

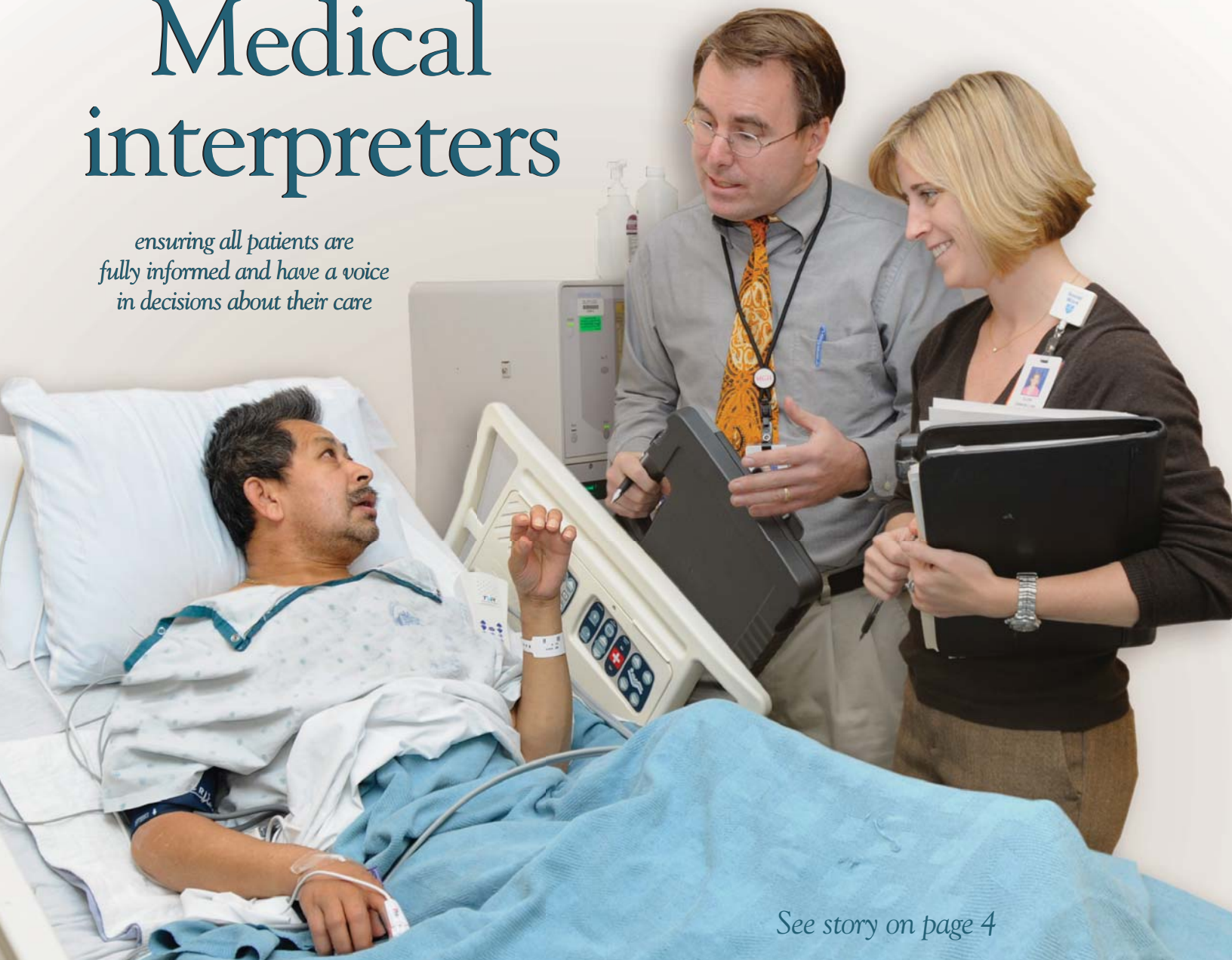
# Caring

Headlines

November 5, 2009

## Medical interpreters

*ensuring all patients are fully informed and have a voice in decisions about their care*



*See story on page 4*

Medical interpreter, Andy Beggs, assists patient, Juan Portillo, to communicate with clinical social worker, Eileen Johnson, LICSW, in the Dialysis Unit.

# Quality and safety is the patient experience

*a visit from Rich Bluni, RN,  
of the Studer Group*



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

Every employee in every role group makes a contribution to the patient experience, no matter how far away from the bedside that employee may be.

Recently, we were fortunate to enjoy a visit from Rich Bluni, RN, of the Studer Group, a consulting firm that employs an evidence-based approach to help healthcare organizations achieve greater patient- and customer-satisfaction, attain higher employee retention, and improve quality indicators across the board. Rich met with Patient Care Services staff and leadership (including Excellence Every Day champions) in a variety of forums throughout the day.

The over-arching theme of Rich's message was that by diligently attending to quality and safety issues, healthcare organizations can, by extension, improve clinical and operational outcomes. Ensuring that quality and safety standards are met ensures a positive experience for patients and families. And if you think about it, it makes sense.

In his push to have clinicians think about quality and safety in tandem with patient-satisfaction, Rich used a phrase that resonated with me. He talked about 'worthwhile work.' Clinicians and support staff need to feel connected to the positive outcomes they help to achieve—they need to be reminded that their daily practice makes a difference in the lives of their patients and families. Every employee in every role group makes a contribution to the patient experience, no matter how far away from the bedside that employee may be.

In making the point that patients and families should be *involved* in quality and safety efforts, Rich shared a parable about a rhinoceros. It seems a team of veterinarians in the wilds of Africa, in an effort to save the rhinoceros population, tranquilized one of the enormous creatures and performed medical procedures on him while he was unconscious. They 'tagged' the rhino's ear so they could continue to track his progress then scurried away before the rhino awoke. Rich wondered if that rhinoceros woke up only to think he'd had a dream in which a team of veterinarians accosted him and pierced his ear!

The point being: we shouldn't keep our quality and safety efforts a secret from patients. Do patients know when they're on fall precautions? How would fall-prevention data differ if hospitals enlisted the aid of patients and families in their fall-prevention efforts? The more people aware of, and actively engaged in, quality and safety activities, the safer the environment of care and the happier patients are.

*continued on next page*

All these strategies give patients a feeling of confidence in their caregivers and a real sense that they're part of the healthcare team. I'm happy that so many of our staff had an opportunity to hear Rich's presentation. It was a wonderful reminder of the 'worthwhile work' we do and the power we all have to make a difference in patients' lives.

Rich advocated the use of 'employee rounding' as part of any safety strategy. Employee rounding is when unit or department leaders survey their staff periodically to ask questions such as:

- Were you able to care for your patients this week as safely as possible? And if not, why not?
- How did communication between caregivers either enhance or inhibit safe care on your unit?
- Tell me about a 'near miss' scenario that might have caused harm to a patient, but didn't
- Have you seen anything in our environment that could be harmful to your co-workers or patients?
- Tell me one way we can help create a safer environment
- Would you feel comfortable having one of your loved-ones treated here? And if not, why not?

In alignment with our own '7Ps' strategy, Rich also recommends hourly rounding on patients. While some organizations employ a loosely 'scripted' dialogue to accompany rounding, Rich prefers an approach that allows clinicians to be themselves while making sure they cover some key points. He suggests each rounding visit consist of:

- comforting language to reduce anxiety
- the performance of scheduled tasks
- an assessment of the 7Ps (Person, Plan, Priorities, Personal Hygiene, Pain, Position, and Presence)
- an assessment of the environment for safety as well as patient-experience issues
- asking the patient, "Is there anything else I can do for you?"
- informing patients when you'll be back
- documenting the visit in the patient's chart

At several of the forums, discussion centered around the use of follow-up phone calls after patients have been discharged. In addition to bolstering patient-satisfaction, follow-up calls have been shown to reduce re-admissions and return visits to the Emergency Room and prevent complications due to early detection of symptoms or problems. Follow-up calls should express concern for the patient while at the same time solicit feedback on quality and safety issues. A typical follow-up call might include comments such as:

- I wanted to call and see how you're doing
- Do you understand your discharge instructions?
- What does your surgical site looks like? Do you see any redness or drainage?
- Do you feel that your caregivers did their best to make sure you got excellent, safe care while you were in the hospital?

Similarly, pre-admission phone calls have helped eliminate misunderstandings among patients and reduce the number of no-shows and late arrivals. All these strategies give patients a feeling of confidence in their caregivers and a real sense that they're part of the healthcare team.

I'm happy that so many of our staff had an opportunity to hear Rich's presentation. It was a wonderful reminder of the 'worthwhile work' we do and the power we all have to make a difference in patients' lives. These are important concepts to consider as we begin to craft our strategic plan for 2010 and beyond.

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# Medical interpreters: communicating across language barriers

—by Anabela Nunes, manager, Interpreter Services

September 30, 2009, was International Translators and Interpreters Day. Observance of this day began as a tribute to St. Jerome, considered the patron saint of translators. Though it has been celebrated since 1953, the International Federation of Translators formally launched International Translation Day in 1991. Today, it is celebrated around the world. During Medical Interpreters Recognition Week, September 28th–October 1st, MGH medical interpreters had an opportunity to showcase some of the innovative ways they deliver language services to patients and families.

Lead coordinator and Spanish medical interpreter, Elizabeth Ramírez, dispatches interpreters from the busy 'command center' in the Gray basement.



Medical interpreters partner with clinical caregivers to ensure patients with limited English proficiency or patients who may be deaf or hard of hearing have access to the same quality of care provided to English-speaking patients. It is essential that all patients be fully involved in decisions about their care, understand and adhere to treatment recommendations, and have access to informed consent. Medical interpreters give non-English-speaking patients a voice and allow caregivers to deliver the highest quality care in a safe environment.

There is no 'typical' day for an MGH medical interpreter. When an interpreter responds to a call, she could be headed for a ten-minute visit or a three-hour session depending on the patient's needs. Interpreters work in every setting from inpatient units, to ICUs, to the Emergency Department, to satellite locations. They work with caregivers from every discipline and are often present during family meetings. To optimize the success of each visit, interpreters are briefed by caregivers ahead of time to help them anticipate what may happen during a session. During sessions, interpreters convey, not just the spoken word, but the unspoken way in which the message is being delivered.

When not providing face-to-face interpreter services, interpreters take to the phones to help patients make appointments, get test results, or re-fill prescriptions.

Most MGH interpreters will tell you it's exhausting, emotionally demanding work. But more importantly, it is rewarding. For more information about MGH Medical Interpreter Services, please call 617-726-3298.

# AMS hosts quality and safety conference

—by Lynn Oertel, RN, clinical nurse specialist

Planners and presenters of the AMS quality and safety conference are (l-r): Jennifer O'Neil, RN; Palmie Riposa, RN; Robert Hughes, MD; Corin Gigler, RN; Walter Moulaison, RN; Irina Seliverstov, RN; Lynn Oertel, RN; and Rachel Corneau, RN.

**O**n Friday, September 25, 2009, Anticoagulation Management Services (AMS) hosted a day-long conference to share quality-improvement and patient-safety initiatives related to the care of anti-coagulated patients. The meeting was co-sponsored by 4S, the software company that created the Dawn AC management system currently used by AMS. Speakers and attendees from across the country and Canada participated in the conference where attendees had an opportunity to learn about strategies to promote safety and quality using the electronic management program.

The success and accomplishments of AMS took center stage as staff members took turns describing various components of the program and the ways in which AMS has used the program to improve systems. Walter Moulaison, RN, nursing director, opened the conference with a look at the methodology used to measure staff productivity in the outpatient environment.

Lynn Oertel, RN, clinical nurse specialist, gave a brief history of events leading up to the current reality in the AMS clinic. She walked attendees through an overview of the many changes that have been made possible because of the new software. Corin Gigler, RN, and Jennifer O'Neil, RN, described valuable communication strategies employed within AMS and the greater hospital community. Irina Seliverstov, RN, and Palmie Riposa, RN, addressed the challenges of caring for patients new to anti-coagulation therapy or resuming therapy during transitional times. Rachel Corneau, RN, provided an overview of a new quality-improvement initiative designed to collect data around the reasons that lead to extremely supra-therapeutic INR values (the lab tests used to monitor patients' response to warfarin therapy). AMS staff demonstrated their passion, knowledge, and commitment to excellence throughout the conference.

The day was also an opportunity to celebrate the 40th anniversary of AMS at MGH. Not only has it grown in terms of the number of patients it serves, it has expanded its services to address the complex needs of patients in their care.

For more information about the services provided by Anticoagulation Management Services, call 6-2768.



# Strong, collaborative practice: the cornerstone of case management

The following narrative was submitted jointly by  
Brenda Donovan, RN, and Julia Shea, RN



Brenda Donovan, RN (right), and Julia Shea, RN

I met Marguerite and Alejandro in 2008. Alejandro was the enrollee, however, after meeting and interviewing him, it became clear to me that this couple needed to be treated as a single unit, and my plan of care needed to encompass both of them.

*Brenda Donovan, RN:* I am a nurse case manager in the Emergency Department. Recently, I had the pleasure of meeting an elderly, English-speaking Portuguese couple. ‘Marguerite,’ the 92-year-old wife, was admitted complaining of difficulty breathing. But nurses were equally concerned about her 88-year-old husband, ‘Alejandro.’ Before I met with this couple, I reviewed Marguerite’s medical record and our case-management documentation. I learned that Alejandro was also being followed by our Care Management Program, and his outpatient case manager for this high-risk Medicare population was Julia Shea.

*Julia Shea, RN:* As a care manager in the Medicare Demonstration Project\*, part of the MGH Care Management Program, I met Marguerite and Alejandro in 2008. Alejandro was the enrollee, however, after meeting and interviewing him, it became clear to me that this couple needed to be treated as a single unit, and my plan of care needed to encompass both of them. When I reviewed their past medical records, I saw repeated instances where, if one of them was hospitalized, the other began to deteriorate. Early on in their care, I was able to identify people in the community who would be available to care for one of them if either of them ever needed to be admitted.

*Donovan:* When I first met Marguerite and Alejandro, I saw two frail, elderly individuals. They appeared too frail to live in the community, and I thought perhaps I had read the wrong notes. Alejandro had suffered a stroke years before and sat slouched in his wheelchair with a cane hooked on the back. To my surprise, he had a beaming smile and promptly introduced himself to me. His wife, Marguerite, had been transferred to MGH from a nursing facility. I learned that they lived in a second-floor apartment in a three-family home; Alejandro, who now lives there alone, climbs the stairs with his cane, receives Meals-on-Wheels, has a home-maker come in regularly, and subscribes to Lifeline through Cambridge/Somerville Elder Services. He takes The Ride when he goes to visit his wife. Marguerite and Alejandro have a son who lives in Texas. Alejandro relies on another tenant in the building to look in on him daily. Alejandro says he’s, “like a son to me.”

*continued on next page*

Emergency-room case management is a special kind of practice—encounters with patients can be brief. But I was able to form a strong, trusting relationship with this loving couple, which I feel helped them through a difficult time.

*Shea:* Though Marguerite and Alejandro have a son who lives in Texas, they can't bring themselves to move there because they're deeply embedded in the close-knit Cambridge Portuguese community. Over the course of many Emergency Department visits, I was called upon to collaborate on a plan of care for which-ever one of them wasn't admitted. I would set up daily transportation to the hospital so they could continue to see each other. Often, when one was admitted, the other would be admitted, too, or stay overnight in the same room. It was very rewarding to know that both Marguerite and Alejandro trusted their case managers. They knew we would care for them and keep them together.

*Donovan:* Marguerite and Alejandro were obviously devoted to each other, constantly reaching out to touch and kiss each other's hands. He visited her every day in the nursing facility, and he assured me he was fine at home by himself. He asked me to arrange for The Ride to pick him up. I phoned their tenant (and friend) who assured me he would be waiting for Alejandro when he arrived home. Alejandro kissed my hand and thanked me when he left.

A few weeks later, I was again asked to see an elderly couple. As I approached the room I recognized Alejandro's unmistakable voice. Again, Marguerite had been transferred from the nursing facility, this time, acutely ill. With my hand on Alejandro's shoulder, he began to tear up. He smiled and kissed my hand. Crying, he said, "How am I supposed to live without her? She has been part of my life for fifty-seven years." I told him I didn't know the answer to that. I told him he was blessed to have had a love like that for so long. We both cried. When we returned to Marguerite's room, Alejandro was relieved to see that she appeared more alert and comfortable. Again, in spite of her illness, she wanted to make sure Alejandro made it home before dark. This time, they both wept when he finally agreed to leave.

I arranged his transportation and notified their tenant to ensure he got home safely. A short time later, Marguerite was admitted to an acute-care unit.

When I returned to work after several days off, I checked on Marguerite. Sadly, I learned she had passed away. When I spoke with Julia, she told me she had gone to Marguerite's wake, and that Alejandro was doing better than expected. She continues to check on him frequently, and I always ask her to give him my best.

Emergency-room case management is a special kind of practice—encounters with patients can be brief. But I was able to form a strong, trusting relationship with this loving couple, which I feel helped them through a difficult time. Also, because Alejandro was part of our Care Management Program, I felt a strong sense of collaboration knowing that he and his wife were well supported.

*Shea:* Losing Marguerite was very hard on Alejandro. Fortunately, his community was there for him. He remains fiercely independent with support from neighbors and Elder Services, and he recently reached out to me for assistance with some community-access issues.

I learned a tremendous lesson from Marguerite and Alejandro. I now make sure that every assessment of elderly patients includes a plan of care for their spouse in the event of illness or hospitalization. I appreciate more than ever, the importance of collaboration with all members of a patient-care team and the value of team work.

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

This story is the epitome of patient- and family-centered care. Brenda and Julia worked together as well as with their patients and the community to ensure strong, consistent care for both Marguerite and Alejandro. Brenda and Julia recognized that these two people were devoted to each other and required special precautions and interventions when either of them became ill. The supports Brenda and Julia put in place enabled this couple to live happily and independently 'together' for as long as they possibly could.

Thank-you, Brenda and Julia.

\* The national Centers for Medicare & Medicaid Services (CMS) selected six organizations to conduct demonstration projects to test strategies to improve the quality of life, minimize complications, encourage better health outcomes, and reduce expenses for the most medically complex Medicare patients. Each enrolled patient is assigned a nurse care manager, who serves as the point of access to care. Care managers help these medically complex patients navigate the healthcare system, checking in with them regularly to ensure they, their families, and others understand the care plan that has been developed to meet the patient's individual needs.

# Celebrating the contributions of case managers

—by Laurene Dynan, RN, case manager

**A**s part of our Case Management Week celebration, MGH case managers sponsored the October 1, 2009, Nursing Grand Rounds, with a presentation by Cheryl Kane, RN, director of Development and street nurse for the Boston Healthcare for the Homeless Program, entitled, “Health Care that Responds to the Needs of our Homeless Men and Women.” Kane shared her passion for nursing and her commitment to caring for this vulnerable patient population.

Kane explained that Boston Healthcare for the Homeless partners with MGH and the Boston Medical Center to provide care and services to homeless individuals. Over the years, their goals have expanded, and they now manage soup kitchens, alcohol detoxification units, battered women’s shelters, and provide care at 88 local shelters and the Barbara McInnis House. They operate street clinics at a number of locations, including Suffolk Downs where they care for transient racetrack workers and coordinate team meetings to provide support for homeless families. Using a fully equipped medical van, a team of care-

providers travels around Boston from 9:00pm to 5:00am every night providing medical and follow-up care to individuals living on the street.

Kane described the insurmountable challenges homeless men and women face every day. The average life expectancy of a homeless person is 43-52 years, and the leading cause of death is cancer. Every day they encounter issues and challenges that quickly take priority over their health care needs. They face basic questions of survival, such as where they’re going to eat or shower, and how to stay warm and dry.

To help meet the needs of the homeless population, Healthcare for the Homeless nurses have developed adaptive techniques to care for their patients. Over time, they’re able to build strong and trusting relationships with their homeless patients. Kane summarized her approach for providing positive, effective street nursing this way: “Get the story, use techniques to engage patients, encourage positive change, formulate realistic care plans, and be creative. Understand each patient’s unique journey.”

For more information on the important work of case managers, call 6-3665.



Above left: Cheryl Kane, RN, of the Boston Healthcare for the Homeless Program, presents at Nursing Grand Rounds. Case managers, Fran Drysdale, RN (center) and Anna Carson, RN, field questions at an informational booth during Case Management Week.



# A look at the new Post Anesthesia Care Unit

*Question:* We heard that MGH recently opened a post anesthesia care unit in the Ellison Building. Can you tell us about that?

*Jeanette:* The Kathy S. Cullen, RN, MS, and David J. Cullen, MD, MS, Post Anesthesia Care Unit opened on September 22, 2009. It's located on Ellison 3. The unit opened with 8 beds, expanded to 12 beds on October 19th, and will begin operating at its full capacity of 20 beds, November 16th. Phase 2 (after B3C opens) will see an expansion to 30 beds.

*Question:* Is there any difference between the new PACU and the existing post anesthesia care units?

*Jeanette:* The new PACU was designed with individual bays to provide privacy for patients while ensuring a safe workplace for clinical staff. Each space has a television and a sitting area for visitors. Bays meet current regulatory standards and are more than twice the size of existing spaces. The new PACU was designed with input from PACU staff members. A mock PACU bay was constructed in the Yawkey garage where staff had an opportunity to make suggestions about everything from the height of the oxygen tubes to where the television should be.

*Question:* What technology is available in the new PACU?

*Jeanette:* Each new bay is fully equipped to meet ICU standards to provide maximum flexibility to the unit. A number of ICU/overnight bays are equipped with ceiling lifts for patient and staff safety. And a de-centralized nursing workstation supports nursing documenta-

tion at the bedside. Large-screen displays allow staff to view the status of patients across PACU settings contributing to a more efficient use of space. Though the new PACU is not part of the initial EMAPPS roll-out, each bay is equipped with EMAPPS-ready computers.

*Question:* Are patients and staff happy with the new space?

*Jeanette:* The Cullen PACU has been very well received by patients and staff alike. It validates the hard work, creativity, and planning invested by staff over the past two years. They've made this unit their own and should be very proud of the finished product.

For more information about the Cullen PACU, call associate chief nurse, Dawn Tenney, RN, at 4-8460.



(Photo provided by staff)

# Announcements

## Nursing Research Committee Journal Club

The next meeting of the Nursing Research Committee Journal Club will take place:

November 11, 2009  
4:00–5:00pm  
Yawkey 2-210.

Janice Meisenhelder, RN, will present, "Terrorism, Post-Traumatic Stress, Coping Strategies, and Spiritual Outcomes."

For more information, call Martha Root, RN, at 4-9110.

## The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,  
7:30am – 5:30pm

Friday, 8:30am – 4:30pm  
(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,  
Thursday,  
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

## Eldercare monthly discussion group

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

Next session:  
November 10, 2009  
12:00–1:00pm

Doerr Conference Room  
Yawkey 10-650

Old friends and new members are welcome

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

## Invitation to registered nurses winter/spring 2010 Program

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

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

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

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

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

## Make your practice visible: submit a clinical narrative

*Caring Headlines* is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services.

Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: [ssabia@partners.org](mailto:ssabia@partners.org). For more information, call 4-1746.

## Call for Abstracts Nursing Research Expo 2010

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

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

Categories:

- Original Research
- Research Utilization
- Performance Improvement

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

For abstract templates and exemplars, visit the Nursing Research Committee website at: [www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org)

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

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**Next Publication**  
November 19, 2009

# Educational Offerings – 2009

November

**9**

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

November

**10**

Chaplaincy Grand Rounds  
"Spiritual Healing as an Alternative,  
Complementary, and Integrative  
Therapy: a Potentially  
Slippery Slope"  
Yawkey 2-220  
11:00am–12:00pm  
No contact hours

November

**11**

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

November

**11**

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

November

**16**

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

November

**16**

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

November

**17**

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

November

**17**

Code Blue: Simulated Cardiac  
Arrest for the Experienced Nurse  
POB 448  
11:00am–3:00pm  
Contact hours:TBA

November

**17**

Ovid/Medline: Searching for  
Journal Articles  
Founders 334  
10:00am–12:00pm  
Contact hours: 2

November

**17**

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

November

**18**

On-Line Electronic Resources for  
Patient Education  
Founders 334  
9:00am–12:00pm  
Contact hours: 2.7

November

**19**

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

November

**19**

Nursing Care for Respiratory  
Compromised Patients  
Bigelow Amphitheater  
12:00–4:00pm  
Contact hours:TBA

November

**20**

PCA Preceptor Course  
Founders 325  
1:00–3:00pm  
No contact hours

November

**24**

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

November

**30**

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

December

**1&2**

PALS Certification  
Simches Conference Room 3-120  
Day 1: 7:45am–4:00pm  
Day 2: 7:45am–3:00pm  
No contact hours

December

**2**

BLS/CPR Certification  
Founders 325  
7:30am–2:00pm  
No contact hours

December

**7&8**

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

December

**8**

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

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

# Are you seeking nursing research opportunities?

— submitted by The Yvonne L. Munn Center for Nursing Research

By providing opportunities to challenge current thinking and identify new ways to shape and influence nursing practice, we enhance patient care and promote health and wellness.

The Yvonne L. Munn Center for Nursing Research serves as a platform for clinically focused nursing research. By providing opportunities to challenge current thinking and identify new ways to shape and influence nursing practice, we enhance patient care and promote health and wellness. To date, 23 research awards and seven post-doctoral fellowships have been awarded through the Center.

The Yvonne L. Munn Nursing Research Awards are presented annually to MGH staff to fund nurse-initiated research to advance nursing knowledge and practice. A doctorally-prepared nurse serves as consultant and mentor to each research team. Applicants seeking Yvonne L. Munn Nursing Research Awards must work full-time as a nurse at MGH. All funded research proposals must be approved by the MGH IRB before the study is conducted. And recipients must submit a progress report to the Center at six-month intervals until the research is completed. Each award is \$1,500.

Please note the following important dates:

- 12-15-09 Letters of intent and nursing-director support are due
- 1-15-10 Proposals are due for the 2010 funding cycle
- 1-22-10 Feedback to applicants following internal review for completeness
- 2-1-10 Requested revisions (if any) are due

Applicants are informed of funding decisions in April, and awards are publicly announced during Nurse Week. For more information about the Munn Research Awards, contact Paul Arnstein, RN, at 4-8517; Marion Phipps, RN, at 6-5298; or Elaine Cohen, RN, at 6-1989.

The Yvonne L. Munn Post Doctoral Fellowship in Nursing Research provides doctorally prepared nurse researchers with time and resources to advance their research and develop proposals in areas of nursing inquiry that can be submitted for funding.

The fellowship subsidizes 400 hours of practice time and related expenses over a two-year period up to \$2,500 to allow the fellow to develop a research proposal that can be submitted for funding. At the end of the fellowship, the fellow presents his/her research to the MGH nursing community. The deadline for applications is February 5, 2010. For more information, call Diane Carroll, RN, at 4-4934, or Mandi Coakley, RN, at 6-5334.



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