

# Caring

Headlines

October 1, 2009

## Flu season is here

Did you get your flu shot yet?

Know the facts. Be prepared  
See story on page 4



Physical therapist, Kathy Phillips, PT, gets flu shot from Paula DeJong, RN, of Occupational Health Services at one of many seasonal flu-shot clinics offered at MGH. For more information, see page 4, or call Occupational Health Services at 6-2217.

# Designing Care

a look at an important new book  
by Richard Bohmer

At the core of *Designing Care* is the underlying belief that the delivery of effective care is all about problem-solving—solving clinical and business problems in tandem using all the data required to make informed decisions.

A

s you know, I'm an avid reader. I'm also a big fan of Richard Bohmer, MBChB, physician, lecturer, researcher, and faculty of the Harvard Business School. So I was thrilled to pick up a copy of Richard's new book,

*Designing Care: Aligning the Nature and Management of Health Care*. It's a wonderful read and a thought-provoking journey through some of the major issues affecting health care today. Richard was kind enough to visit with leadership of Patient Care Services recently and share some of his thoughts about the problems plaguing hospitals and his ideas about how to better design, manage, and deliver care.

Much of the debate we're hearing about healthcare reform focuses on financial concerns—the insurance and reimbursement side of the issue. *Designing Care* focuses on the operational issues that stand in the way of timely, effective, cost-efficient care. Richard's examination of existing systems and the mind-set that brought us to our current reality dovetails with our own work to incorporate evidence-based practice into care-delivery and empower clinicians at the bedside.

*Designing Care* describes a number of factors that have contributed to an American healthcare system that is, "expensive, uncertain, unreliable, and sometimes even unsafe." It talks about the influence of a



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

'business-management' approach to health care; the growing complexity of scientific knowledge and the complexity of healthcare organizations in general; and a failure within the healthcare community to adequately capture and use the wealth of knowledge available to us.

At the core of *Designing Care* is the underlying belief that the delivery of effective care is all about problem-solving—solving clinical and business problems in tandem using all the data required to make informed decisions. To accomplish this, it's necessary to have input from support staff, clinicians, and leaders at all levels of the organization.

The book describes two distinct kinds of care processes: iterative, composed of multiple cycles of trial and error and experimentation in search of answers and knowledge; and sequential, a more linear approach that makes use of known science, placing less emphasis on learning and more on the carrying-out of established protocols. With the diverse patient population

*continued on next page*

we see at MGH, we use iterative and sequential care processes all the time.

It's important to understand and distinguish between these two care processes because they (should) inform the way hospitals design and manage care. Each process requires a different set of tools, resources, thinking, and organizational support. But, according to *Designing Care*, many healthcare organizations fail to distinguish between these two processes. They apply the same set of management tools to both, resulting in a failure to optimize either.

Every time patient care is delivered, there is an opportunity to learn, to acquire new knowledge that can be applied to future patients. This new knowledge can be both clinical and operational. There is, in fact, a dynamic relationship between the two. And both must be considered when designing care systems. Both have impact on the ability of an organization to improve itself and its outcomes.

What we know from our own experience, and what Richard reminds us in *Designing Care*, is that the line between business and clinical practices in the delivery of patient care is blurred. Organizations have a responsibility to develop and share knowledge that impacts care delivery. And more and more, that knowledge is both scientific and organizational. Systems must be deliberately designed to capture, disseminate, and incorporate both.

What Richard describes in *Designing Care* is not a simple undertaking. There's no universal solution that can be applied to every organization. Each organization must have an understanding of its own clinical processes and an appreciation for how those processes relate to the acquisition and integration of knowledge into future practice. He writes, "...two key operating systems need to be deliberately designed if they are to perform optimally: the operating system for delivering the care that we know, and the operating system for creating new knowledge about which care to deliver in the future and how to better deliver it."

If you've met Richard Bohmer or read his book, you know this article only scratches the surface of his extensive research into the relationship between medical care and management practices. I thank him for his insight into a very complex subject and for raising awareness about these issues that so intrinsically affect patient care.

#### Updates

I'm happy to announce that Kate Whalen, RN, has accepted the position of clinical nurse specialist for the Ellison 8 Cardiac Surgery Step-Down Unit.

And Mary McAuley, RN, has accepted the position of nursing director for the Ellison 19 Thoracic Unit. She will begin her new role on October 26, 2009. Many thanks to Sharon Bouvier, RN, for her interim coverage on Ellison 19.

Every time patient care is delivered, there is an opportunity to learn, to acquire new knowledge that can be applied to future patients. This new knowledge can be both clinical and operational. There is, in fact, a dynamic relationship between the two. And both must be considered when designing care systems.

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# What you need to know this flu season

— compiled from information provided by Occupational Health Services

## Employee Flu-Shot Clinics

CNY Building 149  
First Floor Lobby  
Thursday, October 1st  
8:30am–3:00pm  
Thursday, October 8th  
8:30am–1:00pm

Charlestown Navy Yard  
Building 36 (IHP)  
Speech Center  
Monday, October 5th  
8:00am–12:00pm

MGH West, PARC  
Conference Room  
Monday, October 5th  
2:00–5:00pm

**A**s every healthcare provider is well aware, flu season is upon us, and there is great interest in both the seasonal and H1N1 influenza (also known as swine flu). Much work is being done across the country to try to predict the course and severity of these flu strains. Public officials are working to develop and distribute effective vaccines as quickly and efficiently as possible. While H1N1 has dominated the news of late, we can't let it overshadow the need for seasonal flu vaccination.

The most important step healthcare providers can take to protect themselves and others from the flu is to get vaccinated. Occupational Health is offering its annual employee seasonal flu-shot clinics on the main campus, at MGH health centers, and in a number of other ambulatory care facilities. The H1N1 vaccine will be offered beginning later this month or in early November.

A new state regulation requires healthcare workers to report their vaccination status for both seasonal and H1N1 flu. We will share information about how to do this in the coming weeks.

While vaccination offers the best protection against the flu, there are other steps you can take to help prevent contracting and spreading the flu:

- Avoid close contact with people who are sick, and keep your distance from others if you're sick
- Keep your hands away from your eyes, nose, and mouth

- If you're sick, stay home
- Cover your mouth and nose with a tissue when coughing or sneezing. Throw the tissue away, and clean your hands. If a tissue is not available, cough or sneeze into your upper sleeve
- Practice effective hand hygiene by using an alcohol-based hand sanitizer or washing hands with soap and water for at least 15 seconds
- Use disinfectants to clean frequently touched surfaces, such as phones and keyboards

If you develop a fever of more than 100° and a cough, sore throat, or muscle aches, stay home. For influenza-type illness, employees need to remain out of work for seven days or 24 hours after the resolution of symptoms, whichever is longer. Contact Occupational Health at (617) 726-2217 before returning to work.

The MGH Walk-in-Clinic and a number of primary-care and specialty practices are administering seasonal flu shots to patients. To augment these efforts, a seasonal flu-shot clinic for adult patients has been set up in the Wang Ambulatory Care Center Lobby, Monday through Friday from 8:00am–7:00pm, and Saturday and Sunday from 9:30am–4:00pm. Children should be vaccinated by their own healthcare providers.

Please bring your ID badge and wear loose-sleeved clothing when getting a flu shot. Those unable to attend a clinic can go to Occupational Health on Thursdays, between 10:30am and 4:30pm, or call 6-2217 to schedule an appointment. Thank-you for your support as we plan and prepare for flu season.

# Nurse, patient share life-altering experience

—by Margaret Driscoll, RN, staff nurse, Bigelow 11 Medical Unit



Margaret Driscoll, RN, staff nurse  
Bigelow 11 Medical Unit

Six years as a nurse may not seem like a long time, but I've experienced a lot... Recently, as I cared for Mr. F, I experienced something I'd never experienced before. I witnessed Mr. F having a stroke.

Six years as a nurse may not seem like a long time, but I've experienced a lot. I've seen a variety of illnesses and taken care of people from all walks of life. I've seen people recover from life-threatening illnesses, and people grow seriously ill from mild ailments. I've seen patients die, both expected and unexpectedly. I've been involved in code situations and seen my share of bedside emergencies. But recently, as I cared for Mr. F, I experienced something I'd never experienced before. I witnessed Mr. F having a stroke.

It was a day like any other. I went in to meet a new patient. I introduced myself, checked his vital signs, discussed his progress, his plan of care. Mr. F was a funny man who hadn't lost his Irish brogue after coming to Boston "years ago." I treated his nausea, learned about his grandchildren, and talked about what he did for a living. When it came time to wash up, I walked Mr. F to the shower. He used his walker. Nothing out of the ordinary.

At lunch time, Mr. F called me to help him. He had started to eat lunch but needed a little assistance. As I helped him arrange some pillows on his bed, we were talking about some recent test results when, all of a sudden, he stopped talking. I said his name and asked him to speak. He couldn't. I asked him to squeeze my hand. When I grabbed both of his, only his left hand responded. Lifting both his arms off the bed, his right arm fell limp. Mr. F had muscle control on his left side only.

I immediately called for the team. I took a set of vitals and an EKG.

When the doctors arrived, I told them, "Mr. F is having a stroke."

A whirlwind of activity followed. The Stroke Team was activated, Mr. F was sent for a stat head CT. When he returned to the unit, the news was shared that nothing could be done. I went in to see Mr. F. He looked at me with eyebrows raised, mouthing words, but unable to speak. He was scared, frustrated, and tired. He made eye contact but I couldn't tell if he understood what I was saying. My heart broke as I thought of Mr. F just hours earlier, joking with me in his Irish accent and funny grin.

Describing how this situation affected me is difficult. But at least I have the ability to express my thoughts. I can write, speak, convey my ideas. Mr. F may never have that ability again. He's lived a lifetime and may never again be able to reminisce about it. He may never be able to say, "I love you," to his grandchildren. The idea of having your thoughts trapped inside is frightening—emotions un-expressed, needs un-met, words un-said.

I have cared for many stroke patients, many with aphasia. But I never knew any of those people beforehand—never heard their voices, knew their sense of humor, their feelings, their ideas. Though I only knew Mr. F for six hours before he had a stroke, it was enough to make me mourn the fact that Mr. F's life would never be the same.

I felt blessed to have had the chance to talk and laugh with Mr. F that day.

# The bonds we share with patients are lessons we keep for life

As more community hospitals have begun offering cardiac catheterizations, the population on our unit has changed. We're seeing more acute patients requiring a higher level of care.

**M**y name is Amy Dietz, and I'm a staff nurse on the Ellison 11 Cardiac Interventional Unit. Being a registered nurse can be emotionally demanding, but it's always rewarding when you know you've touched a patient and family and given them the best care you can. Over the past year, I've cared for a changing population on Ellison 11. When I started working in the Cardiac Interventional Unit, most patients were between 40 and 70 years old, had suffered their first myocardial infarction, or been newly diagnosed with heart disease. Most patients stayed for one night following a stent placement.

I was a new nurse, and these patients were very complex with acute cardiac needs requiring emergent care. Sometimes, patients with peripheral vascular disease, heart failure, arrhythmias or other cardiac conditions would be admitted bringing great diversity to our nursing practice. As more community hospitals have begun offering cardiac catheterizations, the population on our unit has changed. We're seeing more acute patients requiring a higher level of care. As a more experienced nurse now, I'm seeing that complicated patients who need the integrated care of multiple teams are more difficult to care for.



Amy Dietz, RN, staff nurse,  
Ellison 11 Cardiac Interventional Unit

When I arrived at work for a night shift earlier this year, I received report on an independent 66-year-old man with amyloidosis (a metabolic disorder characterized by a build-up of starch in organs and tissue) with cardiac and kidney involvement. I didn't realize how much care and coordination Mr. M would require, but I was delighted to take on the challenge. Also, I could never have anticipated the impact this patient would have on my nursing practice, and how much he would change my outlook on life.

Mr. M had been diagnosed with amyloidosis in 2008. He had been treated with a chemotherapy drug and steroid hormones, but was admitted to Ellison 11 due to worsening symptoms of heart failure. He was here to be evaluated for a heart transplant. During his stay, he underwent cardiac catheterization and subsequent stem-cell transplant and high-dose chemotherapy. Mr. M had no other significant past medical his-

*continued on next page*

tory. His cardiac catheterization revealed no significant coronary artery disease or elevated pressures. Mr. M continued with his heart-transplant work-up, which included many invasive tests and a long hospitalization during which I was his primary nurse.

I created a heart-transplant check-list for Mr. M and organized his care and many tests. I made Social Services aware of the ongoing support Mr. M needed for himself as well as his family members who were relocating to the area from another state.

Unfortunately Mr. M spent the 4th of July holiday in the hospital. He had planned to spend it at the Jersey shore, and coincidentally, I happened to be going to the Jersey shore for a family vacation. That was one of many things we had in common. Mr. M and I discovered that his career path was similar to my father's. He worked with healthcare leadership, and as we talked, we realized that Mr. M's brother had worked with my father a while back in Philadelphia. Mr. M gave my father an autographed copy of his book. He had a great attitude and took advantage of the prime view from Ellison 11 to watch the fireworks display over the Charles.

Mr. M wrote an article in a journal he'd created, recalling how impressive the Ellison 11 staff were and how well we worked together as a team. In the article, he noted how we had engaged him in his care plan. It was encouraging to read this when I returned from my 4th of July holiday. Mr. M had sent it to me and his other primary nurses.

Unfortunately, Mr. M's health took a turn for the worse while I was gone causing him to be taken to the Ellison 9 Cardiac ICU for intravenous dobutamine treatment. I visited him there on my first day back after the holiday. Mr. M was stoic and pleasant. He never hinted at how much he missed his family and friends, or talked about his fear of the future. Instead he showed me pictures of his grandson and told me about his wife moving to Boston.

Mr. M was on the transplant list for about two weeks before he became septic and lost the function of his kidneys. He was placed on CVVH (continuous veno-venous hemofiltration) a form of dialysis. While Mr. M was in the CCU, I visited him every week to let him know staff on Ellison 11 were thinking about him and hoping for the best. During our visits, we talked about the positive things in his life, but we always dis-

cussed his care and future options. Mr. M wanted to know what was going on at all times.

During one visit, he appeared distant. He later told me he knew his journey was coming to an end, and he was thankful for everything I'd done for him, especially the on-going support and nurse-patient relationship we shared. He loved his nurses on Ellison 9, but he never forgot us on Ellison 11. He called us his 'first MGH home.'

It was soon discovered that Mr. M's amyloidosis had moved to his pulmonary system. A lung nodule was biopsied. Mr. M decided he was done fighting and requested palliative care. He called Ellison 11 one Sunday night to say good-bye to Joyce, Lauren, and me, and to thank us for our excellent care.

Mr. M died peacefully the next morning with his family around him. There had been only a small window of opportunity for a heart transplant, and as Mr. M had said in our last visit, "Amy, it just wasn't meant to be."

He wrote in his last journal article, "I have had a long, fulfilling life with many blessings. If I could have lived longer, my goal would have been to learn even better ways of helping people. I have had many long days and nights to feel my heart fill with the human and divine kindnesses that you have shown me, and I would love to be able to do that for you, as well."

The only thing Mr. M would have done with extra time, would have been to help more people. He taught me to live each day, be kind to yourself and others. Help people, and avoid self-absorption. Find and spread faith. Make life count.

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

We talk frequently about the 'symbiotic' nature of the clinician-patient relationship. What a wonderful example this narrative is. Amy's care, concern, and influence on Mr. M continued even after Mr. M left her unit. They continued to have a powerful effect *on one another* as Mr. M neared the end of his life. What must Amy and her fellow nurses have done to instill in Mr. M the sense that Ellison 11 was his, 'first MGH home.' And what must Mr. M have done to instill such meaningful lessons in his caregivers: live each day, be kind to yourself and others. Find and spread faith. Make life count. Indeed.

Thank-you, Amy.

He later told me he knew his journey was coming to an end, and he was thankful for everything I'd done for him, especially the on-going support and nurse-patient relationship we shared. He loved his nurses on Ellison 9, but he never forgot us on Ellison 11. He called us his 'first MGH home.'

# Professional Achievements

## Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, was appointed a member of the Technical Expert Panel for Hip Fracture Pain by the Agency for Healthcare Research & Quality in July, 2009.

## Banister recognized

Guardia Banister, RN, executive director, The Institute for Patient Care, was named one of ten distinguished alumni of the University of Texas, in Austin, in August, 2009.

## Doody re-appointed

Joan Doody, RN, nurse practitioner, Heart Failure & Cardiac Transplant Program, was re-appointed a member of the Board of Directors of the Alliance for Heart Failure Patients, in June, 2009.

## Lee appointed

Susan Lee, RN, nurse scientist, The Yvonne L. Munn Center for Nursing Research, was appointed a Harvard Macy scholar by the Harvard Macy Institute, in June, 2009.

## Nurses publish

Linda Pitler, RN, Thoracic Aortic Center; Richard Pompei, RN, Diabetes Research Center; Charlene Malarick, RN, Center for Pain Medicine; Robert Sutherland, RN, Diabetes Research Center; Judith Leamy, RN, Weight Center; and Mary Larkin, RN, Diabetes Research Center, authored the article, "De-Mystifying Clinical Research Nursing," in *The Monitor* (the Association of Clinical Research Professionals' professional journal), in September, 2009.

## Curran certified

Judith Curran, RN, clinical nurse specialist, became certified as an advanced oncology clinical nurse specialist by the Oncology Nursing Society, on August 15, 2009.

## Madden certified

Janet Madden, RN, clinical nurse specialist, NICU, became certified as a neonatal clinical nurse specialist by the American Association of Critical Care Nurses, on August 19, 2009.

## Nilson Connolly certified

Theresa Nilson Connolly, RN, Neurology, became certified as a neuroscience nurse by the American Nurses Credentialing Center, in July, 2009.

## Beninato publishes

Marianne Beninato, PT, physical therapist, authored the article, "Using the International Classification of Functioning, Disability, and Health as a Framework to Examine the Association Between Falls and Clinical Assessment Tools in People with Stroke," in the July, 2009 *Physical Therapy*.

## Nurse, physician, publish

Beth-Ann Norton, RN, of the MGH Crohn's and Colitis Center; and David Rubin, MD, co-authored the educational offering, "Ask the Experts: Updates in Ulcerative Colitis, Current Approaches to Medical Therapy," in *Practicing Clinicians Exchange*, in September, 2009.

## Rodenhi presents

Kyle Rodenhi, PT, physical therapist, presented, "Golf Fitness Evaluations/Training and Golf Specific Exercises," at the LPGA Golf Clinics for Women, in Sharon, July 13 and 20, 2009.

## Creech presents

Marie Creech, PT, physical therapist, presented, "New Times, New Technologies: an Introduction to Office Ergonomics," at the Asian American Journalist Association, in Boston, August 13-14, 2009.

## Lee receives prestigious grant

Recently, Susan Lee, RN, nurse scientist, The Yvonne L. Munn Center for Nursing Research, was awarded a \$900,000 grant for Patient Care Services and the department of Nursing, for the project, "Re-Tooling for Evidence-Based Nursing Practice," from the Division of Nursing, Bureau of Health Professions, Health Resources, and Services Administration, under the US Department of Health and Human Services. This research will focus on the continued expansion of nursing knowledge, skills, and competencies related to evidence-based practice through continuing-education programs; provide opportunities for nurses to participate in mentored, unit-based evidence-based practice projects; and help build an organizational infrastructure essential to supporting and sustaining evidence-based practice at MGH.

## Connors publishes

Patricia Connors, RN, clinical nurse specialist, Perinatal Unit, authored the book, *The Perinatal Nurse's Guide to Avoiding a Lawsuit*, in August, 2009.

## Viser and Woodbury present

Anne Viser, PT, physical therapist, and Lisa Woodbury, physical therapy aide, presented, "Athletic Trainers: ACL Injury Prevention Clinic," at Cambridge Rindge and Girls Latin Soccer Programs in Cambridge, in August, 2009.

## Doody presents

Joan Doody, RN, nurse practitioner, Heart Failure & Cardiac Transplant Program, presented, "Integrative Medicine and Alternative Therapies: a Review of Holistic Approaches to Patient Care," at the 2009 American Association of Heart Failure Nurses annual meeting, in Minneapolis, June 27, 2009.

## CNSs publish

Clinical nurse specialists, Virginia Capasso, RN; Jacqueline Collins, RN; Catherine Griffith, RN; Cynthia Ann LaSala, RN; Susan Kilroy, RN; Ann Martin, RN; Jill Pedro, RN; and Susan Wood, RN, authored the article, "Outcomes of a Clinical Nurse Specialist-Initiated Wound Care Education Program Using the Promoting Action on Research Implementation in Health Services Framework," in the September, 2009, *Clinical Nurse Specialist*.



# Ensuring patients are transported safely

*Question:* Inpatients at MGH are transported to many diagnostic areas. How is the decision made as to whether a licensed clinician needs to be involved in the transport?

*Jeanette:* Any unstable patient, especially mechanically ventilated patients, patients requiring more than 50% oxygen, and patients with a tracheostomy tube or airway stoma should be accompanied by a licensed clinician. With mechanically ventilated patients, both a nurse and a respiratory therapist should accompany the patient. The same is true for non-invasively ventilated patients if they require continuous ventilation or if ventilation is needed when lying flat.

*Question:* I understand the need for a licensed clinician with patients on high concentrations of oxygen or who are mechanically ventilated, but why do all tracheostomy or airway-stoma patients require a licensed clinician to accompany them?

*Jeanette:* These patients, though they may appear stable, can develop respiratory distress with little warning; they require the presence of a licensed clinician capable of handling airway emergencies. These patients need a licensed clinician to advocate for them since they have limited ability to communicate.

*Question:* After transporting high-risk patients, do I need to stay with them during the procedure?

*Jeanette:* Yes. Someone who can handle airway emergencies must always be present with the patient. When these patients arrive in the diagnostic area, they should be seen as soon as possible to minimize the time the patient and the clinician are away from the unit.

*Question:* It's my understanding there's a special form that has to accompany all patients who are transported within the hospital. Is that true?

*Jeanette:* We are currently piloting a 'Sticker to Ride' program on three units in an attempt to improve safe hand-offs from one clinician to another. The nurse caring for the patient brings the transport documentation before each transport. Signing the green sticker indicates that the nurse knows it's safe for the patient to travel to the test area with a capable MGH transporter without the presence of a licensed clinician. After identifying herself to the patient, the transporter double-checks the two patient identifiers and assists the nurse in transferring the patient to a wheelchair or stretcher. The transporter signs her name and the arrival time on the sticker when they reach the designated area. Returning patients to their units involves the same process in reverse. We're hoping for smoother, safer hand-offs from one area to another with the active participation of transporters.

*Question:* Is there a Safe Patient Transport Policy?

*Jeanette:* The Transporting Patients Safely policy is being updated. It can be found in the on-line Clinical Policy and Procedure Manual under MGH Policy and Procedures, Clinical References.

Other issues related to the safe transport of patients are currently being addressed. You'll hear more about this in the near future.

For more information about transporting patients safely, contact Marian Jeffries, RN, at 4-4031; Susan Gavaghan, RN, at 4-4802; Neila Altobelli, RRT, at 4-4494; or Bob Kacmarek, RRT at 4-4490.

# Announcements

## New Privacy Regulations

As of Wednesday, September 23, 2009, new federal privacy regulations are in effect requiring that patients and the Department of Health and Human Services be notified when protected health information is breached. The new regulations include penalties (fines, prison, and civil and criminal liability) for employees and individuals.

The Privacy Office has scheduled a number of educational sessions to discuss these important changes. To schedule a session for your unit or department, call Paula Moran, at 6-6360 or Mary Lee Gamache at 6-2465.

## Third annual Care of the Patient with Vascular Disease Conference

Sessions will offer information on care of patients with vascular problems. Topics will include: prevention, diagnostics, treatment and nursing care.

Thursday, October 8, 2009  
8:00am–4:00pm  
Simches Conference Room 3-120

### Registration:

- MGH employees  
— no fee
- Partners' employees  
— \$50 per day
- Non-Partners' employees  
— \$100 per day

Pre-registration is required

Please contact:

The Norman Knight Nursing  
Center for Clinical & Professional  
Development  
at 6-3111.

## Meet the author

Eva M. Selhub, MD, senior staff physician at the Benson Henry Institute, will be discussing her book, *The Love Response: Your Prescription to Transform Fear, Anger, and Anxiety into Vibrant Health and Well Being*

October 19, 2009

12:00–1:00pm

Blum Patient & Family Learning  
Center

All are welcome

Stop by and bring your lunch

For more information,  
call 4-7352

## 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

## 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.

## Third annual Best Practices in Acute Care for Older Adults Conference

2-day program provides evidence-based foundation to help improve knowledge and expertise in caring for older adults

Friday, October 16 and  
Monday, October 26, 2009  
8:00am–4:30pm  
O'Keefe Auditorium

Registration:

- MGH employees  
— no fee
- Partners' employees  
— \$50 per day
- Non-Partners' employees  
— \$100 per day

Pre-registration is required

Please contact:

The Norman Knight Nursing  
Center for Clinical & Professional  
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6-3111

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For more information, call:  
617-724-1746

### Next Publication

October 15, 2009

# Educational Offerings – 2009

October

**5 & 19**

ACLS Provider Course

Day 1: 8:00am–4:30pm

O'Keefe Auditorium

Day 2: 8:00am–3:00pm

Thier Conference Room

No contact hours

October

**6**

BLS Heartsaver Certification

Founders 325

8:00am–12:00pm

No contact hours

October

**6**

Simulated Critical-Care  
Emergencies

POB 448

7:00–11:00am

Contact hours: TBA

October

**6**

Clinical Analysis of the 12-Lead  
ECG, sponsored by the Boston  
ICU Consortium

Wolfe Auditorium

Tufts Medical Center

8:00am–4:30pm

Contact hours: TBA

October

**7**

Code Blue: Simulated Cardiac  
Arrest for the Experienced Nurse

POB 448

7:00–11:00am

Contact hours: TBA

October

**13**

New Graduate RN  
Development Program

Founders 311

8:00am–4:30pm

Contact hours: TBA

October

**14**

Nursing Grand Rounds

Haber Conference Room

11:00am–12:00pm

Contact hours: 1

October

**19 & 20**

Advanced Trauma Care for  
Nurses

Day 1: O'Keefe Auditorium  
7:00am–5:00pm

Day 2: Bigelow Amphitheater

9:00am–7:00pm

Contact hours: 19

October

**19 & 20**

Oncology Nursing Society  
Chemotherapy Biotherapy  
Course

Day 1: Yawkey 2-220

Day 2: Yawkey 10-650

8:00am–4:30pm

Contact hours: TBA

October

**20**

Code Blue: Simulated Cardiac  
Arrest for the Experienced Nurse

POB 448

7:00–11:00am

Contact hours: TBA

October

**21**

Simulated Bedside Emergencies  
for New Nurses

POB 419

7:00am–2:30pm

Contact hours: TBA

October

**22**

Psychological Type & Personal  
Style: Maximizing your  
Effectiveness

Charles River Plaza

8:00am–4:30pm

Contact hours: TBA

October

**22**

Nursing Grand Rounds

O'Keefe Auditorium

1:30–2:30pm

Contact hours: 1

October

**23**

Health Care at the Crossroads:  
Ethics Symposium for Healthcare  
Providers

O'Keefe Auditorium

8:00–4:30pm

Contact hours: TBA

October

**26**

Intermediate Arrhythmia

Simches Conference Room 3-120

8:00–11:30am

Contact hours: 3.5

October

**26**

Pacing Concepts

Simches Conference Room 3-120

12:15–4:30pm

Contact hours: 3.75

November

**2**

CPR Mannequin Demonstration

Founders 325

Adults: 8:00am and 12:00pm

Pediatrics: 10:00am and 2:00pm

No BLS card given

No contact hours

November

**2 & 16**

ACLS Provider Course

Day 1: 8:00am–3:00pm

O'Keefe Auditorium

Day 2: 8:00am–3:00pm

Thier Conference Room

No contact hours

November

**3**

BLS/CPR Re-Certification

Founders 325

7:30–10:30am and 12:00–3:00pm

No contact hours

November

**3**

Phase I Wound-Care Education  
Program

Simches Conference Room 3-120

8:00am–4:30pm

Contact hours: 6.6

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

# Firenze retires after 43 years of service

—by Alan Goostray, RN

(Photo by Kertine Laurent)



Darryl Firenze, RN (center), at her farewell bash with (back, l-r): Lisa Morrissey, RN, and Alan Goostray, RN, and (front) Lori Pyburn, RN, and peri-operative associate chief nurse, Dawn Tenney, RN.

After 43 years of continuous service, almost to the day, peri-operative nurse, Darryl Firenze, RN, retired on September 11, 2009. She began her career at MGH on September 12, 1966. A graduate of the Lynn Hospital School of Nursing (no longer in existence), Firenze saw many changes over the course of her career. She worked in the White operating rooms, Baker operating rooms, and Phillips House operating rooms, ushering in the transition from ether to more modern anesthetics and witnessing the introduction of minimally invasive, same-day surgeries. Despite the changes, the patient was always at the center of Firenze's practice.

Firenze mentored many new nurses. Says Susan Porter, RN, operating room nurse, "I owe everything I know about the care of GYN patients to the teachings of Darryl Firenze." Firenze was always willing to share her knowledge and insight.

Firenze's retirement marks the end of an era. Said one colleague, "I was born the same year Darryl began her career." She will be missed.

**Caring**  
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