

Caring

Headlines

September 17, 2009

Joint Commission visit *validates culture shift to Excellence Every Day*

See stories on page 2 and page 9



At Joint Commission de-briefing meeting with Patient Care Services staff and leadership, senior vice president for Patient Care, Jeanette Ives Erickson, RN, celebrates success of the "Educate, communicate, motivate" model used by Excellence Every Day champions.

The Joint Commission meets Excellence Every Day



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

I want to
thank each of
you for the part
you played in
transforming our
culture from one
of cyclical readiness
to one of ongoing
preparedness with
your commitment
to Excellence
Every Day.

It has not been the norm in recent years for hospitals to eagerly await the arrival of the Joint Commission survey team nor to celebrate their departure with a sense of pride and accomplishment. But that is precisely the scenario that played out at MGH over the past months, culminating with our Joint Commission survey the week of August 24, 2009. I want to thank each of you for the part you played in transforming our culture from one of cyclical readiness to one of ongoing preparedness with your commitment to Excellence Every Day.

Some of you may recall when Ann Scott Blouin, RN, executive vice president of the Joint Commission, visited us earlier this year. She told us about the, “new vision of the Joint Commission to partner with health-care organizations to transform health care into a high-reliability industry.” She said the Joint Commission was committed to building alliances with hospitals to advance the cause of safe patient care; that they were trying to strike a balance between the evaluative and regulatory functions with increased focus on coaching, teaching, and mentoring.

I’m happy to report that Dr. Blouin was true to her word. That is exactly the experience we had with our Joint Commission visit. It was clear from the outset that our colleagues from the Joint Commission were caring, passionate professionals whose primary concern was the same as ours—safe, high-quality patient care.

Time and time again throughout the week, we heard positive feedback from our guests about our com-

mitment to patient- and family-centered care. On more than one occasion, they asked permission to share our best practices with other organizations. They listened with interest as we showcased our passion for quality and safety in putting our patients’ needs first. They commented on:

- our outstanding fall-risk assessment and fall-prevention efforts
- the success and effectiveness of the New Graduate in Critical Care Program
- our ability to actively involve patients and families in their care with an emphasis on patient education
- our ‘robust and thorough’ time-out practices
- the ability of new employees to respond to questions with confidence and understanding
- our commitment to hand hygiene in all settings
- the inter-disciplinary nature of our teamwork and collaborative practice
- our electronic order-entry, medication-administration, and documentation practices
- the effectiveness of our restraint policy and procedures

continued on next page

Using the three-pronged approach of, Educate, Communicate, and Motivate, the same model that served us so well in achieving Magnet designation, we created a 'perfect storm' of pride, accountability, and transparency— staff couldn't *wait* for Joint Commission surveyors to come to their units.

- the success of our Excellence Every Day champions model

One surveyor who visited the Labor & Delivery Unit was so impressed with the cleanliness of patient rooms, she asked to meet the unit service associates who had taken such pride in their work. When unit service associates, Madalena Texeira and Maria Texeira, stepped into the room, they were given a standing ovation. Maria was so moved by the experience, she called home to tell her husband. (I hope he was duly impressed!)

This year, MGH served as a pilot site for the first integrated survey of both the hospital and the clinical laboratories. This year also saw a change in the Joint Commission scoring process, which made for a much more sensitive barometer of compliance. The revised scoring system was intended to:

- be more reflective of an organization's performance
- be more transparent
- be more easily understood by all involved
- take into account that some standards have a greater impact on patients than others do

But none of these changes detracted from staff's ability to clearly and concisely articulate our practice and convey with enthusiasm our commitment to exceptional care. Using the three-pronged approach of, Educate, Communicate, and Motivate, the same model that served us so well in achieving Magnet designation, we created a 'perfect storm' of pride, accountability, and transparency— staff couldn't *wait* for Joint Commission surveyors to come to their units. This represents a culture shift that just five years ago many of us would not have thought possible.

Our journey to Excellence Every Day has been advanced with single-minded attention to what is best for our patients. It was toward that end that we:

- launched the Patient Care Services Office of Quality & Safety, led by director, Keith Perleberg, RN
- aligned collaborative governance with Excellence Every Day
- embraced evidence-based practice
- re-structured our Clinical Support Services under director, George Reardon, to ensure patient-care areas were safe, clean, and quiet
- listened to patients and families when they told us what was working and what wasn't
- garnered support of leadership across Patient Care Services in fostering Excellence Every Day

During our survey, the Joint Commission issued a statement on its website citing the importance of effective leadership in preventing medical errors. Our surveyors shared that many of the strategies referenced in that statement were alive and well and visible at MGH.

Truly, this Joint Commission survey was unlike any I've ever participated in. Perhaps nursing director, Susan Caffrey, RN, said it best when she said, "I feel as though we've helped usher in a new era of Joint Commission accreditation." (See page 9 for more comments from our colleagues.)

I want to thank you for your leadership and commitment. I am continually impressed by your diligence, integrity, and spirit. It is a privilege to work with colleagues who strive so unwaveringly to take exceptional care of our patients and families.

Thank-you and congratulations.

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Celebrating clinical nurse specialists: one CNS's story

—by Yasmin Khalili, RN, clinical nurse specialist

My name is Yasmin Khalili, and I first worked as a clinical nurse specialist (CNS) in May of 2000 after earning my master's degree in Nursing from McGill University School of Nursing.

I was one of two CNSs in the Brain Tumor/Neuro-Oncology program at Montreal Neurological Hospital. When I came to Boston more than a year ago, I wasn't

sure the CNS role would be the same as in Montreal. I was worried I wouldn't find a CNS position that would be as stimulating, challenging, or rewarding as what I'd experienced before. After doing some research, however, I was hopeful that MGH would provide an exciting opportunity. I was thrilled when I was offered a position as clinical nurse specialist on Phillips House 22.

Though I had several years experience working as a clinical nurse specialist, starting at an institution as big

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MGH clinical nurse specialists gather on the Bulfinch lawn.



(Photo by Paul Batista)

Consistent with the description put forth by the National Association of Clinical Nurse Specialists, CNSs have many spheres of practice: working at the bedside with patients; consulting with colleagues and establishing nursing practice standards; and contributing to nursing policy and quality-improvement initiatives throughout the hospital community.

as MGH was a bit daunting. I'll never forget the interview process—it was the biggest group interview I'd ever had. Of course, that turned out to be a good thing, because when I started at MGH, many of the faces were familiar from my big group interview.

From the very first day of orientation, my preceptor, Joanne Empoliti, RN, was great. She introduced me to the MGH community. I gradually met the rest of the clinical nurse specialists, each with different specialties and bodies of knowledge. They were so welcoming and continue to be a source of great support. Working and interacting with the CNS group has reinforced the feeling that I'm in the right place.

Several months into this new position, I was thrilled to realize that though the role may be somewhat different from my past experience, the essential elements of the CNS role are the same. Consistent with the description put forth by the National Association of Clinical Nurse Specialists, CNSs have many spheres of practice: working at the bedside with patients; consulting with colleagues and establishing nursing practice standards; and contributing to nursing policy and quality-improvement initiatives throughout the hospital community. CNSs are a vital link in translating new research findings into practice and fostering evidence-based protocols. While enhancing both quality and patient safety, CNSs are integral members of the healthcare team, advancing healthcare delivery and driving innovation in a complex care environment.

I've seen many new initiatives since coming to MGH: EMAPPS, roll-out of the new patient controlled analgesia (PCA) pumps, and of course Excellence Every Day. In each and every undertaking, the CNS group shows the utmost collaboration and fellowship, continually looking for ways to improve outcomes and positively impact quality of care for patients and families. They are unwaveringly committed to supporting the great work that staff nurses do every day.

CNSs participate in a number of forums to discuss issues related to nursing practice (CNS group meetings, surgical CNS group meetings, the Wound Care Task Force, etc.) As a new clinical nurse specialist, I have benefited from their knowledge and expertise, ongoing staff mentorship, and support. They continuously come up with new ways to look at our practice.

I feel privileged to work with such an extraordinary group of CNSs, staff nurses, and support staff. The work would not be possible without the support of nursing directors and the entire Patient Care Services team. I look forward to our up-coming projects as we strive to achieve Excellence Every Day.

Over the past eight years, my CNS colleagues and I have been involved in developing the Neuro-Oncology program and ensuring safe, high-quality care for patients over the entire trajectory of their illness. Change is sometimes difficult, but CNSs are always evolving, always looking at the big picture, and always facilitating a shift to the desired outcome. I feel very lucky to work in an environment that values and supports the role of clinical nurse specialist.

First National CNS Week September 1-7, 2009

Celebrating 72,000 clinical nurse specialists
nation-wide

Clinical nurse specialists work:

- at the bedside to improve outcomes and evidence-based practice
- with other nurse colleagues to establish best practice models, create and monitor policies, and design nursing practice standards
- with other hospital leaders to enhance quality and patient safety

A clinical nurse specialist is:

- a nurse leader with a master's degree or doctorate in clinical nursing
- a clinical expert in a specialty area
- a vital link in translating new research into nursing practice at the bedside
- a pioneer in hospital programs that enhance quality and patient safety
- an essential resource to colleagues across disciplines
- an innovator who drives improvements in a complex environment
- a 'systems thinker' who looks at the big picture

Life lessons, clinical experience, intertwine for new therapist

Not two minutes into the conversation, Mr. L began to question my training and my ability to carry out interventions. As a new graduate with a barely-broken-in license, it wasn't difficult for Mr. L to rattle my confidence.

My name is Amanda Kunkel, and I am a relatively new physical therapist. I had many expectations prior to beginning my year-long internship at MGH in September of 2008. Though I had no prior clinical experience at MGH, I was very familiar with its strong reputation for medical care and clinical expertise from attending the MGH Institute for Health Professions and living in the Boston area. Throughout my internship, I realized the true meaning of that word, 'expertise,' and just how much it applies to the care physical therapists provide.

Mr. L is a 55-year-old professor and Navy commander, who, after a three-month stay in an ICU at another hospital, was admitted to MGH due to multiple unexplained complications, such as intestinal ischemia, following abdominal surgery.

Mr. L was evaluated by a physical therapist in the ICU here at MGH, then transferred to the unit where I was the primary therapist. The therapist who had evaluated Mr. L documented his long hospitalization. She let me know that Mr. L had been curious about the training physical therapists receive here and had many questions about the rationale behind his care. As a new clinician, this made me nervous.

The ICU therapist had noted a problem with Mr. L's ankle and suggested the use of serial casting versus a more dynamic splinting. Having never used serial casting, I sought out my clinical specialist, Bob Dorman, for insight on how this clinical decision is usually made. During this meeting, Bob and I decided it would be



Amanda Kunkel, PT, physical therapist

best for me to continue with the current plan of care and develop a rapport with Mr. L prior to making any changes. At the time, I thought this was good advice as it would give me time to conduct further testing and gather more data. I realize now how much more there was behind that decision.

Upon introducing myself to Mr. L, I was struck not only by his physical impairments, but by how intimidating he was as a person. Here was a patient, as vulnerable as a human being can be, receiving medication and nutrition through tubes, having to hold his hand over his tracheostomy site to speak clearly, and with barely the energy to sit on the edge of his bed. Yet somehow, he was one of the most intimidating people I'd ever met.

I told Mr. L I was the primary therapist on the unit and I'd be the one carrying out his physical therapy plan of care. Not two minutes into the conversation, Mr. L began to question my training and my ability to carry out interventions. As a new graduate with a barely-broken-in license, it wasn't difficult for Mr. L to rattle my confidence.

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In my first few weeks working with Mr. L, I struggled to find a balance between allowing him to maintain some control and using my own knowledge and skill to make changes in his plan of care. Mr. L did not have a definitive diagnosis for the eight weeks he spent on our unit. His medications had changed a number of times, and scans and lab tests were continually conducted in an attempt to find the underlying reason for his ischemia. He became frustrated with the many doctors overseeing his care and, what he considered, the overwhelming changes they were making. Mr. L insisted on a set schedule and became very impatient when things didn't occur precisely on his terms. For about a week, he became detached, keeping his eyes closed most of the time and declining to participate in therapy, saying he was too exhausted.

Almost eight weeks to the day after his admission, a definitive diagnosis was made re-directing Mr. L's medical care yet again. But because there was some certainty attached to this diagnosis, Mr. L's attitude changed almost immediately. He felt the many months he'd spent in the hospital now had meaning, and an appropriate plan of care was in place. He could see light at the end of the tunnel. Doctors predicted he would need another four to six weeks in the hospital, but at least there was an end in sight.

The improvement in Mr. L's psychological state led to improved participation in PT, but only at a shallow level. He participated, at times begrudgingly, with continued trepidation regarding the plan of care, and with little or no adherence to his independent exercise program. I spoke with Mr. L about the importance of doing exercises on his own for greater improvement and the need for him to take more responsibility for his own health. I continued to work with Mr. L five times per week. I re-evaluated him each week finding slight improvement in his impairments, but no large gain in his overall function. I again sought the help of my clinical specialist.

Bob read through my documentation, and we met to discuss what I felt were Mr. L's three main impairments, how I measured those impairments, and what interventions I was using to try to help. Through my conversation with Bob, I realized a large part of the challenge I was experiencing with Mr. L wasn't in determining what I wanted to work on and how. The challenge was involving Mr. L in those decisions. Bob accompanied me to a treatment session, and we broached the subject of Mr. L's physical therapy goals. He didn't have all the answers that day, but that conversa-

tion changed the dynamic between us. I realized that while I thought I had been allowing Mr. L to maintain some control, I had really been giving up my own control over the sessions. Mr. L needed to articulate our long-term goals in order for me to truly involve him in his physical therapy plan.

Mr. L had been in the hospital for five months. For five months, he hadn't been home with his family. For five months, he'd needed assistance to get out of bed. He hadn't been able to engage in his hobbies, life work, or daily routines. For five months, he didn't know if he'd ever return to his former life. And for those five months, I had no way of knowing if certain goals were realistic or not. I had made the decision early on that Mr. L would need rehab. Now that there was a four-to-six-week time frame, I realized those four to six weeks would constitute Mr. L's rehab—right here at MGH.

Mr. L began using the stationary bike for aerobic conditioning. Prior to his illness, he rode a stationary bike and reported that he enjoyed bike-riding outside, as well. He started using the stairs as an additional mode of aerobic exercise, one that is functional and necessary for his return to the community. We continued to work on his posture, range of motion, strength, and his personal goal of being able to return to work as a professor and Naval officer. He now saw our work together as a means to an end rather than endless exercises and chores with no benefit.

I learned so much from my interactions with Mr. L, it's difficult to fit it all in one narrative. I learned about the importance of prioritizing the patient's impairments and how those priorities change over time. I learned the importance of providing truly patient-centered care. I learned that communication, like every other PT intervention, must change as the patient changes. And above all, I learned to look at the patient as a whole instead of the sum of his impairments.

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

As clinicians, we bring knowledge, skill, and experience to every patient-care situation. But as this narrative demonstrates, it is the patient's own willingness, ability, and involvement that allows a therapeutic partnership to develop. Mr. L taught Amanda many lessons that will enrich her practice and benefit future patients. Perhaps Amanda also taught Mr. L something about working together to achieve common goals.

Thank-you, Amanda.

We continued to work on his posture, range of motion, strength, and his personal goals of being able to return to work as a professor and Naval officer. He now saw our work together as a means to an end rather than endless exercises and chores with no benefit.

Ben Corrao Clanon Memorial Scholarship

—by Mary Ellin Smith, RN, professional development coordinator

On August 27, 2009, Sheila Grimmel, RN, became this year's recipient of the Ben Corrao Clanon Memorial Scholarship, an award given annually by Regina Corrao and Jeff Clanon in memory of their son, Ben, who was a patient in Newborn Intensive Care Unit in 1986. Ben would have turned 23 this year. The award recognizes a NICU nurse selected by his/her colleagues, who demonstrates exemplary practice, a commitment to primary nursing, and on-going support and advocacy for patients and families.

NICU nursing director, Peggy Settle, RN, described Grimmel as having the exquisite ability to partner with families in even the most challenging situations. In their remarks, Corrao and Clanon described the stress, anger, and anxiety inherent in any NICU hospitalization



(Photos by Paul Batista)

and how important it is for staff to be able to help families cope. Grimmel, surrounded by friends and family members, thanked her colleagues for the honor of being recognized.

For more information about the Ben Corrao Clanon Memorial Scholarship Award, contact Peggy Settle, RN, at 6-9340.

At left (l-r): Regina Corrao; Jeff Clanon; award recipient, Sheila Grimmel, RN; nursing director, Peggy Settle, RN; and associate chief nurse, Debra Burke, RN, at award ceremony in the NICU.

Above: Grimmel accepts award.

What our colleagues are saying about the Joint Commission survey...

“You should be very proud of your staff. They did a fabulous job. They were impressive, eloquent, and professional. Their care and compassion for their patients and for each other came through loud and clear.”

—Mel Heike, RN, staff specialist (in an e-mail to the leadership of the Phillips House 22 General Surgical Unit)

“The woman from the Joint Commission made me feel so proud. It was the way she talked to me, telling me my unit looked so clean and I was doing a great job. She tried to shake my hand, but I had my gloves on. I tried to take them off, but she stopped me. She understood. She was such a nice, regular person.”

—Aclouse Augustin, unit service associate

One surveyor asked Anais, a new therapist about her orientation to MGH. Anais beautifully articulated her entry into practice here noting the strong support and mentorship she received. At the end, the surveyor told Anais what a wonderful job she was doing, especially considering she'd only been here for five weeks.”

—Jackie Mulgrew, PT, physical therapy clinical specialist

“From the minute the surveyors arrived on our unit, they went out of their way to put us at ease. As we began the review of the patient's record, it felt like she was asking us to share our practice, not quizzing or interrogating us. Surveyors seemed genuinely interested in learning more about how we provide safe, quality care to our patients.”

—Susan Morash, RN, nursing director

“They were tough, but fair. Surveyors were skilled professionals who knew what they were looking for. And staff subscribed to the same high standards. It was the first time I experienced that mutual respect between surveyors and clinicians. You could see how both sides were committed to bringing excellence to every patient encounter.”

—John Murphy, RN, Quality & Safety staff specialist

“The Joint Commission Survey was vigorous. There was much enthusiasm on both sides of the review. Because of Excellence Every Day, we were prepared.

—Maureen Hemingway, RN, Excellence Every Day champion

“I'm brimming with pride over the confidence and willingness of staff to participate in the survey. Some units were so eager to show off, they were actually disappointed that they weren't visited.”

—Gerry Cronin, operations manager

It was the best prepared Chaplaincy has ever felt for a Joint Commission visit. We proudly saw the Excellence Every Day culture in the inter-disciplinary and compassionate care provided to all patients and families. It's becoming second nature.

—Michael McElhinny, MDiv, director of Chaplaincy

“I sensed a growing confidence in staff each day... colleagues seeing one another in the hallway and flashing a 'thumbs up!' A hug in the Coffee Central line, whispering, 'We did it !'”

—Pat Rowell, disabilities awareness project manager

“The mission of MGH came alive during the Joint Commission visit. They saw an inter-disciplinary team that was laser-focused on patients and families.”

—Gaurdia Banister, RN, executive director, PCS Institute for Patient Care

“Collaboration! Clearly the reviewers were interested in discussing in a collaborative manner how we provide excellent care every day. More importantly, staff educated reviewers on how excellent care should be provided every day. I'm very proud of how our staff showcased their best practices.

—Bob Kacmarek, RRT, director, Respiratory Care

Announcements

We're all responsible for the patient experience

How would you complete the following sentences?

- I show respect by...
- I anticipate needs by...
- I communicate and inform by...
- I show responsiveness by...
- I show pride in our environment by...

Send your responses to:
mgchahps@partners.org

Those who submit responses by September 18, 2009, will be entered in a raffle for a chance to win an iPod Touch.

Thank-you for owning the patient experience at MGH.
For more information, call Richard Corder at 4-2832.

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.

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.

Research Nurse Roundtable

Tuesday, September 22, 2009
12:15-1:15pm
Garrod/Mendel Conference Room
Simches Research Building
Lunch will be provided

The Research Nurse Roundtable provides a forum for nurses who work in clinical research to discuss issues common to their practice.

The Roundtable meets once a month and is led by experienced research nurses in collaboration with the MGH Clinical Research Program Education Unit.

For more information about the Research Nurse Roundtable, contact Linda Pitler, RN, at 3-0686.
To register, contact Hillary Dearborn 6-3310.

Sponsored by the MGH Clinical Research Program.

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 Development
6-3111

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

Next Publication
October 1, 2009

Educational Offerings – 2009

September

24

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

September

25

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

September

29

Oncology Nursing Concepts
Yawkey 4-820
8:00am–4:00pm
Contact hours:TBA

September

29

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

September

30

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

October

1

BLS/CPR Certification for Healthcare Providers
Founders 325
8:00am–2:00pm
No contact hours

October

1

Management of Patients with Complex Renal Dysfunction
Founders 311
8:00am–3:30pm
Contact hours:TBA

October

1

Neuroscience Nursing Certification Course
O'Keefe Auditorium
8:00am–4:30pm
Contact hours TBA

October

2

PALS Instructor Class
Simches Conference Room 3-120
7:30am–4:00pm
No contact hours

October

5

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

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

21

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

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

Safe Patient-Handling Fair

October 1st under the Bulfinch Tent

—submitted by Tucker O'Day, program manager, Ergonomics

The second annual Safe Patient-Handling Fair, to be held Thursday, October 1, 2009, under the Bulfinch Tent, is intended to promote health and safety for patients and caregivers alike. Manual handling of patients can contribute to back and shoulder strains for caregivers and create discomfort for patients. The

fair, hosted by The Norman Knight Nursing Center for Clinical & Professional Development, Occupational Health Services, and Partners Healthcare Ergonomics, will present options for handling patients safely and comfortably while protecting staff from injury.

The fair will offer demonstrations of equipment, such as motorized transport chairs, bariatric machines, inflatable

fall-prevention devices, and slings that work in conjunction with ceiling lifts to make lifting easier for caregivers and less stressful for patients. Whole Foods is providing snacks, and attendees will be able to get a flu shot during the fair. All attendees who visit at least three exhibits will be entered into a raffle to win a Wii console and Wii Fitness software.

The Safe Patient-Handling Fair will be held from 11:00am–2:00pm and 3:00pm—5:00pm Thursday, October 1st. For more information about the fair or the equipment to be featured, contact Tucker O'Day, program manager for Ergonomics, at 6-6548.



At last year's Safe Patient-Handling Fair, staff got hands-on experience with patient-transfer equipment.

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Boston, MA 02114-2696

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