

Caring

Headlines

September 2, 2010

Blending science and storytelling

One discipline's journey toward a meaningful narrative culture



(Top row, l-r): Mary Knab, PT; Ann Jampel, PT; Rebecca Fishbein, PT, and Michael Sullivan, PT, at recent in-service presentation for out-patient physical and occupational therapists. See story on page 4.

An interview with our new director of the Office of Patient Advocacy

As reported in the July 22, 2010, issue of Caring Headlines, Robin Lipkis-Orlando, RN, formerly the nursing director for Inpatient Psychiatry, has assumed the role of director of the MGH Office of Patient Advocacy. The Office of Patient Advocacy serves as liaison between patients and the hospital, responding to patient inquiries, grievances, and accolades.

In her role as director, Robin will also oversee the MGH Disabilities Program.

Many of us know Robin from her years as a staff nurse and nursing director, but for those who don't, I thought this would be a good opportunity to get to know her.



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

Jeanette: Robin, how are you enjoying your new role as director of the Office of Patient Advocacy?

Robin: I'm thrilled to have the opportunity to shape and expand the services provided by this department. The work of the Office of Patient Advocacy is crucial to the success of MGH. I've only been in this role for eight weeks, and I've spent much of that time meeting with my predecessor, Sally Millar, who was director for 14 years. Sally ushered the department through a pivotal period of growth and change, and I'm fortunate to have her as a resource as I transition into this role. (Millar left the Office of Patient Advocacy to focus on Informatics and the Acute Care Documentation project.) I've also been meeting with key members of PCS leadership and shadowing the advocates to get a sense of how they work.

Jeanette: What is your vision for the future of the Office of Patient Advocacy?

Robin: I really want to instill in all employees a sense that patient advocacy is everyone's responsibility. I want to help foster collaboration between patients, families, and healthcare providers in all aspects of care

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and decision-making. I think there are opportunities to educate staff about the issues we hear about from patients; to keep staff informed about the trends we see and use that feedback to improve care and services. We're in a position to help design meaningful programs, enhance access to care and services, and promote our reputation as the provider of choice for patients with diverse needs.

Jeanette: Is it too soon to have a plan to achieve those goals?

Robin: Achieving these goals will require the participation of every member of the MGH community. We'll seek input from our wonderful patient-family advisory councils. We'll work closely with departments that play a key role in improving the patient and fam-

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ily experience. And I can foresee the Office of Patient Advocacy forming a patient-family advisory council of our own. This is something I plan to explore in the coming year.

Not everyone knows about the Office of Patient Advocacy, so I'd like to increase our visibility through unit rounds and other avenues. I think having our team serve as greeters in the Main Lobby would go a long way toward raising awareness. We're exploring a number of strategies.

Jeanette: What are some of the responsibilities of the advocates?

Robin: I'm lucky to have a committed and capable team of advocates. No two days are the same. We listen to concerns voiced by patients and families; respond to complaints; explain hospital policies and procedures; provide information on various services; clarify healthcare information; act as liaison between patients and clinicians when there's a difference of opinion; participate in meetings to represent the patient and family's perspective; identify quality-improvement and patient-safety opportunities; and receive accolades about positive patient experiences and share that feedback with the clinical team.

Jeanette: And the patient advocates are...?

Robin: We currently have four patient advocates: Diann Burnham, RN; Denise Flaherty, RN; Linda Kane, LCSW; and Stephen Reardon. Our advocacy coordinator and notary public is Lani Mauricio. We recently welcomed Zary Amirhosseini as disability program manager. We'll be undertaking new and important work to enhance our environment and increase our knowledge around caring for, and working with, people with disabilities.

Each member of the team brings a wealth of knowledge and experience. They're an incredible support to clinicians, patients, and families.

Jeanette: Where is the Office of Patient Advocacy?

Robin: The office is located on the lower level of the Wang Building (WACC -018). We can be reached at 617-726-3370.

Jeanette: Robin, thank-you for speaking with us. We all look forward to supporting and working with you as you take on this important role.

Updates

I'm happy to announce that Adele Keeley, RN, will assume the nursing director position for the Bigelow 7 Inpatient Gynecology Unit starting September 7, 2010.

Cynthia Moreira Bowes, RN, has accepted the position of clinical nurse specialist for the Yawkey 8 Infusion Unit.

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Blending science and storytelling

PT's journey toward a meaningful narrative culture

—by Rebecca Fishbein, PT; Ann Jampel, PT; Mary Knab, PT; and Michael Sullivan, PT

Ann Jampel, PT (left); Michael Sullivan, PT; and Mary Knab, PT, at recent physical and occupational therapy out-patient in-service presentation

As members of Patient Care Services, we take pride in working in a narrative culture. But how many of us stop to consider what that means or whether we really do have a narrative culture? Are we exploring ways to enhance our use of narratives as a tool to develop practice, foster self-exploration, and advance learning? Clinicians in Physical and Occupational Therapy have

grappled with these questions since the inception of the Clinical Recognition Program and continue to explore ways to enrich their practice through the sharing of narratives.

Says Michael Sullivan, director of Physical and Occupational Therapy, “Our journey to understand narratives began during the early days of the Clinical Recognition Program. I’d be lying if I said that incorporating narratives was a natural fit for our staff. As clinicians more adept with facts and scientific data, we were more comfortable with empirical evidence and case studies as a means of learning from our patient experiences.”

Complicating matters, says Sullivan, is the fact that, “Physical and Occupational Therapy had a longstanding supervisory model for guiding staff in clinical and professional development. It’s a process that occurs naturally as staff seek help from clinical specialists in managing patients and consult more experienced clinicians about their professional goals.”

The first year of the Clinical Recognition Program required the use of narratives as part of our review process. The goal was to place each staff member at one of four levels: entry-level, clinician, advanced clinician, or clinical scholar. But using a single narrative to determine whether staff were entry or clinician level, “ran counter to our philosophy and had the potential to result in incorrect decisions,” says Sullivan. “I wondered how we could merge our model with the clinical narrative model, which I perceived could have great value.”

To resolve this conundrum, we sought advice from authority, Gail Jensen, PT, who had developed a model of acquisition of professional expertise in Physical

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Physical Therapy (continued)

Therapy. As Patricia Benner had done in nursing, Jensen used clinical narratives to inform her research.

Recalls Sullivan, “The guidance we received from Dr. Jensen was a pivotal moment for the department. Gail enlightened us to the value narratives hold as a tool in exploring and understanding clinical experiences. Most importantly, she helped us understand that narratives could be an essential alternative approach to reflecting on how we think about our patients.”

Sullivan began to think differently about narratives. “As a department, we revised our staff competencies and annual review documents to reflect the Clinical Recognition Program levels and worked with clinical leadership to consistently use the language of the Clinical Recognition Program in their interactions with staff. This not only ensured consistency of recommendations around placement levels but freed narratives from being the sole evidence for those recommendations. It allowed me to change my approach as I met with staff to discuss their narratives. What once felt like an ‘interrogation’ became an opportunity to co-construct their experiences caring for patients. Today, when I meet with staff, I try to understand not only the learning they take away from a particular patient situation, but also their experience writing the narrative. I’ve been surprised by how frequently staff articulate specific insights derived from this process of reflective writing.”

Therapist, Amanda Kunkel, PT, said during a narrative un-bundling session with Sullivan, “I enjoy writing... so it didn’t feel like a chore. I knew this patient had been a turning point for me... but putting it down in writing, even more than reflecting back... made me realize a little more than I had realized in that moment.”

Since the inception of the Clinical Recognition Program, Sullivan has read and helped co-construct hundreds of narratives with entry- and clinician-level physical and occupational therapists. Recently, along with colleagues Gail Jensen, PT; Ann Jampel, PT; and Mary Knab, PT, Sullivan presented these experiences at the American Physical Therapy Association’s Combined Sections Meeting. In preparing that presentation, Sullivan kept coming back to one question: “So where are we now?”

In an attempt to answer that question, the department held focus groups comprised of entry, clinician, and advanced level staff to better understand their perceptions of narrative-writing and the clinical recognition process. Focus groups revealed that staff strongly

value the narrative-writing and un-bundling process and wonder where this will lead as a department.

“That doesn’t surprise me,” says Knab. “The process of narrative-writing and un-bundling offers clinicians a powerful tool for learning from their own clinical practice.” Physical and occupational therapists, like many healthcare professionals, are taught to rely on empirical data and scientific evidence to inform clinical practice. Says Knab, “That’s not a bad thing. But you run the risk of producing health professionals who are unable to leverage other equally important ways of discovering truth and gaining clinical knowledge. I’m referring to narrative-writing as an alternative way of ‘knowing.’”

Where the scientific approach seeks knowledge free of personal meaning, narratives focus on contextual knowledge and the meaning that can be gleaned from specific patient encounters. The former relies on controlled methods of study; the latter grows out of reflecting on, writing about, and sharing our stories from clinical practice. A growing number of theorists and health educators assert that we need to become equally good at both if we’re to successfully provide patient-centered, evidence-based care of the highest quality.

So where *are* we now? Leadership of PT and OT have discussed an expanded use of narratives. Recently, the two departments held an in-service presentation for out-patient staff to talk about and share narratives.

Says Jampel, “We’ve used narratives over the past year as part of our monthly clinical instructor group. Staff members working with students wrote narratives about specific patient experiences they had with their students. Both the writers of the narratives and the clinical instructors who acted as un-bundlers reported they gained insight into clinical practice and their role as clinical teachers through these rich discussions.”

Says Sullivan, “I’m privileged to have the opportunity to read narratives and speak with our staff about their clinical experiences in a manner far different from the one in which I was educated. I have learned an enormous amount from them through these experiences and have a growing appreciation for the value narratives afford in our understanding of the clinical experience. I believe there is enormous un-tapped potential that can be leveraged even more fully.”

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The Hausman Fellowship and reflections on the importance of a diverse workforce

—by Deborah Washington, RN, director, PCS Diversity Program

Why is it important to have a diverse professional workforce? What does it take to find and hire baccalaureate-prepared or advanced-practice minority nurses? What circumstances make getting through nursing school different if you're black, Hispanic, or Asian? Gone are the days when diversity means hiring, 'at least one.'

At MGH we've made great strides in our diversity program. But there is still more to do. I'm reminded of

2010 Hausman fellows, Penny Marengé (left) and Jason Villarreal, with fellowship co-chair, Bernice McField-Avila, MD



(Photo by Paul Batista)

this whenever I teach the diversity portion of the RN Orientation Program. Nurses from all over the world apply to work here. As new hires, they see our organization with fresh eyes. Often, they comment on how few minorities they see among our professional staff.

And then there's the paradox presented to me in a recent hallway conversation with a colleague. In talking about our diversity journey, she said, "We seek change without change." That thought-provoking statement isn't easy to accept, which is precisely why we can't dismiss it. Which brings me to Jason and Penny and the Hausman Fellowship.

The Hausman Fellowship was created in 2007 to help promote recruitment of minority nurses to better meet the needs of our diverse patient population. The fellowship has a distinct design, a clear purpose, and a solid focus on outcomes. Penny Marengé and Jason Villarreal are the 2010 Hausman fellows. As nursing students, they spent eight weeks rotating through clinical sites to broaden their nursing knowledge, learn leadership skills, and explore the significance of cultural identity and its influence on patient care. Each week, Bernice McField-Avila, MD, co-chair of the fellowship, and I met with Penny and Jason. Through these conversations we monitored the growth of these young professionals as they interacted with the MGH community.

Does it take something special to teach a minority student or hire and retain a minority nurse? Is it really that important to have a diverse workforce? How often have we heard that our workforce should mirror our patient population? Can MGH, a predominately non-

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minority professional environment, provide a learning experience that's meaningful to minority students?

Look at these quotes from Jason's daily journal.

"Thank-you for teaching by example." "I felt welcomed the moment I stepped onto the unit." "Thank-you for having confidence in me." "I saw mutual respect for patients and student nurses." "It was not lost on me that you introduced yourself, not as a preceptor, but as a colleague."

Confidence-instilling minority and non-minority teachers provided a flawless learning experience for our Hausman fellows. First-time experiences, if handled well, can be the foundation of a strong sense of self.

Again, quotes from Jason's journal demonstrate what I mean as he talks about doing his first-ever vital signs on a child, his first exposure to oncology care, and his first night shift. Or this one: "It was the first time I ever had a conversation in Spanish with a person from China about an article written in Cantonese." The sheer joy of learning is evident in these words.

If we truly want a workforce that mirrors our patient population, we need to do something to make that claim real. We need to teach and hire. In the minority-non-minority dyad, it should be indistinguishable when identifying the ones who gain.

The Hausman Fellowship follows non-traditional pathways to help students accumulate knowledge. Take the experience of spending time at the White Front Desk. "It was evident that you do your work always thinking of the other person, regardless of whether she is old, young, immigrant, lost, angry, or in a hurry."

Interviews with hospital leaders open students' eyes to concepts such as having a vision for the future, overcoming hardship, and having a plan for your career. As Penny wrote: "I spent most of the weekend researching the people I would be interviewing, the work they had done, the committees they chaired, the colleges they had attended."

Then, of course, there are the sobering moments. "For the first time I literally walked with a patient on her last journey as staff caringly prepared her body then escorted her as a team to the morgue."

How is it different being a minority nursing student? Perhaps the answer is whom students turn to for guidance. Jason wrote, "Please pass along my thanks to the USA on your unit. I'd like to thank him for his soft-spoken wisdom." Maybe the difference is in the minority student's view of the world. "Thanks for the great conversations about community health, health disparities, and our work to end them. I took particular enjoyment in our lunchtime conversations about issues

affecting society and healthcare-delivery—from sexuality to sexual identity to ethnicity, socio-economics, and much more."

I wonder how often this kind of conversation takes place among individuals who aren't ethnically or culturally different. Does the 'emotional intelligence' of a minority nurse frame the patient experience differently? For some time now, we have been adding to our understanding of the subtleties of how people from different cultures communicate. Penny wrote: "Today was by far the hardest day, emotionally. Working with nurse M, we provided patient education to two newly diagnosed breast-cancer patients. At one point, I had to blink back tears. One patient mentioned that she was starting college in the fall. It made me think about how the people we interact with every day may be going through so much. We don't stop and get to know what's going on in the lives of others."

Perhaps the greatest outcomes of this fellowship are enhanced self-knowledge and clinical skills. As Penny put it: "Two months ago I walked into MGH to interview for the Hausman fellowship wearing the same outfit I have on today. The outfit may be the same, but the person inside is definitely not. We are forever indebted to the Hausman family for their investment in the lives of minorities students. The Hausman fellowship is a journey. Throughout this journey, I experienced diversity on so many fronts—from shadowing a male nurse and learning about the challenges he faced in a field dominated by women; to interviewing the chair of the Gay, Lesbian, and Transgender Group and seeing how far they've come in terms of acceptance and integration into the organization; to watching a volunteer in a wheelchair make his way through the corridors of the hospital."

The questions posed in the first paragraph are central to what must be considered if we are to bring diversity to our nursing staff. The goal is recruitment *and* retention. Why is it important? What makes it so complex? What do we have to do to eliminate barriers to a nursing career for minority students? If we're uncertain about the answers to these questions, then our work is cut out for us. We want MGH to be the place nurses come to learn and flourish. There are no secondary considerations as to who those nurses will or can be.

As so clearly stated by one Hausman Fellow, "Every day I'm so grateful I was chosen. I'm glad there will be more fellows next year. There are so many minority students who just need that one person to believe in them."

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Evidence-based practice growing at MGH

—by Lynda Brandt, RN, clinical project specialist, and Liz Johnson, RN, clinical nurse specialist

In making crucial decisions about patient-care delivery, it is essential that our practice be evidence-based. The Re-Tooling for Evidence-Based Nursing Practice project is funded by the Division of Nursing of the Bureau of Health Professions, Health Resources and Services Administration. The goal of the project is to infuse a common language and understanding of evidence-based practice (EBP) throughout MGH Nursing. Launched in January, 2010, through The Institute for Patient Care, the EBP project has reached more than 500 MGH nurses through classes, forums, and HealthStream courses. The aim is to provide nurses with opportunities for education and skill-development in order to provide high quality care to our patients using best evidence.

In May, 20 nurse leaders from a variety of specialties attended a three-day workshop, The Clinical Inquiry Institute: an Evidence-Based Approach, designed to teach the philosophy, science, and procedures of evidence-based practice. Nationally recognized expert, Marita Titler, RN, professor of Nursing and associate dean for Practice and Clinical Scholar-

ship at the University of Michigan School of Nursing, brought humor, candor, and a remarkable depth of clinical knowledge to the course. Titler authored The Iowa Model of Evidence-Based Practice to Promote Quality Care with a focus on evidence-based practice as an organizational endeavor.

Titler challenged nursing directors, clinical nurse specialists, and staff development specialists during the three-day workshop. Interactive discussion gave participants a new perspective on evidence-based practice. Participants learned how to articulate evidence-based questions, navigate the evidence-based practice process, and identify strategies to implement practice changes based on evidence and new nursing knowledge.



(Photos provided by staff)

These on-going seminars provide opportunities to network and refine skills. The goal is to educate a community of nurse experts who can help translate nursing knowledge into practice. These experts will be poised to support their colleagues interested in implementing evidence-based changes on their units.

The Evidence-Based Practice project team offers monthly classes on the principles and strategies of evidence-based practice. Classes are listed on the calendar of The Norman Knight Nursing Center for Clinical & Professional Development. Consultation is available for nurses interested in evidence-based practice, and the team is available to teach, lead discussions, or help start unit-based journal clubs. For more information, contact Lynda Brandt, RN, at 643-6671.

Above: Marita Titler, RN, professor of Nursing at University of Michigan School of Nursing, confers with workshop participant

Below: MGH nurses who attended the three-day Clinical Inquiry Institute workshop

Looking back at an auspicious moment in MGH history

On Friday, August 20, 2010, MGH paused to observe an auspicious anniversary. Two hundred years earlier, on August 20, 1810, prominent physicians, James Jackson, MD, and John Collins Warren, MD, wrote a letter to the citizens of Boston articulating the need for a hospital and requesting financial support to build one. The letter described

how the poor and disenfranchised in post-colonial Boston had few places to turn when they were sick or injured.

It was this letter that first articulated the quote that now graces the Main Lobby of MGH welcoming visitors as they arrive: “When in distress every man becomes our neighbor.” Bostonians were inspired, and funds poured in. On February 25, 1811, the Massachusetts Legislature granted a charter to establish Massachusetts General Hospital. And the rest, as they say, is history.

On August 20th, the MGH community came together to hear a reading of this landmark document from the balcony of the Bulfinch Building. Before hundreds of employees and visitors and several descendants of Drs. Jackson and Warren, chief of Emergency Services,

Alasdair Conn, MD, introduced speaker, Tyrone Latin, who delivered a stirring reading of the historic letter.

Said MGH president, Peter Slavin, MD, “We hope everyone will take a moment to reflect on the meaning of this anniversary. We want to thank our staff and volunteers, donors, patients, and families. It is your dedication, skill, and support that has brought us to this moment in time and will carry us into the next century of MGH history.”

Below: employees and members of the extended MGH community gather on the Bulfinch lawn to hear a reading of the historic letter containing the quote, “When in distress every man becomes our neighbor.”

At right: MGH employee, Tyrone Latin reads the letter.



Making time for the important things

new graduate nurse's experience in the Neuro ICU



Sarah Abbott, RN, staff nurse,
Neuroscience ICU

I knew caring for Mr. M would test my organizational skills as he was receiving multiple medications around the clock and in-depth neurological exams every two hours.

My name is Sarah Abbott, and I am a new graduate nurse in the Neuroscience Intensive Care Unit. As a new nurse, sometimes the tasks seem endless and daunting. The pills that have to be crushed, the IV antibiotics that need to be hung, the neurological exam that needs to be completed. The list never seems to get shorter. Although my novice practice is still evolving, I've already come to realize that sometimes the smallest things can make the biggest difference in a patient's outcome.

I recently found myself taking care of Mr. M, a 38-year-old man who had been in a horrific accident. He'd been riding his bicycle when he was struck by a truck and propelled head first into the windshield of an oncoming vehicle. Though Mr. M had been wearing a helmet, he suffered severe traumatic brain injuries requiring him to be admitted to the Neuro ICU. Mr. M's condition was critical for many weeks as his primary injuries (multiple skull and facial fractures) were complicated by swelling of his brain. As Mr. M's brain became increasingly swollen, his intracranial pressure rose to dangerous levels requiring the placement of an extra-ventricular drain. Unfortunately, the pressure in his brain continued to increase, so it was necessary to

perform a bilateral hemi-craniotomy to remove a large portion of his skull. Because of Mr. M's dependence on a ventilator, he also needed tracheostomy and gastrostomy tubes placed.

When I received report on Mr. M, his neurological status was critical but stable. He was barely able to open his eyes spontaneously and unable to track or focus. He couldn't speak, stick out his tongue, or respond to commands with his upper extremities. He was able to bend his knee slightly, but only on his left side. On the plus side, Mr. M's intracranial pressures were now under control, and he had been weaned off the ventilator to a trach mask.

I knew caring for Mr. M would test my organizational skills as he was receiving multiple medications around the clock and in-depth neurological exams every two hours. The extra-ventricular drain and his intracranial pressures needed constant monitoring; he required suctioning and tracheostomy care; and he was scheduled for a chest X-ray and head CT scan.

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When we finished, Mr. M sat neatly upright surrounded by pillows, his helmet protecting his very delicate head. I felt a sense of accomplishment as I looked at the man sitting before me. While Mr. M couldn't tell me how he felt, his family observed, "He looks more like himself."

I discussed my plan for the day with my preceptor who offered suggestions about prioritizing. I began by assessing Mr. M's vital signs, monitor settings and a multitude of IV solutions. I made a mental (and written) list of the tasks I needed to accomplish. I did a complete neurological exam from head to toe. I listened to his lung and abdominal sounds and did a full body assessment. I gathered and administered medications. I re-positioned, suctioned, and provided mouth care.

Mr. M seemed a bit better than I had expected. His "Get to Know Me" poster (a pictorial tool used for patients who are unconscious or unable to communicate with staff) was filled with pictures of a person who looked very different from the one who lay before me. They showed a young, vivacious man loved by family and friends. A big, warm smile stared at me from the photographs. The Mr. M I knew had a blank expression, nothing that resembled the youthful, happy man in the pictures. A sadness crept up inside me. But I had to set it aside as I prepared for Mr. M's portable CT scan.

Somewhere between morning rounds and visits with family, I found a moment to collect my thoughts. What next? I looked at my list and saw, "Out of bed." I looked at Mr. M and the room filled with tubes, lines, and cords all connected in one way or another to my patient. I made the decision that getting Mr. M out of bed was my new top priority.

I'm aware of the benefits associated with getting patients up out of bed. I knew it would improve Mr. M's respiratory status and decrease his risk of contracting pressure ulcers. It would help maintain his musculoskeletal system and foster normal bowel function. Transferring Mr. M to his chair would decrease his chances of getting a blood clot. Any one of these benefits would be enough to want to mobilize Mr. M. But my mind went to that big smile I saw in the pictures. Before his accident, Mr. M had been a normal, healthy adult with no ailments or limitations. Now, he was a very sick man who required help in every aspect of his daily living. While in my care, I was responsible not only for completing tests and exams and administering medications, but also for Mr. M's emotional health. If nothing else, getting him out of bed and into a chair would be a major step in helping him feel better.

Deciding to get someone out of bed and *actually* getting someone out of bed are two very different things, especially in an ICU. I realized this was going to take some time and require a few more sets of hands. Mr. M was attached to numerous monitoring and assistive machines, and he was temporarily missing a large portion of his skull. But I was determined to help him get out of bed. I got a chair lift, a protective helmet, and called a co-worker for some much needed help. The process became an elaborate dance of un-hooking and hooking wires and tubes, keeping a close eye on Mr. M's vital signs and equipment, and ensuring he remained safe. From start to finish, the process took about 30 minutes.

When we finished, Mr. M sat neatly upright surrounded by pillows, his helmet protecting his very delicate head. I felt a sense of accomplishment as I looked at the man sitting before me. While Mr. M couldn't tell me how he felt, his family observed, "He looks more like himself." Though busy, the rest of my shift went smoothly. It had been well worth the time and effort to get Mr. M out of bed.

In my brief experience as a nurse, I've had days when I thought I'd never complete all the tasks necessary to care for my patients. In a setting where a patient's status can change dramatically in an instant, it seems there's never enough time. But when the opportunity presents itself to do a little bit more, even if time is limited—seize it. I can't say that Mr. M's outcome was influenced by my actions, but I do know that his family saw a little more of him sitting in that chair that day. Working with Mr. M taught me to always re-assess my priorities and plan of care and never underestimate the power of seemingly small things—things like getting a patient out of bed for a little while.

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

People may forget the things you say, but they never forget the way you make them feel. Sarah is a new nurse. Her enthusiasm, apprehension, determination, and commitment to her patients all come through in this wonderful story. Even with 'the list' of tasks fresh in her mind, Sarah recognized the importance of getting Mr. M out of bed—not just for his physical well-being, but for his and his family's emotional well-being. Her efforts gave Mr. M and his family a brief glimpse of normalcy during a harrowing time.

Thank-you, Sarah.

Holden presents at July Journal Club

—submitted by the Nursing Research Committee Journal Club

Patient safety officer, Lela Holden, RN, of the MGH Center for Quality & Safety, presents at July meeting of the NRC Journal Club.

On July 14, 2010, Lela Holden, RN, patient safety officer of the MGH Center for Quality & Safety, presented her research on, “Communication and collaboration: it’s about pharmacists as well as physicians and nurses,” which was published in the February 1, 2010, on-line journal, *Quality and Safety in Health Care*.

Holden began her research by analyzing studies on patient safety. She found a disconnect between doctors and nurses that could potentially impact patient safety. Communication and collaboration have been researched in the acute-care setting, but literature on the subject is limited in the ambulatory-care area. Since most care in the United States is provided in the out-patient setting, her study sought to determine if communication differences that impact patient safety in acute-care settings exist in the ambulatory setting, as well.

Holden used the Safety Attitudes Questionnaire as her survey tool. The questionnaire contained six sub-scales:

teamwork climate; safety climate; perceptions of management; job satisfaction; working conditions; and stress recognition. It addressed inter-professional collaboration and communication and contained a comment section for recommendations. She conducted her research at four US Air Force ambulatory care facilities and included six types of healthcare professions: doctors, nurses, nurse practitioners, physician assistants, pharmacists, and technicians.

Her research questions were: What are the differences among the four clinics related to the overall safety climate and the six dimensions of patient safety? And what are the differences among the various role groups related to the overall safety climate, the six dimensions of patient safety, and collaboration and communication?

She surveyed 213 subjects in four clinics and concluded that ambulatory-care settings differ from inpatient settings in that collaboration between physicians and nurses is not as negatively perceived. But all healthcare professionals should seek to improve their interactions with other team members. An unexpected finding showed respondents under age 31 scored significantly lower on overall safety in four of the six sub-scales.

Limitations of the study included sample size and setting. Holden observed that future research could focus on conflict-resolution as a means of cultivating safety, and opportunities to enhance teamwork should be directed toward younger staff in all role groups.

The next Nursing Research Committee Journal Club presentation will be held September 8, 2010, at 4:00pm in Bullfinch 222. Janice Goodman, RN, will present, “Detection, Treatment, and Referral of Perinatal Depression and Anxiety by Obstetrical Providers.” For information, call Martha Root at 4-9110.



(Photo by Paul Batista)

PCS welcomes new disability program manager

The primary focus of the disability program manager is to guide initiatives that ensure equal access to MGH by all patients, families, visitors, and others so their experience at MGH is a positive one.

With a nod of thanks to Carmen Vega-Barachowitz, CCC-SLP, director of Speech, Language & Swallowing Disorders, who unofficially and enthusiastically led our efforts around disability awareness for many years, the MGH community is happy to welcome Zary Amirhosseini to the newly created role of disability program manager. Reporting to the director of the Office of Patient Advocacy, the primary focus of the disability program manager is to guide initiatives that ensure equal access to MGH by all patients, families, visitors, and others so their experience at MGH is a positive one.

Amirhosseini comes to MGH from Harvard Divinity School where she served as disability services coordinator, overseeing student disability services, arranging academic and housing accommodations, and presenting workshops for faculty and staff on disability culture and etiquette, among many other responsibilities. At MGH, Amirhosseini will coordinate Patient Care Services and hospital-wide disability initiatives; field questions and concerns related to access; meet with patients and families to assist in planning visits to MGH; determine appropriate accommodations for patients, families and visitors; recommend, coordinate, and help implement changes to our physical space to make MGH more accessible to individuals with disabilities; respond to any complaints related to access; provide training and education to MGH staff on topics related to disabilities; and act as liaison for community services.

Says Keith Perleberg, RN, director of the PCS Office of Quality & Safety, "We're fortunate to have a person of Zary's experience to guide our efforts around disability awareness and equitable access to MGH. She is a delightful



Zary Amirhosseini,
disability program manager

spirit, and I know she'll take an active role in ensuring the highest level of service for our patients, families, and visitors with special physical needs."

Says Amirhosseini, "I look forward to being a resource for MGH staff and a voice for our patients with disabilities. My motto is: 'Educate and accommodate.' This will mean enhancing our website for those with disabilities so they're aware of resources and services available at MGH and in the community. As an organization, I hope we can start thinking of ways to be more proactive in identifying and coordinating services for patients with disabilities so their time at MGH is pleasant and satisfying."

October is Disability Awareness Month. Look for information booths in the Main Lobby. For more information about disability awareness, contact Zary Amirhosseini at zamirhosseini@partners.org.

Clinical Ethics Residency for Nurses (CERN)

—by Ellen Robinson, RN; Pamela Grace, RN; Martha Jurcak; and Reverend Angelika Zollfrank

In contemporary nursing, care dilemmas, especially at the end of life, require nurses to have specialized knowledge and skills in ethical decision-making. In response to this need, a new program, the Clinical Ethics Residency for Nurses (CERN), is being introduced this fall. Funded by the Division of Nursing Health Resources and Services Administration within the US Department of Health and Human Services, the CERN program is designed to build understanding of clinical ethics among registered nurses at MGH and BWH through didactic teaching, simulation, and a mentored practicum.

The goal of the CERN program is to:

- increase the number of registered nurses with knowledge, skills, and competencies in clinical ethics who can assume consultive and leadership roles on unit- and department-based ethics rounds and committees
- improve access to high-quality clinical care and consultations to improve the quality of care, eliminate health disparities, and improve outcomes

The idea for CERN emerged as a result of ongoing conversations about the demands of contemporary nursing practice, recognizing that nurses need advanced knowledge, decision-making and clinical-ethics skills to effectively address patient care issues. In a survey of MGH nurses conducted in December, 2009, 72% of respondents reported that such knowledge is very

important in their practice. 65% reported being involved in a distressing clinical situation in the past year and felt they needed better skills. 59% said they were interested or extremely interested in a clinical ethics residency program.

The CERN program will be held two days a month for seven months. The curriculum is based on the American Society for Bioethics and Humanities Clinical Ethics Task Force publication, *Improving Competencies in Clinical Ethics Consultation: an Education Guide*, and professional nursing standards in ethics. Contact hours will be awarded for the didactic portion of the program.

The target audience for CERN is staff nurses and advanced practice nurses, including nurse practitioners, nursing directors, nursing supervisors, and clinical nurse specialists. Seventeen nurses will be accepted; the project will be repeated over the next two years.

Application criteria:

- staff nurses need two years experience, a written statement of interest, a commitment to do the reading, and a statement of support from a supervisor
- advanced practice nurses need one year experience in an advanced-practice role, a written statement of interest, a commitment to do the reading, and a statement of support from a supervisor@

CERN will run from October, 2010, through May, 2011. To apply, e-mail: rlemole@partners.org, or call 6-1854. For more information, call Ellen Robinson at 4-1765. Send applications to Rosemarie Lemole, Founders 341, by September 15, 2010.

Let us take you on a journey...



Clinical Ethics Residency for Nurses

MGH supports comprehensive response to domestic violence

Domestic violence is a serious and pervasive health issue. Domestic violence is defined as a pattern of coercive control used by one partner over another, which may include: sexual and physical assault; social isolation; economic, emotional, and psychological abuse; threats; and harassment.

One in four women will experience domestic violence in her lifetime.

Question: Why is domestic violence considered a healthcare issue?

Jeanette: In addition to injuries resulting from physical assaults, domestic violence can have many physical and mental-health consequences. Domestic violence has been linked to arthritis, chronic neck and back pain, migraines, sexually transmitted infections, and chronic pelvic pain. Survivors of domestic violence are more likely to experience depression, post traumatic stress disorder and substance abuse. Healthcare providers are in a unique position to be able to recognize abuse and offer appropriate interventions in a safe, non-threatening environment.

Question: What resources are available at MGH for domestic violence survivors?

Jeanette: HAVEN at MGH provides free, confidential counseling and advocacy to survivors of domestic violence (patients, employees, and community members). HAVEN provides training, consultation, and policy-development for healthcare providers. Domestic violence advocates are available on the main campus and at the Revere and Chelsea health centers, Monday through Friday 8:30am–5:00pm (617-724-0054).

A Partners Employee Assistance domestic violence coordinator is available to employees or employees' family members for confidential advocacy, counseling and consultation (617-726-6976).

MGH Police & Security is available for safety planning and consultation (617-726-2121).

Question: What can I do?

Answer: There are a number of things you can and should do:

- Educate yourself about domestic violence and the resources available (visit: www.janedoe.org)
- Ask domestic-violence screening questions in a sensitive way, and make sure patients are alone when you ask
- Join the MGH Domestic Violence Working Group (for information, e-mail emspeakman@partners.org)
- Request a HAVEN training in your area (call 617-724-0054 or e-mail emspeakman@partners.org)
- Be aware of signs of abuse, and offer support and resources
- Make sure you have HAVEN brochures and referral cards on hand; you never know when you may need them

Question: I understand October is Domestic Violence Awareness Month. Do we have anything planned?

Jeanette: The MGH Domestic Violence Working Group is hosting several events including an information table in the Main Lobby on October 5, 2010, from 7:00am–12:00pm, and October 6th from 10:00am–2:00pm.

A presentation on October 13th from 12:00–1:00pm in the Thier Conference Room will focus on the new stalking and harassment law.

And a “Teen dating and violence” panel discussion featuring representatives from local domestic violence programs will be held October 20th from 3:00–5:00pm in the Thier Conference Room.

All are welcome.

For more information, call Liz Speakman at 617-726-7674.

Professional Achievements

Pallotta certified

Sheila Pallotta, PT, physical therapist, became certified as a pediatric specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Klein certified

Jodi Klein, PT, physical therapist, became certified as an orthopaedics specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Lenehan elected

Gail Lenehan, RN, clinical nurse specialist, Emergency Department, was elected, president of the Emergency Nurses Association, June 14, 2010.

Norton spotlighted

Beth-Ann Norton, RN, nurse practitioner, Crohn's and Colitis Center, was interviewed for the article, "Healthy Lifestyle and Nutrition," in *Crohn's Advocate Magazine*, June, 2010.

Townsend publishes

Elise Townsend, PT, physical therapist, authored the article, "Functional Recovery in Children and Adolescents with Spinal Cord Injury," in *Pediatric Physical Therapy*, in May, 2010.

Carroll appointed

Diane Carroll, RN, nurse researcher, was appointed a member of the Annual Meeting Committee, for the American Association of Heart Failure Nurses, in June, 2010.

Growney appointed

Marion Growney, RN, nurse practitioner, Transplant Surgery, was appointed vice president for the Massachusetts Coalition for Nurse Practitioners, May 7, 2010.

Morganti and Singh publish

Katie Morganti, RN, nurse practitioner, Cardiac Arrhythmia Service, and Jagmeet Singh, MD, recently authored the article, "Pharmacologic Advancements in Atrial Fibrillation," in *EP Lab Digest*.

Donovan certified

Melissa Donovan, RN, staff nurse, became certified as a medical surgical nurse by the American Nurses Credentialing Center, in July, 2010.

Folger certified

Abby Folger, PT, physical therapist, became certified as a cardiopulmonary specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Maslowski certified

Allison Maslowski, RN, staff nurse, became certified as a medical surgical nurse by the American Nurses Credentialing Center, in July, 2010.

Rodenhi certified

Kyle Rodenhi, PT, physical therapist, became certified as an orthopaedics specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Costello certified

Meaghan Costello, PT, physical therapist, became certified as a neurology specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Arsenault recognized

Sheila Arsenault, RN, unit nurse leader, Adult Medicine, MGH Chelsea Health Center, received the Donna Marie Grenier Award for Nursing Excellence, June 18, 2010.

Zachazewski appointed

James Zachazewski, PT, physical therapist, was appointed, chair of the Massachusetts, Division of Professional Licensure Board of Allied Health Professions, for 2009–2010.

Nurses publish

Sue Myers, RN; Patricia Reidy, RN; Brian French, RN; Jeanne McHale, RN; Margery Chisholm, RN; and, Martha Griffin, RN, authored the article, "Safety Concerns of Hospital-Based New-to-Practice Registered Nurses and Their Preceptors," in a recent issue of *Journal of Continuing Education in Nursing*.

Waak certified

Karen Waak, PT, physical therapist, became certified as a cardiopulmonary specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Therapists present

Physical therapists, Maura Ament, PT; Lillian Dayan Cimadoro, PT; and Robert Dorman, PT, presented, "Early Mobility in Acute Care: What are We Doing and How Do We Know," at the Annual Conference of the American Physical Therapy Association, in Boston, June 18, 2010.

Curley and McLaughlin present

Occupational therapists, Suzanne Curley, OTR/L, and Leslie McLaughlin, OTR/L, presented, "Management of the Burn Patient," to the Spaulding Network of Outpatient Occupational Therapists, June 8, 2010.

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, presented, "Temperature Management in the Neuroscience Patient: Research to Practice," at the University Hospital System Case Medical Center in Cleveland, May 18, 2010.

Dorman presents

Robert Dorman, PT, physical therapist, presented, "Staying on Your Feet—How to Keep Your Balance and Prevent Falls," at the Annual Conference of the American Physical Therapy Association, in Boston, June 19, 2010.

Perry presents

Donna Perry, RN, professional development coordinator, presented, "The Role of Health Professionals in Promoting Human Dignity Through Socio-Political Advocacy," at the Health Professional College, Al Quds University, Abu Deis, Palestine, on May 23, 2010.

Perry also presented a 3-day workshop: "Introduction to Transcendental Method: a Qualitative Research Method Grounded in Human Experiences"; and, "Transformative Peace-Building: Israeli and Palestinian Combatants for Peace," at the same venue.

Wright certified

Sarah Wright, PT, physical therapist, became certified as a cardiopulmonary specialist by the American Board of Physical Therapy Specialists, in June, 2010.

Zommer certified

Heidi Zommer, PT, physical therapist, became certified as a neurology specialist, from the American Board of Physical Therapy Specialists, in June, 2010.

Inter-disciplinary team presents

Social worker, Matthew Silvia-Perkins, LICSW; Cary Friedman, MD; Claire Carswell, MD; and Richard Gomborg, MD, presented, "A Gay Old Time: Evolving Psychoanalytic Paradigms of Homosexuality," at the Third Annual Lecture of the Boston Psychoanalytic Society and Institute in Boston, June 3, 2010.

Healey presents

Lauren Healey, PT, physical therapist, presented, "A Comprehensive Course on Cardiovascular and Pulmonary Practice in the Management of Patients in the Acute Care Setting: a Case-Based Approach Using Human Simulation," at the Annual Conference of the American Physical Therapy Association, in Boston, June, 2010.

Nurses present

Rosemary O'Malley, RN; Lynda Brandt, RN; Patricia Crispi, RN; Carol Ghiloni RN; Patricia Grella, RN; Judy Gullage, RN; Kathleen Larrivee, RN; Jennifer Mills, RN; and Laura Sumner, RN, presented, "Closing the Loop on Medication Safety," at the Trends in Clinical Informatics: a Nursing Perspective Conference, in Waltham, May 22, 2010.

Case managers present

Case managers, Maureen Veducchio, RN, and Anna Carson, RN, presented, "Case Management Alliance Program—A Practice-Based CM Program Targeting High-Risk, Commercially Insured Patients," at the National Case Management Society of America Conference, in Orlando, June 10–11, 2010.

Professional Achievements (continued)

Russo presents

Occupational therapist, Katherine Russo, OTR/L, presented, "Traumatic Hand Injuries," at Tufts University, June 9, 2010.

Waak presents

Karen Waak, PT, physical therapist, presented, "Community Outreach Event," at the Annual Conference of the American Physical Therapy Association, in Boston, June, 2010.

Michel presents

Theresa Michel, PT, physical therapist, presented her poster, "Autonomic Dysfunction and Fitness in HIV-Infected Adults," at the Annual Conference of the American Physical Therapy Association, in Boston, June, 2010.

Perry presents

Donna Perry, RN, professional development coordinator, presented, "Transformative Peace-Building: Israeli and Palestinian Combatants for Peace," at the Conflict Resolution Department of Ben Gurion University in Be-er Sheba, Israel, May 17, 2010.

Perry presents

Donna Perry, RN, professional development coordinator, presented, "Transformative Peace-Building: Israeli and Palestinian Combatants for Peace," at the Peace through Dignity in the Middle East Conference at the United Nations, April 28, 2010.

Tulchinsky presents

Ellen Tulchinsky, PT, physical therapist, presented, "Autonomic Dysfunction and Fitness in HIV-Infected Adults," at the Annual Conference of the American Physical Therapy Association, in Boston, June, 2010.

Capodilupo and Mullen present

Theresa Capodilupo, RN, nursing director, and Corey Mullen, RN, clinical nurse specialist, presented their poster, "Constructing a Designated Education Unit at Massachusetts General Hospital," at the Designated Education Unit, Sharing the Good News Conference, Baystate Health Center, in Amherst, May 21, 2010.

Callahan publishes

Janet Callahan, PT, physical therapist, authored the article, "Vestibular Prehab," in the *Journal of Neurologic Physical Therapy*, in June, 2010.

Hultman honored

Todd Hultman, RN, nurse practitioner, received the 2010 Nursing Appreciation Award from the MGH Internal Medicine Residency Program, June 3, 2010.

Arnstein publishes

Paul Arnstein, RN, pain clinical nurse specialist, published the article, "Balancing Analgesic Efficacy with Safety Concerns in the Older Patient," in *Pain Management Nursing*, in June, 2010.

Johnson appointed

Elizabeth Johnson, RN, clinical nurse specialist, was appointed chair of the Advanced Oncology Nursing Certification Test Development Committee by the Oncology Nursing Certification Corporation of Pittsburgh, in July, 2010.

Steiner presents

Linda Steiner, PT, physical therapist, presented her poster, "Effect of the Arthritis Foundation Exercise Program on Community-Dwelling Adults: Results of a Three-Year Study," at the Annual Conference of the American Physical Therapy Association, in Boston, June, 2010.

Lee's study funded

Susan Lee, RN, nurse scientist, received a three-year award under the Affordable Care Act of 2010, for "Re-Tooling for Evidence-Based Practice," from the US Department of Health and Human Services Health Resources and Services Administration, in July, 2010.

Nursing research funded

Ellen Robinson, RN, ethics clinical nurse specialist; Pamela Grace, RN, nurse scientist; and Martha Jurchak received a three-year award under the Affordable Care Act of 2010, for the "RN Residency in Clinical Bioethics Mediation Project," from the US Department of Health and Human Services Health Resources and Services Administration, in July, 2010.

Blakeney presents

Barbara Blakeney, RN, presented, "Change is Great. You Go First," at the Tau Kappa Chapter of Sigma Theta Tau, in Albany, New York, July 8, 2010.

Van Leuvan certified

Allison Van Leuvan, RN staff nurse, became a certified national asthma educator, by the National Asthma Educator Certification Board, July 26, 2010.

Townsend presents

Elise Townsend, PT, physical therapist, presented, "Item Writing Training," at the Federation of State Boards of Physical Therapy, in Alexandria, Virginia, July 23–25, 2010.

Nurses present

Amanda Coakley, RN, staff specialist; Joanne Empoliti, RN, clinical nurse specialist; and Christine Anness, RN, staff specialist, presented, "Preparing for Automation: a Standardized Model for Documentation and Communication," and, "Assessment and Enhancement of a Fall-Prevention Program," at the North American Nursing Diagnosis International Conference, in Madrid, in May, 2010.

Inter-disciplinary team presents

Kathleen Miller, RN; Donna Peltier-Saxe, RN; John Denninger, MD; Albert Yeung, MD; Gregory Fricchione, MD; Herbert Benson, MD; Victoria LePoutre; Dinah Gilburd, LICSW; and, Cally Woodard, RN, presented, "A Mind Body Intervention for Depression in a Community Health Setting," at the 30th Annual Meeting of the American Holistic Nurses Association, in Colorado Springs, June 4, 2010.

Robinson, Jurchak and Powers present

Ellen Robinson, RN; Martha Jurchak; and Carol Powers, presented, "Cardiopulmonary Resuscitation Not Medically Indicated: Conceptual, Community, and Policy Development," at the 6th International Conference on Clinical Ethics Consultation, International Society for Clinical Bioethics, at the Center for Health Care Ethics, in Portland, Oregon, May 11–13, 2010.

O'Brien certified

Claire O'Brien, RN, nursing director at MGH West, became a certified nurse executive by the American Nurses Credentialing Center, July 23, 2010.

Gigler and Oertel publish

Corin Gigler, RN, and Lynn Oertel, RN, Anticoagulation Management Services, authored the article, "Understanding Hypercoagulopathies," in *Nursing 2010*

Phipps, Carroll and Tsiatoulas publish

Marion Phipps, RN; Diane Carroll, RN; and Anastasia Tsiatoulas, RN, authored the article, "Music as a Therapeutic Intervention on an Inpatient Neuroscience Unit," in *Complimentary Therapies in Clinical Practice*, 2010.

Mannix presents

Catherine Mannix, RN, nursing director, presented, "A Feasibility Study of Low-Cost Self-Administered Skin-Care Intervention in Head and Neck Cancer Patients Receiving Chemo-Radiation," at the 2010 Congress of the Oncology Nursing Society, in San Diego, May 13, 2010.

Manley and Lee present

Bessie Manley, RN, nursing director, and Susan Lee, RN, nurse scientist, presented their poster, "Nurse Director Rounds: a Model for Patient and Staff Satisfaction," at The Forum on Health Care Leadership, in Washington, DC, July 29–August 2, 2010.

Clinical Recognition Program

The following clinicians were recognized May 1–August 1, 2010

Advanced clinicians:

- Erica Tuggey, RN, General Medicine
- Sharon Nadworny, RN, Cardiac Intensive Care Unit
- Katherine Russo, OTR/L, Occupational Therapist
- Natalie Cusato, LICSW, Social Services
- Tym Farley, RN, Knight Center for Cardiovascular Interventional Therapy
- Patricia Noonan, RN, Cardiac Step-Down Unit

Clinical scholars:

- Christine McCarthy, RN, Medical Intensive Care Unit
- Janet Bell, RN, NICU

Taking clinical pastoral education to the next level

advanced inter-disciplinary CPE

Question: What is the new Advanced Inter-Disciplinary Clinical Pastoral Education program?

Jeanette: Beginning this September, the MGH Chaplaincy is offering an advanced inter-disciplinary clinical pastoral education program in three consecutive units. The program is geared toward the learning needs of healthcare providers and future healthcare chaplains. Healthcare providers learn to integrate spiritual care-giving into clinical practice. Future healthcare chaplains gain core competencies through an innovative curriculum.

Question: Can you describe the curriculum?

Jeanette: In the clinical pastoral education program, students learn counseling skills; they learn about clinical ethics and diverse religious and spiritual beliefs. While pastoral care is the special expertise of chaplains, it's helpful for nurses and other care providers to be literate in spiritual and religious issues as they care for a diverse patient population.

Question: Why an inter-disciplinary program?

Jeanette: As far as we know, this is a one-of-a-kind program. Inter-disciplinary teams collaborate successfully in many clinical areas. Inter-disciplinary education in spiritual care offers a venue to practice spiritual literacy and share knowledge across disciplines. Each clinical specialty, each healthcare provider, brings an important perspective to the care of each patient, and working together is key.

Question: Is the program inter-faith?

Jeanette: Yes. Religious and cultural belief systems are like different languages. In the Inter-Disciplinary CPE program, caregivers and future healthcare chaplains will learn to speak these languages. The program is both inter-faith and inter-disciplinary.

Question: Who is eligible for the program?

Jeanette: Clergy and religious leaders from all religious backgrounds who have completed 400 hours in clinical pastoral education are eligible to apply. Nurses, physicians, physical therapists, social workers, psychologists, or any direct patient caregiver may apply.

Question: What effect will the Advanced Inter-Disciplinary CPE program have on patient care?

Jeanette: Chaplains and healthcare providers trained in spiritual care help patients get in touch with their spiritual resources and facilitate coping. Nurses will be empowered to assess when a patient might appreciate a prayer. The healthcare team may feel encouraged to explore a spiritual crisis with a family. Chaplains can share their knowledge of the many faith traditions. We're fortunate to have a well-trained group of chaplains available to patients of all faiths and those of no particular faith. Using the language of meaning to identify spiritual strengths, all clinicians can make a difference in the experience and quality of the care delivered at MGH.

Announcements

Call for Applications

Jeremy Knowles Nurse Preceptor Fellowship

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

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

Applications are due by September 10, 2010.

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

Knight Visiting Scholar

Patricia M. Reilly, RN, program manager for Integrative Care at BWH is the 2010 Knight Visiting Scholar. A recognized expert in complementary therapies, Reilly has lectured extensively on stress-reduction, leadership-development, and caregiver fatigue. Her research focuses on the impact of complementary therapies on patients and clinicians.

Reilly will present, "The Shift is on! Are you ready to take the Quantum Leap?"

Thursday September 23, 2010
Grand Rounds: 1:30-2:30pm
O'Keeffe Auditorium

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

MGH Bicentennial Logo

Submit your ideas

The LVC Retail Shops will help celebrate the hospital's 200th anniversary by carrying items featuring the MGH bicentennial logo. Please submit suggestions for items you'd like to see included. The first 25 staff to submit unique and usable ideas will receive a \$10 LVC Retail Shop gift card.

E-mail ideas to:
generalstoresurvey@partners.org
("MGH General" in Outlook)

Nursing History

Call for photos and artifacts

In preparation for the MGH bicentennial, the department of Nursing is creating a book commemorating major nursing milestones.

The Nursing History Committee is looking for photographs, articles, artifacts, and information that would help describe the journey of MGH nurses, especially pre-1995.

If you have anything you'd like to suggest or lend to the effort, please contact Georgia Peirce, director, PCS Promotional Communications and Publicity, at 4-9865.

Pathways of Healing

Mind-Body-Spirit
Continuing Education Program
presented by
the MGH Nurses' Alumnae
Association

September 24, 2010
8:30am-4:00pm
O'Keeffe Auditorium

Speakers

Dr. Herbert Benson, director,
MGH Mind-Body Institute;
Amanda Coakley, RN, staff
specialist

\$30.00 for MGHNAA members
and MGH employees
\$40.00 for all others

Register by September 17, 2010
at: www.mghsonalumnae.org
or e-mail mghnursealumnae@partners.org

6 Contact Hours

Spanish for healthcare workers

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

Weekly classes start the week of September 12, 2010. Classes meet for 10 weeks from 5:30-7:30pm in the Yawkey Building. \$150 fee includes all materials. Payment is due by September 7th.

For more information, call John Coco at 4-3368

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Submissions

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

Next Publication
September 16, 2010

Clinical Pastoral Education program

connecting to the spiritual resources within

—submitted by members of the summer 2010 CPE program

So, a priest, a rabbi, a Methodist, an Episcopalian, a Presbyterian, and a Unitarian Universalist walk into a hospital... No, it's not the beginning of a joke, it's how we came to MGH, June 1, 2010. Six of us, each training in our own tradition, came to MGH to participate in the Clinical Pastoral Education program—that is, to learn how to give compassionate care and spiritual support. But the Clinical Pastoral Education internship focuses on much more than just skills. It asked us to get to know ourselves—and each other. We delved into our strengths and weaknesses, hopes and fears, while immersing ourselves in the lives of patients, families,

and staff. Getting in touch with what makes each of us human enabled us to meet patients with empathy and serve their spiritual and religious needs. Hopefully, in more than 1,500 visits, we were able to help patients be more connected to the spiritual resources

(Photo by Paul Batista)



Reverend Angelika Zollfrank (left) with recent graduates of the summer 2010 CPE program (l-r): Lev Nelson, Ross Ponder, Elizabeth Nguyen, Rebecca Gettel, and Jeffrey Johnson

they carry within. We are humbled by the work we did this summer. We're grateful that MGH offers such a program and contributes so richly to clergy education.

The world needs hope. People need hope. Spirituality can be a catalyst for bringing people together. MGH is doing its part... six students at a time.

For more information about the CPE program, call Angelika Zollfrank at 4-3227.

Caring
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September 2, 2010

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