

# Caring

Headlines

December 16, 2010

## PT fund-raiser promotes exercise and spirit of giving



Families enrolled in the Power Up program participate in a yoga/relaxation class at the Chelsea HealthCare Center. (See story on page 5.)

# Looking back on 2010: a year of challenges and triumphs

When I think  
back on this year,  
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35 years.

**I**t seems like just yesterday that I sat down to reflect on our achievements for 2009, and here it is already the end of 2010. When I think back on this year, one of my most vivid memories is our survey by the Centers for Medicare and Medicaid Services (CMS), the first such survey in more than 35 years. I'm sure you recall their two-week visit in February when surveyors came to MGH to review our patient-care practices, policies, and procedures. This was a crucial survey as every hospital that receives payment for Medicare and Medicaid patients must comply with the Conditions of Participation set forth by the CMS. On June 16th, we received their final report issuing no citations serious enough to be considered a violation. I thank you again for your dedication to meeting and exceeding patient expectations and regulatory requirements.

I know we all recall with horror the devastating earthquake that struck Haiti in January killing hundreds of thousands and injuring thousands more. Our response to the tragedy was swift and unequivocal—with clinicians deploying to Haiti to provide much-needed medical care, and staff here at MGH rallying to support our Haitian colleagues. Our support of this embattled nation continues to this day.

On June 1st, our dear friend, director emeritus of The Center for Innovations in Care Delivery, Ed Coakley, RN, retired after a 39-year career as a staff nurse, nurse manager, and executive nursing leader. And Patient Care Services welcomed two new members to its leadership team: Robin Lipkis-Orlando, RN, our new director of the MGH Office of Patient Advocacy, and Zary Amirhosseini in the newly created role of disability program manager.



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

The Yvonne L. Munn Center for Nursing Research, sponsored a forum for doctorally prepared nurse researchers that attracted participants from across the country. The forum opened an important dialogue among nurse researchers about ways to advance nursing research across clinical and academic settings.

Our visiting scholar programs enjoyed a robust year with visits from Terry Foster, RN, from Saint Elizabeth's Medical Center in Kentucky; Patricia 'Pat' Reilly, RN, program director of Integrative Care at BWH; Debra Moser, RN, from the Center for Bio-Behavioral Research in Self-Management of Cardiopulmonary Disease at the University of Kentucky; and Nancy Fugate Woods, RN, from the University of Washington School of Nursing in Washington state.

We continued to advance our diversity agenda with the Hausman Fellowship and the Gil Minor Nursing and Health Professions Scholarship. Penny Mareng and Jason Villarreal were the 2010 Hausman fellows, completing an eight-week rotation to broaden their knowledge and leadership skills and explore the impact of cultural identity on patient care. I loved Penny's quote: "Two months ago I walked into MGH to inter-

*continued on next page*

view for the Hausman fellowship wearing the same outfit I have on today. The outfit may be the same, but the person inside is definitely not. We are forever indebted to the Hausman family for their investment in the lives of minorities students.” I echo that sentiment.

The Institute for Patient Care received funding to create a video-conferencing studio on Ellison 23. The project, called the Nursing Education Network Project, will give MGH its first audio-visual studio for nursing education capable of reaching staff on any device able to connect to the Partners intranet. The studio is scheduled to open in September of 2011.

Our Social Services department coordinated a 12-hour, clinical training program in Cognitive Behavioral Therapy for Social Workers in Hospital Settings; held an 8-week Crucial Conversations workshop to learn how to apply various conflict-management strategies to their clinical and inter-personal relationships; developed content and trained staff in suicide and homicide protocols to be in compliance with a new state law that gives clinical social workers authority to emergently hospitalize individuals in danger of causing harm to themselves or others.

This year, PCS piloted a new model for its award recognition program. Nominations for awards were solicited early in the year, and a single, multi-award, presentation ceremony, *One Celebration of Many Stars*, was held in October to honor the recipients. A standing-room-only crowd filled the Bullfinch Tent to see 12 deserving PCS employees accept their awards.

The Norman Knight Nursing Center administered its first-ever Evaluation of the Professional Learning Environment for Nurses, a comprehensive learning-needs assessment, the results of which will contribute to a new educational platform called Learning Bundles.

The Center for Innovations in Care Delivery conducted a pilot study to explore equine-assisted learning as a methodology to strengthen nurse presencing.

As part of a Sandbox Innovation Challenge, several inter-disciplinary teams brainstormed ways to safely reduce the use of in-dwelling Foleys to prevent urinary tract infections. In March, a team of nurses on the White 11 Medical Unit won that challenge reporting a 49% reduction in Foley usage on their unit.

With the help of the Ladies Visiting Committee, MGH opened a branch of the Images oncology boutique at The North Shore Cancer Center. The boutique offers patients on the north shore an array of wigs, prostheses, and other mastectomy products without having to travel into Boston.

The PCS Human Resources team hired a total of 627 new employees in fiscal year 2010.

More than 1,700 nursing students completed clinical rotations at MGH and affiliated health centers during this academic year.

As if that weren’t enough, I haven’t even mentioned our success in hand hygiene, pain-management, the cleanliness of patients’ rooms, pet therapy, gero-palliative care, advance-care planning, our new nurse-practitioner care model, the re-design of collaborative governance, and so much more. No wonder I look forward to coming to work every day; I am privileged and energized to be part of this extraordinary team.

We face some formidable challenges as we go into 2011, but I know with our collective wisdom, commitment, and ingenuity, we’ll have even more to celebrate next year. Thank-you for your passion and creativity; thank-you for making MGH the world-class institution it is.

Have a wonderful, safe holiday.

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# Why we do what we do

## *A nurse's Thanksgiving remembrance*

**M**y name is Lisa Carter, and I have been a nurse for more than 15 years. In that time, I have seen health care change dramatically. Patients are sicker. My days never seem to catch up with themselves.

I always wonder if I'll have time to truly get to know my patients. Technology is advancing at an astonishing rate. I know I have a commitment to give the best care I can, and sometimes that knowledge is stressful. Sometimes, I go home so tired it takes everything I have to put my kids to bed before passing out on the couch. Why do I do it? Why do *we* do it? Why do nurses come back day after day?

For me, the answer is the feeling you get when you make a difference in someone's life. I'll never forget last Thanksgiving. Yes, I would rather have been home with my family. But I had a liver patient in the ICU who was comatose. Her daughter had called several times then came in to check on her. I could see the stress in the daughter's eyes. I tried to comfort her, but the only person who could have done that was her mother. I spoke with the daughter for a while, and soon she left to go home to her Thanksgiving dinner.

One of my colleagues asked me to help her with a patient. I went into the room and found a young woman only a few years older than me sitting on a commode as if she were a 70-year-old woman who'd had a stroke. She began to tell me about her life. She told me she had been diagnosed with a brain tumor 13 years ago and was given only a year to live. She had undergone experimental chemotherapy and felt lucky to be alive. She had climbed Mount Washington and met the man who became her husband. She had had one child via C-section and adopted another. She felt fortunate to have such great friends and a family who supported her. I sat there and listened to her. With



Lisa Carter, RN, staff nurse

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each story, I became more and more amazed. I became more uplifted. Never did she talk about the fact that she was dying or the pain. It reminded me of the book, *Tuesdays with Morrie*. She was an inspiration. I told her mother what an extraordinary daughter she had, then I gave her a big hug and left the room feeling privileged to have met such an extraordinary person. I had so much joy in my heart, I didn't think it could get any better. But it did.

I went back to my comatose patient for hourly rounds. I had only been in the room a short time when all of a sudden she opened her eyes. She began tracking me. I spoke to her for a few minutes just to make sure I wasn't imagining it. Then I went to the phone and called her daughter. She cried when I told her.

"I'll be right there!" she exclaimed.

I left the hospital that night feeling as if I'd been given a gift. I went home and told my family I'd had the best Thanksgiving. This is just one example of why we do what we do. I feel truly blessed when people allow me into their lives. Every day I remind myself: "No matter how bad my day is, I'm not the one lying in that bed." Our patients deserve the best possible care, and that's why we come to work every day, that's why we do what we do. When it's my turn to be the one lying in the bed, I, too will want the best possible care. And if I come to MGH, I know that's what I'll get.

# PT gives as good as it gets

*Staff raise money to support Power Up, a program designed to fight childhood obesity*

**Below:** at the ceremonial check presentation are (l-r): Michael Sullivan, director; Physical and Occupational Therapy; Heidi Zommer, PT, senior physical therapist; and from the Chelsea HealthCare Center, pediatrician, Wanda Gonzalez, MD; physical therapist, Sofia Devine, PT; physical therapy clinical specialist, Marie Brownrigg, PT; and administrative director, Jeanette McWilliams. **At right:** children and family members do yoga as part of the Power Up curriculum.

For the past few years, a cornerstone of the annual Physical Therapy Month observance at MGH has been a service-oriented, fund-raising project to support a particular group or program that makes a difference in the lives of MGH patients. In the past, the Social Services Fund and the Avon Cancer Center have been recipients of Physical Therapy's fund-raising efforts. This year, in addition to impacting patients' social and medical needs, PT wanted to support a program that aligned with their own work to promote wellness and physical fitness. The Power-Up program seemed like the perfect fit.

Power Up is a nutrition and exercise program offered by the Chelsea HealthCare Center for overweight and obese middle-school students and their parents. Developed by pediatrician, Wanda Gonzalez, MD; nu-

tritionist, Jennifer Vetree, RD; community health educator, Ming Sun; physical therapist, Sofia Devine, PT, and others, the family-oriented program is designed to help children and parents make healthier dietary and exercise choices. With increased family participation, children have greater success attaining and maintaining a healthy lifestyle, which contributes to healthier weight. The program addresses several major causes of obesity, including excess consumption of soft drinks and other high-sugar beverages, excess food consumption, lack of physical activity, excess television viewing, and susceptibility to mainstream advertising.

Power Up provides children and parents with education in nutrition, lifestyle, and exercise that influences the choices they make regarding snacks, meals, leisure time, and physical activity. The five-week program empowers participants to take an active interest in and control over their weight and health. Because

the program combines education and actual physical exercise, children come away with a positive, knowledge-based outlook that they can sustain over time.

For more information about the Power Up program, or about Physical Therapy's annual fund-raising initiative, call 6-2961.



(Photo provided by staff)

# Treating edema: a delicate balance of meeting patients' needs and answering wishes

Four years ago, after recognizing a need for more specialized knowledge, I became a certified lymphedema therapist (CLT). Since then, I've had the opportunity to further develop my clinical skills and decision-making and share that knowledge with my colleagues.

**M**y name is Andrea Bonanno, and I have been a physical therapist for 12 years, the last seven solely on the Private Medicine Oncology Service caring for patients with either a primary oncologic diagnosis or adult patients admitted for management of acute medical issues.

I would like to share a story of a patient who had a lasting impact on my clinical practice. 'Sam' was a 50-year-old man with a history of non-small-cell lung cancer who was undergoing chemotherapy on an outpatient basis. He presented to his oncologist with complaints of pain and edema in his legs that had persisted for a couple of days. Diagnostic testing revealed deep venous thromboses (clots) extending from below his knees to his upper thighs. Sam was admitted and started on anticoagulation medication, but he continued to have pain and swelling and further testing revealed a worsening of his clots that required additional intervention. The vascular medicine team treated Sam with TPA (tissue plasminogen activator) and heparin via catheters to the involved veins and thrombectomies (removal of the clots) to break up the blockages and improve his circulation.

After almost three weeks and extensive treatment for his blood clots, I met Sam when a colleague requested my assistance in managing his edema. My knowledge and skill in examining and treating patients



Andrea Bonanno, PT, physical therapy clinical specialist

with edema have developed over the years as I've cared for more patients with oncology diagnoses. Four years ago, after recognizing a need for more specialized knowledge, I became a certified lymphedema therapist (CLT). Since then, I've had the opportunity to further develop my clinical skills and decision-making and share that knowledge with my colleagues.

Before I could determine whether Sam needed intervention, I needed to examine him and learn his history. Sam had been in treatment for cancer for two years. His past medical history did not reveal any predisposing risk factors (obesity, venous insufficiency, etc.) for developing edema, nor had he had surgery or radiation which could have impacted his lymphatic system. Based on his history and hospital course, I hypothesized that Sam's edema was due to the previous blockage of his lower-extremity veins (the blood clots), potential trauma to his veins during the procedure to remove the clots, and immobility from being hospitalized for three week.

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My experience treating Sam has stayed with me as I encounter more patients referred for management of edema. While understanding how edema can develop and how it can be treated is critical, understanding what's important to patients and families is equally important in developing an intervention plan.

Armed with a hypothesis as to why Sam's lower extremities were swollen I was ready to meet him and determine whether an intervention was warranted. In his hospital bed with his wife at his side, Sam shared that they lived with their three sons. Before being admitted, Sam had been able to perform all activities of daily living independently. He was still working full-time as an engineer, though he'd been working from home recently due to increased fatigue which he associated with his cancer treatment. While Sam gave an accurate history, his wife often expanded on the information he provided. She shared that their family had some upcoming events that were very important to them, including a family trip to Disney World and their eldest son's college graduation. I realized that Sam's wife was a source of support as well as a strong advocate for Sam, and she needed to be included in the decision-making process.

My clinical exam revealed that Sam's legs were swollen, but he had good blood flow to his legs as evidenced by palpable and strong pulses in his feet. Sam's skin and sensation were intact. He required assistance to transfer to and from bed and used a rolling walker to ambulate due to the increased weight of his legs from the edema. Given the impact the edema and procedure he'd undergone were having on his ability to function, I thought Sam should begin using compression to decrease the edema. This would allow him to walk and get in and out of bed with greater ease.

I shared my impression with Sam and his wife and recommended a trial of a multi-layer compression bandaging (a three-layer bandage assists in moving fluid back into venous circulation) in hopes of reducing the edema. Later, he could be fitted for compression stockings. I made this recommendation based on studies that show favorable results (a decrease in the size of swollen limbs) in patients who've undergone compression bandaging and were later fitted for compression garments. Compression garments should not be worn at night due to the increased compression caused by being in a supine position. Rather, a nighttime bandaging system (multi-layer) could be used to give the veins a 'break' from the constant pressure of a compression garment.

Sam and his wife were open to my thoughts regarding edema-intervention strategies, but their priorities were the upcoming vacation to Florida (where it would be hot!) and their son's graduation in less than a month. I realized that asking Sam to wear a three-layer bandage to Florida might interfere with his ability to enjoy

his family vacation. While going directly to a compression garment (skipping the bandaging step) would likely limit the amount of reduction in edema, I thought the benefit of being able to enjoy their vacation outweighed the risks. I made the necessary phone calls to arrange for Sam to be fitted for compression stockings, which he could wear on his upcoming trip. I initiated a multi-layer compression bandage, instructing Sam and his wife on how to apply the bandage for nighttime use. Sam's wife was a quick study. As I had recognized during my first meeting with them, she played an important role in the success of his edema-management program.

My experience treating Sam has stayed with me as I encounter new patients referred for management of edema. While understanding how edema can develop and how it can be treated is critical, understanding what's important to patients and families is equally important in developing an intervention plan. While Sam had expressed a desire to decrease the swelling in his legs so he could get in and out of bed and walk with greater ease, he was really more interested in spending time with his family during their upcoming vacation and graduation ceremony. Understanding those concerns drove me to take a non-traditional approach to his edema-management recognizing that he could follow up with traditional edema-management after those important events.

I often think of Sam and his wife when I'm examining and treating patients with edema. Every patient is unique. I need to make sure I hear their wishes and choose an intervention that's effective for their needs but also suited to their wishes.

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

With her years of clinical experience, Andrea knew that achieving the best outcome for Sam would involve partnering with him and his family to arrive at a solution that would meet his most pressing needs—even if he himself wasn't able to articulate those needs. Andrea listened. She 'heard between the lines.' She recognized the importance of the family trip and their son's graduation, and she tailored her intervention to meet those needs.

Andrea's knowledge of current treatment protocols and willingness to use a non-traditional approach gave Sam the ability to manage his edema and achieve his goals.

Thank-you, Andrea.

# How analyzing data translates to safe patient care

## *Understanding the work of the Patient Care Services Financial Management team*

*Question:* I know we classify patients in QuadraMed (formerly Medicus) every day. What is that data used for?

*Jeanette:* The single most important use of the data we gather using QuadraMed is quantifying patients' needs for care and ensuring that appropriate nursing resources are in place to effectively meet those needs. Data are also entered into our cost accounting system and used as a basis for unit and departmental fiscal considerations.

*Question:* How is this data used to create a budget for my unit?

*Jeanette:* By using historical data from QuadraMed, we can create projections for the upcoming fiscal year. In essence, we translate patients' care requirements into staffing levels. Using this workload data, we're able to match staffing levels more closely with the need for nursing care on each unit. We also use this data to describe the differences between units with similar census but dissimilar patient populations or to identify trends in patient populations.

*Question:* How do we know the staffing level determined by the system is correct?

*Jeanette:* The system enables valid and reliable standardized workload measurement that allows for comparison of acuity, workload, and staffing across units and institutions. We benchmark our data with other Partners hospitals and other academic medical centers that use QuadraMed. Reports for each unit are produced weekly, monthly, and annually, which allows us to see trends. Trend data is used to adjust staffing levels to match nursing workload.

*Question:* It feels as if my unit is busier these days. Is workload increasing?

*Jeanette:* In general, patient acuity and nursing workload are gradually increasing, but that trend is not consistent throughout the whole hospital. The trend is flat in some units, more pronounced in others. The rise in average acuity has had a major impact on nursing-care resources. Increased acuity, when combined with shorter lengths of stay and more frequent admissions, discharges, and transfers, means a higher 'tempo' of care.

*Question:* That sounds complicated. Who does all these calculations?

*Jeanette:* Staff in Patient Care Services Financial Management Systems keep track of all this data. Starting in February, projections for the upcoming fiscal year will be used to create a preliminary budget for each unit. In addition to creating a staffing budget, we also project costs for non-salary items such as medical supplies. Working in conjunction with the associate chiefs, nursing directors, and the MGH Budget Office, we then refine the numbers over many iterations. The process is usually completed by late July.

For more information about QuadraMed, nurse staffing levels, or the work of the PCS Financial Management team, call 4-0944.



# Recycling at MGH

## *Balancing patient and staff safety with our concern for the environment*

*Question:* Does MGH have a recycling program?

*Jeanette:* MGH is committed to reducing our environmental footprint. We have worked hard to implement safe, convenient, cost-effective recycling options. Blue and green recycling bins are available in offices, patient areas, and public spaces throughout the hospital.

*Question:* What can we put in the blue and green bins?

*Jeanette:* Blue bins are for paper (any kind of paper—white and/or colored computer paper, newspapers, magazines, and corrugated cardboard). Green bins are for uncontaminated plastics, glass bottles, and cans. Any plastic container with the number 1–7 can be placed in the green bins. Cardboard boxes may be placed beside either bin.

*Question:* If something comes in contact with blood or bodily fluid, can it still be recycled?

*Jeanette:* No, that would constitute a health hazard. Patient safety takes precedence over recycling. Dirty or contaminated plastics, plastic bags, and Styrofoam cannot be recycled. If a plastic container does not have a number from 1–7 on the bottom, it cannot be recycled.

*Question:* Can the glass baby bottles in the nursery be recycled?

*Jeanette:* Yes, glass baby bottles can go in the same green bins as recyclable glass, cans, and plastic containers.

*Question:* Are the pink plastic water containers recyclable?

*Jeanette:* Yes, all plastics should be labeled with a number. If the number on the bottom is 1–7, it can be recycled.

*Question:* Does the cafeteria recycle?

*Jeanette:* Yes. Eat Street Café, the largest hospital cafeteria in Boston, recycles everything it can. More than 8,500 people purchase meals from the Eat Street Café every day—that's a lot of bottles, cans, and plastic. When diners place their trays on the conveyor belt as they leave the cafeteria, Nutrition & Food Services workers sort the plastic, glass, and cans for appropriate recycling.

*Question:* Is there a plan to eliminate Styrofoam trays from Eat Street Café?

*Jeanette:* Although reusable trays are better for the environment, they can also pose a health problem when left unattended after use, and reusable trays also produce waste when cleaned. There are times when disposable (Styrofoam) trays are a good option.

*Question:* What can we do to help?

*Jeanette:* We rely on the participation and input of staff, patients, and families to continually improve existing programs and develop new recycling initiatives. The money saved by simply turning off lights and recycling newspapers and containers adds up quickly.

MGH recycled more than two million pounds of waste in 2010 for a savings of \$116,000.

For more information on recycling at the MGH, contact Bill Banchiere, director of Environmental Services, at 6-2445.

# Professional Achievements

## Murphy certified

Amanda Murphy, RN, staff nurse, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center, in October, 2010.

## Carroll appointed

Diane Carroll, RN, nurse researcher, was appointed a member of the Editorial Board for *Heart & Lung*, in November, 2010.

## Davis appointed

Sheila Davis, RN, nurse practitioner, Infectious Disease, was appointed, director of Global Nursing, for Partners In Health, in November, 2010.

## Fitzgibbons appointed

Meghan Fitzgibbons, volunteer coordinator, was appointed area chair of the Massachusetts Association of Directors of Healthcare Volunteer Services in June, 2010.

## Roberge honored

Barbara Roberge, RN, nurse practitioner, Geriatric Medicine, received the Portrait in Primary Care award, from the MGH Stoeckle Center, at the 10th anniversary celebration, November 1, 2010.

## Shaw honored

Christopher Shaw, RN, staff nurse, Infectious Disease, received the Excellence in Action award from MGH president, Peter Slavin, MD, September 29, 2010.

## Young recognized

Denise Young, RN, clinical nursing supervisor, received the Safety in Action Award, from the MGH Center for Quality & Safety, September 8, 2010.

## Camooso Markus certified

Carol Camooso Markus, RN, staff specialist, became a certified healthcare quality professional by The National Association for Healthcare Quality, October 21, 2010.

## Bartush appointed

Paul Bartush, director, Volunteer; Interpreter; Information Associates and LVC Retail Shops, was appointed, president of the Massachusetts Association of Directors of Healthcare Volunteer Services, June 30, 2010.

## Piotrowski certified

Julie Piotrowski, RN, nurse practitioner, became certified in Ostomy Care by the Wound, Ostomy, and Continence Nurses Certification Board in October, 2010.

## Pollini certified

Diana Pollini, RN, staff nurse, became certified in Cardiac Vascular Nursing, by the American Nurses Credentialing Center in October, 2010.

## Sybertz certified

Courtney Sybertz, RN, staff nurse, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in October, 2010.

## Capasso appointed

Virginia Capasso, RN, clinical nurse specialist, was re-appointed as adjunct assistant clinical professor for the Institute of Health Professions in October, 2010.

## Team publishes

Paul Bartush; Barbara Boucher; Victoria Heidelberg; Sherri Ward; and Valerie Weber authored the book, *Strategic Planning for Healthcare Volunteer Administrators*, in August, 2010.

## Duquette certified

Leah Duquette, RN, staff nurse, became certified in Medical-Surgical and Gerontological Nursing, by the American Nurses Credentialing Center in October, 2010.

## Kakarala co-moderates

Sheetal Patel Kakarala, LCSW, Social Services, co-moderated the panel, "Women's Health in CF Care and the Psychosocial Complexities," at the 24th Annual North American Cystic Fibrosis Conference in Baltimore, October 21, 2010.

## Nurses present poster

Gaurdia Banister, RN, executive director, The Institute for Patient Care; Joy Williams, RN, staff nurse, Radiology; Barbara Badio, RN, General Medicine; Sheridan St. Jour, RN, staff nurse, Central Resource Team; and Marion Winfrey, RN, presented their poster; "Famous Black Nurses in History You May Never Have Heard of: and the Honor Role of Firsts," at the centennial anniversary of the Massachusetts Board of Registration in Nursing in Boston, October 29, 2010.

## Logan certified

Tara Logan, RN, staff nurse, became certified in Critical Care Nursing by the American Association of Critical Care Nurses, in October, 2010.

## Gilmartin certified

Kelly Gilmartin, RN, staff nurse, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in October, 2010.

## Wu presents

Lin Wu, RN, staff nurse, Cutaneous Biology Research, presented, "The Quality of Healthcare for Asian Americans," to the Medically Induced Trauma Support Services Group, at Roxbury Community College, August 27, 2010.

## Bolton presents

Rachel Bolton, RN, staff nurse, presented, "Proton Radiation Therapy: the Treatment with Bragging Rights," at the 34th Annual Conference of the Association of Pediatric Hematology/Oncology Nurses in Minneapolis, October 15, 2010.

## French and Coakley present

Brian French, RN, simulation program manager, and Ed Coakley, RN, director emeritus, AgeWISE, presented, "Palliative Care Planning for the Chronically Ill," at the Connecting Classroom and Clinical Learning through Simulation Conference in Burlington, October 8, 2010.

## Gage and Gordon present

Susan Gage, RN, staff nurse, and Susan Gordon, RN, nurse practitioner, presented, "What's Wrong with Mother? Delirium in the Hospitalized Older Adult-Nursing Aspects and Case Study: the Changing Faces of Arline," at the Annual Conference of the National Gerontological Nurses Association in Palm Springs, October 16, 2010.

## Norton presents

Beth-Ann Norton, RN, nurse practitioner, Crohn's and Colitis Center, presented, "Helping Members Manage their Inflammatory Bowel Disease," at Harvard Pilgrim Health in Wellesley, October 6, 2010. She also served as an expert panel member on, "Advances in Inflammatory Bowel Disease for Allied Health Professionals," at the IBD Research Group Forum in Tulsa, Oklahoma, October 20, 2010.

## Butler honored

Rochelle Butler, LPN, was recently named a 'Portrait in Primary Care' by the John D. Stoeckle Center for Primary Care Innovation for her remarkable care every day in every way.

## Coakley and Duffy publish

Amanda Coakley, RN, staff specialist, and Mary Duffy, RN, nurse scientist, authored the article, "The Effect of Therapeutic Touch on Post-Operative Patients," in the *Journal of Holistic Nursing* in September, 2010.

## Guanci publishes

Mary Guanci, RN, clinical nurse specialist, authored the chapters, "Cerebrovascular Events of the Cerebrovascular System: Acute Stroke," and "Temperature Management of Neuroscience Patient," for the AANN Core Curriculum of the American Association of Neuroscience Nurses in October, 2010.

## Team publishes

Patricia Dykes, RN; Diane Carroll, RN; Ann Hurley, RN; Stuart Lipsitz; Angela Benoit; Frank Chang; Seth Meltzer; Ruslana Tsurikova; Lyubov Zuyov; and Blackford Middleton, MD, authored the article, "Fall Prevention in Acute Care Hospitals: a Randomized Trial," in the *Journal of the American Medical Association*, November, 2010.

## Clinical Recognition Program

The following clinicians were recognized September 1–December 1, 2010

### Advanced Clinicians:

- Cheryl McGah, RN, MGH West
- Denise Lauria, RN, Main OR
- Tina Chisholm, RRT, Respiratory Care
- Leslie Smith, RRT, Respiratory Care
- Amy Corveleyn, LICSW, Social Services
- Robert Ferdinand, RN, IV Therapy Team
- Marcia Salvucci, RN, Main OR
- Linda Reed, RN, Main OR

### Clinical Scholars:

- Catherine Griffith, RN, GCRC
- Abigail MacDonald, LICSW, Social Services
- Meaghan Rudolph, RN, Psychiatry and General Medicine

# Announcements

## New hours for Back-up Childcare Center

The MGH Back-Up Childcare Center offers occasional and temporary care for children of MGH employees and patients, aged 9 months–12 years.

Hours of operation have changed; the Center is now open from 6:30am–5:45pm daily.

For more information or registration form, visit: [www.partners.org/childcare](http://www.partners.org/childcare).

## Bridge construction affects MGH

The Craigie Bridge near the Museum of Science will undergo construction from November 6, 2010, through April 24, 2011. Employees, patients, and visitors are encouraged to take public transportation when traveling to and from the hospital.

For the latest in traffic changes, access the Department of Transportation website at [www.mass.gov/massdot/charlesriverbridges](http://www.mass.gov/massdot/charlesriverbridges).

## Collaborative Governance

Applications are now being accepted for collaborative governance. Collaborative Governance integrates multi-disciplinary clinical staff into the formal decision-making structure of Patient Care Services. To learn more about how to join a collaborative governance committee (Diversity, Ethics, Informatics, Patient Education, Practice, Quality, or Research) contact Mary Ellin Smith, RN, at 4-5801.

## Call for Abstracts Nursing Research Expo May, 2011

Submit your abstract to display a poster during the 2011 Nursing Research Expo

Categories:  
Original Research  
Research Utilization  
Performance Improvement

For more information contact Laura Naismith, RN, or Teresa Vanderboom, RN, or Nursing Research Committee at: [mghnursingresearchcommittee@partners.org](mailto:mghnursingresearchcommittee@partners.org).

Abstracts must be received by January 31, 2011.

## On-Site Spanish Classes

Learn commonly used Spanish phrases to enhance communication with Spanish-speaking patients. MGH, in partnership with HablEspañá Language Center, offers three levels of Spanish classes emphasizing practical communication for the hospital setting.

Classes begin the week of January 23, 2011.

Classes meet once a week for ten weeks  
5:30–7:30pm  
Yawkey Building

\$150 fee includes all materials. Payment is due by January 10th.

For more information contact John Coco at 4-3368.

## Are you Gluten-intolerant?

One out of every 120 Americans is gluten intolerant, which is why patient services coordinator, Elaine Budnik-Caira has created a website to help inform the public and the MGH community about this growing problem.

For more information, visit: [www.gfhomecooking.com](http://www.gfhomecooking.com)

## MGH Chaplaincy Schedule of Holiday Services

Holiday Songfest  
Thursday, December 16, 2010  
12:00–1:00pm  
Main Corridor

Christmas Day service  
Saturday, December 25th  
12:15pm  
MGH Chapel  
All are welcome

Roman Catholic Masses  
Christmas is a holy day of obligation  
Mass will be held at 4:00pm on Friday, Christmas Eve, December 24th (the vigil Christmas mass), and Saturday, Christmas Day, December 25th.

Saturday, New Years Day, January 1, 2011, The Solemnity of Mary, the Mother of God, is not a holy day of obligation.

Holiday greetings to all those who celebrate(d) Ramadan, the Hindu festival of Diwali, the African American festival of Kwanzaa and to those of all faiths and spiritualities.

For more information, call 6-2220

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# Handling hazardous drugs

## Guiding principles to protect our patients, ourselves, and the environment

**Question:** I understand there's a new policy related to the safe administration of hazardous drugs. Can you tell us about it?

**Jeanette:** The Safe Administration, Handling, and Disposal of Hazardous Drugs policy was crafted by an inter-disciplinary committee with representatives from Nursing, Pharmacy, and Environmental Services. The evidence-based policy covers the handling of hazardous drugs from their arrival on the loading dock, through preparation, to administration and disposal.

**Question:** Why is safe handling important?

**Jeanette:** Every employee who comes in contact with hazardous drugs is responsible for the safety of the MGH community. While hazardous drugs will never be completely eliminated from the hospital environment, clinicians can minimize the risk to the environment by using personal protective equipment and by carefully following the guidelines put forth in the policy.

**Question:** What is the purpose of the new sign?

**Jeanette:** Patients who receive hazardous drugs excrete those drugs through bodily fluids. The signs serve as a warning to employees who may come in contact with those bodily fluids so they can take the appropriate safety precautions and prevent the spread of contamination.



**Question:** Our unit doesn't administer chemotherapy. Why would that be important to me?

**Jeanette:** Chemotherapy and other hazardous drugs can be administered on any unit in the hospital, so it's important that all employees know how to protect themselves, their patients, and their colleagues.

**Question:** How can we obtain more signs?

**Jeanette:** Signs can be ordered through Standard Register (#86172). Special protective gowns, gloves, spill kits, and chemotherapy waste containers can be ordered from Materials Management. A HealthStream education module will be released soon.

For more information, speak to your clinical nurse specialist or review the policy in Trove.



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