

Caring

Headlines

May 6, 2010

Visiting Scholar for Cardiac Nursing focuses on unique needs of cardiac patients

See story on page 4 and clinical narrative on page 8



Visiting cardiac scholar, Debra Moser, RN (at podium), during panel discussion with cardiac staff nurses (l-r): Tara Logan, RN; Halary Patch LeBlanc, RN; Patricia Noonan, RN; Jessica Wiggins, RN; and Christina Gancarz, RN.

The Hausman Fund for Nursing Workforce Diversity

There's no limit to what people can do when they get involved

During her two rounds of treatment at MGH, Mrs. Hausman made an observation. She noted that her fellow patients were of all races, backgrounds, religions, and socio-economic levels. But most of her caregivers were white.

Several years ago, Margaretta Hausman was a patient at MGH. She had always been a person of conscience, interested in social justice, and involved in charitable activities. A social worker and graduate of Brown University, Mrs. Hausman had done her share of community service, tutoring minority students in college and working with native American tribes in Alaska. She counselled clients at a psychiatric hospital in England, and still today works with troubled and disenfranchised individuals at an outpatient mental health clinic. By the time Mrs. Hausman came to MGH for cancer treatment almost ten years ago, she already had an impressive history of advocating for people less well off than she.

So when she volunteered to be a member of the MGH Cancer Center Patient & Family Advisory Council and was introduced to our own Deborah Washington, director of PCS Diversity, it wasn't surprising that these two formidable women hit it off.

Mrs. Hausman put it this way: "Deb is a force to be reckoned with. Over time, I came to see what a wonderful mentor and motivator she was. She 'modeled' leadership for those in less empowered positions. She inspired young people to set high goals and value education. She was a true advocate for diversity at every level."

During her two rounds of treatment at MGH, Mrs. Hausman made an observation. She noted that her fellow patients were of all races, backgrounds, religions, and socio-economic levels. But most of her caregivers were white. As you can imagine, this gave Mrs. Haus-



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

man, Deb Washington, and the Patient & Family Advisory Council something to think about.

"I knew Deb had some wonderful ideas," said Mrs. Hausman. "I knew Mass General could do great things if they had the resources."

And so began the journey to create the Hausman Fund for Nursing Workforce Diversity. Today, The Hausman family's investment supports programs designed to promote the recruitment and retention of minority nurses to better meet the needs of a diverse patient population. The Fund focuses on three distinct nursing populations:

- Nursing students at local universities
- Foreign-born nurses in need of education or credentials in order to practice in the United States
- MGH employees currently enrolled in nursing programs

The Hausman Nursing Fellowship, a ten-week summer internship, pairs senior nursing students from local universities with minority nurse preceptors at MGH to provide future nurses of color with opportunities for

continued on next page

“It’s important to me to see this program grow. The world is diverse, and I think this program can help open people’s minds and perspectives. I encourage others to get involved. It’s not just about money—there are many ways to contribute. There’s no limit to what people can do when they get involved.”

—Margaretta Hausman

meaningful clinical, practical, and social learning experiences. Three former fellows are now full-time nurses at MGH.

The Hausman Fund for Foreign-Born Nurses helps foreign-born employees obtain required education and training to practice in this country. One component of the program is an accent-reduction initiative proposed by Barbara Blakeney of The Center for Innovations in Care Delivery. This pilot program helps foreign-born nurses minimize their accents by working with a speech therapist to improve pronunciation and elocution. The accent-reduction initiative has helped participants understand and communicate better; enjoy greater confidence; and strengthen their resolve to pursue nursing leadership positions.

The Hausman Nursing Scholarship is presented to MGH employee(s) of diverse backgrounds currently enrolled in an accredited nursing program. Four scholarships were presented in December of 2009 to assist recipients in advancing their education.

Alexis Seggalye, a former Hausman fellow currently working at MGH, recalls, “I had the privilege of meeting people in different leadership roles. Each of these leaders shared hours of their time with me. It’s not every day you get to sit down and have a conversation with people of that stature. It was one of the highlights of my experience as a Hausman fellow.”

Former Hausman fellow, Stephanie Poon, a student in the Nursing Program at UMass, Amherst, is currently doing her clinical rotation at Holyoke Medical Center. Stephanie urges future Hausman fellows to, “Take as much as you can from the program. It’s an unbelievable opportunity to learn. I’m one step ahead in my Advanced Med-Surg rotation because of what I learned as a Hausman fellow. You’ll see things you could never see in school— it’s a whole different kind of learning.”

Mrs. Hausman recently told me, “I feel lucky to be part of this program. Anyone can support research—and that’s a great thing to do. But I’m happy to be able to do something for *people*, to give something back. It’s important to me to see this program grow. The world is diverse, and I think this program can help open people’s minds and perspectives. I encourage others to get involved. It’s not just about money—there are many ways to contribute. There’s no limit to what people can do when they get involved.”

I’m glad Mrs. Hausman ‘feels lucky’ to be part of this program. But for my part, I feel lucky that Mrs. Hausman chose MGH for her care all those years ago, and that she had the good fortune to run into Deb Washington. Our patients, our staff, and our hospital are better today because of that chance meeting.

For more information about the Hausman Fund for Nursing Workforce Diversity, call the Development Office at 3-0468.

In this Issue

Visiting Scholar for Cardiac Nursing.....	1	Chaplaincy Honors Eucharistic Ministers.....	10
Jeanette Ives Erickson.....	2	A Fond Farewell to Father Celsi.....	11
• Making a Difference: the Hausman Fund		Quality & Compliance in the MGH Transplant Center.....	12
Visiting Scholar for Cardiac Nursing.....	4	Fielding the Issues.....	13
Advance Care Planning.....	5	• Important Practice Reminders	
Clinical Nurse Specialist.....	6	Announcements.....	14
• Pain Assessment: Simple and Meaningful		Be Fit Seminar.....	15
MGH Recognized for Diversity Program.....	7	A New Look for Information Associates.....	16
Clinical Narrative.....	8		
• Christina Gancarz, RN			

Fifth Visiting Scholar for Cardiac Nursing comes to MGH

—by Diane L. Carroll, RN, Yvonne L. Munn nurse researcher

On April 8 and 9, 2010, in recognition of the unique contributions of cardiac nursing, the MGH Heart Center welcomed Debra Moser, RN, the fifth visiting cardiac scholar to come to MGH since the inception of the program. During her visit, Moser participated in a number of presentations, poster sessions, unit rounds, and a panel discussion with cardiac nurses.

Moser is a professor, the Linda C. Gill endowed chair of Nursing, principal investigator, and director for the Center for Biobehavioral Research in Self-Management of Cardiopulmonary Disease at the University of

Kentucky. Moser's research focuses on improving self-care and quality of life in cardiac patients. She has studied the interaction of bio-behavioral variables as predictors and outcomes in cardiovascular patients.

Moser's presentation, "State of the science in self-care in heart failure: How much does self-care matter?" addressed nursing interventions to improve outcomes in heart-failure patients. She discussed medication compliance, adherence to diets, emotional responses, health literacy, and symptom-recognition. Her second presentation, "Anxiety Management," described methods of assessing anxiety and identified nursing interventions such as increasing perceived control, cognitive therapy, and social support.

A well-attended panel discussion gave five staff nurses a forum to present clinical narratives. Tara Logan, RN, Cardiac Surgical ICU; Christina Gancarz, RN, Cardiac Surgical Step-Down Unit; Halary Patch LeBlanc, RN, Cardiac ICU; Patricia Noonan, RN, Cardiac Step-Down Unit; and Jessica Wiggins, RN, Cardiac Intervention Unit, all read narratives describing complex cardiac patients and their unique needs and the interventions they provided to meet those needs. Moser offered comments drawing on her expertise in bio-behavioral, psychosocial, and family care.

Posters were displayed outside O'Keeffe Auditorium highlighting innovative clinical practice in the Knight Center for Interventional Cardiovascular Therapy, the Electrophysiology Laboratory, and other cardiac units. The Cardiac Practice Committee, chaired by Leann Otis, RN, had an opportunity to speak with Moser about publishing in nursing journals and other topics.

Moser accompanied staff on unit rounds where discussion centered on motivating heart-failure patients to participate in self-care, managing anxiety, and patient- and family-centered care.

For more information about the Visiting Scholar for Cardiac Nursing Program, call Diane Carroll, RN, at 4-4934.

Visiting cardiac nurse scholar, Debra Moser, RN, dialogues with cardiac staff nurses during panel discussion focusing on the unique needs and care of cardiac patients.



Raising awareness about advance care planning

—by Patricia Wright, RN

With a lilt of sunshine and the sweet caressing breeze of spring, a new season is upon us. And with it, the PCS Ethics in Clinical Practice and Patient Education committees joined forces to celebrate National Health Care Decisions Day. On April 16, 2010, representatives of the two committees staffed an informational booth in the Main Corridor to raise awareness about advance care planning.

The goal of this annual observance is to give patients, staff, and visitors an opportunity to learn about advance care planning and advance directives. Copies of the Massachusetts Health Care Proxy form and brochures describing the role of a healthcare proxy were available. Nurses, chaplains, and physicians answered questions to

help ease the anxiety that sometimes accompanies thoughts of advance care planning.

Three points stressed by committee members were the peace of mind you get from: knowing your healthcare provider will honor your wishes; knowing the person you appoint will work in your best interests; and knowing you can review and revise your advance care directive at any time. People need to know that if they choose not to be kept alive by extraordinary measures, their wishes will be honored.

A common misconception is that advance care directives are just for the elderly, but people of all ages who want to have a say in their care and ease the burden of end-of life decisions for family members should complete an advance care directive.

An added bonus came when the Advanced Care Directive Team received word that based on their

efforts, a special proclamation had been issued by Mayor Menino declaring April 16th Healthcare Decisions Day in Boston.

Hundreds of people stopped by the booth to collect packets of information. But for those who weren't able to stop by, for more information, or to obtain a copy of the Massachusetts Health Care Proxy form, visit the Blum Patient & Family Learning Center, or call 4-7352.

Below left: Cynthia LaSala, RN (left), coach of the Ethics in Clinical Practice Committee, and Nancy Davis, RRT, co-chair of the Patient Education Committee, staff advance care planning booth. **At right:** Patricia Wright, RN (left) and Susan Warchal, RN, field questions about health care proxies.



Making pain assessment simple and meaningful

—by Paul Arnstein, RN, pain clinical nurse specialist

I was asked to evaluate a patient for painful diabetic neuropathy that was interfering with her physical therapy. Ms. B described herself as a 78-year-old ‘tough cookie’ who had endured many hardships. But this pain in both her feet, “burned hot enough to heat Gorham County” in her home state. When asked to rate her pain from zero (no pain) to ten (worst pain imaginable), she struggled to answer.

“Would you describe it as mild, moderate, severe, or extreme?” I asked.

Eventually, she said it was between mild and moderate. She said the pain scales confused her; she never knew what to say. Indeed, her rating seemed inconsistent with the intense burning pain she had described.

As we discussed her comfort and function goals, she said she wanted to be able to walk, drive, and socialize. Currently, her pain prevented her from getting out of bed. Based on our conversation, the Functional Pain Scale indicated that her pain was more severe than she admitted and was preventing her from doing anything requiring exertion. We decided to avoid confusing words and numbers and focus on what was important — getting her pain to a tolerable level so she could be active.

Policy states that pain is to be assessed before and after a patient receives analgesics. The timing of re-assessment is particularly important in establishing the safety and efficacy of medication, and it varies based on the specific therapy. Using our clinical knowledge, we re-assessed Ms. B’s pain within an hour of receiving medication and documented her response.

The treatment had enhanced her activity level and enabled her to better participate in physical therapy. She also had an improved mood and was better able to sleep. This created a challenge for the night nurse who didn’t want to wake Ms. B to ask how her pain was. Instead, she recorded Ms. B’s respiratory rate and, using the checklist of non-verbal pain indicators, noted the absence of behaviors commonly displayed by people in pain.



Paul Arnstein, RN, pain clinical nurse specialist

Ms. B’s case is not unusual. Research and our internal audits show that 30% of verbal adults don’t understand the numeric (0–10) pain scale. When the scale is poorly understood, we can ask for a verbal description of the pain as mild, moderate, severe, or extreme, and document the corresponding number (2, 4, 6, 8). Some, like Ms. B, require a more concrete way to measure their pain by using the Functional Pain Scale or the checklist of non-verbal pain behaviors when asleep or unable to verbalize their discomfort.

Pain is a universal experience and frequently encountered in healthcare settings. MGH has a long tradition of advancing safe, effective pain-management. In the absence of the ability to precisely measure pain, we need to rely on a variety of scales that yield clinically meaningful information. Toward that end, we’ve compiled a list of ‘first-line’ pain tools (at the bedside) that can be used to guide pain therapy. The tools used for Ms. B were appropriate for an adult on a general care unit, but other tools may be more appropriate for children or critical-care patients. Visit the new intranet site <http://intranet.massgeneral.org/pcs/Pain/index.asp> for a description of these first-line tools. This is especially important because the assessment and management of pain is a basic right of all patients.

For more information about pain management, call Paul Arnstein, RN, pain clinical nurse specialist, at 4-8517.

Clinical Leadership Collaborative, Ives Erickson, honored at UMass Community Breakfast

Senior vice president for Patient Care, Jeanette Ives Erickson, RN; and UMass Chancellor, Keith Motley, at 24th annual UMass Community Breakfast.

On March 25, 2010, at the 24th annual UMass, Boston, Community Breakfast, senior vice president for Patient Care, Jeanette Ives Erickson, RN, accepted the Chancellor's Award for Long-Standing Community Commitment and Service for her leadership in creating and spearheading the Clinical Leadership Collaborative for Diversity in Nursing. She dedicated the award to the thousands of nurses she represents at MGH.



(Photo provided by UMass Boston)

Accepting the award, Ives Erickson said, "We are committed to advancing the diversity of the nursing profession. We want to make sure that every American has equal access to health care."

In the summer of 2007, the Partners Chief Nurse Council under the leadership of Ives Erickson, created the Clinical Leadership Collaborative for Diversity in Nursing. Partners HealthCare and the University of Massachusetts College of Nursing and Health Sciences joined forces to create a program that would support the leadership-development of diverse nursing students. Students with proven academic excellence and a commitment to improve the health of their communities were recommended for the program based on their potential to become future leaders in nursing and health care. Students received scholarships and were ensured clinical rotations at hospitals within the Partners network.

The CLC program partners students with diverse nurse mentors and leaders from Partners institutions. Mentors provide support and guidance to students in effectively managing any issues (racial, ethnic, clinical, or cultural) that may arise.

The program strives to prepare future nurses through role-modeling and the imparting of wisdom from nurse mentors in a collaborative, educational environment. The hope is for diverse students to feel nurtured and supported as they transition from student to clinical nurse.

On March 4, 2008, the first orientation session took place at UMass, Boston, with the hope that the program would change the face of nursing and healthcare leaders of the future.

For more information about the CLC program or to become a mentor, contact Gaurdia Banister, RN, executive director of The Institute for Patient Care at 4-1266.

Patient-centered care sometimes means helping patients cope

I was returning to the nurses' station when I saw 'Liz' up from her bed, sitting in a chair by the window. She was gazing out into the night, tears flowing from her swollen eyes, the soft sounds of sniffles barely reaching the hallway.

My name is Christina Gancarz, and I am a cardiac nurse. On this particular night, all patients had been tucked in, evening medications administered, covers pulled up over their tired bodies, pillows fluffed and positioned optimally for sleep. After checking on my last patient, I was returning to the nurses' station when I saw 'Liz' up from her bed, sitting in a chair by the window. She was gazing out into the night, tears flowing from her swollen eyes, the soft sounds of sniffles barely reaching the hallway.

It took me a second to realize who was crying. I had admitted this woman the day before. She was in her 60s and had undergone cardiac surgery about a week before. She had been re-admitted to MGH with severe chest pain. She had arrived on the unit with a nitroglycerin drip, the first patient I'd ever cared for who had one, and I was told in report that she was anxious and seemed to be in a volatile mood. Labs were drawn, tests completed, a myocardial infarction was ruled out. Only a small amount of peri-cardial fluid had been detected, so doctors decided not to intervene—the amount of fluid was so small, not even enough to drain. Liz was frustrated by this seemingly 'hands-off' approach, and as a result, she was annoyed at everyone. She wanted something to be done about her pain, and she wanted answers now.



Christina Gancarz, RN, cardiac staff nurse

So to see her crying, to see her displaying even the slightest bit of emotion other than nervous anxiety, stunned me. I paused, said a quick prayer, and entered the room unsure of what I was going to say or why she was crying.

Situations like these always make my heart jump and my stomach feel as though it's in my throat. As a young child, I had a severe language disability that limited my ability to communicate. To this day, whenever I'm in a situation where I have to make a quick decision or speak on a moment's notice, I become tongue-tied.

It was in that mindset that I said, "Liz? Is everything okay? Are you all right? Did something happen?"

She replied through her sobs, "Um, I don't know, I just don't know. I guess I'm just depressed. I'll get through it, I just don't know what to do with myself right now."

I started to say something to soothe her, but unexpectedly, she continued.

continued on next page

“Christina, I’ve depended on myself all these years. I don’t want to depend on anyone else. My sister’s not around; my brother is somewhere else. It’s just me. I’ve never had to rely on anyone before. I’ve lost my job because of this surgery. I never expected this. I don’t know what to do. I just never thought about this before. Until now.”

“Liz,” I said, “you’re not yet fit to take care of yourself. It’s important that someone be able to help you around the house for at least a little while, while you’re recovering. You need time for your body to heal. As for depending on other people, I can’t imagine what you must be feeling, but I too, find it challenging to ask for help.”

I told her a humorous story about how I usually wait until the last minute to ask for assistance. She chuckled, and the tears started to fade.

I asked her, “Do you think you could try to let people help you just a little, especially now while you’re not physically able? You don’t have to do this by yourself. You don’t have to go through this alone.”

“I know, I know,” she answered softly. “It’s been like this all my life. Just me. I’ve never needed anyone. I’ve never wanted to depend on anyone because I’m the only one who won’t fail me. But I’ll get through it, I’m just depressed.”

I realized these feelings weren’t just the result of her heart surgery.

“Liz, you don’t have to ‘get through’ anything,” I said. “Having heart surgery is a huge ordeal and a stressful burden. Let me help if you’re feeling depressed. I can set you up with some resources to make life a little easier for you and give you some assistance emotionally, as well. Would you like to see a social worker?”

“Oh no, no. I don’t need a social worker.”

Remembering she was Catholic, I said, “Would you like to see a chaplain?”

“No, no. I don’t want to see a priest.”

I tried one last thing. “How about a psychiatric nursing specialist? He or she might be able to help you re-focus on some positive thoughts.”

“No, I don’t want any of that. I’m all set, I’ll get over it.”

It was then I realized that I was the *only* one who could make a difference. Liz didn’t want to see anyone else. If I didn’t take this opportunity to say something supportive, she might not hear it tonight when she needed it most. Why was I chosen to be there that night, this young woman who has struggled with speech all her life?

I was about to ask if she wanted Ativan, but I stopped. I remembered the rosary beads in my pocket. I always carry them with me and finger them when I’m nervous or scared.

I said, “Liz, what or whom do you rely on for support?”

“Myself,” she said. “Though sometimes I pray to God.”

“May I give you something?” I said.

Her eyes widened.

“This is a set of rosary beads I’ve been carrying with me for weeks. I keep them close in times of struggle or challenge. I finger the beads and cross whenever I’m nervous or overwhelmed. I want you to have something to hold onto when you’re in despair, and know that the Lord is with you, beside you in your time of need, and that you’ll never be alone.”

Tears welled up and streamed down her face. We hugged, I got her back to bed and made her comfortable. She thanked me for everything I’d done.

She still wanted the Ativan to help her sleep, and I gave it to her. The Ativan may have calmed her, but I think our conversation began the healing of her heart, something an anti-anxiety drug couldn’t do.

The next day, I visited Liz and she was calmer than she’d ever been. I couldn’t believe it, but she was actually smiling. I had the pleasure of discharging her the following day, and on her way out of the room she said, “I think I can do it this time.”

Look what God had done, I thought. He had spoken through me to this woman when she needed Him. Maybe God had brought me to this unit, not only to help repair the physical heart, but the emotional one, as well.

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

Comfort comes in many forms. Some people turn to loved ones, others to nature, art, or religion. A key element of patient-centered care is knowing where patients look for physical, spiritual, and emotional support. As clinicians, we can’t force our philosophies or religious beliefs on patients, but we can support them in ways that are meaningful to them. And that’s what Christina did with her offering of the rosary beads. Liz’s call for help may have been vague and couched in stoicism, but Christina heard it and responded with perhaps the only thing Liz found meaningful. Comfort comes in many forms.

Thank-you, Christina.

The next day,
I visited Liz and she
was calmer than
she’d ever been.
I couldn’t believe
it, but she was
actually smiling. I
had the pleasure of
discharging her the
following day, and
on her way out of
the room she said,
“I think I can do it
this time.”

Chaplaincy honors volunteer Eucharistic ministers

—by Gina Murray, Chaplaincy office and program manager

On April 22, 2010, the MGH Chaplaincy held a retreat to celebrate the nearly 50 volunteers who serve as Eucharistic ministers. These men and women have collectively volunteered tens of thousands of hours bringing valuable ministry to patients, families and staff. Says Chaplaincy director, Michael McElhinny, MDiv, “The phrase I hear most to describe Eucharistic ministers is ‘Our angels in pink.’”

This year’s retreat was bitter-sweet with the knowledge that Father Celestino Pascual, theological advisor for the Eucharistic ministers, would be leaving the Chaplaincy to return to the Philippines. In his farewell address, ‘Father Celsi,’ as he is known by friends and

colleagues, reflected on the Road to Emmaus from the Christian scriptures, leaving an indelible mark on those in attendance.

Eucharistic minister, Elizabeth Maloney, recalled visiting a patient facing a life-threatening operation who “did not have God in his life.” At his request, Maloney prayed with him and gave him some holy cards. A few weeks later, the patient remembered Maloney and expressed his profound appreciation for her pastoral presence in his time of need.

Said Eucharistic minister, William Toomey, “Based on my own experience as a patient, I know the spiritual value of a visit by a Eucharistic minister. I’m honored to give that support back to the patients I see.”

Oncology chaplain, Katrina Scott, facilitated a forum for sharing reflections, comments, and questions. Eucharistic ministers, Robert Dunn and Richard Keyes, led the group in singing hymns.

Father Tom Mahoney, reviewed accepted Eucharistic practices and procedures, highlighting the responsibilities of the role. Said Mahoney, “It is an honor to work with these dedicated volunteers. They take their role seriously and are always engaged in dialogue about how to better serve patients and families.”

The Chaplaincy appreciates the contributions of our Eucharistic ministers as they offer comforting prayers and distribute the Holy Eucharist. Says Gina Murray, Chaplaincy office and program manager, “I feel privileged to work with these extraordinary men and woman. Day after day, I’m humbled by their unwavering commitment and incredible faith.”

For more information about the Chaplaincy Eucharistic Minister Volunteer Program, call 6-2226.

Eucharistic ministers gather for annual retreat for educational and spiritual renewal.



Bidding farewell to a cherished friend and devoted chaplain

—by Michael McElhinny, MDiv, director of Chaplaincy

There was something more to Celsi, a gentle spirit that set him apart, a generous presence that grew in your heart. He was a roving ambassador for the Chaplaincy throughout the MGH community.

At a recent retreat for the more than 50 volunteer Eucharistic ministers in the MGH Chaplaincy, Father Celestino Pascual, reflected on “The Road to Emmaus” from the Christian scriptures. The passage describes three men on a journey. Two of the men recognize the third as Jesus Christ because of how he acts and what he does while he’s with them. The two disciples want Jesus to remain with them, but Jesus must move on to other people and other places.



Since June of 2000, MGH has been blessed to have Father Celsi providing compassionate care to patients, families, and staff. While he did all the things you’d expect from a staff chaplain—pastoral visits, sacraments, chapel services—that’s not what I’ll remember him for. There was something more to Celsi, a gentle spirit that set him apart, a generous presence that grew in your heart. He was a roving ambassador for the Chaplaincy throughout the MGH community. He was equally comfortable talking to doctors, unit service associates, carpenters, and secretaries. I was always amazed at how many people knew Father Celsi. Why? Because he stopped to talk to people, took the time to ask how they were, and listened to their answers. When Celsi smiled at you, you felt better; you knew someone cared about you. We saw goodness in this humble man and it was contagious.

A chaplain is supposed to be a faith-filled person, and Celsi is, but he’s more—he’s deeply spiritual in a surprising way. RACU nurse, Mary Findeisen, RN, captured this in a clinical narrative a while back. Staff was struggling over withdrawing care from a patient and Father Celsi reminded them, “We don’t withdraw care, we provide care. Yes, the ventilator will be withdrawn, but then we provide a different kind of care.” He helped staff see that when a cure is not possible, family-centered care always is. Providing the best care is what I’ll remember most about him. It’s not easy to praise Father Celsi, as he so readily deflects credit. I know he’ll smile at me and his eyes will sparkle as he says, “God alone provides.” Thank God for providing Father Celsi Pascual to us, and many blessings on him and his family as he returns home to the Philippines. We will not forget him.

MGH Transplant Center: the Quality and Compliance Program

—by Amy Norrman, quality and compliance data manager, MGH Transplant Center

Members of the Transplant Center Compliance Team (standing, l-r): Linda Irwin, RN, compliance director; and Angela Marquez, administrative director. (Seated): Nahel Elias, MD, director of quality assurance; Amy Norrman, quality and compliance data manager; and Jay Fishman, MD, associate director of the Transplant Center.

Quality is a top priority at MGH. Since its inception 30 years ago, the MGH Transplant Center has offered heart, kidney, liver, lung, pancreas, and pancreatic islet transplant programs for adults and children. The Transplant Center performs approximately 150 solid-organ transplants each year and sees more than 500 patients in its pre- and post-transplant clinics. Patient outcomes in the center are among the best in the country, consistently matching or exceeding national averages.

Part of providing quality care is maintaining a strong quality and compliance program that ensures adherence to regulatory standards and compliance with

our own policies and high standards. In light of our growing patient population and the changing requirements of state and local agencies, three new positions were created within the Transplant Center: director of quality assurance, compliance director, and quality and compliance data manager.

For the past year, the entire staff of the Transplant Center has worked together to meet requirements and improve patient care. Led by the associate director of the Transplant Center, the director of quality assurance, and the administrative director, the Compliance Program is on track to achieve 100% compliance through staff education and process improvement.

The Compliance Program ensures that all patients receive appropriate education and that care is coordinated in a multi-disciplinary team approach that includes special services. All members of the Transplant team participate in a review of patient care and discharge planning. Safety procedures, such as blood-typing for donors and recipients, are assessed. New teaching materials have been developed for patients and staff to ensure everyone understands the transplantation process.

Transplant surgery requires coordination of care across all disciplines. The multi-disciplinary transplant team is comprised of nurses, transplant coordinators, social workers, transplant surgeons and physicians, nutritionists, financial coordinators, pharmacists, and a living donor advocate. The Transplant Center Compliance Program assesses documentation at every step of the transplant process. Every member of the transplant team is accountable for making each patient's experience as safe and pleasant as possible.

For more information about the Transplant Center Compliance Program, call Amy Norrman at 3-4009.



Some important practice reminders for staff

to help ensure Excellence Every Day

Question: What does it mean to “thin” a medical record?

Jeanette: For patients who have prolonged hospitalizations, sometimes it’s necessary to “thin” their medical records. This simply means re-organizing the information to make it more accessible for caregivers. The first three sections are separated out and designated as Volume I. The remaining sections are designated as Volume II. Each section should be labeled appropriately, and all volumes should stay on the unit until the patient is discharged.

Question: What is a nursing order?

Jeanette: Registered nurses can initiate nursing orders—orders that don’t require a physician’s co-signature. Nurses can write nursing orders for the following consult services:

- Chaplaincy
- Nutrition & Food Services
- Smoking Cessation Program
- Social Services
- Wound Care

All other orders require a physician’s signature before initiating (e.g., medications, IVs, flushing Foleys, etc.)

Question: Why can’t staff store food or snacks in medication refrigerators?

Jeanette: This is a question of patient- and staff-safety. Medication safety is a top priority; strict adherence to state, federal, hospital, and Joint Commission standards must be maintained at all times. Without exception, refrigerators labeled, “For medication use only,” should not be used for food or snacks.

Question: What is malignant hyperthermia?

Jeanette: Malignant hyperthermia is a life-threatening disease of the skeletal muscles triggered in some patients by inhalation of volatile anesthetics or succinylcholine. A diagnosis of malignant hyperthermia is made by a physician or anesthesiologist; symptoms include (some or all of the following):

- tachycardia
- tachypnea, spontaneous hyperventilation
- unexplained worsening hypercarbia
- arrhythmias
- dark blood in the surgical field despite adequate inspired oxygen
- cyanotic mottling of skin
- unstable blood pressure
- profuse sweating
- fever: rapid rise (to as high as 108°F)
- fasciculations and/or rigidity

If you suspect a patient has malignant hyperthermia:

- call 6-8910 (Main Operating Room control desk)
- explain that you have a malignant hyperthermia emergency. Give the patient’s location, and state your need for a malignant hyperthermia kit and an anesthesiologist

Alternatively, call 6-3333 (hospital emergency operator), and request a RICU consult page for a malignant hyperthermia emergency.

Question: Why is it necessary to document blood-sugar and insulin doses?

Jeanette: To ensure all team members are aware of a patient’s insulin management, blood sugar and insulin administration should be documented on the back of the Diabetes/Insulin Medication Administration Record and in EMAR, as appropriate.

Announcements

Be Fit Lunchtime Seminars

Join advanced personal trainer, Mike Bento of The Clubs at Charles River Park, for a one-hour, lunchtime Be Fit seminar. Topics vary

Next session:
May 25, 2010
12:00–1:00pm
Bigelow 4 Amphitheater

For more information, call 6-2900.

Support Service Employee Grant

Deadline for application is
Friday, June 11, 2010

Sponsored by MGH Training and Workforce Development, the Support Service Employee Grant Program is part of the MGH effort to recruit and retain a skilled workforce. The program is open to eligible non-exempt employees working in clinical, technical, service, and clerical positions who want to improve their skills and advance within the MGH community.

To qualify for the grant, applicants must be employed at MGH for a minimum of two years and meet additional eligibility requirements.

For more information, or to download an application, visit the HR website at: http://is.partners.org/hr/New_Web/mgh/mgh_training.htm or call John Coco at 4-3368.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Clinical pastoral education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2010 MGH Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients and families or staff who wish to integrate spiritual caregiving into their professional practice.

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 8:30am–5:00pm. Additional hours are negotiated for the clinical component.

Deadline for application is May 20, 2010

For more information, call Angelika Zollfrank at 4-3227.

Eldercare monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscovitz, 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:
May 4, 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.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,
7:30am – 5:30pm
Friday, 8:30am – 4:30pm
(closed Monday)

Platelet donations:
Monday, Tuesday, Wednesday,
Thursday,
7:30am – 5:00pm

Friday, 8:30am – 3:00pm
Appointments are available
Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

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
May 27, 2010

Be Fit seminars a 'hot' lunchtime ticket

Advanced personal trainer Mike Bento (right), answers question following recent lunchtime Be Fit session

If attendance is any indication, lunchtime Be Fit sessions are growing in popularity, attracting scores of employees from throughout MGH. Held monthly, lunchtime Be Fit sessions are sponsored by The Clubs at Charles River Park and presented by Mike Bento, advanced personal trainer. Bento embraces an evidence-based approach to health and fit-

ness, offering an assortment of training regimens and fitness tips to support safe, effective exercise.

On April 15, 2010, Bento talked about “self-myofascial release,” a technique used to increase range of motion and flexibility by gently breaking down soft-tissue adhesions and releasing painful trigger points. The process requires the use of a foam roller, a cylindrical piece of hard-celled foam, typically six inches in diameter by one or three feet long. By positioning your body atop the roller and using your own body weight to apply pressure, you essentially give yourself a deep-body massage.

Says Bento, “As you roll across the foam, look for tender areas or trigger points, and hold that position for about thirty seconds or slowly roll back and forth over the hot spot to decrease muscle density and relieve muscle aches and pains.”

The second half of the session dealt with an alternative to traditional ‘core training.’ Bento recommends exercises that provide high-muscle activation over traditional sit-ups, curls, and crunches, which can actually contribute to lower back pain. He demonstrated a number of bridge, or plank, exercises that help strengthen the core without harming the back. Contrary to popular belief, says Bento, “‘Six-pack abs’ are not a product of sit-ups as much as they’re a product of proper diet.”

For more information about lunchtime Be Fit seminars, e-mail Mike Bento at mbento@partners.org, or call The Clubs at Charles River Park at 6-2900.



*Educational offerings can now be found on the
Knight Nursing Center for Clinical & Professional Development website
http://www2.massgeneral.org/PCS/ccpd/cpd_sum.asp
For more information, call 6-3111.*

A new look for information associates



You may have noticed a subtle change at information desks throughout the hospital recently. On Wednesday, April 21,

2010, as part of the department's annual strategic planning initiative, information associates debuted a whole new look. The team was charged with choosing attire that would be more welcoming and professional as information associates are often the first people patients and visitors see when arriving at MGH.

If you like the new look, don't hesitate to let them know. A little positive reinforcement never hurt anybody!

Caring
Headlines
May 6, 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

