

Caring

Headlines

March 5, 2009

African American Pinning Ceremony



See story on page 4

This year's honorees of the African American Pinning Ceremony (l-r): Jennifer Dubose, LPN, Blood Donor Center; Raymond Hawkins, OR perfusionist; and Audrey Jasey, RN, staff nurse, Ellison 16

Minimizing the risk of suicide for patients in our care



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

At MGH, any patient identified as having an emotional or behavioral need, regardless of unit or location, can receive a psychiatric consultation. Our goal is to maximize the safety of every patient who may be at risk for suicide.

Whenever a person takes his own life, it's tragic. When it happens in a hospital setting, there's an added layer of anguish because this is a place where people come to get better. It's our responsibility to keep patients safe. That's the thinking behind National Patient Safety Goal #15, Assessing Patients at Risk. Part 1 of Goal #15 states: The organization identifies patients at risk for suicide. This goal applies primarily to patients in psychiatric hospitals, but it also applies to patients in general hospitals whose primary diagnosis is an emotional or behavioral disorder. Hospitals are required to:

- conduct an assessment to identify specific patient and/or environmental factors that could increase or decrease the risk of suicide
- address the patient's immediate safety needs and provide the most appropriate setting for care
- provide information such as the contact information for crisis hotlines to individuals at risk for suicide and their families

At MGH, our Care of Suicidal Patients Policy promotes a proactive approach to identifying and caring for patients who may have suicidal tendencies. It states:

- Any patient admitted following an actual or suspected self-destructive act is considered to be at risk for suicide until an evaluation of suicide risk confirms there is no need for suicide precautions
- Any patient who, while in the hospital, engages in self-destructive behavior or indicates verbally or non-verbally that he/she may be at risk for suicide or self-destructive behavior must be evaluated regarding such risk

At MGH, any patient identified as having an emotional or behavioral need, regardless of unit or location, can receive a psychiatric consultation. The Psychiatry Consultation Service and/or the Psychiatric Nursing Consultation Service are available to see patients wherever they may be in the hospital. Our goal is to maximize the safety of every patient who may be at risk for suicide.

Because this is such an important and complex issue, I'd like to share some frequently asked questions to clarify some of the salient components of this policy.

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For more information about the care and treatment of suicidal patients, call the Psychiatric Consultation Service at 6-2984; Psychiatric Nursing Consultation Service at 4-9107; or Christina Stone, psychiatric clinical nurse specialist, at 6-7705.

Question: Should restraints be used for patients at risk for suicide?

Answer: Restraints shouldn't be applied routinely for patients on suicide precautions. Restraints should only be employed when a patient is at imminent risk of harming herself, and then only in compliance with the MGH Policy on Restraint Use.

Question: Who initiates suicide precautions?

Answer: Suicide precautions can be initiated by the attending or responsible physician, by a psychiatric consult physician, or by the patient's nurse prior to an order being written by the physician. Suicide precautions must be re-evaluated every 24 hours by the responsible physician or psychiatric consult physician and documented in the medical record.

Question: What do suicide precautions entail?

Answer: A number of measures comprise MGH suicide precautions. A prompt in Provider Order Entry (POE) helps guide clinicians through the appropriate interventions. As described in our Care of Suicidal Patients Policy, suicide precautions include:

- one-to-one observation of the patient at all times in as unobtrusive a fashion as possible
- a thorough search of the patient's belongings to remove any items the patient might use to harm herself
- visitors of patients on suicide precautions will be checked for items that could be dangerous to the patient

- an 'eye sweep' or search of the patient's room to remove any potentially dangerous items
- paper trays for all diet orders; no metal or breakable dishes should be brought to the patient's room
- off-unit diagnostic exams should take place after suicide precautions have been discontinued. Alternatively, a staff member should provide one-to-one observation to and from the exam site

Patients on suicide precautions should not be permitted to be discharged against medical advice (AMA) until seen by the responsible physician or psychiatric consult physician. In the event of an emergency involving a suicidal patient, staff should call for assistance immediately by pushing the blue code button; call Police & Security (6-2121); notify the responsible physician; and/or stat page Psychiatry for an urgent consultation. Do not physically engage the patient. Keep yourself, other patients, and staff safe even if it means leaving the immediate area.

Documentation of interventions provided to suicidal patients should include a risk-assessment, a list of any items confiscated during a search, notes related to the initiation and ongoing use of suicide precautions, and a detailed report at change of shift.

For more information about the care and treatment of suicidal patients, call the Psychiatric Consultation Service at 6-2984; the Psychiatric Nursing Consultation Service at 4-9107; or Christina Stone, RN, psychiatric clinical nurse specialist, at 6-7705.

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African American Pinning Ceremony

a celebration of contributions to MGH, a reflection of the positive change in our community

—by Deborah Washington, RN, director, PCS Diversity Program

Receiving their pins and shawls are this year's African American Pinning Ceremony honorees (l-r): Jennifer Dubose, LPN; Audrey Jasey, RN, and Raymond Hawkins. Veteran MGH nurses, Pat Beckles, RN, and Ron Greene, RN, do the pinning.

If you happened to be in O'Keeffe Auditorium on Friday, February 13, 2009, you might have thought you'd stumbled into an enormous family reunion. People hugging. People smiling. People welcoming one another with open arms. In fact, it was the 9th celebration of Patient Care Services' African American Pinning Ceremony, and it was especially meaningful this year with the inauguration of Barack Obama so fresh in our memory. It was a timely backdrop for a celebration of the achievements of our African American colleagues who provide outstanding care to patients, and it was an opportunity to personalize our feelings of national pride and optimism.

This year's honorees, Audrey Jasey, RN, staff nurse, Ellison 16; Jennifer Dubose, LPN, staff nurse, Blood Donor Center; and Raymond Hawkins, perfusionist in the operating room, were presented with the now-traditional shawl and pin by veteran nurses, Ronald Greene, RN, and Patricia Beckles, RN. Said Deborah Washington, RN, director of the PCS Diversity Program, "In celebrating the contributions of Audrey, Jennifer, and Raymond, we honor their single-mindedness and commitment to do their best for others."

Jasey is a 2009 recipient of the New England Regional Black Nurses Association Excellence in Nursing Award (see story on page 16) and a member of the

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Celebration (continued)

PCS Diversity Steering Committee. Dubose is one of the original members of the Minority Nurse Recruitment and Retention Committee initially created to develop strategies to increase the number of minority nurses at MGH. Hawkins is the 2009 recipient of the The John H. Gibbon, MD, Award that honors one clinician annually who has made a significant contribution to the cardiopulmonary discipline and the related field of extracorporeal circulation. Hawkins is only the second African American to receive the Gibbon Award.

In keeping with tradition, the Pinning Ceremony integrated recognition and acknowledgement with an opportunity to learn, have fun, and reflect on past accomplishments. Attendees were treated to a game of 'Diversity Bingo' where they could demonstrate their

knowledge of African American history at MGH. The Bingo game board consisted of a grid depicting various events and milestones in the evolution of MGH as a diverse institution, and attendees were asked to identify the date, location or significance of each entry. Five correct answers in any direction was enough to declare Diversity Bingo. Entries on the game board included such events as: the year the Board of Trustees formally endorsed a policy on diversity at MGH (1995); the year the first African American was promoted to chief medical resident at MGH (1998); the location of the Masjid at MGH (Founders 1); and the first time *Caring Headlines* devoted an entire issue to diversity and culturally competent care (1997).

As a visible reminder of how far we've come on our diversity journey, Washington resurrected an exercise first conducted at MGH more than ten years ago. She asked attendees to group themselves according to how long they've been employed at MGH. The number of employees from diverse backgrounds in each group was starkly different from when the exercise was conducted more than a decade ago. Said Washington, "It's especially promising to see how many minority individuals comprise the group of new employees. Yes," she said, "we've come a long, long way."

Attendees at this year's African American Pinning Ceremony play Diversity Bingo, trying to identify milestone events in the history of MGH.



Patient Care Services welcomes new director of Financial Management Systems

On February 16, 2009, Thomas Elliott, RN, assumed the position of director for Financial Management Systems for Patient Care Services. Elliott, who began his career as a staff nurse in a surgical intensive care unit in Cincinnati, brings a wealth of knowledge and experience from a variety of healthcare settings both clinical and administrative. His administrative career has focused on managed care, financing, strategic planning, project-management, and the development of disease-management systems.

New director of Patient Care Services Financial Management Systems,
Thomas Elliott, RN



Elliott has held positions as administrative director for a self-funded, managed-care plan for employees at the University of Miami; vice president of Managed Care at Collegiate Health Care, a national network of student health centers affiliated with managed care plans; and most recently as an administrator in the High Performance Medicine Program at Partners HealthCare where he helped plan and deploy a CMS demonstration project at MGH: Care Management for High-Cost Medicare Beneficiaries.

Says Elliott, “While working on the CMS demonstration project, I had the privilege of working closely with representatives from many services and departments at MGH—Nursing, Information Systems, Legal, Finance—I was so impressed by the teamwork and can-do attitude I saw. There was real enthusiasm, a willingness to create something new, to do whatever it took to implement new programs in a timely manner.”

Elliott sees his new position as an opportunity to provide support to numerous clinical areas and use his business and clinical background to improve care delivery. Says Elliott, “With the help of my team and the support of everyone within Patient Care Services, I think we have a real opportunity to optimize the utilization of our human, fiscal, and material resources.”

Says senior vice president for Patient Care Services, Jeanette Ives Erickson, RN, “We’re fortunate to have a director of Financial Management Systems with the depth and breadth of experience Tom possesses. He brings an extensive knowledge and understanding of business planning, finance modeling, and information system development. I hope you’ll join me welcoming Tom to his new role.”

Elliott’s office is located in POB 420. He can be reached at 617-606-1829.

Marie C. Petrilli Oncology Nursing Award

—by Julie Goldman, RN, professional development coordinator

Congratulations to Kathleen (Katie) Murphy, RN, and Kathleen Cote, RN, on being selected this year's recipients of the Marie C. Petrilli Oncology Nursing Award.

This year's recipients of the Marie C. Petrilli Oncology Nursing Awards, in recognition of their compassion and commitment to the care of oncology patients, are nurses Kathleen (Katie) Murphy, RN, staff nurse on the Ellison 14 Hematology-Oncology Unit, and Kathleen Cote, RN, nurse practitioner in the Gillette Center for Women's Cancers.

This year's celebration, held January 27, 2009, in Boston's picturesque North End, brought the Petrilli family and Petrilli Fund board members together to see the fruits of their vision—two nurses honored for their compassion and commitment in the care they provide to cancer patients and their families.

Murphy has been a staff nurse on the Ellison 14 Hematology-Oncology Unit for three years. Says nursing director, Ellen Fitzgerald, RN, "Katie brings an enthusiasm to her practice that is infectious. She's always interested in learning more, improving her practice, and advancing the care of patients on the unit. She has a holistic approach to nursing and has worked to create an environment that focuses on healing. Katie was instrumental in bringing Therapeutic Touch, an alternative care treatment, to patients on our unit."

An oncology nurse practitioner, Cote, was nominated by Nancy Schaeffer, RN, and Catherine Furlane, RN, oncology nurse-practitioner colleagues who describe Kathleen as, "ever-present and available to her patients. Her passion for knowledge and her commitment to individualized care to patients and families make her a perfect candidate for this award."



Kathleen Murphy, RN,
staff nurse, Ellison 14
Hematology-Oncology Unit



Kathleen Cote, RN,
nurse practitioner, Gillette
Center for Women's Cancers

Says Cote, "I knew I wanted to be a nurse when I spent a summer as a nurse's assistant in a nursing home." Cote met and cared for an elderly patient with liver cancer. "When the patient passed away, I remember thinking what an honor it had been to care for her at the end of her life. I knew I wanted to be a nurse. In retrospect, I think that experience also set the stage for my becoming an oncology nurse."

The Marie C. Petrilli Oncology Nursing Awards are the result of the efforts of Marie's husband, Al Petrilli, and his brother, David, who created the Marie C. Petrilli Memorial Cancer Research and Treatment Fund almost ten years ago to help raise money and awareness about cancer care and treatment. Congratulations to Murphy and Cote on being named this year's recipients.

For more information about the Marie C. Petrilli Oncology Nursing Award, contact Julie Goldman, RN, professional development coordinator at 4-2295.

Sometimes innovations in care happen right at the bedside

During his first admission, Josh spent five months in the Pediatric ICU. I took care of him frequently and became very familiar with his care and very close to him and his family.

My name is Carolyn Pelley, and I have been a staff respiratory therapist at MGH for about five and a half years. I've been a primary therapist in the Pediatric and Neonatal ICUs for about four years and an ECMO-certified respiratory therapist for about two years.

While reviewing my assignment sheet recently, I saw that one of my worst fears had come true — 'Josh' had been re-admitted. Josh had been admitted originally when he was 18 months old for severe respiratory failure due to viral infections. He had spent a long portion of his stay on ECMO (extracorporeal membrane oxygenation, a treatment that uses an artificial lung and pump to support patients with acute respiratory failure). He had had a tracheostomy and gastrostomy tube placed. During his first admission, Josh spent five months in the Pediatric ICU. I took care of him frequently and became very familiar with his care and very close to him and his family. Eventually, he was transferred to a rehabilitation hospital where he did well, spending large portions of his days off the ventilator. But it was there that he contracted parainfluenza virus and was transferred back to MGH.

When I got report from the night therapist, she explained that Josh had severe bronchospasm requiring a continuous bronchodilator and intravenous terbutaline. His acute respiratory failure coupled with chronic respiratory failure necessitated the use of heliox with



Carolyn Pelley, RT
respiratory therapist

high ventilatory support, sedatives, and muscle relaxing medications to help him maintain adequate gas exchange. I understood the principle of heliox (a low-density gas used to help alleviate symptoms of airway obstruction) and had used it many times, but never on a mechanically ventilated patient. The night therapist and I went to the bedside, and she reviewed the technical aspects of heliox with me.

When she left, I assessed Josh's breath sounds, ventilator graphics, and lung mechanics. I heard expiratory wheezes with scattered rhonchi (rattling sounds). I suctioned his trach tube, which didn't make a big difference. From his breath sounds, I knew his airway resistance was high. I measured his plateau pressure and positive end-expiratory pressure (PEEP) which showed that some gas was being trapped inside his lungs. I made sure the heliox tanks were appropriately connected and full and that his continuous albuterol was attached and functioning properly. I checked on my other patients, then waited for the medical team to round on Josh.

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Caring for
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Though Josh was
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After thinking more
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During rounds, the resident explained how Josh had come to be back at MGH. She reported his vital signs and ventilator mechanics. The attending physician asked me to briefly explain the difference between peak and plateau pressures. I explained that peak inflation pressure (PIP) was the pressure required to distend the airway and inflate the alveoli (the place where gas is exchanged), and the plateau pressure was the pressure required to just inflate the alveoli. I used some drawings and gave some examples. I reassured the team that even though Josh's PIP was high, his alveoli weren't being exposed to those pressures, as most of that pressure was being used to force the gas past his constricted airways.

As we developed a plan, I expressed my concern about Josh's continued bronchospasm. He was taking every agent available to treat it, but there was no sign of improvement. I wondered if the effectiveness of the drug would be increased if we switched his albuterol treatments to a metered dose inhaler. Even though the dose of his bronchodilator seemed high, Josh was only receiving the drug during inhalation, which, due to his airway disease, was very short. If more of the medication could be delivered to his airways, there might be some improvement in his clinical status. I explained that if we discontinued his continuous bronchodilator, we could stop his muscle-relaxing medications, transition him to pressure support ventilation and let him breathe on his own at a rate and pattern that was most comfortable for him. With the additional flow required to power the continuous nebulizer, Josh wasn't able to trigger the ventilator when he wanted a breath, so pressure support ventilation wouldn't be possible as long as the bronchodilator was in-line. The team agreed. We transitioned Josh to metered-dose-inhaler treatments every 30 minutes.

A few hours later, Josh's breath sounds and lung mechanics had improved, the muscle relaxing drug had been removed, and Josh started to move. His respiratory mechanics and lung sounds improved further, so we spaced his treatments to every hour instead of every 30 minutes. By evening, Josh was more active. Since I had cared for Josh many times before, I had a good rapport with his mom. She had spent nearly every night at the hospital and fully understood what was going on. She explained that she and Josh's dad had had some training around ventilators and tracheostomy-tube care and had even changed Josh's trach tube at the rehabilitation facility. As I was about to leave, Josh turned over in his crib and his tracheostomy tube dislodged. I turned to his mom and asked what she would do. In the back of my mind, I knew Josh and his family were

working toward taking Josh home and she would need to feel comfortable changing and replacing the trach in emergent situations. Since she had already changed the trach in a controlled situation, I thought it would be good practice for her to try it now. The nurse and I encouraged her through every step. She did everything correctly. From the relieved look on her face, I knew she felt more confident in her ability to care for her son.

The next morning, I was glad to hear in report that Josh had had a stable night. He stayed on metered-dose-inhaler treatments with improving mechanics. That morning, before rounds, Josh's resident approached me with a care plan. She asked if I'd review the difference again between peak and plateau pressures. I was more than willing. She asked if I thought it was a good idea to switch Josh to pressure support ventilation. I said I did because it would allow him to breathe more naturally according to his own needs.

By afternoon, Josh was breathing comfortably on pressure support. He was alert, smiling, and playing with his toys. Over the next week, we were able to wean his ventilator support, space his metered-dose-inhaler treatments farther apart, and discontinue heliox and sedative medications. We got Josh close to his baseline ventilator settings before transferring him back to rehab in anticipation of being discharged home.

Caring for Josh taught me to question what might be considered 'typical' medical therapies. Though Josh was taking every agent available to treat his bronchospasm, he wasn't improving. After thinking more deeply, I wondered if there was a way to deliver his medications that would achieve a better effect. It can be difficult to make changes when a patient is so critically ill, but this case has made me want to look at every intervention more closely to see if there are opportunities for improvement.

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

This narrative beautifully demonstrates Carolyn's knowledge and understanding of ventilator technology, specialized respiratory drugs, airway mechanics, and most importantly, her patient, Josh. Carolyn recognized the limited effect the medication was having on Josh and advocated for a change in the medication delivery system. Clearly, the team respected her judgment and expertise. Carolyn went on to ensure that Josh's mom was proficient at changing the trach, providing guidance and support every step of the way. What wonderful examples of innovative thinking at the bedside.

Thank-you, Carolyn.

Short- and long-term benefits of nurse-family connections in the ICU

—by Lillian Ananian, RN, clinical nurse specialist

Having conversations with family members about the relationship between lifestyle choices and health gives ICU nurses the opportunity to have a long-term impact on public health by influencing the choices of other family members and future generations.

Admission to the Intensive Care Unit (ICU) is a time of crisis for patients and families. One reason is the very real possibility of death associated with a critical illness. It is estimated that 20% of ICU patients (nationally) die during their admission or shortly thereafter.

The importance of palliative care in the ICU setting evolved from this recognition that one in five patients will die. With funding from the Robert Wood Johnson Foundation, the Medical Intensive Care Unit (MICU) engaged in a project to try to achieve successful integration of palliative and critical care. Components of the program included leadership collaboration within the ICU; education to support the role of palliative care nurse champions; open visiting hours; palliative-care education for house staff and other ICU disciplines; integration of a palliative care specialist into daily work rounds; family meetings; introduction of Get to Know Me posters, staff support; and modeling of inter-disciplinary teamwork.

Open visiting addresses the needs of ICU family members. Nancy Molter's 1979 study of ICU families identified their need to receive understandable information and to be near their loved one. Numerous studies have confirmed this need for accurate and current clinical information which allows for a degree of hope.

Family presence at the ICU bedside adds another dimension to the practice of ICU nursing. Nurses support the universal need for hope in a number of ways,



Lillian Ananian, RN
clinical nurse specialist

including integrating the family into the environment. Encouraging families to provide support to their loved one while assuring them that the patient's clinical needs will be met by the team provides the space and permission required to maintain family integrity.

There's a potentially more far-reaching impact associated with nursing and ICU family presence. Many patients come to us with unfortunate outcomes associated with lifestyle choices. Diagnoses related to smoking, alcohol, and drug abuse are common. Having conversations with family members about the relationship between lifestyle choices and health gives ICU nurses the opportunity to have a long-term impact on public health by influencing the choices of other family members and future generations.

Open visiting is not without challenges, particularly when the patient is clinically unstable. But supporting the patient-family connection is extremely meaningful for both the patient and the family, and it can have an impact beyond the immediate ICU stay. The reach may be incalculable if it serves as an avenue to improve societal health, reduce societal morbidity and mortality, and reduce healthcare costs.

Go Red for Women

—by Jackie Mulgrew, PT, physical therapy clinical specialist

Hearth disease is the number-one killer of women in the United States. On February 6, 2009, National Wear Red Day, Americans across the country and right here at MGH wore red to show their support for women's heart-disease awareness. Many individuals and departments at MGH participated in the campaign, including physical and occupational therapists who lent their creativity and enthusiasm to help educate and inform patients, visitors, and staff about the importance of good heart health.

On February 12th, members of the Inpatient Cardiac Physical Therapy Team staffed an inter-disciplinary booth in the Main Corridor to raise awareness about heart-failure treatment and prevention. Therapists provided information about the importance of physical activity and exercise in preventing and treating heart failure.

In keeping with the theme of the color red, PT and OT sponsored a blood donation drive to support the effort. At press time, physical and occupational therapists had donated 35 units of blood.

Congratulations and thank-you to all who participated. For more information about the MGH Heart Center visit <http://www.mass-general.org/heartcenter>.



Physical and occupational therapists from throughout the MGH community Go Red for women's heart-disease awareness



(Photos provided by staff)

Professional Achievements

Zachazewski presents

James Zachazewski, PT, physical therapist, presented, "Rehabilitation of Women's Sports Injuries," at the New England American College of Sports Medicine, in Providence, Rhode Island, November 13, 2008.

Loureiro and Plante present

Physical therapists, M. Jane Loureiro, PT, and Diane Plante, PT, presented, "Cervicogenic Headache and Dizziness Related to Cases and Literature," at the American Physical Therapy Association of Massachusetts, Annual Chapter Meeting, in Southbridge, November 8, 2008.

Nippins moderates

Matthew Nippins, PT, physical therapist, moderated the roundtable discussion: "Designing and Implementing Exercise Programs in Cystic Fibrosis," at the North American Cystic Fibrosis Conference, in Orlando, Florida, October 25, 2008.

Escher presents

Anne Escher, OTR/L, occupational therapist, presented her poster, "Lighting and Contrast: Environmental Issues for Older Adults," at the Massachusetts AOTA Annual Conference, in Westford, September 26, 2008.

Singer appointed

Marybeth Singer, RN, Gillette Center for Women's Cancers, was appointed a member of the Oncology Nursing Certification Corporation Advanced Practice Role Delineation Study Committee, for 2009–2010, in January, 2009.

Zollfrank appointed

Angelika Zollfrank, MDiv, supervisor, MGH Chaplaincy, was appointed a member of the Association for Clinical Pastoral Education's Regional Accreditation Committee, in Decatur, Georgia, in January, 2009.

Hanson certified

Amy Hanson, PT, physical therapist, became certified as a lymphedema specialist at the Norton School of Lymphatic Therapy in Los Angeles, in January, 2009.

Levin and Morris publish

Barbara Levin, RN, and Nancy Morris, RN, co-authored the article, "Pressure Ulcer," in *NAON: Smartcard*, January 5, 2009.

Lang certified

Betsy Lang, LICSW, social worker, became certified in Thanatology: Death, Dying and Bereavement, by the Association for Death Education and Counseling, in January, 2009.

Nippins presents poster

Matthew Nippins, PT, physical therapist, presented his poster, "Moderator Platform Presentation: Exercise Studies in Cystic Fibrosis," at the North American Cystic Fibrosis Conference, in Orlando, Florida, October 23, 2008.

Fitchette, Garlid and Zollfrank publish

Angelika Zollfrank, MDiv; Catherine Garlid, MDiv; and George Fitchette, DMin, co-authored the book, *Expanding the Circle: Essays in Honor of Joan E. Hemenway*.

Martin Arcari presents

Patricia Martin Arcari, RN, clinical nurse specialist, Benson Henry Institute for Mind Body Medicine at MGH, presented, "Cultivating Resilience in a Professional Nursing Staff: Results of a Pilot Program," at Spirituality and Healing in Medicine: the Resiliency Factor, in Boston, December 13, 2008. Martin Arcari also presented, "Managing Your Life: One Moment at a Time," at the Harvard Business School, in Allston, December 9, 2008.

Brownrigg presents

Marie Brownrigg, PT, physical therapist, presented, "Healthy Backs and Back Packs," at Chelsea High School, January 5, 2009.

Lang appointed

Betsy Lang, LICSW, social worker, was appointed a member of the Review Group of the National Marrow Donor Program, Office of Patient Advocacy, in Minneapolis, in January, 2009.

Burchill and Curley present

Occupational therapists, Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, presented, "Anatomy of the Flexor/Extensor Tendons," at Tufts University in Medford, January 26, 2009.

Repper-DeLisi presents

Jennifer Repper-DeLisi, RN, psychiatric staff nurse, presented, "Consultation for Behavior Management," at the Academy of Psychosomatic Medicine, in Miami, November 21, 2008.

Perry publishes

Donna Perry, RN, associate nurse scientist, The Institute for Patient Care, and associate director, The Thomas S. Durant Fellowship for Refugee Medicine, authored the book, *Catholic Supporters of Same-Gender Marriage: a Case Study of Human Dignity in a Multicultural Society*.

Cabral, Radwin and Wilkes publish

Laurel Radwin, RN; Howard Cabral; and Gail Wilkes, RN, co-authored the article, "Relationships Between Patient-Centered Cancer Nursing Interventions and Desired Health Outcomes in the Context of the Health Care System," in *Research in Nursing & Health*, in January, 2009.

Macauley presents

Kelly Macauley, PT, physical therapist, presented, "Broaden Your Horizons: Physical Therapists Volunteering Abroad," at Boston University, October 1, 2008.

Neveu appointed

Jennifer Neveu, PT, physical therapist, was appointed, chair of the Nominating Committee of the American Physical Therapy Association of New Hampshire, in Concord, in January, 2009.

Inter-Disciplinary team presents

Mary Lussier-Cushing, RN; Jeanne McHale, RN; Jennifer Repper-DeLisi, RN; and Theodore Stern, MD, presented, "Inter-Disciplinary Simulation to Enhance Management of Changes in Mental Status: Content, Theory, and Practice," at the Academy of Psychosomatic Medicine, in Miami, November 21, 2008.

Tyrrell presents

Rosalie Tyrrell, RN, professional development coordinator, presented, "Understanding and Leading a Multi-Generational Workforce," (sponsored by Northeastern University, Boston College, Simmons College, Regis College and the University of Massachusetts, Boston) at VA Faculty Orientation Day, in West Roxbury, January 9, 2009.

Inter-Disciplinary team presents

Jeanne McHale, RN, clinical nurse specialist; Monique Mitchell, RN, staff nurse; Jennifer Repper-DeLisi, RN, staff nurse; Mary Lussier-Cushing, RN, clinical nurse specialist; Beth Nagle, RN, clinical nurse specialist; and Theodore Stern, MD, presented their poster, "Using Simulation Sessions to Improve the Recognition, Evaluation, and Management of Patients with an Altered Mental Status," at the Academy of Psychosomatic Medicine 2008 Conference, in Miami, November 20, 2008.

MGH announces operational initiatives

maintaining the highest degree of efficiency in clinical and operational processes

In challenging economic times, hospitals that maintain the highest degree of efficiency in their clinical and operational processes are in a better position to achieve long-term success.

Question: I've heard there are a number of operational initiatives being undertaken throughout the hospital. Can you tell us more about that?

Jeanette: In challenging economic times, hospitals that maintain the highest degree of efficiency in their clinical and operational processes are in a better position to achieve long-term success. With that in mind, MGH president, Peter Slavin, MD, worked with senior leadership to identify a number of operational initiatives for 2009.

Question: Where are we in the process?

Jeanette: Six areas have been identified where opportunities exist to improve patient flow, optimize revenue, and reduce costs. Teams have been formed to address each of these areas. Each team, led by a senior administrator and clinical chief, has measurable goals and objectives to be achieved this year.

Question: Can you tell us what these operational initiatives are?

Jeanette: The six teams are addressing the following operational issues:

Length of Stay Management

Charge: improve the efficiency of care on the Medical Service to reduce length of stay and enhance capacity. Lead by: Rick Bringham, MD, and Denny Ausiello, MD.

Perioperative Patient Flow

Charge: optimize flow of perioperative patients from first encounter in the Emergency Department or physician office to hospital discharge to improve access to care, quality of care, and financial performance.

Lead by: Ann Prestipino and Andy Warshaw, MD.

Emergency Department Patient Flow

Charge: improve quality and efficiency of care for patients who enter through the Emergency Department.

Lead by: Peter Slavin, MD, and David Torchiana, MD.

Access to Inpatient Care

Charge: streamline patient and clinician access to MGH.

Lead by: Jeanette Ives Erickson, RN, and Alasdair Conn, MD.

Supply Management

Charge: develop ongoing principles and practices to minimize supply expense.

Lead by: Jean Elrick, MD, and James Thrall, MD.

Research Densification

Charge: optimize utilization of existing MGH research space.

Lead by: Rick Bringham, MD, and Jerry Rosenbaum, MD.

Question: Are there other components of this initiative?

Jeanette: Three teams will support this work: Budget Performance Management, lead by Sally Mason Boemer and Jeff Davis; Process Improvement, lead by Gregg Meyer, MD, and Mary Cramer; and Communication, lead by Peggy Slasman and Deborah Colton.

For more information about the operational initiatives, contact the appropriate leader.

Announcements

Taking the First Step

MGH Training & Workforce Development will host the second in its Steps to Success series, "Taking the First Step: Strategies to get on a Successful Career Path"

March 12, 2009
12:00–1:00pm
Yawkey 2-210

This seminar will help identify barriers that may prevent adult learners from returning to school and provide information on how to get on a successful career path. HR staff will address issues such as: goal-setting, managing priorities, and staying motivated.

For more information, send e-mail to: mghtraining@partners.org.

Norman Knight Visiting Scholar Program

Judy Murphy, RN, vice president, Information Services for Aurora Health Care in Milwaukee, will visit MGH as the 2009 Norman Knight visiting scholar. A nationally recognized expert on system methodologies, automated clinical documentation, and technology supporting evidence-based practice, Murphy will meet with staff and present at grand rounds:

"The Copernican Shift: the Patient as the Center of the Universe"

Tuesday March 31, 2009,
2:00–3:00pm
O'Keefe Auditorium
Reception to follow

For more information, contact Mary Ellin Smith, RN, at 4-5801.

Elder care discussion group

Elder care monthly discussion groups are sponsored by the Employee Assistance Program.

Next session:
March 10, 2009
12:00–1:00pm
Yawkey 7-980

All are welcome. Bring a lunch. For more information, call 6-6976.

Hand hygiene video available

A patient-friendly video has been produced to help educate patients, families, and visitors about the MGH Hand Hygiene Program. Produced by the STOP (Stop Transmission of Pathogens) Task Force, the video is available on Channel 31 in English and Spanish. Over the next few months, posters will be placed in patients' rooms with instructions on how to access the video.

For more information, contact Judy Tarselli, RN, at 6-6330.

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.

Submit abstracts

MGH Clinical Research Day

The Clinical Research Program invites investigators from across the hospital to submit abstracts for Clinical Research Day. Abstracts should be submitted at: <http://crp.abstractcentral.com> by March 19, 2009.

Abstracts will be presented at the annual poster session.

Thursday, May 28, 2009
at 8:00am (keynote address)
under the Bulfinch Tent

For more information, call Suzanne Guerette at 4-2900.

Career Information Day

Healthcare practitioners provide insight into their disciplines at the 6th annual Career Information Day

March 25, 2009
10:30am–3:40pm
Thier Conference Room

40-minute sessions will include a 20-minute presentation followed by 20 minutes of questions and answers.

Careers will include:

- Nursing, 10:30–11:10am
- Medical Imaging (Radiography), 11:15–11:55am
- Medical Technology, 12:00–12:40pm
- Surgical Technology, 12:45–1:25pm
- Professional Billing Office and Medical Coding, 1:30–2:10pm
- Electrodiagnostic (Sleep) Technologists, 2:15–2:55pm
- Respiratory Therapy, 3:00–3:40pm

Sponsored by MGH Training and Workforce Development. For more information, contact John Coco at 4-3368.

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Submissions

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

Next Publication

March 19, 2009

Educational Offerings – 2009

March

11

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

March

11

OA/PCA/USA Connections
Bigelow 4 Amphitheater
1:30–2:30pm
No contact hours

March

11

Nursing Research Committee's
Journal Club
Yawkey 2-210
4:00–5:00pm
Contact hours: 1

March

13 & 27

Pain Relief Champion:
State of the Art and Science
O'Keeffe Auditorium
8:00am–4:30pm
No contact hours

March

16

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

March

17 & 18

PALS Certification
Simches Conference Room 3120
Day 1: 7:45am–4:00pm
Day 2: 7:45am–3:00pm
No contact hours

March

18

Cardiac/Vascular Nursing
Certification Preparation Course
Haber Conference Room
8:00am–4:00pm
Contact hours: TBA

March

18

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

March

19

Workforce Dynamics:
Skills for Success
Charles River Plaza
8:00am–4:30pm
Contact hours: 6.5

March

19

Basic Respiratory Nursing Care
Bigelow Amphitheater
12:00–4:00pm
No contact hours

March

23

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

March

24

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

March

25

Simulated Bedside Emergencies
for New Nurses
POB 419
7:00am–2:30pm
Contact hours: TBA

March

26

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

March

27

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

March

30 & 31

Advanced Trauma Care for
Nurses
Founders 3
Day 1: 7:00am–7:00pm
Day 2: 7:00am–7:00pm
Contact hours: TBA

March

30

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

March

30

Anticoagulation: Focus on
Thrombosis-Prevention and
Treatment
O'Keeffe Auditorium
8:00am–4:30pm
Contact hours: TBA

March

31

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

April

1

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

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

Jasey receives NERBNA 2009 Excellence in Nursing Award

Jasey, a 12-year veteran of MGH and a highly-skilled nurse, is known for her ability to form relationships with patients and families.

On February 6, 2009, at a gala reception at Boston's Copley Marriott Hotel, Audrey Jasey, RN, staff nurse on the Ellison 16 Medical Unit, was honored as one of this year's recipients of the New England Regional Black Nurses Association's Excellence in Nursing Awards.

Jasey, a 12-year veteran of MGH and a highly-skilled nurse, is known for her ability to form relationships with patients and families. She is a respected colleague, caregiver, and mentor for young nurses and nursing students. Eager to help guide the next generation of nurses, she served as a mentor for the Clinical Leadership Collaborative, a partnership between the University of Massachusetts, Boston, and Partners HealthCare designed to support minority nursing students.

A long-standing and active member of the Patient Care Services Diversity Steering Committee, Jasey recently assumed the position of co-chair, helping to advance the committee's ambitious agenda. She has served as a member of the Ethics in Clinical Practice Committee and a Magnet champion during the hospital's Magnet Certification process.

In her letter of nomination, director of the PCS Diversity Program, Deborah Washington, RN, wrote:



Audrey Jasey, RN, staff nurse,
Ellison 16 Medical Unit

“Audrey takes advantage of every opportunity to teach new staff and instill in every member of the team a respect for patients as individuals. To Audrey, nursing is personal. She’s not afraid to make sacrifices or take a stand to advocate for her patients. Excellence reveals itself in personal integrity.”

As an added bonus, our own Gaurdia Banister, RN, executive director for the Institute for Patient Care, was keynote speaker at the reception.

Patient Care Services joins the rest of the MGH community in congratulating Jasey on this tremendous honor.

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