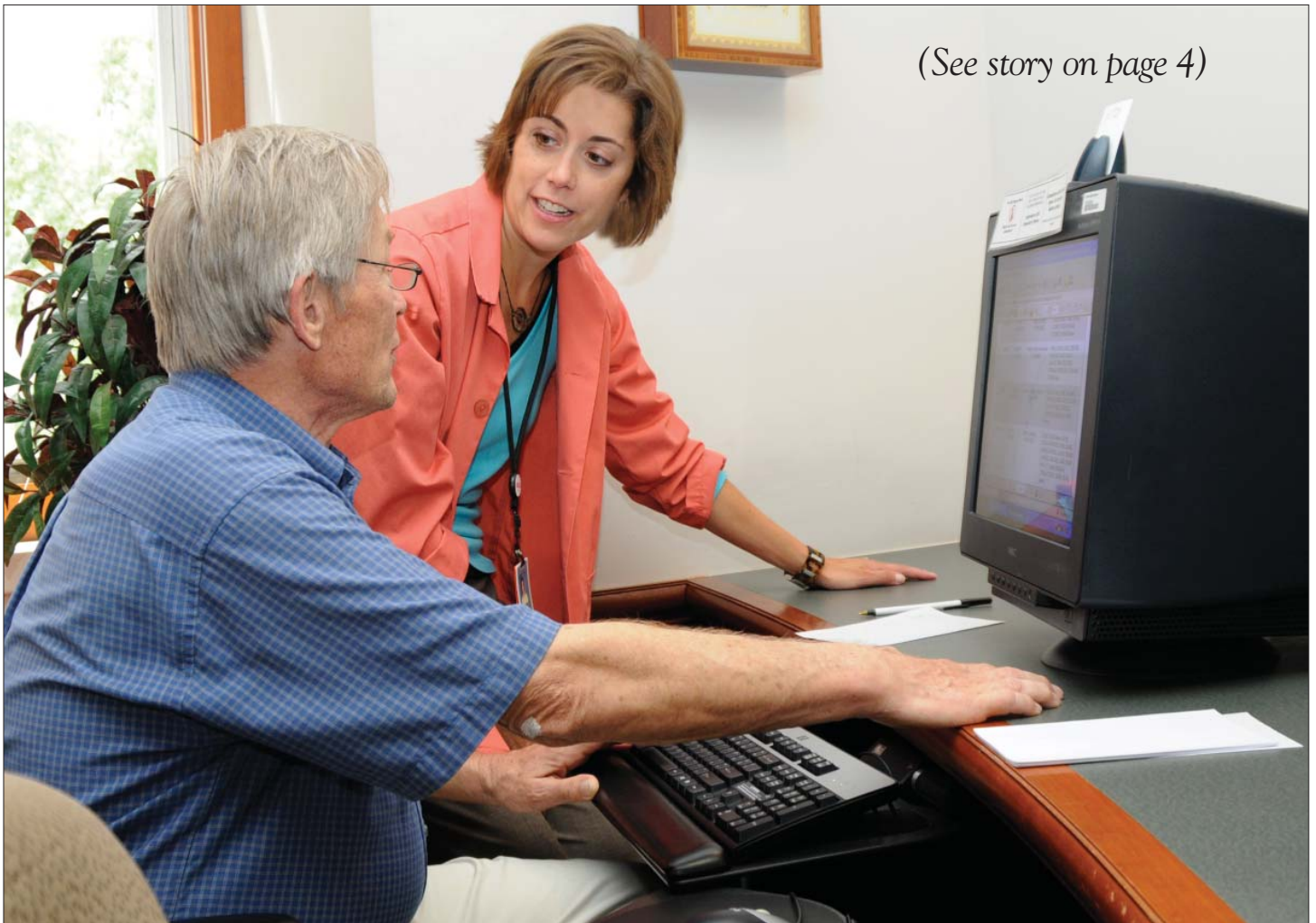
Caring

Headlines

June 18, 2009

MGH volunteers

Thank-you for your invaluable service to our patients and staff



(See story on page 4)

MGH volunteer, Anissa Bernardo, helps visitor, Jerry Cleaver, find health information on-line in the Blum Patient & Family Learning Center.

Nursing documentation: the benefits far outweigh the challenges

The best documentation describes the care we provide to our patients and anticipates, in writing, the care likely to be needed in the future. We are committed to providing excellent documentation, but we know there are challenges.

Those of you who know me, know I like to be provocative. So I'm going to begin with a thought-provoking exercise. I'd like to ask you to imagine two diametrically opposite realities. Imagine for a moment a healthcare environment in which there is absolutely no documentation. No medical records, patient charts, flow sheets, no written communication whatsoever among members of the healthcare team. If you're imagining what I'm imagining, it's a pretty chaotic picture with poor patient satisfaction and even poorer patient outcomes.

Now imagine a healthcare setting where documentation is magically performed. Through some miracle of modern technology, as soon as you think it, it appears in the patient's medical record. It is 100% complete, thorough, and accurate. There is virtually no chance for mis-communication among clinicians; information is shared quickly and legibly, and it is available whenever it's needed. Patient satisfaction is high and patient outcomes are consistently more positive.

I don't know about you, but the second scenario is far more appealing to me. Unfortunately, there is no magic documentation fairy. We must rely on ourselves and our colleagues to provide timely, accurate information. But what these scenarios give us is a sense of what excellent documentation should look like and why it is so important.

Nurses are perpetually looking for ways to ensure patient safety and improve care. One very basic way we



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

do this is through our documentation. Through documentation, we communicate critical information about our assessments, diagnoses, treatment, and ongoing evaluation of patients. We try to be thorough and concise, knowing that our documentation will be read by caregivers in other role groups, disciplines, systems, and settings. And let's not forget the patient and family.

The best documentation describes the care we provide to our patients and anticipates, in writing, the care likely to be needed in the future. We are committed to providing excellent documentation, but we know there are challenges. Extensive regulatory requirements make some aspects of nursing documentation seem redundant. And precise, detailed documentation takes time. It's estimated that nurses spend 15–25% of their time documenting patient care, and in some cases, even more than that. Of concern to many nurses is the sense that meeting these documentation requirements cuts into the time they spend providing direct patient care.

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In many ways, our documentation is exemplary. When consultants visited several months ago to assess our readiness for the Joint Commission survey, they remarked that our nursing progress notes were some of the finest they'd seen. But opportunities for improvement still exist in some areas.

Ensuring safe patient hand-offs from one caregiver to the next, from one shift to the next, by way of nursing documentation is a crucial part of Excellence Every Day. We need to be mindful of both safety and efficiency in our documentation practices.

As many of you know, Patient Care Services is leading the Acute Care Documentation project under the guidance of Sally Millar, RN, director for PCS Information Systems. The Acute Care Documentation project is automating inpatient documentation, including patient assessment, notes, care plans, and flow sheets. In short, automated systems will replace the 'green books' and the 'gray charts.' The goal of the Acute Care Documentation project is to improve communication among clinicians while streamlining the documentation process.

Three units (the Ellison 4 Surgical Intensive Care Unit; the Ellison 9 Cardiac Care Unit; and the White 9 Medical Unit) will serve as pilot sites for the Acute Care Documentation project beginning in November, 2010. But regardless of *how* documentation is completed, we need to hold ourselves accountable to the policies we've crafted regarding documentation. These policies are intended to ensure optimal patient care as well as compliance with requirements established by accrediting and regulatory agencies.

In many ways, our documentation is exemplary. When consultants visited several months ago to assess our readiness for the Joint Commission survey, they remarked that our nursing progress notes were some of the finest they'd seen. Pain assessment and re-assessment is documented more than 90% of the time. But opportunities for improvement still exist in some areas, including:

- Nursing Data Sets
- Patient Problem/Outcome/Intervention Sheets
- Vital-sign monitoring and documentation pre- and post-transfusion
- Morse Fall Scale on admission and daily thereafter
- Care of patients in restraints
- Accurate labeling of specimens
- Communication and documentation of critical results
- Daily emergency equipment and code-cart checks

Florence Nightingale wrote about the importance of a nurse's ability to observe. It is through documentation that we capture the richness of what we observe in our patients. It is a core responsibility of our profession, and it affects every patient and family we care for. The benefits of effective documentation are far greater than the sum of the individual tasks we perform. And it's up to us to make sure it stays that way.

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Volunteer Recognition Day

a celebration of selfless giving and the MGH volunteer spirit

—by Meghan Fitzgibbons, project specialist, MGH Volunteer Department

On June 2, 2009, the MGH community came together under the Bulfinch tent to celebrate the extraordinary service of its dedicated volunteers at the annual MGH Volunteer Recognition Luncheon.

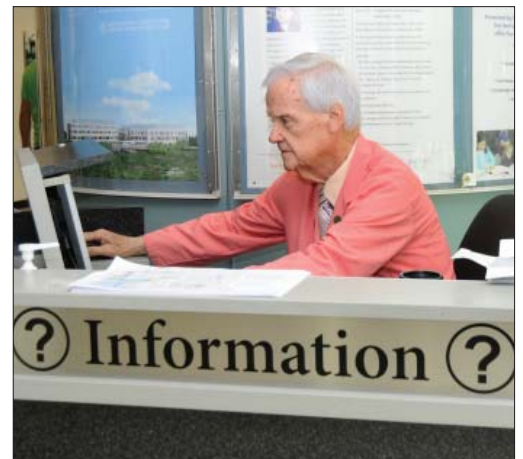
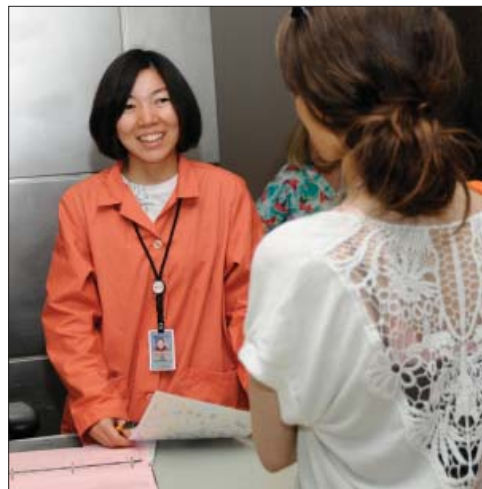
Co-director of the Volunteer Department, Paul Bartush, welcomed staff, administrators, special guests, volunteers and their families, saying, “The synergy between MGH staff and volunteers is evident every day. These partnerships are powerful. They help make our community more welcoming and have a positive impact on the patient experience. As we honor individual award recipients this year, we also honor the legacy of all MGH volunteers and their commitment to our patients, colleagues, and community.”

MGH president, Peter Slavin, MD, cited the countless contributions made by volunteers assisting patients and visitors in navigating the hospital especially during construction of the Building for the 3rd Century. Slavin commended volunteers for their efforts to improve the experience for patients and visitors who come to our hospital.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, reminded those in attendance of how the work of MGH volunteers aligns with the hospital mission and strategic goals. Citing examples of contributions on patient care units and in the Emergency Department, the Greeter Program and Eucharistic ministers, said Ives Erickson, “Our Volunteer Department is a valued and integral part of our healthcare team.” Slavin and Ives Erickson were joined by chairperson of the MGH Board of Trustees, Cathy Minehan, to present this year’s awards.

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(L-r): MGH volunteers (in the familiar pink jackets), Samiya Daad, Kana Augen, and Charlie McCarthy assist patients in a variety of ways during their volunteer shifts at MGH.



Recognition (continued)

The Jessie Harding Award acknowledges volunteers who contribute to MGH in a significant and special way. It was named after an original member of the messenger service that began at MGH on December 8, 1941, in response to the attack on Pearl Harbor. Carol Toronto, this year's recipient of the Jessie Harding Award, began volunteering at MGH in February of 2005 and has contributed more than 800 hours of service. Toronto serves in the busy volunteer office fielding phone calls and distributing meal tickets, parking stickers, and pet therapy assignments. Toronto greets volunteers and welcomes newcomers. Says Bartush, "She's a delight to be around and everyone who meets her is touched by her humor and compassion."

Clockwise from top left: senior vice president for Patient Care, Jeanette Ives Erickson, RN; MGH president, Peter Slavin, MD; chair of the MGH Board of Trustees, Cathy Minehan; co-director of Volunteer Services, Paul Bartush; are joined below by co-director of Volunteer Services, Pat Rowell (left) and Jessie Harding Award recipient, Carol Toronto.



(Photo by Michelle Rose)

The Trustees Award recognizes the extraordinary efforts of an MGH department or staff member who works collaboratively with the Volunteer Department. This year's recipient of the Trustees Award was the Yawkey 8 Infusion Unit. Joanne Lafrancesca, RN, nursing director, and Sheena Smead, administrative operations manager, worked with the Volunteer Department to help improve patient throughput on the unit. The Infusion Unit treats as many as 150 patients each day, sometimes experiencing delays due to the high volume. In a pilot study, an MGH volunteer helped seat 45 patients in a four-hour shift resulting in shorter waits and increased productivity for staff. Today, ten volunteers work regular shifts on the Infusion Unit to help minimize delays. Since August of 2008, volunteers have given more than 430 hours of service in this position.

Annual service awards were presented to:

- Anne Barron, MGH Senior Health
- Hal Berman, Proton Therapy Center
- Gloria Leitner, Bulfinch Medical Group Patient Education Center
- Osaretin Osayi-Osazuwa, Emergency Radiology
- Frederique Schutzberg, Emergency Department
- Haydee Vasquez, Eucharistic minister
- Anthony Wohl, Book Cart
- GianCarlo Zolfonoon, patient escort

For more information about volunteer opportunities, contact the MGH Volunteer Department at 6-8540 or visit their website at: www.massgeneral.org/volunteers.

Exploring patient education from a multi-disciplinary perspective

—by Judy Gullage, RN; Janet King, RN; Angela McColgan, RN; and Laura Sumner, RN, of the Patient Education Committee

Patient education plays a crucial role in patient safety when patients are discharged home. Many patient outcomes are directly related to their understanding of the treatment plan and their knowledge about self-management. An integral part of a clinician's initial assessment is identifying the patient's learning needs, preferred learning style, and readiness to learn. Once the assessment is complete, a teaching plan is formed to meet the patient's educational needs. The quality of patient education is impacted by a clinician's ability to access and use appropriate teaching tools and their ability to evaluate a patient's learning to ensure knowledge is retained.

To explore patient education practices from a multi-disciplinary perspective, the Patient Education Committee (PEC) developed a 26-question survey and distributed it to more than 3,000 clinicians in July, 2008. Clinicians were asked about their patient-education practices to explore whether clinicians:

- assess patients' learning needs
- know how to develop an education plan and access on-line patient-education resources
- implement a teaching plan using appropriate resources and teaching techniques
- evaluate patient learning
- document patient education
- have confidence, skill, and knowledge in teaching

The survey was completed by 568 clinicians, of which 70% worked in the inpatient setting. The response rate by discipline was: nurses, 15%; physical therapists, 25%; dietitians, 44%; respiratory therapists, 22%; social workers, 50%; occupational therapists, 42%; and speech pathologists, 20%.

The survey asked how clinicians address patient-education needs, and the break-down was as follows:

Assessment	% who responded 'Always'
Assess patients' learning needs	59%
Assess patients' preferred learning style	38%
Assess barriers to language	67%
Assess readiness to learn	60%
Consider patients' culture when teaching	59%
Include the family in teaching	48%

The survey showed that 78% of clinicians are extremely or very comfortable using a computer. The most commonly used patient-education resources are: MGH Patient Education Discharge Documents (63%); MedlinePlus (52%); CareNotes (50%); and the MGH Patient and Family Learning Center (44%).

Respondents were asked which MGH on-line educational resources they're aware of and use.

Resource	Aware of	Use
CareNotes/DrugNotes	55%	50%
eMedicine	49%	41%
Harvard Patient Education Website	16%	9%
Intelihealth	11%	7%
MedlinePlus	55%	52%
Cancer Resource Room website	43%	35%
Blum Center website	50%	44%
Patient Education Discharge Documents	66%	63%
PCOI Patient Instructions	43%	37%
Patient Education Committee website	33%	28%
Treadwell Library Consumer website	37%	28%

Of the on-line resources mentioned, more than 50% of clinicians didn't know how to use them. Only 7% use patient-education videos available on demand through the MGH television system.

The survey showed 86% of clinicians review new materials with patients as part of their teaching plan, and 80% have patients demonstrate new skills when taught to them. When asked "What can we do to make patient education easier for you?" More than 200 clinicians provided suggestions, including: 1) Have one central location for patient-education; 2) Provide in-service training on what is available for patient education; 3) Keep it simple; 4) Provide a search engine; 5) Streamline everything; 6) Get the word out about these resources; 7) Provide materials in other languages; 8) Provide more computers; and 9) Less navigation to get to materials. Of the 568 clinicians who completed the survey, 97% have confidence in their teaching abilities.

The Patient Education Committee is developing strategies to make it easier for staff to find and access patient-education materials. Several new on-line patient education resources have been added to the Partners Handbook. The committee will continue to educate staff about new resources and support staff in their patient-education practices.

A center without walls

The Norman Knight Nursing Center for Clinical & Professional Development: looking forward to a bright future

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

Webster's Dictionary defines resource as: "an available source of wealth; a source of aid or support that may be drawn upon when needed; the ability to deal resourcefully with unusual problems." The Norman Knight Nursing Center for Clinical & Professional Development, often called, 'the Knight Center,' embodies all of these qualities.

Since its creation in 1997, the Knight Center (originally known as The Center for Clinical & Professional Development, and the Quality Assurance, Research & Staff Development Department prior to 1997) has existed for the sole purpose of being an educational resource for nurses and support staff. Originally designed to centralize orientation and in-service functions, the Knight Center quickly became responsible for on-going clinical training and the education and development necessary to promote excellence in nursing care. Throughout its 12-year history, the Knight Center has

grown to include many functions now associated with our professional practice model. In 2007, the Knight Center became one of the founding pillars of The Institute for Patient Care and continues to bring high-quality educational programming to MGH nurses and support staff. Several activities once associated with the Knight Center have been re-positioned within the Institute to create a more coordinated synergy throughout the system.

Because on-going self-development is necessary for advancement, the Knight Center is engaging in a self-assessment process to help re-define what it means to be a resource to the department of Nursing. Toward that end, the Knight Center recently revised its mission statement to read: The mission of the Norman Knight Nursing Center for Clinical & Professional Development is to promote life-long learning and clinical excellence by establishing, supporting and fostering learning opportunities for the attainment of knowledge and skills necessary for safe, competent and compassionate, patient-centered care.

In harmony with the new mission statement, a change has been made to the job title and job description of Knight Center nursing staff. Previously known as clinical educators, the job title has been changed to 'professional development specialist,' a truer reflection of what these Knight Center nursing staff members do. The change comes after many months of re-examining and editing the job description. More than just a title change, the job description symbolizes the beginning of a new chapter for the Knight Center and a recommitment of the entire team to being the epicenter of learning for nurses.

In the coming months, you'll see more of our professional development specialists as they put into practice their newly adopted definition of being a 'resource' to you, your colleagues, and your unit. We welcome your suggestions, ideas, and feedback as we continue to grow and learn as your primary educational resource. Please feel free to call me at 3-6530.

Director of The Norman Knight Nursing Center for Clinical & Professional Development, Gino Chisari, RN (seated), with members of his staff (front row, l-r): Mary O'Brien; Ginger Capasso; Laura Sumner; Roberta Raskin-Feldman; Sheila Golden-Baker; June Peterson; and Tom Drake. (Back row): Sheila Burke; Phil Waithe; Kathleen Larrivee; and Mary McAdams. Not pictured: Gail Alexander.

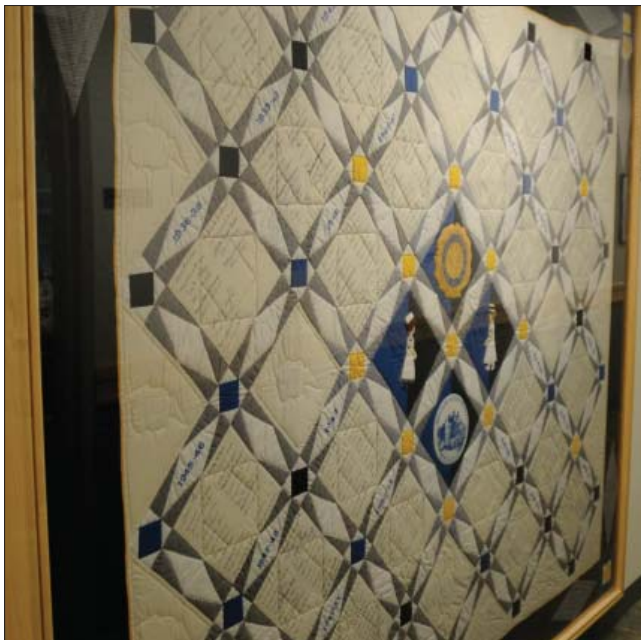


(Photo provided by staff)

Signature quilt reflects history of nursing education at MGH

—by Linda Lass Orrell, RN, MGH School of Nursing, class of '67; Marlene Norton, RN, MGH School of Nursing, class of '61; and Gaurdia Banister, RN, executive director, The Institute for Patient Care

If you haven't already seen it, it's worth a trip to The Norman Knight Nursing Center for Clinical & Professional Development on the third floor of the Founders Building. That's where the 'signature quilt,' a gift from the MGH School of Nursing alumnae has found a permanent home. How the quilt was made and how it came to hang in the Knight Center is an interesting story. At the 1995 Alumnae Homecoming, the Board of the MGH Nurses Alumnae Association solicited ideas for the 125th MGH School of Nursing Anniversary Celebration. Lois Borden Breen and Doris Robbie Gilbert, MGH School of Nursing class of 1945, offered to make a quilt to be auctioned at the celebration. A quilt design was proposed that would bear the signatures of MGH School of Nursing alumnae. More than 480 signatures were collected.



(Photo provided by staff)

Kits were sent to those who volunteered to do the sewing. The top layer of the quilt, which was entirely hand-pieced, was finished on March 24, 1997, then sent to be hand-quilted by Amish quilters at the Quiltery in Allentown, Pennsylvania. The design was adapted from a design in *Great American Quilts* by Beverly Cosby.

The finished quilt is 80x100 inches. In the center are four squares arranged

in the shape of a diamond. In the top square is an appliqué of the school pin, in the left square is a student nurse, at the bottom is the old Bulfinch Building logo, and on the right is a graduate nurse. Surrounding the center diamond are alumnae signatures dating back to the class of 1920.

The reverse side contains handwritten notes from nurses who attended the 125th celebration or who sent a note along with their signatures. Each color of fabric symbolizes something about the MGH School of Nursing. White represents the aprons, cap, and graduate uniform; yellow represents the school color; blue checks represent the uniform of 1885; solid blue represents the early 1885 uniform; solid black represents the band around the cap as well as the shoes and stockings; and the off-white fabric was recycled from actual aprons used at MGH.

The quilt was auctioned off at the 125th celebration in September, 1998. In memory of deceased classmate, Jamin Schofield Guarino, the class of '59 purchased the quilt and returned it to the Alumnae Association for permanent display at MGH.

So, if you want to see a little piece of nursing history at MGH, stop by the third floor of the Founders Building. You can't miss it.

Reflections of an Excellence Every Day champion

—by Lin Wu, RN, staff nurse and Excellence Every Day champion

I've been able to use my knowledge to become a more skilled and effective Excellence Every Day champion. I've also seen first-hand the value of working as a team and learning from the team. Together, we have done great things on White 9.

The Excellence Every Day program was created through the Office of Quality & Safety to help solidify employees' investment in a culture of perpetual Joint Commission readiness. The intent is to 'stamp' every action, every plan, every intervention with excellence. Excellence Every Day is an opportunity to showcase the exceptional care we deliver to every patient, every day. MGH is a large, multi-faceted organization, but we are among the top five healthcare organizations in the country.

The delivery of safe patient care is the primary mission of the hospital. Every unit has one purpose: to provide care that reflects the best of our hospital policies and procedures. We meet Joint Commission standards and National Patient Safety Goals because we are committed to excellence for every patient and every family.

In order to advance the goal of Excellence Every Day, each unit has identified a champion. I serve as the Excellence Every Day champion on the 25-bed, White 9, acute-care General Medicine Unit. Most of our patients come directly from the Emergency Department, some from other hospitals with single or multi-system medical and psychiatric problems. As Excellence Every Day champion, I communicate information about MGH policies, Joint Commission standards, and National Patient Safety Goals via e-mail, bulletin-board postings, in-service training, and staff meetings. Each week, I encourage staff to take quizzes based on National Patient Safety Goals and award prizes. Recently, I conducted a study on my unit to review information related to patient falls and injury. I'm working on a plan to identify high-risk patients on the unit



Lin Wu, RN, staff nurse and Excellence Every Day champion

each day and create a rounding process to assess patient-safety needs, especially those at high risk for injury. My work as Excellence Every Day champion has helped staff understand National Patient Care Goals such as two patient identifiers, sound-alike look-alike drugs, and medication safety.

As a senior nurse, Excellence Every Day champion, and holder of a master's degree in Healthcare Management, I appreciate the value of this important initiative. I've been able to use my knowledge to become a more skilled and effective Excellence Every Day champion. I've also seen first-hand the value of working as a team and learning from the team. Together, we have done great things on White 9. As we move forward, I hope to become more knowledgeable about Joint Commission standards so I can be more effective in supporting our culture of continuous quality improvement and excellence. We all play a role in keeping MGH one of the top healthcare organizations in the country.

As I reflect on this past year as an Excellence Every Day champion, I realize how much I've learned and how proud I am to be a part of this initiative.

Therapist uses teamwork, tenacity, and a very special birthday to motivate transplant patient

When I first met Gary he was so weak and deconditioned, it took two people to help him sit on the edge of the bed. So when he told me his goal was to return home for his daughter's third birthday in four weeks, I was skeptical.

My name is Katie Teele, and I am a physical therapist on the inpatient service. A primary focus of physical therapy is working with patients to achieve their goals. Sometimes that means being able to transfer to and from a wheelchair, other times it could mean running a marathon. At the end of the day, no matter how much we intervene, teach, encourage (and occasionally bribe), it's ultimately the patient who must want to achieve his goal. As a therapist, seeing patients reach their goals is one of the most fulfilling parts of my job.

The longer I work here, the more patients amaze me. 'Gary' is one recent example.

Gary is a quiet, sweet-natured, 46-year-old man with a lovely, outgoing wife and two young daughters. Gary had had a heart transplant after his heart was damaged by a viral infection. Prior to the transplant, he had spent two months in the hospital, including his birthday and Father's Day.

When I first met Gary he was so weak and deconditioned, it took two people to help him sit on the edge of the bed. So when he told me his goal was to return home for his daughter's third birthday in four weeks, I was skeptical. Based on my examination, I anticipated Gary would require at least four weeks of physical therapy at an inpatient rehabilitation facility before he'd be able to go home.

When I explained this to Gary, he was crushed. Part of the role of a physical therapist is to ensure patients' goals are realistic and attainable. When they're not, we



Katie Teele, PT, physical therapist

try to find a way to compromise without shattering their hopes or quashing their motivation. Gary was realistic. He understood his recovery would take time, and he agreed to the plan for rehab. But his daughter's birthday was never far from his mind.

Gary was one of the most driven people I have worked with. Within several days, he progressed from sitting on the edge of the bed with support, to sitting independently, to standing with the assistance of two people and a walker, to eventually walking to the window. He fatigued quickly but was always willing to do "just one more." Gary and I worked with a tireless and incredible nursing team who practiced with him throughout the day, helping him progress.

For medical reasons, Gary was not able to transfer to a rehab hospital, but the team saw the progress he was making. After his first walk down the hallway, everyone (including Gary) was thinking, 'Maybe he'll make that birthday party after all.' I reassessed Gary's status and was at a crossroads. He was improving significantly faster than I had anticipated, but he still needed a lot of physical assistance, and he fatigued quickly.

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Many questions ran through my head: Would he be able to manage at home? Would his wife be physically able to help him if he needed it? Was it safe to push him? Were we being too aggressive because we were caught up in the emotion of wanting him to be able to go home in time for his daughter's birthday? What would happen if we tried and failed?

I did a lot of reflecting, spoke with my clinical specialist, and utilized my clinical reasoning skills to answer these questions. I spoke with the case manager about the possibility of discharging Gary directly to home. I described what he was able to do, what we needed to work on, and how long I anticipated it would take for him to get there. We discussed his social supports, namely his wife; the physical and emotional abilities she would need to take care of him and two small children; and his home set-up and the equipment and support services he would need to optimize his function and safety at home.

Together, we determined that being discharged home was an option. We approached the medical teams to determine if it was medically safe, feasible, and realistic. Everyone agreed. It was.

I spoke with Gary and his wife, Peg, about going home and what it would require from a physical-therapy perspective. They had a lot of emotion invested in his returning home for their daughter's birthday. I made it clear that the most important thing was safety and Gary's continued recovery. They needed to be aware that he could have unforeseen setbacks (both medical and physical) given the nature of his surgery and recovery. If they weren't able to cope with any of these obstacles, then planning to return home would not be safe or realistic.

Gary was demonstrating progressively more independence and tolerance for activity with appropriate hemodynamic responses every day. His strength was improving. He was on track to reach his goal. I spoke with Gary and Peg to determine how they each felt about the plan—did they feel it was achievable for themselves individually and for one another. It was crucial that Peg be completely comfortable with the plan. As Gary's primary caregiver, she had to be willing and able to learn a number of new things. She agreed to do anything necessary in order to help him. They were both ready and willing to give it their best shot to get Gary home.

To assess whether Gary was going to be able to manage at home we needed to replicate his home environment. Peg took several measurements at home: the height of the bed, the steps from the garage, the inside

stairs, the height of the toilet, chairs, etc., and we started practicing. When Gary was unable to manage alone, Peg had to help. Standing up from a sitting position was Gary's biggest challenge. Using a gait belt to optimize safety, I demonstrated the correct way to help Gary move, and they practiced until they were able to do it on their own.

Gary was determined and diligent. Every day was a balancing act of pushing or holding back as his body told me what he could and couldn't handle. More often than not, the challenge was holding him back while still letting him feel as if he was making headway. Gary made incredible progress, but sometimes his gains were subtle and he needed help to see them. He understandably became frustrated, particularly when he tired. I'd often hear him say, "I wish I could just stand up on my own."

He had bad days, but he always kept his goal in mind. He wanted to be home for his daughter's birthday, and so he persevered.

As his strength, balance, and endurance improved, Gary was able to walk independently. Soon, he could go up and down stairs. Equipment was ordered, services were set up, and fingers were crossed that he would make it home in time.

When I first met Gary, I was sure he would need to be discharged to an inpatient rehab facility. I could not have been happier when he proved me wrong. When Gary left the hospital, he did so by walking through the doors with a smile on his face. He and his wife arrived home in time to have cake and celebrate their daughter's birthday together.

Gary returned for a visit a few weeks later. Within minutes of being back, he sat down in a chair and immediately stood up on his own. I was amazed. Like I said, he was one of the most driven people I have ever worked with.

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

That's what we do. We use all the tools at our disposal to motivate, help, and heal patients. Yes, Katie had doubts as to whether Gary would be able to be discharged home. But she allowed herself to move to a more aggressive approach based on the goals, desires, and determination of her patient. Taking all the important issues into consideration (safe transfer, contingency plans, family involvement, and of course, his daughter's birthday) Katie engaged with Gary and his wife to turn a 'plan' into reality. Sometimes the right motivation can be the strongest medicine of all.

Thank-you, Katie.

When I first met Gary, I was sure he would need to be discharged to an inpatient rehab facility. I could not have been happier when he proved me wrong... He and his wife arrived home in time to have cake and celebrate Katie's birthday together.

PATA colleagues come to the aid of patient in distress

—by Stephanie Cooper, educational development & project specialist

Operations manager,
Judy Sacco (left) and
patient care associate,
Melissa Belfast, in the Pre-
Admission Testing Area.

When you work in health care, you don't know what each day is going to hold. One morning this past February, operations manager, Judy Sacco, stepped out of the Pre-Admission Testing Area and encountered a patient in distress. Mrs. 'Brown,' an outpatient, was on her way to the

Transfusion Service when she experienced a sudden episode of incontinence and needed to get to a ladies room immediately. Sacco quickly intervened.

While escorting Mrs. Brown to the rest room, Sacco's colleague in the Pre-Admission Testing Area, patient care associate, Melissa Belfast, happened by. Recognizing that Sacco and Mrs. Brown were in need of immediate assistance, she dropped everything to help.

Although patient care associates in the Pre-Admission Testing Area are rarely called upon to provide this type of personal care, Belfast drew on her years of experience working on the Phillips House 20 Medical Unit. She knew Mrs. Brown was scared, upset, and embarrassed. She went to her side, spoke calmly to her, and offered to accompany her to the rest room to help her freshen up.

Belfast asked Sacco to retrieve some soap, towels and clean scrubs for Mrs. Brown, and with the patient's consent helped her wash up, change clothes, and get comfortably situated in a wheelchair. Belfast stayed with Mrs. Brown until it was time for her appointment.

Says Belfast, "Mrs. Brown had taken some medication prior to coming to the hospital, and it resulted in a case of very urgent diarrhea. She felt so bad and was so apologetic. But you know, I was happy to help. I would hope someone would do the same for my mother or anyone else in that situation. She must have thanked me a million times."

Belfast enjoys helping patients. People never forget kindness, she says. Recently, Belfast was approached by a medical student during his rotation in the Emergency Department. He remembered her from when she had cared for his father in the Phillips House. "My dad has passed away," he told her, "but I will never forget the way you cared for him. You were so patient and kind."

Says Belfast, "You have to love what you do and do it with a good heart."

Excellence Every Day doesn't get much more 'excellent' than that.



Cullens cement their commitment to the PACU with generous gift

—submitted by the MGH Development Office

Dedicating the new Kathy S. Cullen, RN, MS, and David J. Cullen, MD, MS, Post-Anesthesia Care Unit, are (l-r): MGH president, Peter Slavin, MD; Kathy and David Cullen; anesthetist-in-chief, Jeanine Wiener-Kronish, MD; and senior vice president for Patient Care, Jeanette Ives Erickson, RN.

Together, Kathy Cullen, RN, and David Cullen, MD, provided clinical leadership in the Post Anesthesia Care Unit (PACU) for more than two decades, Kathy as nursing director for 25 years until she retired in 2006, and David as medical director for 18 years. Because of the high quality of care delivered in the PACU and the many opportunities they were afforded during their own careers, the Cullens decided to make a major donation to support the creation of the new PACU.

Few individuals know the PACU better than the Cullens. This is where patients come after surgery to be monitored and observed during recovery. David helped

design the current PACU, which opened in 1976, and Kathy participated in the planning of the new unit, expected to open later in the summer.

On May 26, 2009, PACU staff and hospital leadership, past and present, gathered in the Lawrence House to recognize and thank the Cullens for their generous gift. Said Jeanette Ives Erickson, RN, senior vice president for Patient Care, “Kathy and David, thank-you for helping us forge the way to a new and better environment for patients recovering from surgery. You’ve both given so much already with your wisdom, leadership, and compassion. This is a wonderful, lasting reminder of your commitment to patient care and your generosity of spirit.”

The Cullens agreed that the gift was motivated by the excellent care provided in the PACU. Said Kathy, “You know that we know how hard you work every day to accomplish great things and do good work for our patients. This gift is our way of ‘paying it forward,’ of helping in a small way to support your efforts.”

For David, the gift also serves as a tribute to his wife. “Kathy is a major reason I wanted this gift to go to the PACU,” he said. “She managed this unit with two principles foremost in her mind: first, what is best for the patient; and second, how can I be of help? Being useful and helpful are at the core of her being.”

MGH president, Peter Slavin, MD, added his thanks to the chorus of accolades, saying, “David and Kathy have served as role models for our institution, first as exceptional caregivers and leaders, and now as donors. We thank them for giving back to the institution to which they have already given so much.”



(Photo by Paul Batista)

Chaplaincy gives thanks for eucharistic ministers

—by Gina Murray, office manager; and Michael McElhinny, director, MGH Chaplaincy

What is a Eucharistic minister? According to patient feedback, Eucharistic ministers are one of the most valuable resources in the MGH Chaplaincy. They are Catholic laypeople specially commissioned to distribute Holy Communion, which Catholics believe is the Body of Christ. Gina Murray, Eucharist minister coordinator, and Father Celestino Pascual, theological advisor, in collaboration with the MGH Volunteer Office provide Eucharistic ministers with the necessary training to minister safely in the hospital setting. Currently, 50 Eucharistic ministers ranging in age from their mid-20s to their mid-80s, give nearly 450 hours of service each month.

Given that two out of three MGH patients identify themselves as Catholic, the need for Eucharistic ministers is clear. Typically, Eucharist ministers are assigned to certain units, so patients and staff can get to know them. Eucharistic ministers have been called, 'angels in pink jackets' as they volunteer their time, offer a comforting prayer, a peaceful presence, or the Sacrament of Holy Communion. Their presence allows Catholic chaplains to be available to respond to sacramental emergencies and more complex spiritual situations.

According to Gina Murray, "Our Eucharistic ministers are the best. I'm truly honored to work with these amazing, gifted

men and women who inspire me daily. Their commitment, generosity, and dedication mean so much to the MGH community. We're grateful for the support of our director, Michael McElhinny, and the leadership of the Volunteer Department."

In the words of our Eucharistic ministers:

"Knowing that I might help bring healing to another with the gift of Eucharist has awakened in me the gift of presence, of being totally with another. Being part of the healing ministry at MGH has deepened my compassion for others, opened my heart to those made vulnerable by illness, and strengthened my commitment to serve."

—Ellen Connell

"In supporting the Chaplaincy, Eucharistic ministers receive many blessings and gifts for their services: peace, wisdom, and the mystic experience of giving the Body of Christ to patients."

—Kenneth Quinlan

"I have gained a profound appreciation for the hospital's commitment to caring for the entire patient... physically, emotionally, and spiritually."

—Susan Maguire

If you're Catholic, keep an eye out for our 'angels in pink.' Eucharistic ministers are a gift to the MGH community, and we are grateful for their service. For more information about Eucharistic ministers, call the Chaplaincy at 6-2220.



The MGH Chaplaincy recently hosted its volunteer Eucharistic ministers retreat, which featured a special presentation by Father Robert Reed of Catholic.TV.

Photo provided by staff

Shawl-making, a sacred act of giving, a treasured memory of kindness

—By Katrina Scott, MGH chaplain

I first became aware of prayer shawls some four years ago when ‘Mary,’ an avid knitter disabled from metastatic breast cancer, introduced me to knitting: “It’s the one thing I can still do for others,” she had said. Mary spoke of the comfort and warmth of hand-made shawls. A deeply spiritual person who followed the Native American Lakota tradition, Mary believed her knitting could be a gift to others. We sat in the Cancer Resource Room searching the Internet for patterns and ideas.

Shawls have been part of folk traditions for millennia. The first shawls, or ‘shals,’ were part of traditional clothing in ancient Persia worn by both males and females. The Jewish ‘tallit’ is a shawl worn while reciting morning prayers or in the synagogue on the Sabbath.

Prayer shawls derive from the ancient spiritual practice of ‘intentionality’ by which the maker’s positive thoughts

are imbued into her creation. When Mary began knitting, she offered a blessing, dedicating her creation to the comfort of the person who would receive it. She wove a pink ribbon into each shawl, a reminder of her own cancer experience and the hope she still carried. Mary made more than 50 prayer shawls before she died, each one given anonymously to an MGH cancer patient, each one a masterpiece. Every patient who received one of Mary’s shawls was deeply touched.

This year, using some of the yarn Mary gave me, I decided to try making my own prayer shawl. Cox infusion coordinator, Fay Rafferty, taught me some basic crochet steps, and I was ready—or so I thought. To my disappointment, finger cramps, confusion, and frustration plagued my shawl-making experience. It became a daily grind instead of the positive experience I’d hoped it would be. Then one day, I stopped worrying about yarn tension and dropping stitches and started thinking about Mary, our lunches together, holding hands, and long-distance phone calls. My intention became one of remembrance, of shared moments. I was at peace, held in love and kindness by the memory of this woman, knitting. My finished shawl turned out to be short, uneven, and wavy. But it was perfect.

Infusion coordinator, Fay Rafferty (left), helps chaplain, Katrina Scott, crochet a prayer shawl. Hand-made, spirit flags carrying messages of hope are visible in the background.



Mary’s Blessing

*May the Creator’s grace be upon this shawl...
Warming, comforting, enfolding and embracing.*

May this mantle be a safe haven...

A sacred place of security and well-being...

Sustaining and embracing in good times as well as difficult ones.

*May the one who receives this shawl be cradled in hope,
Kept in joy, graced with peace, and wrapped in love.*

Mitakuye Oyasin (this is a Lakota prayer meaning, ‘We are all related’). This prayer honors the sacredness of each individual’s spiritual path, acknowledging the sacredness of all life (human, animal, plant) and creating an energy of awareness that strengthens not only the one praying, but the entire planet.

Professional Achievements

Ahmed appointed

Stephanie Ahmed, RN, nurse practitioner in the Emergency Department, was appointed secretary of the Upsilon Lambda Chapter of Sigma Theta Tau International, in April, 2009.

Dorman appointed

Robert Dorman, PT, physical therapist, was appointed a member of the Task Force to Create a Resource for Clinicians for the Management of Patients with Deep Vein Thrombosis, at the American Physical Therapy Association, in Alexandria, Virginia, in April, 2009.

McKenna Guanci appointed

Mary McKenna Guanci, RN, clinical nurse specialist for the Neuroscience Intensive Care Unit, was appointed a member of the Core Curriculum Development Committee for the American Association of Neuroscience Nurses, in April, 2009.

Inter-disciplinary team publishes

Charles Haynes; Angela Ayre, CCC-SLP, speech-language pathologist; Brad Haynes; and Abdessatar Mahfoudhi, authored the chapter, "Reading and Reading Disabilities in Spanish and Spanish-English Contexts," in *The Routledge Companion to Dyslexia*, by Gavin Reid.

Michel publishes

Theresa Michel, PT, physical therapist, published, "Educating Health Professions Students in Communication for Compassionate Care Giving: a Case Study," in the *Journal of Nursing Education*, e-published in April, 2009.

Amatangelo presents

Mary Amatangelo, RN, nurse practitioner in the J. Philip Kistler Stroke Research Center, presented, "Stroke: an Overview, Enhancing Recognition and Treatment Confidence," at Saint Anselm College, April 3, 2009.

Nurses present

Sheila Davis, RN; Stephanie Ahmed, RN; and Valerie Fuller, RN, presented, "Three Views on Practice in the Clinical Nursing Doctorate: Limiting or Liberating," at the 2nd National Conference on the Doctor of Nursing Practice: the Dialogue Continues... at Hilton Head, March 24, 2009.

Blakeney presents

Barbara Blakeney, RN, innovation specialist in The Center for Innovations in Care Delivery, presented, "Innovation in Nursing," at the regional meeting of the New England Organization of Nurse Executives, in Burlington, April 3, 2009.

Nurses present

Clinical nursing supervisors, Ellen Brown, RN; Claudia Curado, RN; and Brenda Morano, RN, presented, "Management of Bedside Emergencies," as part of the Bermuda Hospital Teleconference Series, March 5, 2009.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Stages and Management of Wounds," at Tufts University, April 6, 2009.

Carroll and Mahoney present

Diane Carroll, RN, nurse researcher, and Ellen Mahoney, RN, senior nurse scientist, presented their poster, "Recovery After a Cardiovascular Event for Older Persons and Spouses," at the 9th annual Spring Meeting on Cardiovascular Nursing, in Dublin, April 24–25, 2009.

Carroll presents

Diane Carroll, RN, nurse researcher, presented, "Translating Fall Risk Status into Interventions to Prevent Patient Falls in Acute Care Hospitals," at the 2nd annual Research Symposium at Northeastern University, April 16, 2009.

Cole presents

Elizabeth Cole, PT, physical therapist, presented, "Women's Health Course: Pelvic Physical Therapy Level II," at the American Physical Therapy Association, in Warwick, Rhode Island, March 27–29, 2009.

Nurse leaders present

Gaurdia Banister, RN, executive director, The Institute for Patient Care; Theresa Capodilupo, RN, nursing director; and Corey Mullen, RN, clinical nurse specialist, presented their poster, "The Dedicated Education Unit—an Innovative Model to Address the Faculty Shortage and Enhance Nursing Education," at the North Eastern Organization of Nurse Educators, in Burlington, April 3, 2009.

D'Avolio, Gordon present

Deborah D'Avolio, RN, 65Plus, and Susan Gordon, RN, nursing director, presented, "The Leadership Journey," at the Geriatric Nursing Leadership Academy, Sigma Theta Tau International, in Scottsdale, Arizona, February 24, 2009.

D'Avolio presents

Deborah D'Avolio, RN, 65 Plus, presented, "Professional Presentation and Publication," at the Geriatric Nursing Leadership Academy, Sigma Theta Tau International, in Scottsdale, Arizona, February 26, 2009.

DiClerico presents

Devon DiClerico, RN, nurse practitioner, MGH Wound Care Center, presented, "Update on Wound Care," at the Institute of Health Professions, April 14, 2009.

Dorman presents

Robert Dorman, PT, physical therapist, presented, "The Physical Therapy Management of the Patient with Burns: Acute Care and Beyond," at Boston University, April 9, 2009.

Carroll and Dykes present

Diane Carroll, RN, nurse researcher, and Patricia Dykes, RN, corporate manager, presented "Fall Prevention in Hospitals," at the Partners Quality Summit, March 31, 2009.

Johnston presents

Rebecca Johnston, RN, nurse practitioner, MGH Wound Care Center, presented, "Update on Wound Care," at Boston College, April 16, 2009.

Lang presents

Betsy Lang, LICSW, social worker, presented, "Companioning Model End of Life on an Adult Bone Marrow Transplant Unit," at the International Association of Death Education and Counseling, in Dallas, April 16, 2009.

O'Connor and Quatralo present

Suzanne O'Connor, RN, clinical nurse specialist; and Wanda Quatralo, RN, case manager, presented, "How Conflict and Negotiation Expertise Improves Outcomes," at the 16th National Institute of Case Management Conference, in Boston, April 21, 2009.

Tyrrell presents

Rosalie Tyrrell, RN, presented, "Understanding and Leading a Multi-Generational Workforce," at the annual New and Emerging Leader Seminar, at the Massachusetts Organization of Nurse Executives, in Waltham, April 7, 2009.

Repper-DeLisi presents

Jennifer Repper-DeLisi, RN, psychiatric staff nurse, presented, "Managing Treatment Interference: Ineffective Coping, Addiction, and Personality Disorders," at the Psychiatric Nursing Update at the North Shore Medical Center, April 7, 2009.

Robinson presents

Jennifer Robinson, RN, neurology staff nurse, presented, "Raising Awareness of Heparin-Induced Thrombocytopenia in the Subarachnoid Hemorrhage Patient," at the American Association of Neuroscience Nursing's national meeting, in Las Vegas in March, 2009.

Mahoney, Robinson present

Reverend Thomas Mahoney and Ellen Robinson, RN, clinical nurse specialist, presented, "Caring for Loved Ones at the End of Life," at Holy Family Parish, in Duxbury, March 24, 2009.

Inter-disciplinary team presents

John Perez; Rebecca Norris; Katia Canenguez; Amy-Rex Smith; Elizabeth Tracey; Susan DeCristofaro; and Laurel Radwin, RN, presented, "Prayer and Well-Being Among Cancer Patients: Type of Prayer Matters," at the American Psychological Association Division 36 Religion and Spirituality Mid-Year Conference, at Loyola College in Maryland, in April, 2009.

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, presented, "Complex Case Studies in Stroke: the Use of Mild Hypothermia and Normothermia to Minimize Brain Insult," at the 41st annual American Association of Neuroscience Nurses Conference, in Las Vegas, March 28, 2009.

Guanci also presented, "The Neuroscience Patient: Assessment and Collaborative Care Strategies," at the Intensive Care Nursing Review Series at Concord Hospital, in Concord, New Hampshire, April 13, 2009.

An update on changes in restraint use

Question: Is it true that the standard of care for patients in restraints is changing?

Jeanette: Yes. Both the Joint Commission and the Center for Medicare & Medicaid Services have issued new requirements (effective July, 2009) for the care of patients in restraints.

Question: What are the changes?

Jeanette: The changes are three-fold:

- 1) Patients in medical restraint (non-behavioral) will require a doctor's order every calendar day rather than every 24 hours.
- 2) Patients in behavioral restraint will require vital signs taken every 15 minutes (at a minimum respiratory rate)
- 3) Patients in restraint will require a modification to their individualized plan of care that includes specific interventions for each patient.

Question: Where can these changes be found?

Jeanette: The MGH Restraint Policy has been revised to reflect these changes. The policy is available in TROVE.

Question: Has anything else changed?

Jeanette: Restraint definitions have been updated to reflect the new Joint Commission framework. The Joint Commission describes the use of restraints as either *non-behavioral* or *behavioral*.

Restraint for *non-behavioral* purposes is during acute medical or surgical care that supports medical healing. Some examples of non-behavioral symptoms related to medical or surgical conditions include: delirium due to high fever or sepsis; dementia; alcohol withdrawal; or patients pulling at their tubes or lines.

Restraint or seclusion for *behavioral* purposes is to protect patients against injury to themselves or others due to an emotional or behavioral disorder. Some examples of behavioral symptoms not related to medical or surgical conditions include: psychotic or manic episodes; attempted suicide; physical assault; or violent or aggressive behavior.

Question: How is MGH responding to the new Joint Commission standard that requires a written care plan for patients in restraint?

Jeanette: Care plans have been developed for Patients in Medical Restraint (non-behavioral) and Patients in Behavioral Restraint and will be posted on the PCS Clinical Resources intranet > Patient Problem > Safety.

Question: Will the same restraint flow sheets be used?

Jeanette: No. Restraint flow sheets have been modified to reflect these changes.

Question: How will staff be educated about these changes?

Jeanette: Unit-based education will be provided, and the Healthstream Restraint Module is being updated to reflect these changes. That module will be available soon. For more information, contact Chris Annese, RN, at 6-3277.

Announcements

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.

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.

Save the Date Boston Health & Fitness Expo

Partners HealthCare and Channel 7 NBC/CW present the third annual Boston Health & Fitness Expo

June 27 and 28, 2009
10:00am–5:00pm
Hynes Convention Center

More than 70,000 adults and children are expected to attend the Expo, which is free to the public.

For more information, visit:
www.bostonhealthexpo.com.

A Meeting of Hearts and Minds

Moderated by
Barbara Moscovitz, LICSW

Author, Paula Span, will discuss her book, *When the Time Comes: Families with Aging Parents Share their Struggles and Solutions*.

A panel discussion will follow with panelists:

- Peg Sprague, family member featured in the book
- Cornelia Cremens, MD, geriatric psychiatrist
- Andrea Cohen, co-founder and CEO of HouseWorks
- Nancy Shapiro, executive director, Goddard House

Session will include a conversation with the audience.

Thursday, June 25, 2009
6:00pm
(5:30pm reception)
O'Keefe Auditorium

For more information, call
617-928-1010.

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.

Summer Jobs Program offers free summer help

Boston's Summer Jobs Program may be the solution to your vacation coverage this summer. The MGH Summer Jobs program provides meaningful, part-time employment to Boston youth while providing staffing support for MGH. The program is funded through Human Resources and is available at no cost to participating departments. The only requirement is a commitment to provide a meaningful work experience in a supportive environment.

The program runs from July 8–August 21, 2009, Monday–Friday, 25 hours per week. The program is supported by an on-site program manager who works closely with participating departments.

For more information, call Galia Wise in the MGH Center for Community Health Improvement at 4-8326.

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For more information, call:
617-724-1746

Next Publication

July 9, 2009

Educational Offerings – 2009

June

25

Workforce Dynamics:
Skills for Success

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

June

25

Nursing Grand Rounds

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

July

6

BLS/CPR Re-Certification

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

July

7

BLS/CPR Certification for
Healthcare Providers

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

July

8

Nursing Grand Rounds

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

July

8

Nursing Research Committee's
Journal Club

Yawkey 2-210
4:00–5:00pm
Contact hours: 1

July

10

PCA Educational Series

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

July

13, 14, 24,
27, 28 & 31

Boston ICU Consortium Core
Program

CSEM
7:30am–4:30pm
Contact hours: TBA

July

14

Chaplaincy Grand Rounds

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

July

15

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse

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

July

20

BLS Heartsaver Certification

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

July

20

Ovid/Medline: Searching for
Journal Articles

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

July

21

Pediatric Simulation Program

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

July

23

Nursing Grand Rounds

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

July

27

Oncology Nursing Concepts

Yawkey 2-200
8:00am–4:00pm
Contact hours: TBA

July

28

BLS/CPR Re-Certification

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

July

29

CPR Mannequin Demonstration

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

July

30

Management of Patients with
Complex Renal Dysfunction

Founders 311
8:00am–3:30pm
Contact hours: TBA

August

4

BLS/CPR Re-Certification

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

August

7

PALS Re-Certification

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

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

Reminding the MGH community about the importance of advance care planning

On April 16, 2009, Patient Care Services' Ethics in Clinical Practice and Patient Education committees came together to recognize the 2nd annual National Health Care Decisions Day by hosting an information booth in the Main Corridor. Hundreds of information packets were distributed. The Revere and Back Bay health centers joined in the effort, offering booths to recognize National Health Care Decisions Day at their locations.

At left: Ethics clinical nurse specialist, Ellen Robinson, RN, fields questions at advance care planning information booth.

Top right: Robinson; Daphne Noyes, MGH chaplain; and patient education specialist, Taryn Pittman, RN, staff booth in Main Corridor.

Below right: Susan Lozzi, RN, and Bonnie Luongo, RN, at the advance care planning booth in Revere.



(photo provided by staff)

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