

Caring

Headlines

November 18, 2010

Celebrating National PT Month



Lisa Grodsky, PT, staff physical therapist, works with patient at the MGH Physical Therapy Sports Center. (See story on page 4.)

Special Nursing Grand Rounds focuses on healthcare reform

And with more than three million nurses practicing nation-wide, the nursing profession represents the largest segment of the national healthcare workforce. No matter how you look at it, nurses are going to play a pivotal role in the future of health care in this country.

I was happy to see so many in attendance at the October 28, 2010, Nursing Grand Rounds where the topic was healthcare reform: what it means to MGH nurses, and how the mid-term elections might affect this important new legislation. I was joined by my colleague, Deborah Colton, senior vice president for External Affairs, as we tried to unbundle this complicated issue in a way that was meaningful to those who will be affected most.

Framing our discussion were the recommendations issued recently by the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) who assert:

- nurses should practice to the full extent of their education and training
- nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression
- nurses should be full partners with physicians and other healthcare professionals in re-designing health care in the United States
- effective workforce-planning and policy-making require better data-collection and an improved information infrastructure

Some of the recommendations put forth by the RWJF and the IOM include:

- removing scope-of-practice barriers for nurses
- expanding opportunities for nurses to lead collaborative improvement efforts
- implementing nurse residency programs



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

- increasing the proportion of nurses with baccalaureate degrees to 80% by 2020
- doubling the number of nurses with doctoral degrees by 2020
- ensuring that nurses engage in lifelong learning
- preparing and enabling nurses to lead the change to advance health
- building an infrastructure for the collection and analysis of inter-professional healthcare workforce data

Deb provided an overview of the 2010 Affordable Care Act—what we commonly refer to as healthcare reform—and what it means in light of the current economic situation. She reminded us that this legislation represents the broadest overhaul of health care since the 1965 creation of Medicare and Medicaid. And with more than three million nurses practicing nationwide, the nursing profession represents the largest segment of the national healthcare workforce. No matter how you look at it, nurses are going to play a pivotal role in the future of health care in this country.

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Care re-design, cost-control, and the elimination of waste will be the primary focus of healthcare organizations for the foreseeable future. The more volatile the economic climate, the more important it is to remain true to our values.

What's clear is that as healthcare reform unfolds, hospitals will be called upon to do more with less. Sacrificing quality of care is not an option. Limiting access to care is not an option. If we are to maintain the same high standards of patient care, we must learn how to provide that care differently. Nurse practitioners and other advanced practice nurses are good examples of where opportunities may exist to re-design care. We must be innovative in our thinking. True reform cannot be achieved through payment reform alone.

We spoke candidly about some of the barriers and challenges confronting us (and the nation) as we work to improve health-care delivery. We talked about possible strategies such as forging partnerships with our medical and allied-health colleagues to identify problems, devise and implement solutions, and work together to achieve common goals. We know that nurses are going to play a key role in healthcare reform—so we need to be part of the decision- and policy-making efforts that will define our future.

Questions arose about the (then) upcoming mid-term elections and how they might affect the future of healthcare reform. We now know that the elections brought significant change in the balance of Congress, which will take effect in January. While some aspects of healthcare reform may be impacted by this shift in power, I think we can safely assume that the major provisions of the bill will remain unchanged. Elements

such as the need for transparency, insurance-reform, care re-design, and the need to eliminate waste and fraud from the system are embraced by both parties.

The take-home message from Nursing Grand Rounds was that the nation is facing difficult economic times. Care re-design, cost-control, and the elimination of waste will be the primary focus of healthcare organizations for the foreseeable future. The more volatile the economic climate, the more important it is to remain true to our values. We must continue to use every resource at our disposal to ensure we deliver the highest quality care to our patients and families.

If you were unable to attend this session of Nursing Grand Rounds, you'll be happy to know it was videotaped; we hope to make it available online in the near future. The Knight Nursing Center is exploring ways to disseminate information shared at grand rounds and other educational venues to a wider audience. Stay tuned.

Update

I'm happy to announce that Patrick Birkemose, RN, has accepted the role of clinical nurse specialist for the CVVH Program. And I'd like to thank Vivian Donahue, RN, for her contributions to the CVVH Program as she transitions to her new position as nursing director for the Cardiac Surgical ICU.

In this Issue

National Physical Therapy Month.....	1	Fielding the Issues I.....	12
Jeanette Ives Erickson.....	2	• an Update on the Lunder Building	
• Nursing Grand Rounds: Healthcare Reform		Fielding the Issues II.....	13
Physical Therapy Month.....	4	• Changes in POE Related to STAT Orders	
Respiratory Care Week.....	6	Disability Awareness Month.....	14
Life-Experience Narrative.....	8	Announcements.....	15
• Emily Smith, PT		2011 Jeremy Knowles Nurse Preceptor Fellowship	20
Annual Collaborative Governance Celebration.....	10		

Physical Therapy (continued)

Speaking at Recognition Reception are (l-r): Michael Sullivan, PT, director, Physical & Occupational Therapy; Jeanette Ives Erickson, RN, senior vice president for Patient Care; Emily Smith, PT, clinical specialist; Matthew Nippins, PT, senior physical therapist; Heidi Zommer, PT, senior physical therapist; and Ellen Tulchinsky, PT, staff physical therapist. Below: physical therapist, Sarah Bell, PT, of MGH West, works with a patient.

Heidi Zommer, PT, senior therapist on the inpatient service, spoke of empowerment. She recalled the time in her own journey when she metaphorically moved out of the passenger seat and began to drive her own career. She asked her colleagues, "Are you driving *your* own career?" She urged her peers to take charge of their professional lives.

As education is a key component of all aspects of physical therapy practice, an interactive educational booth was held Thursday, October 21, 2010, in the Main Corridor. Inpatient and outpatient physical therapists came together to help educate the MGH community with their, "Got Exercise?" information table. Therapists discussed exercise as a function of good health and the role exercise plays in weight loss. Handouts were distributed,

and physical therapists were available to answer questions for staff, patients, and visitors.

Continuing their annual tradition, physical therapists coordinated a community-service, fund-raising project as part of their PT Month celebration. This year's efforts supported the MGH Chelsea HealthCare Center's Power Up Program, developed by MGH Chelsea pediatrician, Wanda Gonzalez, MD. Power Up is an exercise and nutrition program designed to fight childhood obesity through the education of 9–11-year-old students and their parents. Sofia Devine, PT, designed and teaches the exercise component which includes strength-training, aerobic conditioning, dance, and yoga. Fund-raising involved weekly raffles of Red Sox, Patriots, and Bruins tickets; a baby blanket made by Margot Hallgren; a wall quilt made by Jean O'Toole,

PT; gift certificates; and a weekend stay at the Liberty Hotel. At press time, more than \$2,100 had been raised to support the Power Up Program.

Physical Therapy Month was a great success and an opportunity to celebrate the unique contributions physical therapists make to the care of patients and the communities we serve. Through these events and activities, therapists were able to demonstrate their commitment to excellent patient care, health and wellness, public education, and continued service to the community.

For more information about the services provided by the MGH Physical Therapy Department, go to: www.mghphysicaltherapy.org, or call 6-2961.



Celebrating the contributions of respiratory therapists

—by Purris Williams, RRT, respiratory therapist

Standing (l-r): Nancy Davis, RRT, respiratory therapist; David Gagnon, respiratory therapy student; Neila Altobelli, RRT, respiratory therapist; and Rai Singh, RRT, respiratory therapist. Seated: respiratory therapy students, Colby Joyce and Cindy Storey.

This year, National Respiratory Care Week was celebrated October 24–30, 2010. Since its inception in 1982 by President Reagan, this annual event has honored the contributions respiratory therapists make to patient care and positive patient outcomes. At MGH, Respiratory Care Services employs more than 85 registered therapists, many of them local and national leaders through their participation in professional associations. A number of MGH respiratory

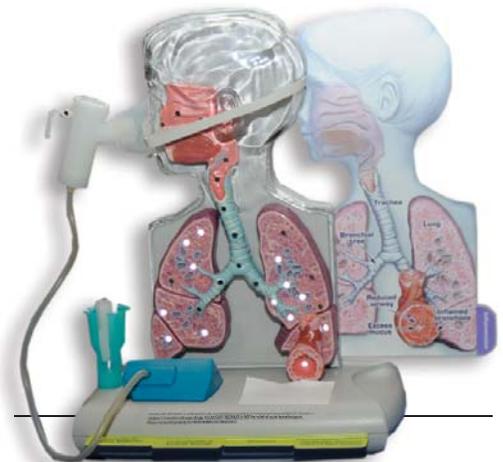
therapists have completed specialized training enabling them to transport critically ill infants from outside facilities or attend the deliveries of high-risk infants. Since 1986, respiratory therapists have provided extracorporeal life-support under the medical direction of MGH pediatric surgeons.

Says Denise Young, RN, clinical nursing supervisor, “We’re fortunate to have such a clinically strong team of respiratory therapists working with us every day.”

Respiratory therapists are highly regarded for their expertise and critical thinking in urgent situations and for their service on the Rapid Response, Adult, and Pediatric Code Blue Teams.

At MGH, respiratory therapists typically provide care to more than 80 patients a day on mechanical ventilators and another 25 with tracheostomy tubes or other artificial airways.

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Model shows how inhaled, aerosolized medication delivered by mask passes through a child's airway into the lungs.

Respiratory Care (continued)

Says Marian Jeffries, RN, clinical nurse specialist, “The comfortable relationship we share with respiratory therapists is evident every day on Ellison 19. Our collaborative practice improves care at the bedside.”

In keeping with its core values of high-quality, cost-effective care, and evidence-based practice, Respiratory Care Services is actively involved in seeking and implementing measures to prevent ventilator-associated pneumonia (VAP). Though only a small percentage of mechanically ventilated patients develop VAP, the cost of treating it is significant. Evidence suggests that a number of small practice changes, such as keeping the heads of patients’ beds elevated and avoiding unnecessary disconnections from the ventilator circuit can decrease the number of cases of VAP. A key part of a respiratory therapist’s role is daily assessment of every mechanically ventilated patient to assess his or her ‘readiness to wean’ from the ventilator. Patients who pass the assessment are given a spontaneous breathing trial. During the spontaneous breathing trial, patients are temporarily allowed to breathe without the help of the ventilator, while remaining closely monitored by the respiratory therapist. Daily assessments lead to shorter duration of mechanical ventilation and accurate identification of readiness to wean.

Below: respiratory therapist, Rai Singh, RRT, fields questions at educational booth in the Main Corridor during National Respiratory Care Week.



Joseph Kratochvil, RRT, has been a respiratory therapist for 35 years. He has seen great change over the years, both in the profession and the technology. Says Kratochvil, “The MGH Respiratory Care Department has been in existence for more than sixty years. In that time, respiratory therapists have evolved from ‘oxygen technicians’ to respected members of critical-care teams throughout the institution.”

With the national observance of Respiratory Care Week comes an opportunity for respiratory therapists and the MGH community to reflect on their practice. MGH respiratory therapists are honored to be part of the patient care team. They strive to learn and share their knowledge with patients and colleagues, day and night, during every shift they work. They rise to the challenge of serving a great institution like MGH and appreciate the unlimited opportunities for professional growth offered here.

A highlight of the week was the information table in the Main Corridor on Wednesday, October 24th. Visitors, staff, and patients stopped by with questions about asthma, sleep apnea, or inquiries about careers in respiratory care.

For more information, call MGH Respiratory Care Services at 4-4480.

Professional journey mirrors five stages of transformational relationship (marriage)

As I began to reflect, I realized I don't have many personal relationships that have lasted 22 years. I was struck by the parallels between my journey and other long-term relationships, like marriage, for instance.

My name is Emily Smith, and I am a physical therapy clinical specialist. In May, I turned 44 years old. And this past July marked my 22nd anniversary at MGH. That means I've worked at this hospital for 22 years—exactly half my life. So, when I was asked to speak at the annual PT recognition celebration, it seemed the perfect opportunity to reflect on my professional journey.

As I began to reflect, I realized I don't have many personal relationships that have lasted 22 years. I was struck by the parallels between my journey and other long-term relationships, like marriage, for instance.

According to the website, www.stayhitched.com, there are five stages in a successful marriage: romance (or the honeymoon stage); reality; child-rearing; accommodation; and transformation (or the success stage). So here are some thoughts on my professional journey as compared to a successful marriage:

Stage 1: The romance or honeymoon stage is characterized by excitement. Differences seem unimportant, even exciting, as the couple focuses on discovering each other and sharing their life together.

In 1988, I was a new graduate of Northeastern University. Earlier that year, I had done a clinical affiliation at MGH (the dating stage) and enjoyed my time as a student here, thriving in an environment where learning opportunities abounded, and challenging patients were the rule rather than the exception. I noticed that well-seasoned, experienced clinicians still worked at the bedside and thought that was a good



Emily Smith, PT, physical therapy clinical specialist

sign. There must be something special happening here. I decided this would be a great place to begin my career.

I worked on the inpatient Neurology Unit where I had an opportunity to work with a wide variety of patients and diagnoses—some I had never even heard of. Not a week went by that I didn't have to look something up. I learned something new every day about medicine, physical therapy, human behavior, and myself.

I spent my first 4½ years happily rotating through many of the inpatient units, absorbing new information—loving my profession, my job, my patients, and my colleagues. It was great.

Stage 2: In the reality stage, couples learn more about themselves and each other in situations they haven't faced before. Some encounters may not be congruent with pre-existing assumptions and expectations. Feelings of disappointment and aloneness are normal, along with a perceived 'let-down' after the excitement of the romance stage.

Some time around 1993, reality set in. The economy was down. MGH was in the midst of a major operations improvement initiative. Plans were underway to combine the two inpatient physical therapy units

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In 2005, I accepted a position as clinical specialist in the Revere HealthCare Center, sharing a position with Ellen Tighe-Ventola. Together, we now lead a great team of clinicians who provide excellent care to the citizens of Revere and beyond.

(Rehab and Chest PT). I had applied for a senior position on the Neurology Unit—twice—and didn't get it either time. (In retrospect, better candidates were chosen, but still, it stung.)

I needed a change. It came in what I thought would be a temporary, 12-month rotation in the outpatient department. But while working in the outpatient setting, rotations were put on hold while the newly combined inpatient department settled into being. I took several continuing-education courses and classes at the IHP to develop my skills and advance my care of orthopedic and neurological patients. I began to take on more complex patients with both orthopedic and neurological diagnoses. As the months passed, I found I enjoyed working with outpatients.

During this time, I survived another departmental re-organization and received a promotion. I was finally a senior therapist, but on the outpatient service, not inpatient as I had planned.

Stage 3: The child-rearing stage is a particularly critical 'new-reality.' Kids transform the focus of a family and dramatically increase the level of stress. There is much more work, distraction, time pressure, and potential conflict.

On Christmas Eve, 1997, I gave birth to my son, Isaac. I thoroughly enjoyed maternity leave, getting to know this new, little person. In 1998, I became a working, single mother. I was fortunate to come back to a part-time position as a senior therapist in the outpatient department.

But it was a struggle. I was sleep-deprived, time-constrained, and pulled in a million different directions. I often felt I wasn't doing enough at home or at work. It was hard to think about developing my practice when I'd fall asleep every time I tried to read something clinically oriented.

I wasn't sure I could be the kind of physical therapist I wanted to be. I thought about doing home care. I even thought about going into business with my sister selling candles at in-home parties.

I admit it. I was a mess.

Stage 4: In the accommodation stage, couples work on their relationship by learning about one another's needs and managing their differences and areas of conflict.

For my performance review in 1998, I struggled to come up with a single goal. When I met with my director, Mike Sullivan, I half expected him to tell me to shape up if I wanted to keep my job. But that didn't happen. He listened to me. He assured me that based on my history, he was sure I'd get my head back in the

game, and he was willing to wait. He said if my only goal was to figure out how to function as a working mother, that was okay.

It was as if a weight had been lifted from my shoulders. I gradually emerged from my post-childbearing fog. I started to get a decent night's sleep, became clearer about my clinical and professional interests, and was able to voice those interests to myself and outpatient leadership. I developed an interest in geriatrics as a way to combine my neurology, orthopedic, and medical backgrounds. I became more committed to clinical education. And I was once again excited to come to work every day.

Stage 5: In the transformation stage, couples enjoy the benefits of marriage, including mutual support and greater respect and understanding as they share their ups and downs and work to keep the relationship strong.

With the support and encouragement of Mike Sullivan, Rebecca Fishbein, our clinical specialists, and my colleagues, I began to find my place in the department again. As always at MGH, opportunities for transformation continued to present themselves accompanied by additional learning, work, and responsibility.

In 2000, when I was offered the opportunity to become the physical therapist in the newly formed Center of Excellence for Huntington's Disease, I was ready to take it on. A year later, when I was invited to serve on the Clinical Recognition Program Steering Committee, I agreed. In 2003, I began teaching at the IHP, becoming an adjunct member of the faculty in 2006. With the support of many people, I was recognized as an advanced clinician in the Clinical Recognition Program in 2005. Thanks to Ann Jampel's nomination, in 2006, I was recognized as Clinical Educator of the Year. In 2005, I accepted a position as clinical specialist in the Revere HealthCare Center, sharing a position with Ellen Tighe-Ventola. Together, we now lead a great team of clinicians who provide excellent care to the citizens of Revere and beyond. In 2007, I became a board-certified geriatric clinical specialist. I am an Excellence Every Day champion. Recently, I began serving on the QA and Safety committees in Revere, and I'm helping to create a Quality and Safety Council for PT and OT.

How's that for a "transformational relationship"?

I appreciate the opportunity to reflect on my professional journey. These past 22 years have been amazingly fulfilling and satisfying. Hopefully, this relationship will continue for another 22 years or so.

Collaborative Governance celebration

—by Mary Ellin Smith, RN, professional development manager

“Collaborative Governance has entered its teenage years,” said Gaurdia Banister, RN, executive director of The Institute for Patient Care. And judging by the excitement of those attending the collaborative governance celebration, Wednesday, October 27, 2010, those adolescent years will be marked by achievement, engagement, and continued success.

Jeanette Ives Erickson, RN, senior vice president for Patient Care, spoke of that success in her opening remarks describing the empowerment clinicians feel as they bring their voice to important clinical decisions.

Banister, spoke of the re-design of collaborative governance in terms of teenage angst. Adolescence is a time of exploration, experimentation, often frustration, but also incredible growth. She thanked committee members and leaders for their dedication and hard work, acknowledging that their efforts have influenced how we practice at MGH.

Keynote speaker, Colleen Person, RN, senior consultant at Creative Health Care Management, spoke about Caring Relationships: the Essence of Professional Practice. She told of her meetings with MGH staff and leadership and how impressed she was that everyone she met reflected a shared purpose to keep patients and

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Keynote speaker, Colleen Person, RN, senior consultant at Creative Health Care Management, speaks about Caring Relationships: the Essence of Professional Practice, at annual Collaborative Governance celebration.



Collaborative Governance (continued)

families at the center of their work. Success comes from working together as collaborative teams, reaching across disciplines and settings to achieve common goals.

Person shared a quote from Mary Koloroutis, RN: “We experience the essence of care in the moment when one human being connects to another.” This engagement and involvement is essential in all disciplines if we are to deliver care that is meaningful, compassionate, and humane. She encouraged everyone

present to pause for a moment to recognize and celebrate their success.

Following Person’s presentation, Banister and Ives Erickson acknowledged outgoing collaborative governance leaders:

- Ginger Capasso, RN, advisor, Nursing Research Committee
- Chelby Cierpial, RN, co-chair, Nursing Research Committee
- Nancy Davis, RRT, co-chair, Patient Education Committee
- Audrey Jasey, RN, co-chair, Diversity Committee
- Edna Riley, RN, co-chair, Nursing Practice Committee
- Susan Warchal, RN, co-chair, Ethics in Clinical Practice Committee

A reception was held in the East Garden Dining Room following the program. For more information about collaborative governance, or to apply for membership to a committee, contact Mary Ellin Smith, RN, at 4-5801.



Clockwise from top left: Gaurdia Banister, RN, executive director, The Institute for Patient Care; Audrey Jasey, RN, outgoing co-chair of the Diversity Committee; Susan Warchal, RN, outgoing co-chair of the Ethics in Clinical Practice Committee, with Jeanette Ives Erickson, RN; attendees applaud collaborative governance leaders; and Edna Riley, RN, outgoing co-chair of the Nursing Practice Committee.

An update on construction of the Lunder Building

Work on B3C, now called The Lunder Building thanks to a generous donation, is progressing on schedule. Almost all outside construction is done. Work now is focusing on finishing touches, such as nursing stations, ceilings, floors, and gardens.

Question: What is the status of the Building for the Third Century (B3C)?

Jeanette: Work on B3C, now called The Lunder Building thanks to a generous donation, is progressing on schedule. Almost all outside construction is done. Work now is focusing on finishing touches, such as nursing stations, ceilings, floors, and gardens.

Question: Gardens? On inpatient units?

Jeanette: Yes. There will be a bamboo garden on the 6th floor and a hanging-garden atrium between the 7th and 10th floors.

Question: How many floors will there be?

Jeanette: The Lunder Building will have 14 floors. Inpatient units will occupy the 6th through 10th floors. The 6th floor will house the Neuro ICU; floors 7 and 8 will house neuro acute-care units; and the 9th and 10th will be medical oncology units.

Question: What about the first five floors?

Jeanette: The first five floors will house the Emergency Department, Radiation Oncology, operating rooms, the receiving dock, and Sterile Processing.

Question: What will the units look like?

Jeanette: Inpatient units will be comprised of two C-shaped sub-units. Each sub-unit will have interaction zones, its own nursing station and support areas, including medication, clean supply, soiled workroom, equipment storage, and a housekeeping area. All inpatient units will have private beds that can be centrally monitored and visible from the nursing station. Each patient room will have its own self-contained nursing station.

Question: When will the building be finished and occupied?

Jeanette: We're hoping that The Lunder Building will be finished by the spring of 2011. We expect the first units to move into their new space next summer.

Question: Will employees be able to see the inside of the building prior to its opening?

Jeanette: We plan to have a series of open houses once all the work is completed. Employees will be invited to tour the new building before it officially opens.

2011 is an important year for MGH, marking our 200th anniversary. The opening of The Lunder Building is a wonderful way to celebrate our bicentennial and re-commit ourselves to the patients, staff, and communities we serve.

For more information about The Lunder Building, contact George Reardon at 6-5392.

For information about our bicentennial celebration, contact Lynn Dale at 6-0954.

Changes in POE for radiology examinations

On November 9, 2010, the system for ordering radiology examinations in POE was updated. Effective immediately, all inpatient exams can be ordered as routine, STAT, or other, and emergency examinations can be ordered as routine or STAT. Examinations requested as routine will include an anticipated turn-around time so clinicians will know what to expect. These changes will help Radiology more accurately prioritize urgent cases and improve patient safety. The following Q&As were prepared by the department of Radiology.

Question: What does STAT mean?

Answer: STAT comes from the Latin word, statim, meaning immediate. In medicine, it's used to denote an emergency situation. MGH Imaging defines 'medical emergency' as a situation where a patient is so ill, he or she cannot wait an hour. If a patient is able to wait for patient transport, the examination should not be considered STAT. In a true STAT situation, medical staff should be prepared to transport the patient immediately.

Question: What constitutes a routine examination?

Answer: Routine is the default option and should be used in almost all cases. The new POE screen includes the anticipated turn-around time for routine examinations.

Question: What about 'other'?

Answer: When you click, other, a pop-up box will appear giving you an opportunity to provide additional information to help radiologists appropriately prioritize the request. Some examples of other might be: pending discharge, prior to morning rounds, or unit will call.

Question: When should STAT be requested?

Answer: It is appropriate to request STAT exams in cases of acute patient de-compensation or when a procedure can't be performed without images (OR cases, for example).

STAT examinations are expensive and cause other patients to be delayed. STAT exams should only be requested in emergent situations as previously described. Effective immediately, when you select STAT in POE, a dialog box will appear asking the ordering physician to call the STAT Emergency line to state the reason for the request. If authorized, you'll be instructed where to bring the patient immediately.

Question: I don't see the STAT read option in POE anymore.

Answer: The STAT read option was removed from POE because all STAT exams automatically receive a STAT read.

Question: It would be easier if we had the ability to select a time to schedule an exam. Is that possible?

Answer: MGH Imaging conducted a pilot in the MICU where staff could schedule inpatient radiology exams. The percentage of STAT requests dropped from 65% to 14%. We do plan to incorporate a scheduling component into the system at some point, but it may take a while. Stay tuned.

Question: When ordering Nuclear Medicine exams, I often get a message to call the department directly. Now will I have to call the STAT hotline too?

Answer: No. Same as before, call Nuclear Medicine at 617-725-8350.

Question: Why is there no 'other' category for ED requests?

Answer: All ED exams are done with as little delay as possible so there's no need to further prioritize.

For more information about ordering radiology exams, contact Jennifer Davenport at 6-9048, or Della Abedi-Tari at 6-6680.

Disability Awareness Month at MGH

—by Zary Amirhosseini, disability program manager

Below: patient advocate coordinator, Lani Mauricio, staffs informational booth in the Main Corridor during Disability Awareness Month.

Below right: author, Lisa Iezzoni, MD, speaks in The Blum Patient & Family Learning Center.

Efforts to raise awareness about equality in the workplace as it relates to individuals with disabilities began in 1945 when Congress enacted a law declaring the first week in October, National Employ the Physically Handicapped Week. In 1962, the word 'physically' was removed to acknowledge the employment needs and contributions of individuals with all types of disabilities. And in 1988, Congress expanded the observance to a full month changing the name to, National Disability Employment Awareness Month.

During the month of October, to help raise awareness about this important subject, informational booths and presentations

were held at MGH to spotlight some of the resources available. It was hoped that events would help educate the hospital community about issues related to accessibility of care for individual with physical and cognitive disabilities. A wide array of services and organizations was featured:

- MGH Deaf Services: American Sign Language, and CART services for deaf or hard-of-hearing patients
- Occupational Health Services
- Boston Center for Independent Living (www.bostoncil.org)
- *65plus*: information related to the care of older adults (Deborah D'Avolio, 643-4873)
- The Institute for Community Inclusion at UMass, Boston
- Paralyzed Veterans of America (www.pva.org)
- Massachusetts Rehabilitation Commission
- Fidelity House Human Services



Author, Lisa Iezzoni, MD, was on hand to talk about her book, *More Than Ramps: a Guide to Improving Health Care Quality and Access for People with Disabilities*, and speak candidly about the challenges and obstacles faced by many.

Treadwell Library displayed books and journals featuring disability-related articles by MGH staff.

For more information, contact Zary Amirhosseini, disability program manager, through the Office of Patient Advocacy (at 6-3370), or e-mail MGHaccessibility@partners.org.

Announcements

Are you Gluten-intolerant?

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

For more information, visit:
www.gfhomecooking.com

Bridge construction affects MGH

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

For the latest in traffic changes, access the Department of Transportation website at www.mass.gov/massdot/charlesriverbridges.

Collaborative Governance

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

How to write an Abstract

The Research Committee is hosting its annual class on, "How to Write an Abstract for a Nursing Research Expo Poster," presented by Carolyn Paul.

December 3, 2010
12:00–1:00pm
Buckley Conference Room
Blake 8
1 contact hour

For more information, call 4-1526.

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.

Call for Abstracts Nursing Research Expo May, 2011

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

Categories:
Original Research
Research Utilization
Performance Improvement

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

Abstracts must be received by January 31, 2011.

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.

Next session:
December 14, 2010
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome
Feel free to bring a 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.

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2011 Jeremy Knowles Nurse Preceptors

—by Mary Ellin Smith, RN, professional development manager

Henderson
and Swigar Droste
receive 2011
Jeremy Knowles
Nurse Preceptor
Fellowship.

This year's recipients of the Jeremy Knowles Nurse Preceptor Fellowship are Katherine Swigar Droste, RN, staff nurse in the Ellison 9 Cardiac Intensive Care Unit, and Elizabeth Henderson, RN, staff nurse in the Emergency Department.

Swigar Droste graduated from the Crouse-Irving Memorial School of Nursing and received her bachelor of science degree in Nursing from the University of Massachusetts. She has worked in the Cardiac Intensive Care Unit since 1998 and has precepted 14 nurses, ten of who were new graduates. One of Swigar Droste's preceptees, Christie Majocha, RN, wrote in her letter of support, "Katie was not only a great source of knowledge, but from the start, she was interested in what I could bring to the team. I found this very encouraging, and I know I acclimated to the environment and pace of the unit more quickly because of her."

Henderson is a graduate of Northeastern University and currently enrolled in the MS/PhD program at Boston College. She has practiced at MGH since 2001; prior to working in the ED, she worked in the Bigelow 13 Burn Unit. Patricia Mian, RN, clinical nurse specialist in the Emergency Department, wrote, "Elizabeth is an expert clinical teacher and resource. She also models the professional and human side of nursing during this crucial orientation period. She teaches her preceptees both the art and science of nursing."

The Jeremy Knowles Nurse Preceptor Fellowship was established to recognize and honor exceptional nurse preceptors who exhibit the qualities of scientific inquiry, teamwork, compassion, and leadership. Knowles preceptors are distinguished for their excellence in educating and inspiring new nurses and advancing their clinical and professional development. Recipients receive financial support to promote their educational and professional development as clinicians, preceptors, and mentors.

For more information, please contact Mary Ellin Smith, RN, at 4-5801.

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