

Caring

Headlines

September 3, 2009

Patient care associates *valuable members of the healthcare team*



See story on page 4

During recent PCA educational session, professional development specialist, Roberta Raskin Feldman, RN, shows Ellison 14 Hematology-Oncology Unit patient care associate, Karen DiGilio, how to disconnect a short peripheral IV line.

Patient and family advisory councils

one more way to ensure the patient's voice is heard

It is implicit in our mission that our work, our care, and our decisions be guided by the needs of our patients. But to truly be guided by the needs of our patients, we must first *listen* to them.

In my last column, “The patient experience: the driving force behind patient care,” (August 20, 2009) I spoke about the importance of listening to our patients to gain a deeper understanding of what they experience while in our care. It is implicit in our mission that our work, our care, and our decisions be guided by the needs of our patients. But to truly be guided by the needs of our patients, we must first *listen* to them.

Through a variety of tools and surveys, we have access to patient-satisfaction data and feedback from patients about what we’re doing and how we can improve. The H-CAHPS, for example (Hospital-Consumer Assessment of Healthcare Providers and Systems) and other data-collection instruments help us tap into information about how patients perceive their experience of care. And this is helpful in informing our decisions about how to prioritize our time and resources.

Another way we ensure our patients’ voices are heard is by inviting them to participate in patient and family advisory councils. Patient and family advisory councils bring together clinical and administrative staff, patients, and family members to talk about issues relevant to the patient’s experience. These councils advise hospital leadership on matters relating to patient-provider relationships, safety, quality improvement, patient education, and other issues they may deem relevant to patient care.



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

Most patient and family advisory councils are comprised of some combination of direct caregivers, support staff, administrators, former patients or family members, parents of pediatric patients, and/or members of the community. Membership or length of participation on patient and family advisory councils varies, and members are not compensated or reimbursed for their participation.

MGH has long recognized the value of patient and family advisory councils, so we’re ahead of the curve in meeting the Massachusetts Department of Public Health’s directive for hospitals to establish patient and family advisory councils by October 1, 2010. The new regulation requires hospitals to report annually on the progress and accomplishments of their advisory councils and to make these reports available to the public and to the Health Department upon request.

continued on next page

We applaud the new legislation encouraging the creation of patient and family advisory councils because we know first-hand the benefits of partnering with our patients. We are grateful for their participation and the positive impact their voice has had on care delivery and the patient experience.

One of the longest standing advisory councils at MGH is the MassGeneral Hospital for Children’s Family Advisory Council, which was formed in the fall of 1998 to foster alliance between parents, children, and professionals and to reinforce a spirit of responsiveness to the needs of pediatric patients and their families. Among its many accomplishments, the Family Advisory Council has established an on-line website for frequently asked questions; produced instructive videos for medical residents and inpatient staff; participated in pain initiatives and research studies; and consulted on the design of the pediatric emergency department.

In November, 2001, the MGH Cancer Center created an advisory council that is today comprised of six staff members, five family members, and 16 patients of diverse ages, diagnoses, socio-economic status, and life experience. The group meets an average of once a month for two hours with agenda items suggested by staff, patients, and family members alike. With a focus on learning and sharing information, the Cancer Center Patient and Family Advisory Council has helped to formally integrate the patient-family experience into teaching, training, building design and patient care, and serves as a model for other advisory councils both within and outside of MGH.

In 2007, the MGH Heart Center established a patient and family advisory council currently comprised of four MGH staff members and 11 patients and family

members. The council has had input into patient-education initiatives, customer service and patient satisfaction projects, and efforts to enhance patient- and family-centered care. Their future work will focus on the creation of disease-specific support groups and providing input into patient-education tools, continuity of care initiatives, staff orientation, and multi-disciplinary education within the Heart Center.

Of note, the Maxwell & Eleanor Blum Patient & Family Learning Center makes use of a patient and family advisory council to provide feedback on its many services, to field-test educational materials, and to guide decisions around educational programs, information displays, and acquisition of new materials.

These are just some of the advisory councils at MGH that enlist the involvement of patients and family members. We applaud the new legislation encouraging the creation of patient and family advisory councils because we know first-hand the benefits of partnering with our patients. We are grateful for their participation and the positive impact their voice has had on care delivery and the patient experience.

Update

I’m pleased to announce that Karen Waak, PT, has assumed the position of inpatient physical therapy clinical specialist covering the Ellison 4 Surgical Intensive Care Unit, and the Ellison 7, White 7, and Bigelow 7 surgical patient care units.

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Opportunities abound for patient care associates

—by Sheila Golden-Baker, RN; Mary O'Brien, RN; Roberta Raskin Feldman, RN; Sheila Burke, RN; and Phil Waithe, RN

Recognizing the invaluable contributions of this important role group, staff of The Norman Knight Nursing Center for Clinical & Professional Development have designed a comprehensive program to support the on-going growth and learning needs of these pivotal caregivers.

Patient care associates (PCAs) are integral members of the healthcare team at MGH. Providing 'hands-on' care to our patients, PCAs work in tandem with professional nurse colleagues to meet the myriad, complex needs of patients and families. Recognizing the invaluable contributions of this important role group, staff of The Norman Knight Nursing Center for Clinical & Professional Development have designed a comprehensive program to support the on-going growth and learning needs of these pivotal caregivers. Some of the programs available to PCAs include:

The re-designed PCA Orientation

In June of 2008, a new and improved PCA Orientation Program was launched to meet the current needs of PCAs. The program focuses on core skills such as utilization of 12-lead EKGs and phlebotomy and new skills such as pulse oximetry, using Guldman ceiling lifts, and best practices in the care of older adults. Designed with input from nursing leaders and informed by the results of a national survey, the program allows PCAs to spend more clinical time on their unit under the guidance of a preceptor. Response to the re-designed PCA Orientation has been very positive.

The PCA Educational Series

Launched in January of 2009, Promoting Patient Care Success through Learning: an Educational Series, is a monthly, one-hour, educational program that focuses

on the patient experience and reviews common clinical conditions that PCAs are likely to encounter. (Alison Daley, PCA on the Ellison 9 CCU, won a contest entitling her to name the series.) Select programs are offered on evenings and weekends to reach a broader group of PCAs.

The PCA Preceptor Course

The PCA Preceptor Course provides PCAs with the tools they need to serve as mentors and preceptors for incoming PCAs. The program is designed for PCAs currently serving as preceptors or those who may do so in the future. The course is offered twice a year.

OA/PCA/USA Connections

This monthly education program provides support staff with information on a broad range of topics, such as "Your Role in Code Blue." Programs are offered for day-, evening-, and night-shift employees. All sessions have been well attended and positively received.

Recently, senior vice president for Patient Care, Jeanette Ives Erickson, RN, and the department of Nursing initiated the PCA Perceptions of the Work Environment Survey. The survey was designed to provide leadership with feedback about the work experience of PCAs. The survey will help inform on-going efforts to ensure PCAs receive the most timely and relevant educational opportunities to continue to be effective and satisfied in their roles.

For more information on any of these programs, call professional development specialist, Sheila Golden-Baker, RN, at 6-1343.

Privacy and security

Understanding your responsibility and the ramifications of breaches

With faster, more advanced technology comes increased opportunity for identity theft and breaches of privacy and security. Staff can help minimize the threat of security breaches by using two identifiers to ensure patients are who they say they are, and by keeping a close eye on patients' protected health information. The MGH Privacy Office is your partner in keeping patient information private and secure.

A number of practices are reported to the Privacy Office. And while I'm sure they're unintentional violations of confidentiality, they are violations nonetheless, and staff need to be aware of the potential ramifications.

Question: What are the most common breaches of confidentiality here at MGH?

Jeanette: A number of practices are reported to the Privacy Office. And while I'm sure they're unintentional violations of confidentiality, they are violations nonetheless, and staff need to be aware of the potential ramifications. Some violations include:

- protected health information deposited un-shredded into waste baskets
- computers left on and unlocked
- faxes sent to wrong numbers
- protected health information left in conference rooms after meetings or rounds
- clinicians accessing the medical records of patients no longer under their care
- inadvertently passing patient information to someone else

Question: How does the new American Reinvestment and Recovery Act relate to these issues?

Jeanette: The American Reinvestment and Recovery Act, more commonly known as the economic stimulus package, strengthens the language and enforcement of HIPAA regulations. Specifically:

- breaches of confidentiality are to be reported to all individuals whose protected health information has been violated
- criminal penalties will be applied to individual employees responsible for breaches in confidentiality

Question: What's the most important thing you can do to prevent a breach?

Jeanette: The pace of work is demanding, but taking the extra minute to check a name, medical record number, or address can prevent mistakes.

- Don't take protected health information out of the hospital
- Don't use personal e-mail (outside of Partners.org) to transfer information unless you know it's okay with the patient and you've documented his/her approval
- Double- and triple-check fax numbers before faxing any private health information
- Encrypt your PDAs, laptops, and USB sticks

Question: Who should we contact if we become aware of a breach in confidentiality?

Jeanette: Contact the Privacy Office at 6-6360 if you suspect a breach. The sooner a breach is reported, the easier it is to conduct a thorough investigation and get accurate facts. The Privacy Office is also available to assist with clarification of HIPAA policies.

‘Everlasting connections’ keep human spirit strong

By the time he left that first day, he had a better understanding of his treatment plan and was much less fearful. I felt an instant connection with Mr. B. We were a team from the very beginning.

My name is Elizabeth Favulli, and I am a staff nurse on the Yawkey 8 Infusion Unit. When I met Mr. B for the first time, little did I know his six-month prognosis would stretch into 14 months and include a wedding, an anniversary, grandchildren’s birthday parties, cook-outs, cherished holidays, and treasured time with his family.

The first day Mr. B presented for his chemotherapy treatment, he was restless and apprehensive. He had no idea what to expect. It was up to me to help him get through this difficult day and the months ahead. We sat and talked about the treatment plan, his fears, hopes, and needs. He wanted to feel better so he could enjoy the family he so adored. By the time he left that first day, he had a better understanding of his treatment plan and was much less fearful. I felt an instant connection with Mr. B. We were a team from the very beginning.

Mr. B’s case was complex. He had a large mass on his left kidney and the cancer had spread to his liver, lungs, and lymph nodes. The plan was to initiate a combination of IV and oral chemotherapeutic agents. His tumor was so large and vascular that he required weekly blood transfusions and injections to maintain a safe hematocrit. He had felt dizzy and fatigued for months. Because his venous access was so poor, I en-



Elizabeth Favulli, RN, staff nurse
Yawkey 8 Infusion Unit

couraged him to have a port-a-cath placed to save him the discomfort of numerous attempts to insert an IV line. This would lessen the stress of coming in for treatments. He agreed.

The metastatic renal-cell carcinoma was so aggressive it affected Mr. B’s electrolytes. His calcium level was high so he was given Zometa and Pamidronate to reduce the serum levels, and he required pain management for tumor-related discomfort.

Mr. B’s condition was considered so advanced at the time of his diagnosis that his daughter moved her wedding date up to ensure her father would be able to attend.

Mr. B wanted to walk his daughter down the aisle no matter what it took. As the wedding approached, we did everything we could to make sure he was feeling well. We kept him hydrated, gave him blood transfusions, and allowed him to take a break from chemotherapy before the big day. Mr. B was more fatigued than he was when he initially arrived, and he had be-

continued on next page

come wheelchair-bound. But on the day of the wedding, he stood up from his wheelchair and danced with his daughter. I wasn't at the wedding, but the image of Mr. B dancing with his daughter will stay in my heart forever. I felt a sense of accomplishment. I had helped him survive and achieve this important goal. I had so much admiration for his determination and resilience.

Mr. B's life revolved around his family. His favorite thing was to have a house full of people. On the 4th of July, he had a cook-out at his home with more than 40 people. His face lit up when he talked about the Italian food his wife prepared. He loved her so much. He'd say, "She makes the best gravy. You have to try her lasagna!" I laughed every time his Italian face lit up as he talked about food and his wife's cooking. Even on his worst days, the infusion unit was brighter the moment he entered. Being part of Mr. B's life made me smile, in spite of the circumstances.

After a few months, things changed. Mr. B became angry, frustrated, and upset. He was told he probably wouldn't live to have Thanksgiving with his family. He was depressed and hopeless as palliative care was introduced. He wanted to stay in bed due to his increased vertigo and fatigue. He had developed a number of side-effects, including mouth sores, increased pain, loss of appetite, and dehydration. He was so unsteady, he fell several times at home necessitating the fire department coming to help him up. Eventually he was transferred to a nursing home because he required more medical attention than he could get at home.

At the nursing home, he developed a necrotic ulcer on his heel for which he received IV antibiotics. All he wanted was to be home with his family. His body became weaker as the days progressed but his spirits remained high.

Surprising his medical team, Mr. B made it home for Thanksgiving. His urge to live was renewed, and he set a new goal to spend Christmas with his grandchildren. He was told not to plan on it, but he didn't give up. When Christmas and New Year's came and went, Mr. B set his sights on his birthday in February—and a trip to Foxwoods. Once again, his doctors said it was an unrealistic goal, and once again, he proved them wrong. Mr. B went to Foxwoods with his family and friends, enjoying dinner and a night at the casino. He was a winner at the casino and a winner with the goals he set for himself.

Finally, Mr. B's body just couldn't take any more. The cancer spread to his brain. It was time for hospice. I, along with his doctors, nurse practitioner, social

worker, and palliative care nurse, helped individualize a plan of care to support Mr. B at the end of his life. I helped educate and assist family members so they could care for Mr. B at home during the last few months of his life. That's where he wanted to be; that's where he was happy. I, along with his other MGH caregivers, showed Mr. B's family how to meet his needs. His wife, daughter, and sons learned to use the Hoyer lift, give injections, manage his medications, and control his pain. Soon, his MGH team transferred Mr. B into the care of his family.

I watched as the B family incorporated the dying process of their loved one into their daily activities. Yes, dying is a process, but living happens along the way. Mr. B's spirit was so strong, he was able to take part in many family events. We instilled hope in each other as we continued to talk regularly. We believed in each other. I last saw Mr. B when he came in for his blood transfusion. When I said good-bye that day, I didn't expect it to be the last time. He had proven us wrong so many times before.

Mr. B was 62 years old when he died. I was fortunate to be able to attend his funeral service, where I heard the most beautiful eulogy describing his life. Mr. B and I had grown and learned together. We learned that statistics can be wrong. We learned how important hope, faith, and love are when dealing with terminal illness. I am so sad Mr. B is no longer here, but happy when I think of his amazing spirit. It was a privilege to have known him. He was always so appreciative of every little thing I did for him. I hope he knows how much I learned from him. The connections we make with the people we care for are everlasting. Hope and the human spirit prevail.

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

As with any terminal illness, patients and families want to make the most of the time they have together. Through constant support and understanding, Elizabeth helped Mr. B and his family reap every last moment of joy and fulfillment. From enabling him to participate in his daughter's wedding to educating the family around end-of-life care, Elizabeth was a constant source of help and reassurance. Life is full of surprises. Thanks to Elizabeth and her colleagues, Mr. B and his family were able to enjoy some unexpectedly enriching final days.

Thank-you, Elizabeth.

Mr. B and I
had grown and
learned together.
We learned that
statistics can be
wrong. We learned
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are when dealing
with terminal
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Professional Achievements

Romano inducted

Maryalyce Romano, RN, staff nurse on the Ellison 11 Cardiac Interventional Unit, was inducted into the Pi Epsilon chapter of Sigma Theta Tau International, in July, 2009.

Cohen appointed

Elaine Cohen, RN, professional development manager; The Yvonne L. Munn Center for Nursing Research, was appointed a consultant to the newly-formed Center to Champion Nursing in America, in Washington, DC, on July 29, 2009.

Duffy, certified

Catherine Duffy, RN, Palliative Care Services, became certified as an advanced hospice and palliative nurse, by the National Board of Certification of Hospice and Palliative Nurses, in June, 2009.

Stefancyk certified

Amanda Stefancyk, RN, nursing director; White 10 General Medicine, became certified as a nurse manager and leader by the AONE Credentialing Center and the AACN Certification Corporation, in July, 2009.

Transplant Center recognized

The MGH Transplant Center received the Silver Award in Patient Education for its patient-education booklet, *Transplantation: What do I Need to Know?* from The Health Information Resource Center in Libertyville, Illinois, in June, 2009.

Coakley publishes

Amanda Coakley, RN, staff specialist, authored the book, *Exploration of Energy Expenditure Between Provider and Recipient of Therapeutic Touch (TT) Treatment and Response to (TT) on Healthy Individuals*, in Germany, in 2009.

Nurses publish

Eileen Stuart-Shor, RN, and Susan Stengrevics, RN, authored the article, "Preventing the Progression of Heart Failure from Syndrome to Disease: if not You, Who?" in the June, 2009, *Progress in Cardiovascular Nursing*.

Coakley and Mahoney publish

Amanda Coakley, RN, staff specialist, and Ellen Mahoney, RN, senior nurse scientist, authored the article, "Creating a Therapeutic and Healing Environment with a Pet Therapy Program," in, *Complementary Therapies in Clinical Practice*, in August, 2009.

Singer publishes

Marybeth Singer, RN, staff nurse, Gillette Center for Women's Cancers, authored the article, "The Impact of Co-Morbid Illness and Lifestyle in the Multi-Disciplinary Management of Lymphedema: a Case Approach," in the NLN Newsletter, *Lymph Link*.

Singer also wrote, "Lymphedema in Breast Cancer: Dilemmas and Challenges," in the *Clinical Journal of Oncology Nursing*.

Inter-disciplinary team publishes

Patricia Dykes, RN; Diane Carroll, RN; Ann Hurley, RN; Angela Benoit; and Blackford Middleton, MD, authored the article, "Why do Patients in Acute Care Hospitals Fall? Can Falls be Prevented?" in the July-August, 2009, issue of the *Journal of Nursing Administration*.

Banister presents

Gaurdia Banister, RN, executive director; The Institute for Patient Care, presented, "The Institute for Patient Care: Advancing Clinical Excellence Through Collaboration, Education and Research," at the National Black Nurses Association Conference, in Toronto, August 4, 2009.

Oertel presents

Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Services, presented, "Optimizing Warfarin Therapy: Strategies for Success," as part of the Bermuda Hospital Teleconference Series, June 30, 2009.

Professional development specialists present

Professional development specialists, Laura Sumner, RN, and Sheila Burke, RN, presented, "Evaluation of Basic Arrhythmia Knowledge Retention and Clinical Application by Registered Nurses," at the National Nursing Staff Development Organization Conference in Philadelphia, July 11, 2009.

Clinical Recognition Program

Clinicians recognized May-July, 2009

Advanced Clinicians:

- Patricia Bergschneider, RN, Vascular Surgery
- Elzbieta Gilbride, RN, General Medicine
- Jennifer Robinson, RN, Neuroscience Critical Care
- Jayne Hill, RN, Radiation Oncology
- Colleen Arsenaault, RN, Emergency Department
- Karen Waak, PT, Physical Therapy
- Jennifer Mello, SLP, Speech Language Pathology & Swallowing Disorders
- Margaret Callen, RN, Psychiatry
- Kathleen Selleck, RN, Radiation Oncology
- Amy Hanson, PT, Physical Therapy
- Erin Sinclair, RN, Cardiac Intensive Care
- Heather Robertson, RN, Oncology/Bone Marrow Transplant

Clinical Scholars:

- Colleen Lowe, OTR/L, Occupational Therapy
- Carol Harmon-Mahony, OTR/L, Occupational Therapy

Process improvement

What is it, and why is it important?

Process Improvement is ongoing. It is a method of constantly seeking to identify and reduce waste and inefficiency in our work... By reducing waste and inefficiency, we improve the hospital experience for patients, families, and staff.

Question: I've been hearing people talk about process-improvement initiatives in their departments. What does that mean? Is it a hospital-wide initiative?

Jeanette: MGH has a rich history of process improvement. We continually seek to improve ourselves and our organization. Process improvement is a tool that help us meet our goals related to quality, safety, service, and efficiency.

Process Improvement is ongoing. It is a method of constantly seeking to identify and reduce waste and inefficiency in our work. As such, it is never 'done.' By reducing waste and inefficiency, we improve the hospital experience for patients, families, and staff.

Question: What is the 'process' for process improvement?

Jeanette: Once a specific project is identified, an interdisciplinary team is formed to study the process. Any steps identified that don't add value are eliminated. Critical to success is ensuring that those most knowledgeable about the process are empowered to design and implement the improvements. The team is guided by trained facilitators and supported by executive sponsors and others who help remove barriers to ensure success. This work requires a commitment from everyone associated with the process and relies heavily on input from staff and employees at all levels.

Coordinated by Mary Cramer, Process Improvement program director, approximately 45 MGH staff members have received training in the techniques of facilitating process-improvement projects. The effort is on-going, and more people are being trained to assume these roles.

Question: What is the primary focus of process improvement?

Jeanette: Our focus is always to improve the experience for our patients, families, and staff. Our mission statement says we are, "guided by the needs of our patients and their families." Process improvement involves everyone at MGH. With an emphasis on quality, safety, service, and efficiency, we are being thorough and systematic in identifying, evaluating, and improving the systems and processes that affect patient care and patient satisfaction (such as access to care and length of stay).

Process improvement initiatives are intended to make workflow as smooth and efficient as possible so patients experience care that is both seamless and satisfying.

Question: Is process improvement about downsizing?

Jeanette: Process improvement is about better care delivery and higher-quality service. It's about patient safety and improving patient- and staff-satisfaction. It is not about reducing staff or assigning blame. The focus is on improving processes from the perspective of those closest to the work.

Process improvement is a collaborative effort designed to eliminate unnecessary tasks so we can do what we come to MGH every day to do—take care of patients.

For more information on any of our process improvement initiatives, contact George Reardon, director, PCS Clinical Support Systems, at 4-5952.

Announcements

New Perspectives on Mind and Body

2009 MGH Nurses Alumnae Fall Reunion Educational Program co-sponsored by the MGH Institute of Health Professions School of Nursing

Friday, September 25, 2009
Simches Auditorium
8:00am-4:30pm

\$20 before July 1, 2009
\$30 after July 1, 2009

6 nursing contact hours

Must register by
September 11, 2009

For more information,
call 6-3114.

Third annual Care of the Patient with Vascular Disease Conference

Session 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
6-3111

Bill Kneeland memorial service

There will be a memorial service to celebrate the life of Bill Kneeland, RN, staff nurse, who passed away earlier this summer. Friends, family, and colleagues are invited to attend.

Wednesday
September 16, 2009
2:00pm
MGH Chapel

For information, contact Kathleen
Stakes, RN, at 6-7505

First National CNS Week September 1-7, 2009

Celebrating 72,000 clinical nurse
specialists across the nation

Clinical nurse specialists work:

- at the bedside to improve outcomes and evidence-based practices
- 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

Jeremy Knowles Nurse Preceptor Fellowship

Call for Applications

Applications are now being accepted for The Jeremy Knowles Nurse Preceptor Fellowship. The fellowship recognizes exceptional preceptors for their excellence in educating, inspiring and supporting new nurses or nursing students in their clinical and professional development.

The one-year fellowship provides financial support to pursue educational and professional opportunities.

Applications are due
by September 8, 2009.

For more information, contact
your clinical nurse specialist or
Mary Ellin Smith, RN,
at 4-5801.

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
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6-3111

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Publisher

Jeanette Ives Erickson, RN
senior vice president
for Patient Care

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Gaurdia Banister, RN

Volunteer Services, Medical
Interpreters, Ambassadors,
and LVC Retail Services
Paul Bartush

Distribution

Ursula Hoehl, 617-726-9057

Submissions

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

Next Publication
September 17, 2009

Educational Offerings – 2009

September

9

BLS/CPR Certification for
Healthcare Providers

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

September

9

Pediatric Simulation Program

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

September

9

Nursing Grand Rounds

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

September

9

Nursing Research Committee's
Journal Club

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

September

10

BLS/CPR Re-Certification

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

September

11, 14, 15,
21, 25 & 29

Greater Boston ICU Consortium
Core Program

Faulkner Hospital
7:30am–4:30pm
Contact hours: TBA

September

14 & 21

ACLS Provider Course

Day 1: 8:00am–4:30pm
O'Keefe Auditorium

Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hour

September

15

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse

POB 448
11:00am–3:00pm
Contact hours: TBA

September

16

Simulated Bedside Emergencies
for New Nurses

POB 419
7:00am–2:30pm
Contact hours: TBA

September

17

Preceptor Development: Learning
to Teach, Teaching to Learn

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

September

17

Nursing Care for Respiratory-
Compromised Patients

Bigelow Amphitheater
12:00–4:00pm
No contact hours

September

21

Assessment and Management
of Psychiatric Problems
in Patients at Risk

O'Keefe Auditorium
8:00am–4:30pm
Contact hours: TBA

September

21 & 22

Intra-Aortic Balloon Pump

Day 1: VA Boston HealthCare
System, West Roxbury

Day 2: Founders 311
7:30am–4:30pm
Contact hours: TBA

September

22

Simulated Critical Care
Emergencies

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

September

23 & 24

PALS Certification

Simches Conference Room 3-120

Day 1: 7:45am–4:00pm
Day 2: 7:45am–3:00pm
No contact hours

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

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

Clinical Pastoral Education Graduation

—by Angelika Zollfrank, supervisor, CPE Program

On August 14, 2009, six chaplain interns graduated from this year's summer Clinical Pastoral Education (CPE) program. The group of theological students, seminarians, and clergy successfully completed an intensive, 11-week course spending a total of 300 hours providing pastoral care to patients and families and more than 100 hours in educational sessions. During five overnight on-call shifts, chaplain interns monitored intensive care units, responded to emergency calls throughout the hospital, and delivered prayers in response to

requests from the Same Day Surgical Unit. During their on-call shifts, the group responded to more than 260 requests and emergency calls and visited 68 patients prior to surgery.

Chaplains and chaplain interns provide spiritual care to patients, families, and staff of all religious traditions and to those with no specified religion or tradition. The graduation ceremony included prayers and readings from diverse religious traditions. Certificates were presented to graduates by Reverend Angelika Zollfrank, CPE supervisor, Michael McElhinny, director of Chaplaincy, and Ann Daniels, executive director of Social Services and the Chaplaincy.

The next Clinical Pastoral Education program will begin on January 11, 2010. The program will be tailored to healthcare providers

who wish to integrate spiritual caregiving into their clinical practice. Members of all faiths and those with no religious affiliation may apply. Through funding from the Kenneth B. Schwartz Center and the department of Nursing, six fellowships will be awarded. The deadline for applications is September 1, 2009. For information, contact Reverend Angelika Zollfrank at 4-3227.



Reverend Angelika Zollfrank (right) with members of the recent Clinical Pastoral Education graduating class

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