Caring Headlines
March 18, 2010

March is National Social Work Month

(L-r): Barbara Olson, LICSW; Mary Connolly, RN; Alexandra Sobran, LICSW; and Shellie Legere, LICSW, staff educational booth in the Main Lobby during National Social Work Month. (See story on page 4)

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Communication, expectations, and patient satisfaction

As clinicians, we're accustomed to the beeps, bells, and alarms of biomedical equipment and other high-tech devices commonly found on patient care units. But to patients and families, these noises are foreign and can be unnerving.

As with any business in any industry, putting yourself in the customer's position is the best way to ensure a positive experience for the consumer. And health care is no different. How would we want to be treated if we were hospitalized? What would make the experience better, more tolerable, less stressful? I think we all agree that proactive communication goes a long way toward setting realistic expectations, and realistic expectations are the foundation of a positive patient experience.

One aspect of the hospital experience that affects patients on every unit are the various noises that healthcare professionals may take for granted but can be a source of fear, concern, or irritation for patients and families. As clinicians, we're accustomed to the beeps, bells, and alarms of biomedical equipment and other high-tech devices commonly found on patient care units. But to patients and families, these noises are foreign and can be unnerving.

One way to mitigate those fearful feelings is to talk to patients, prepare them for what they'll see and hear while hospitalized. This gives them a chance to ask questions, clarify misconceptions, and feel more comfortable in a clinical setting. Patients are more at ease when they're well informed, and patients who are calm are more apt to be receptive to, and compliant with, their treatment plans.

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

Some of the most common noises in a hospital are the beeps and alarms that come from physiological monitors. Whether patients are connected to a monitor or not, they're likely to hear a monitor alarm during the course of their hospital stay. Wouldn't it make sense to have a conversation with patients and family members early in their stay to let them know they might be hearing these noises; assure them we try to keep noise to a minimum; and explain that in most cases monitor alarms are simply safeguards, not an indication of a serious event.

As in any clinical situation, patients should be encouraged to ask questions or voice any concerns they may have. An on-going dialogue with patients and families about noise or any other aspect of the physical environment is a good thing. It gives us an opportunity to hear patients' concerns, respond in a way that can put their minds at ease, and in some cases, perhaps even rectify issues we may not be aware of. Two-way communication is always helpful.

continued on next page

We're doing some good work related to noise-reduction and educating patients about some of the unavoidable noises in a hospital setting (physiological monitors). The more open we are in our communication about these issues, the more trust we instill in our patients and the more realistic their expectations.

Other noises commonly heard in a hospital include overhead pages and the televisions of patients either in the same room or in neighboring rooms. Even the conversations of staff and/or visitors can be bothersome if you're lying in a hospital bed trying to rest. These are situations where proactive communication with patients and families can help.

We've implemented a number of noise-reduction practices, purchased new technology, and educated staff about the need for quiet, especially during evening and nighttime shifts. We should tell our patients about this important work. Knowing we're aware that noise is an issue that affects patient satisfaction and that we're doing something about it engenders confidence and understanding. We're proud of this work; we should be talking about it.

Under the guidance of George Reardon, director of Clinical Support Services, we've embarked on a program to identify and reduce (or eliminate) some common noises on patient care units. As an alternative to overhead paging, clinicians are now using cell phones, personal pagers, and other wireless devices (except in emergency situations). Guidelines for best practice and utilization of these devices were created to ensure seamless communication while at the same time reducing ambient noise. Cell phones and personal pagers may not be the best solution for all clinical areas, so we are monitoring the effectiveness of these devices with an eye toward how we can improve in the future.

Controlling the noise from televisions was a challenge due to the sheer number of televisions and the different volume preferences of patients throughout the hospital. To help minimize the disturbance caused by loud televisions, we installed pillow speakers on patients' beds. These speakers allow patients to set the volume at a level they can hear without disturbing other patients, and a headphone jack allows for even quieter listening pleasure. Disposable headphones are being piloted on some units.

We know that in the middle of the night, the slightest noise can be jarring. Some units have implemented 'quiet hours' as a strategy to reduce nighttime noise. Other units have made ear plugs available for patients. Various unit-based awareness campaigns focus on staff keeping their voices down and having conversations away from patients' rooms whenever possible. The important thing is that our awareness has been raised, and staff are actively looking at ways to minimize noise.

We're doing some good work related to noise-reduction and educating patients about some of the unavoidable noises in a hospital setting (physiological monitors). The more open we are in our communication about these issues, the more trust we instill in our patients and the more realistic their expectations. We want every patient's experience at MGH to be safe, positive, and comfortable. I welcome your suggestions as we continue this important work.

In this Issue

Social work at MGH:

it's about service, social justice, personal dignity, relationships, integrity, and competence

Like all healthcare disciplines, social work is a noble profession. Social workers help families and individuals deal with challenging issues, improve relationships, solve problems, and get through difficult times. Their diverse practice can involve patients with disabilities, life-threatening diseases, social problems, substance abuse, domestic violence, and much more. Many social workers specialize in a particular patient population or care setting, and in addition to being a resource for patients and families, social workers provide consultation to other healthcare providers, as well.

This year, social work celebrates its 105th anniversary at MGH. In 1905, Dr. Richard Cabot hired the first social worker to help make medical care more effective by addressing the basic needs of poorer patients. In those days, the primary focus of social workers centered around the care of convalescent patients, unmarried pregnant girls, patients 'dumped' at the hospital, and patients with tuberculosis. Though the prevalent issues may have changed, social work remains a discipline dedicated to addressing the emotional and basic needs of all patients.

Below: clinical social worker, Shellie Legere, LICSW (left), and Alexandra Sobran, LICSW, social work clinical director, field questions at educational booth in the Main Corridor during National Social Work Month.

At MGH, clinical social workers work in the inpatient and outpatient settings to help patients and families:

- deal with crises
- cope with illness and other stressors
- identify and solve problems with relationships
- enhance communication with the medical team to ensure active partnership in their own health care
- access hospital and community services

It is known that unresolved psycho-social issues contribute to high healthcare costs and adversely affect healthcare outcomes. Social workers help patients and families address social, emotional, interpersonal, and socio-economic issues.

continued on next page

Common issues include:

- adjustment to chronic and/or catastrophic illness and their treatment
- social and/or financial concerns
- family functioning and communication
- personal safety including abuse, neglect, or violence
- mental illness and emotional distress
- substance abuse
- adjustment to loss/bereavement
- cultural, religious, and language needs

Common interventions include:

- psychotherapy (individual, couples, families, group)
- psychosocial counseling
- care coordination
- relaxation/guided imagery
- cognitive/behavioral therapy
- personal safety planning
- information and referral
- psycho-education (patients, families, community groups)
- stress-management
- consultation

Care and services are as diverse as the social workers who deliver them.

Says inpatient clinical social worker, Lisa Lovett, LICSW, "As a social worker on a neuroscience unit, I work with patients who are often brain-injured or have neurological illnesses. I seek to empower them to maintain their dignity and respect while coping with the impact of what is often a life-changing event. My work with patients and families includes counseling, advocacy, and guidance to community resources to help in planning and setting meaningful goals."

Pediatric social worker, Amy Krasner, LICSW, says, "I have the privilege of working with children and families as they face chronic illness and disability. I provide counseling, assist in identifying appropriate community resources, and help families recognize their strengths during difficult times."

Karon Konner, LICSW, says, "I work on Medicine Team 5, a multi-disciplinary team created to care for patients with complex psycho-social issues. I am also a mental health specialist on the Federal Disaster Medical Assistance Team(DMAT). We deploy domestically and internationally to provide medical care during disasters and other events. Recently, our team deployed to Haiti and established a field hospital adjacent to the GHESKIO health clinic in Port Au Prince.

"My experience as a social worker at MGH prepared me well for my work in disaster and humanitarian relief. Meeting people where they're at, often at a vulnerable time in their lives, to provide emergency crisis-intervention and support mirrors what we do as clinicians at MGH every day."

Social workers are available through walk-in services and scheduled appointments. Social workers are on-site 8:30am–11:00pm, seven days a week, including holidays, and a social worker is on-call after hours. For more information call 6-2640 or visit their website at: www.mghsocialwork.org.

Where you will find MGH social workers:

- Adult
- Pediatrics
- Geriatrics
- Care Management Program
- Domestic Violence
- Liver Transplant
- Kidney Transplant
- Lung Transplant
- Heart Transplant
- Bone Marrow Transplant
- AIDS/HIV
- Cardiology
- Mental Health
- Smoking Cessation
- Neurology
- Oncology
- Emergency Medicine
- Infectious Disease
- Obstetrics/Gynecology
- Family Care Program
- Kids Express/Helping KidsPrograms
- Senior HealthWise
- HOPES Program
- Palliative Care
- Child Protection
- Dialysis
- Cystic Fibrosis
- Network for Patients and Families
- House Medicine
- Private Medicine
- Orthopedics
- Thoracic
- Trauma
- Psychiatry
- Fertility
- Internal Medicine
- Huntington's Disease
- Primary Care
- Surgery
- Burn/Plastic Care

MGH Lung Transplant Support Group

—by Anne Lafleur, LICSW, clinical social worker

MGH is one of the few transplant centers in the nation to offer a lung transplant support group. The group is a community of individuals who come together to share their experience, strength, and hope. The group came into being 20 years ago when the lung transplant program first began and has evolved from a member-run collective to a professional-assisted support group.

The original member-run group was a venue where lung-transplant patients came together and informally shared their experiences with one another. Patient, Sheila Tines, recalls, "Meetings were very different back then. They were really just gatherings that allowed us to complain about our lungs, lives, and situations. It was a much more negative atmosphere, and there wasn't any real structure to meetings."

In 2001, Karen Tanklow, LICSW, became the lung transplant social worker and implemented some changes. The group began meeting twice a month in a large conference room, and Tanklow identified topics for each meeting. Topics included medications, oxygen services, infectious diseases, complications after surgery, financial assistance, and spirituality. The group was visited by a representative of the New England Organ Bank. Tanklow and support group members started an annual memorial service to honor patients who died the previous year.

Says Tines, "I'm not sure when the social worker started, but it was one of the best decisions they ever made. What a change! The meetings had direction and purpose."

Today, the group meets once a month. Meetings are not mandatory (as they once were), but the format that Tanklow established is still in place. Patients and families are welcome to attend. It's helpful for caretakers to attend to better understand what's involved with care following transplant.

Post-transplant patient, Jane Bergeron, says, "Right from the beginning, the team stressed the importance of attending support-group meetings. I rarely missed one. Speakers educated us on what to expect before, during, and after transplant. By the time a match was found, I felt truly prepared—mentally, physically, and emotionally. And even more beneficial than information were the friendships I formed. I treasure my relationships with other patients and my extended MGH family."

Says Paul Canfield, husband of lung-transplant recipient, Patty Canfield, "The group really helped prepare us for the day of transplant. Both Patty and I knew what to expect from listening to the speakers and talking to those who'd been through it. We laughed and cried together. We developed bonds that continue to this day."

Attendance at support-group meetings isn't required, but some patients think it should be. Transplant recipient, Brian Long, says, "It's an absolute must for patients, families, and caregivers. Transplant isn't something you do alone. You need the support of others. If you're too sick to make it to a meeting, send someone for you. When you participate, you're giving to others as much as you're getting in return."

New patient, Jane Burke, has been attending meetings. Says Burke, "I've found them most informative. Speakers address my concerns before I even know I have them, and in a way that's simple and positive. It's a well-balanced program that's given me renewed hope that I'll someday get a second chance at life."

The journey from pre- to post-transplant can be long and stressful. The camaraderie that develops among members is gratifying. Their willingness to help fellow members is heartwarming. From a social-work perspective, it's an honor to be part of this community; what a gift it is to witness the miracle of transplants.

For more information about the Lung Transplant Support Group, call Ann LaFleur, LICSW, at 6-2609.

Ambulatory Practice of the Future

focuses on wellness, collaboration, and work-life balance

—by Maurenn Larkin, human resources communication specialist

When you think of the future of primary care, what do you see? A focus on wellness? A culture of collaborative practice? A workplace that recognizes employees' need for work-life balance?

Opening this summer, the Ambulatory Practice of the Future will be all those things. A new kind of primary-care practice designed for MGH employees and their spouses or partners (enrolled in a hospital-sponsored health plan), the Ambulatory Practice of the Future will offer patients a team-based approach to customized care, and it will offer employees a setting designed to optimize their time, skill, and knowledge.

The Ambulatory Practice of the Future will begin enrolling patients this spring. It is scheduled to open in June.

(Rendering by Anshen & Allen)

"An innovative design of the physical space is critical to team care," says David Judge, MD, medical director of the Ambulatory Practice of the Future. "The effectiveness of team care relies on the ability of nurses, physicians, and allied health professionals to consult, confer, and work together in a collaborative way. The layout of the physical environment can enhance or detract from that synergy."

The Ambulatory Practice of the Future is designed to improve the way patients receive care and also enhance the work-life experience of those providing the care. One way of achieving this involves close attention to the physical space. Unlike many traditional outpatient settings, the architectural design of the Ambulatory Practice of the Future was conceived with the intent of fostering team communication. Open communication among team members engenders shared decision-making, accelerates learning, and promotes true collaboration. Collaborative practice contributes to a safer, more satisfying experience for patients and creates a more gratifying work experience for caregivers.

Says Jeff Davis, senior vice president for Human Resources, "The Ambulatory Practice of the Future grew out of our commitment to provide employees with high-quality wellness programs and an exceptional place to work."

The Ambulatory Practice of the Future will begin enrolling patients this spring. It is scheduled to open in June. For more information, e-mail: apf@partners.org.

Social worker helps elder patient find closure in his final days

Initially, the consult was for permanent nursing-home or assisted-living placement... What began as a routine consult quickly developed into something much more.

My name is Leslie Geer, and I have been a clinical social worker with the Cardiac Service for just one year. But in that time, I've learned a great deal about the complicated clinical situations and demands that hospital social workers encounter. I first received a consult for 'John' when he was admitted through the Emergency Department and hospitalized on the Ellison 10 Cardiac Unit. John was an 89-year-old, single, Caucasian man with no prior cardiac history. He had been feeling increasingly short of breath over the past several months and upon admission, ruled in for heart attack.

Social work was consulted because John had no family or friends and had been living alone in a nearby apartment since the 1970s. Initially, the consult was for permanent nursing-home or assisted-living placement as John had become blind over the past few years and had difficulty performing activities of daily living. What began as a routine consult quickly developed into something much more.

Leslie Geer, LCSW, clinical social worker

In my initial meeting with John, I learned that he had never married, was estranged from his siblings, and had very limited social support. John was receiving some services through the Massachusetts Commission for the Blind, but he depended largely on the bellman, staff, and manager at his apartment building. But it was growing increasingly difficult for them to accommodate John's changing needs. Because of these challenges, John was amenable to assisted living.

I began to work with Case Management regarding John's placement, and together we came up with some good options for him. When I started to discuss these option with John, it led to a conversation about his assets, healthcare proxy, and power of attorney. These were all questions that needed to be answered in order

continued on next page

to secure placement. John and I developed a close relationship. I often spent an hour a day with John, talking and getting to know him. Through our conversations, I learned that John didn't have a power of attorney or a designated healthcare agent. He had saved a great deal of money but hadn't specified how the money should be allocated if he were to die. Since John was unable to tackle any of these tasks while at MGH, arrangements that typically would have been taken care of by family members were delegated to me. During this time, John's health continued to deteriorate, and he was transferred to the Cardiac Critical Care Unit.

I began the process of finding John an attorney who could help him make out a will, create a power of attorney, and designate a healthcare agent. This was necessary for a few reasons: first, if the money John had saved wasn't allocated, it would become an issue for probate court after he died; second, without a power of attorney John could not be placed in an assisted-living facility; and third, without a healthcare agent, there would be no one to speak for John if he became unable to speak for himself. I found an attorney who specialized in elder cases, and together we worked to resolve John's legal and financial issues.

John's wake and funeral were just as he wanted them to be, which gave both the attorney and me a great deal of pride. I know that without our help, John would not have been able to make those important decisions about his life and death.

The attorney and I met mornings to discuss John's case. With John's permission, we gained access to his apartment to get the necessary documents and information. I spent many hours talking to John about his wishes in terms of his health. At one point, he asked if I would be his healthcare proxy. He said I knew him better than anyone. Our conversations were complex and helped establish a relationship that allowed him to feel empowered about personal decision-making and his future.

One afternoon, the attorney and I spent three hours with John in his room on the Cardiac Critical Care Unit. We discussed the allocation of his assets including his apartment and money, the designation of a healthcare agent and power of attorney, and any special instructions he had in connection with those decisions. We spoke at length about his wishes for a funeral service, about where he wanted to be buried, and whom he wanted to be notified.

During this conversation, John held my hand. He felt comfortable discussing his wishes with me and often looked to me for my opinion or advice. He could do this because of the relationship we had developed. I felt our relationship was a privilege, it gave him support as he made these difficult decisions. By the end of our conversation with the attorney, we had completed these important tasks. John requested that many of his assets be given to charity; he willed some of his money to the employees at his apartment building. He designated a healthcare agent and assigned power-of-attorney. After our meeting, he expressed gratitude for all of the work we had done for him.

Once the legal issues had been resolved, the process of finding John an assisted-living facility began. Again, John sought my and the attorney's opinions, and again collectively, we agreed on a facility that met his needs. John was transferred to the assisted-living facility approximately two days after the decision was made. Unfortunately, he died the very next day.

John's wake and funeral were just as he wanted them to be, which gave both the attorney and me a great deal of pride. I know that without our help, John would not have been able to make those important decisions about his life and death. Our time together allowed him to feel supported and cared for at the end of his life.

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

What a wonderful, poignant story. Leslie had no way of knowing when she first met John that she was ushering him through the final days of his journey. But luckily for John, she was. Despite her considerable case load, Leslie found time to sit with John, get to know him, and help him come to peace with the important decisions at the end of his life. Of all the interventions Leslie provided—helping John allocate his savings, choose a healthcare agent, and designate power of attorney—perhaps the most important was just being present with him as he faced these daunting tasks.

Thank-you, Leslie.

Professional Achievements

Nippins recognized

Matthew Nippins, PT, physical therapist, was given the 2009 Presidential Volunteer Service Award at the White House, January 23, 2010.

Chase certified

Jennifer Chase, RN, staff nurse in Anticoagulation Management Services, became certified as an anticoagulation care provider by the National Board for Anticoagulation Providers in January, 2010.

Burchill and Curley present

Occupational therapists, Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, presented, "Anatomy of the Flexor and Extensor Tendons," at Tufts University, January 25, 2010.

Slattery honored

John Slattery, RN, psychiatric staff nurse, received the 2010 Susan M. Dasilva, RN, Award of Distinction January 12, 2010.

Sylvia-Reardon elected

Mary Sylvia-Reardon, RN, nursing director, Dialysis Unit, was elected a member of the Board of Directors of the End Stage Renal Disease Network of New England, in January, 2010.

DeTour certified

Diane DeTour, RN, staff nurse in Anticoagulation Management Services, became certified as an anticoagulation care provider by the National Board for Anticoagulation Providers in January, 2010.

Arnstein and Herr publish

Paul Arnstein, RN, and Keela Herr, RN, co-authored the article, "Pain in the Older Person," in *Bonica's Management of Pain*, 4th Edition.

Winne certified

Maria Winne, RN, nursing director, RACU, became certified as a nurse executive by the American Nurses Credentialing Center, in February, 2010

Gallivan recognized

Theresa Gallivan, RN, associate chief nurse, was named recipient of the 2010 Mary A. Manning Nurse Mentoring Award by the Massachusetts Association of Registered Nurses, in January, 2010.

Gigler certified

Corin Gigler, RN, staff nurse in Anticoagulation Management Services, became certified as an anticoagulation care provider by the National Board for Anticoagulation Providers in January, 2010.

Mahoney honored

Debra Mahoney, LPN, of the Revere HealthCare Center, received the Outstanding Community Service Award, from the Dermatology Nursing Association, December 1, 2009.

Bourgeois publishes

Mary Bourgeois, PT, physical therapist, authored the article, "Pulmonary Rehabilitation Following Acute Exacerbation of Chronic Obstructive Pulmonary Disease," in *PT Journal*, January, 2010.

Wicker certified

Carol Wicker, RN, staff nurse, on the White 10 General Medicine Unit, became certified as a gerontologic nurse by the American Nursing Credentialing Center, in January, 2010.

Sheehan certified

Mary Sheehan, RN, staff nurse in Anticoagulation Management Services, became certified as an anticoagulation care provider by the National Board for Anticoagulation Providers in January, 2010.

Corveleyn presents poster

Amy Corveleyn, LICSW, oncology social worker, presented her poster, "Responding to the Unique Psychosocial Needs of Women with Oral, Head, and Neck Cancer," at the American Psychosocial Oncology Society Conference, in New Orleans, February 17–21, 2010.

Oertel and Libby publish

Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Service, and Edward Libby, MD, authored the article, "Is Patient Self-Testing a Good Thing?" in the *Journal of Thrombosis and Thrombolysis*, 2010.

O'Toole publishes

Jean O'Toole, PT, physical therapist, authored the chapter, "Lymphedema: a Modern Approach to Management in Breast Cancer," in *A Multidisciplinary Approach to Diagnosis and Management*, in December, 2009.

Norton and Kane publish

Beth-Ann Norton, RN, nurse practitioner, MGH Crohn's and Colitis Center, and Sunanda Kane, MD, co-authored the article, "Ask the Experts: Updates in Ulcerative Colitis – Practical Strategies for Improving Treatment Adherence," in *Practicing Clinicians Exchange*, in January, 2010.

Barron and Coakley publish abstract

Anne-Marie Barron, RN, clinical nurse specialist, and Amanda Bulette Coakley, RN, staff specialist, authored the abstract, "Therapeutic Touch Practice and Research on an Inpatient Oncology and Bone Marrow Transplant Unit: Creating a Caring and Healing Environment," in *The Journal of Pediatric Hematology and Oncology,* 2010.

Inter-disciplinary team presents

Patricia Olsen, RN; Bin Zhang, RPh; Nancy Sceery, RD; Janice Heavey, RN; Michelle Picard, RN; and, Janey Pratt, MD, presented their poster, "Evidence-Based Findings of Essential Trace Metal Deficiency and/or Excess in Parenteral Nutrition Patients," at the Annual Conference of the American Society for Parenteral and Enteral Nutrition, in Las Vegas, in February, 2010.

Professional Achievements (continued)

King elected

Janet King, RN, staff nurse, Endoscopy, was elected to the Nominations and Elections Committee of the Society of Gastroenterology Nurses and Associates, in February, 2010.

Harker elected

Jane Harker, RN, staff nurse, Endoscopy, was elected treasurer of the Board of Directors for the Society of Gastroenterology Nurses and Associates, in February, 2010.

Macauley certified

Kelly Macauley, PT, physical therapist, became certified as a cardiovascular and pulmonary clinical specialist by the American Physical Therapy Association at the combined sections meeting in San Diego in February, 2010.

Theodore certified

Peter Theodore, of the Endoscopy Unit, became certified as a scope technician by the Certifying Board of Surgical Processing and Distribution on February 23, 2010. Theodore is the department's first scope technician to be nationally certified.

Therapists present

Physical therapists, Janet Callahan, PT; Kristin Parlman, PT; and Alison Squadrito, PT, presented, "Physical Therapy Management of Patients with Vestibular Dysfunction," at the annual conference of the Massachusetts Chapter of the American Physical Therapy Association, November 7, 2009.

Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Extensor Tendons: Injury and Management," at Tufts University, February 8, 2010.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "The Pain Paradox: Providing Effective Relief While Mitigating Risk," at the American Academy of Pain Medicine, in San Antonio, February 4, 2010.

Berrett-Abebe and Corveleyn present

Oncology social workers, Julie Berrett-Abebe, LICSW, and Amy Corveleyn, LICSW, presented, "Multidisciplinary Approach to Bereavement Services in Breast Oncology," at the American Psychosocial Oncology Society Conference in New Orleans, February 19, 2010.

Burchill and Curley present

Occupational therpists, Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, presented, "Splinting Extensor and Flexor Tendon Injuries," and "Splinting for Flexor and Extensor Tendons," at the School of Occupational Therapy at Tufts University, February 22, 2010.

Carroll presents

Diane Carroll, RN, nurse researcher, presented, "Fall Prevention in Hospitals: Fall TIPS (Translating Interventions for Patient Safety) Toolkit," at the Doctoral Round Table at the University of Massachusetts, in Worcester, February 9, 2010.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Management of Flexor Tendon Injuries," at the School of Occupational Therapy at Tufts University, February 1, 2010.

Kocoloski presents

Hillary Kocoloski, PT, physical therapist, presented, "The Acute Cardiac Patient Case Discussion," at the Physical Therapy Assistant Program, at Bay State College, February 9, 2010.

Healey presents

Lauren Healey, PT, physical therapist, presented, "Further Evidence of the Clinical Utility of the Supine-to-Stand Test in Heart Failure," at the combined sections meeting of the American Physical Therapy Association in San Diego, February 19, 2010.

Klein presents

Aimee Klein, PT, physical therapist, presented, "Responsiveness of the Lower Extremity Functional Scale (LEFS) in Patients with Lower Extremity Musculoskeletal Dysfunction," at the combined sections meeting of the American Physical Therapy Association, San Diego, February 19, 2010.

Levin presents

Barbara Levin, RN, staff nurse, Orthopaedics, presented, "Getting Tangled in Charlotte's Web: Tell my Story," at the American Society of Health Care Risk Management Conference, at Princeton University, January 15, 2010.

Savidge presents

Edgar Savidge, PT, physical therapist, presented, "Stretching and Injury-Prevention Clinic," at the Leukemia and Lymphoma Team Training, February 13, 2010.

Vai certified

Jillian Vai, PT, physical therapist, received the CSCS certification from the National Strength and Conditioning Association, December 4, 2009.

Morgan presents poster

Brook Morgan, RN, staff nurse, Burn Unit, presented her poster, "Using an Early Warning Scoring System to Activate the Urgent Response System," at the Clinical Nurse Leader Summit, in San Diego, January 21, 2010.

Clinical Recognition Program

Clinicians recognized November 2009–February 2010

Advanced clinicians:

- Junjira Saengvanich, RN, Cardiac Surgical Intensive Care Unit/Cardiac Surgical Step-down Unit
- Mary Susan Convery, LICSW, Social Work
- Catherine Griffith, RN, General Clinical Research Center
- Romina Ferrante, RN, Orthopedics
- Mary D'Onofrio, RN, Electrophysiology Lab
- Maura Ament, PT, Physical Therapy
- Jennifer Logan, RN, General Medicine

Clinical scholars:

- Shellie Leger, LICSW, Social Work
- Palmie Riposa, RN, Anticoagulation Management Services
- Angela Abate, RN, Cardiac Surgical Step-Down Unit
- Kerri Tyman, RN, Blake 7 Medical Intensive Care Unit

Cardiac monitoring on general care units

Question: Is there ever an appropriate time to silence a monitor alarm?

Answer: No. Alarms should be active at all times.

Question: Since cardiac monitors are available in patients' rooms, should all patients be put on monitors when they're admitted?

Jeanette: A physician's order is required for a patient to be put on a monitor. If, however, based on the clinical needs of the patient and clinical judgement of the nurse, it is determined that a patient should have a continuous electrocardiogram display, the nurse should collaborate with the patient's physician to obtain the necessary order.

Question: Who is responsible for setting the cardiac alarm limits?

Jeanette: The nurse caring for the patient is responsible for setting alarm parameters. The default alarm parameter is a heart rate of 50-120. The alarm parameters can be altered to meet the needs of each individual patient.

Question: If a patient is on a cardiac monitor, can he or she travel without the monitor?

Jeanette: A physician's order is required to transport a patient without a portable monitor. If the patient requires continuous electrocardiogram display during transport, then the patient must be transported with a portable monitor and be accompanied by a nurse, physician, nurse practitioner, or physician assistant.

Question: Is there ever an appropriate time to silence a monitor alarm?

Jeanette: No. Alarms should be active at all times.

Question: What needs to be reviewed every four hours?

Jeanette: Nurses need to review the history of the monitor every four hours. This review is performed to ensure that all arrythmias are detected and documented. If, during this review, an arrhythmia is identified, a rhythm strip of the event is printed and placed in the patient's medical record.

After the nurse reviews the history, he or she documents the fact that the review was performed on the patient care flow sheet.

Question: What other documentation is required?

Jeanette: Rhythm strips reflecting abnormal beats or rhythms should be printed and placed in the patient's medical record along with the progress note describing the patient's response.

At least one rhythm strip should be included in the progress note at the end of each shift or when accountability for the patient is transferred from one nurse to another.

For more information on cardiac monitoring, contact Joanne Emploiti, RN, at 6-3254.

Video medical interpreting

What is it, and how can I get it?

At MGH, the standard is face-to-face medical interpretation. But as our campus expands, demand for interpreter services grows. We need to constantly explore new ways and new technology to keep pace with demand.

Question: What is VMI?

Jeanette: VMI stands for video medical interpreting. It's a new way of accessing medical interpreters at MGH. In the past, we've provided medical interpreter services in person and by telephone. Video medical interpreting gives us another way to communicate effectively with patients who have limited English proficiency.

Question: How does VMI differ from IPOPs?

Jeanette: IPOPs connect callers with an outside vendor for medical interpreting services. VMI connects callers to our own medical interpreters. These interpreters are stationed in a private video booth in the Medical Interpreters Office in the Gray basement. IPOPs provide audio access only; VMI provides audio and visual.

Question: Will IPOPs and VMI replace in-person medical interpreters?

Jeanette: Absolutely not. At MGH, the standard is face-to-face medical interpretation. But as our campus expands, demand for interpreter services grows. We need to constantly explore new ways and new technology to keep pace with demand.

Question: How does VMI work?

Jeanette: Video devices are mounted on a modified IV pole (similar to the IPOP). They connect to a special VMI port (clearly labeled in each room). The port provides both power and a network connection. By pressing one button and following a few simple prompts, callers are connected to a Spanish interpreter via a video monitor in seconds. With no travel or waiting time, interpreters are able to assist patients quickly, easily—the next best thing to being there in-person.

Question: Where is VMI available and when will I see it on my unit?

Jeanette: VMI is now available on White 8, 9, 11, Blake 13, and Ellison 13. Roll-out will progress throughout the hospital as time and equipment availability allows.

Question: Are all languages available by VMI?

Jeanette: Not yet. Currently, VMI is available in Spanish only. Portuguese will be added soon.

But VMIs can also be used as an IPOP, so clinicians can use a VMI device at any time to connect to an interpreter via an audio feed.

For more information about video medical interpreting, contact Anabela Nunes, manager of MGH Medical

Announcements

Eldercare
monthly discussion group

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

Next session:
April 6, 2010
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome
Feel free to bring your lunch
For more information, call 6-6976 or visit www.eap.partners.org.

Research Nurse Roundtable

"A look at research at the MGH Thoracic Aortic Center"

presented by
Linda Pitler, RN

Tuesday, March 23, 2010
12:15–1:15pm
Garrod/Mendel Conference Room
Simches Research Building

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

Registration is required.
Please register at:
http://hub.partners.org/catalog

For more information about the Research Nurse Roundtable, contact Linda Pitler, RN, at 3-0686.

Sponsored by the MGH Clinical Research Program.

Holy Week 2010 and Passover 5770

Roman Catholic, Ecumenical, and Passover services will be offered throughout the week.

All services will be held in the MGH Chapel on Ellison 1

All are welcome

For a complete listing of times and services, call the MGH Chaplaincy at 6-2220.

Career Information Day

Do you have an interest in allied health professions?
Come to Career Information Day

March 25, 2010
Haber Conference Room

Attend any of the sessions between 10:30am and 4:25pm:

Nursing 10:30–11:10am
Medical Imaging 11:15–11:55am
Medical Technology/Pathology 12:00–12:40pm
Surgical Technology 12:45–1:25pm
Professional Billing Office and Medical Coding 1:30–2:10pm
Electrodiagnostic (Sleep) Technologists 2:15–2:55pm
Radiation Therapy 3:00–3:40pm
Respiratory Therapy 3:45–4:25pm

Employees applying for the Support Service Employee Grant are encouraged to attend.

Sponsored by Training & Workforce Development in Human Resources

For more information, call John Coco at 4-3368.

Taking the First Step

MGH Training and Workforce Development is hosting Taking the First Step: Strategies to get on a Successful Career Path

March 18, 2010
12:00–1:00pm
Satter Conference Room
Yawkey 2-210

This seminar will help employees identify barriers that may be preventing them from returning to school and provide information on how to get on a successful career path. Topics such as: goal-setting, managing priorities, and staying motivated will be addressed.

For more information, call John Coco at 4-3368.

Last Call for Abstracts
MGH Clinical Research Day Deadline: March 19

MGH will celebrate Clinical Research Day, Thursday, May 20, 2010. The Clinical Research Program invites investigators from throughout the hospital to submit abstracts.

The poster session will showcase clinical research at MGH.

Team ($5,000), translational research ($1,500), and individual awards ($1,000) will be given for the best abstracts. A number of departmental prizes will also be awarded.

Submissions must be about clinical research and may include manuscripts published after June 30, 2009.

For more information visit: website: http://www.massgeneral.org/crp; e-mail: crpedu@partners.org; or call Suzanne Guerette at 4-2900.

Published by
Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

Publisher
Jeanette Ives Erickson, RN
senior vice president for Patient Care

Managing Editor
Susan Sabia

Editorial Advisory Board
Chaplaincy
Michael McElhinny, MDiv

Editorial Support
Marianne Ditomassi, RN
Mary Ellin Smith, RN

Materials Management
Edward Raeke

Nutrition & Food Services
Martha Lynch, RD
Susan Doyle, RD

Office of Patient Advocacy
Sally Millar, RN

Office of Quality & Safety
Keith Perleberg, RN

Orthotics & Prosthetics
Mark Tlumacki

PCS Diversity
Deborah Washington, RN

Physical Therapy
Occupational Therapy
Michael Sullivan, PT

Police, Security & Outside Services
Joe Crowley

Public Affairs
Suzanne Kim

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech, Language & Swallowing Disorders and Reading Disabilities
Carmen Vega-Barachowitz, SLP

Training and Support Staff
Stephanie Cooper
Tom Drake

The Institute for Patient Care
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
April 1, 2010

Educational Offerings – 2010

March 18

CVVH Review and Troubleshooting for the Experienced CVVH Provider

Founders 311
8:00am–4:00pm
No contact hours

March 22 & 23

Advanced Trauma Care for Nurses

Founders 3
Day 1: 7:00am–5:00pm
Day 2: 9:00am–7:00pm
Contact hours: TBA

March 24

Preceptor Development: Learning to Teach, Teaching to Learn

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

March 25

BLS/CPR Re-Certification for Healthcare Providers

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

March 26

PCA Educational Series: "Understanding your Patient's Diet and Nutritional Needs"

Founders 325
1:30–2:30pm
No contact hours

March 31

BLS Instructor Program

Founders 325
8:00am–4:30pm
No contact hours

April 1 & 2

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2-220
8:00am–4:30pm
Contact hours: TBA

April 5

BLS/CPR Re-Certification for Healthcare Providers

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

April 5

Diabetic Odyssey

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

April 6

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
11:00am–3:00pm
Contact hours: 2.25

April 7

Simulated Bedside Emergencies for New Nurses

POB 419
7:00am–2:30pm
Contact hours: 3.25

April 7

Achieving Excellence in Evidence-Based Nursing Practice

Founders 311
11:00am–12:00pm
Contact hours: 1

April 13

BLS/CPR Certification for Healthcare Providers

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

April 13

New Graduate RN Development Program

Founders 311
8:00am–4:30pm
No contact hours

April 13

Simulated Critical-Care Emergencies

POB 448
7:00–11:00am
Contact hours: 3.75

April 14

Ovid/Medline: Searching for Journal Articles

Founders 334
10:00am–12:00pm
Contact hours: 2

Beginning April 1, 2010, educational offerings will be found on the Knight Nursing Center website (http://www2.massgeneral.org/PCS/ccpd/cpd_sum.asp) and in the e-newsletter distributed weekly by the Center. For more information, call 6-3111.

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

A commitment of Olympic proportions

—by Gino Chisari, RN, director,
The Norman Knight Nursing Center for Clinical & Professional Development

With the 2010 winter Olympics over, I find myself feeling slightly melancholy. Over the course of the Olympic games, I came to feel connected to the athletes, as if I knew them personally. They became part of my daily life. I was profoundly impressed by their grace, talent, and competitive spirit—the pure joy they derived from their sport. As I became more engaged in the coverage from Vancouver, I found myself cheering not just for American athletes, but for all the competitors, celebrating whenever anyone captured a gold, silver, or bronze medal.

I asked myself if winning a medal was really the point. On one level it's great to win, to receive recognition for a job well done. We all enjoy the praise that comes with achieving success. I think even the humble among us feel a sense of pride at achieving greatness.

With every passing day, I became more impressed— even with the athletes who placed 4th, 10th or last. I thought about the dedication, hard work, and commitment they had invested in themselves, their sports, and their teams. The real achievement was just earning the opportunity to participate in the Olympics. For me, watching from my sofa, the experience of elite athletes coming together from around the globe to share the love of their sports, to learn from one another, to break the barriers of race, gender, religion, age, and nationality was the most inspiring part of the games.

As we reflect on the 2010 Olympic games, I'm struck by the parallels between Olympic athletes and MGH clinicians. Think about it.

1) We make a personal commitment to the principles and ideals of a strong patient-clinician relationship; we care for patients every day or support someone who does
2) We invest intellectual and emotional energy in ourselves and each other; every day we have another opportunity to make a contribution to humanity
3) We are fully present to our colleagues, our patients, and their families; we support each other and work as a team with the patient and family as our central focus
4) We are authentic with ourselves and others; we respect and celebrate our differences
5) We are accountable to ourselves, our team, and our patients; we continually take the time to learn, grow, and develop our skills
6) We re-invest our knowledge, ability, skill, and attitude to be the best we can be as members of the MGH community

Competing in the Olympics may result in a gold medal, but performing well, making the team, being part of something bigger than ourselves—that's the golden opportunity, to me.

Caring Headlines
March 18, 2010

Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston, MA