

# Caring

Headlines

July 7, 2011

## Clinical Ethics Residency

### for Nurses

A multi-faceted program to increase the number of registered nurses possessing specialized skills in clinical ethics

See story on  
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Faculty and participants of the first Clinical Ethics Residency for Nurses (CERN) program

# Privacy policies and protected health information

*Do you know how they apply to you?*

We go to great lengths to protect patients from falls, pressure ulcers, infections, and other negative outcomes—our attention to protecting patients' privacy needs to be just as rigorous.

**A**s healthcare providers, administrators, and support staff, we keenly aware of the importance of protecting patients' privacy. Keeping health information private is as integral to quality health care as providing state-of-the-art clinical interventions. We go to great lengths to protect patients from falls, pressure ulcers, infections, and other negative outcomes—our attention to protecting patients' privacy needs to be just as rigorous.

In the age of electronic communication, protecting any information is a challenge, but protecting health information is vital. More often than not, when health information is inappropriately accessed, it's the result of negligence, ignorance of technology, or basic human error, not an intentional breach of ethics. Which is why it's so important for every healthcare employee to understand the policies and procedures related to the protection of private information and the steps necessary to ensure computers, laptops, and all electronic workstations are secure.

Toward that end, and in compliance with an agreement between MGH and the US Department of Health and Human Services Office for Civil Rights,



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

the hospital is launching an awareness campaign to underscore the importance of protecting health information in all its forms. The campaign is geared toward the entire workforce: professional staff, employees, non-employees, trainees, students, and volunteers.

The campaign centers around three policies:

- Physical Removal and Transport of Protected Health Information and Personal Information
- Laptop Encryption
- Portable USB Drive Encryption

The first policy is a detailed explanation of what protected health information is and how to ensure appropriate safeguards are in place to guard against the “loss; theft; unauthorized access, use, disclosure, alteration, or destruction of protected health information and per-

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The expectation is that all employees will read, understand, and abide by these policies. To support that effort, a HealthStream on-line education module has been created, and employees are asked to complete this training by July 20, 2011.

sonal information in paper form or stored in electronic form on laptops or USB drives.”

The second policy describes the encryption requirements for all laptops, tablets, and netbooks used for business purposes by employees of Partners-affiliated hospitals. Encryption is a security process that transforms data into an unreadable format so it’s only accessible by someone who has the de-coding key or password. Encryption provides a greater degree of security than simple password-protection.

And the third policy describes the encryption requirements for all portable USB drives (sometimes called flash drives, thumb drives, or memory sticks) used to store Partners confidential data.

The expectation is that all employees will read, understand, and abide by these policies. To support that effort, a HealthStream on-line education module has been created, and employees are asked to complete this training by July 20, 2011. (To access the module, log on to HealthStream using your NT or Peoplesoft ID and password and select the course entitled, “MGH CAP Training” under the My Learning tab.) After completing the module, you’ll be asked to attest that

you’ve read and will comply with the policies. If you don’t have access to a computer, terminals are available in the Employee Access Center in Bulfinch 107 from 8:00am–4:30pm. For more information call 6-6338 or speak with your manager.

Please be aware that an on-site monitor may contact you to assess your knowledge and understanding of these policies. But more importantly, your adherence to these policies ensures our patients’ privacy is protected at all times.

As an added incentive to complete your on-line training, MGH is offering a weekly drawing for Red Sox tickets (to the August 17th game against the Tampa Bay Rays at Fenway Park). Once your training is completed, your name will be entered into the drawing, so the sooner you complete the training, the more chances you have to win.

I know you share my commitment to put our patients’ interests first, and it’s in that spirit that I hope you’ll join me in making this matter a top priority.

For more information, please contact the Privacy Office at 6-1098.

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# Clinical Ethics Residency for Nurses

—by Ellen M. Robinson, RN, clinical nurse specialist in Ethics

Staff nurse and clinical ethics resident, Kimberly Ding, RN (second from right), with CERN faculty members (l-r): Martha Jurchak, RN; Angelika Zollfrank; Pamela Grace, RN; and Ellen Robinson, RN.

The Clinical Ethics Residency for Nurses (CERN) is a program designed to increase the number of registered nurses who possess specialized knowledge, skill, and competency in clinical ethics so they can assume consultative roles in ethics rounds and on hospital committees.

After receiving a grant from the US Department of Health and Human Services, a team was formed and quickly began planning this multi-faceted, MGH-based program. Beginning in October, 2010, and concluding in May, 2011, the program provided 98 hours of multi-modal learning opportunities to 13 MGH nurses, five BWH nurses, and one nurse faculty member from the University of Tennessee, Knoxville. CERN nurse residents came from a variety of specialty areas and role groups—from nurse educators to clinical nurse specialists, nursing directors, nursing supervisors, and staff nurses. Learning modes included on-line and didactic education, discussions, readings, role-playing, and clinical mentorships. Feedback from participants has been very positive with nurses reporting they've increased their knowledge, skill, and comfort level in talking with patients, families and colleagues during difficult ethical situations.

Cynthia Johnson, RN, nursing supervisor and participant in the CERN Residency, shared a recent experience involving an elderly man at the end of life whose spouse of many years was having difficulty 'letting go.' After intense work by the inter-disciplinary care team, the spouse instated a Do Not Resuscitate/Do Not Intubate (DNR/DNI) order, only to reverse it when she observed her husband having diffi-

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## Ethics (continued)

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culty breathing. Unable to bear it, she requested life-saving intervention. While the healthcare team didn't agree with the decision, they had difficulty communicating that to the wife. The team was called to intubate the patient.

Johnson overheard the wife tell her husband, "When they connect you to the breathing machine, you'll get better and be able to come home."

Johnson gently told her that her husband would not get well enough to return home. This compassionate but truthful statement turned the situation around. The family met with the team once again and agreed to reinstate the DNR/DNI order. The patient died peacefully the next day while his wife at his bedside.

Said Johnson, "Through my experiences in the CERN program, I had the knowledge, skill, and courage to be truthful with the patient's wife in a compassionate way. I was so pleased that she was with him when he died; it was a privilege for both of them that may not have happened otherwise."

This is one of many ways that CERN graduates use what they learn in the program to work with other members of the inter-disciplinary care team in clinical situations every day.

Faculty for the CERN program include:

- Ellen Robinson, RN, project director and clinical nurse specialist in Ethics
- Pamela Grace, RN, associate professor of Nursing Ethics at the Connell School of Nursing, Boston College
- Martha Jurchak, RN, executive director of Ethics at BWH
- Angelika Zollfrank, director of Clinical Pastoral Education and interfaith chaplain
- Susan Lee, RN, nurse scientist and program evaluator
- Rosemarie Lemole, project assistant.

CERN is supported by The Knight Nursing Center and the simulation centers within The Institute for Patient Care. A celebration-of-completion reception was

held for the first group of CERN nurse residents in the Lawrence House on May 12, 2011.

Application packets for this year's CERN program, commencing in September, are now available and due by August 1, 2011. Applicants will be notified of their acceptance into the program during the week of August 15th. For more information about the CERN program, contact project assistant, Rosemarie Lemole at 6-1854.



(L-r): Jurchak; Zollfrank; Grace; and Robinson, with staff nurse and clinical ethics resident, Kathleen Grinke, RN (second from right).

# Carroll presents on fall-prevention tool kit

—by Martha Root, on behalf of the REBPC Journal Club

**H**ave you ever wished there were guidelines in patients' rooms alerting you to the level of activity they can tolerate? With the research of Patricia Dykes, RN; Blackford Middleton, MD; and Diane Carroll, RN, those guidelines may be on the horizon. On May 11, 2011, nurse researcher, Diane Carroll, presented research published in the *Journal of the American Medical Association* addressing the posting of activity levels in patients' rooms. The study tested the use of a fall-prevention tool kit (FPTK)—a risk-assessment scale capable of improving communication at the bedside. Ten thousand subjects participated in a trial to determine whether the tool kit could help decrease patient falls in acute care hospitals. A driving force behind this research was the cost associated with fall-related injuries in hospitals. While research on the risk of falls is well established, the link to specific prevention interventions is not. This may be the first clinical trial to prove that a technological intervention can reduce falls in short hospitalizations.

Research was divided into four phases over two years. During the first, qualitative phase, compelling evidence was collected from nursing assistants at four local hospitals. Six

concepts emerged from that evidence: patient report, information-access, signage, environment, teamwork, and patient/family involvement. The goal of Phase I was to understand falls from the patient/family perspective, and one conclusion was that clear risk alerts and interventions were needed at the bedside.

Phase II involved developing a prototype tool kit using the Morse Fall Scale (MFS), which has been proven to be valid and reliable. Phase III involved identifying icons for the FPTK (visit: <http://www.jama.com> to see icons). The tool kit identified interventions specific to patients' areas of risk, then a poster was printed out to display these interventions. During Phase IV, subjects were randomized from the four hospitals. Each hospital tested two units—an intervention unit and a control unit. Intervention units displayed the patient-specific posters at the patient's bedside.

Results showed fewer patient falls and a significantly lower adjusted fall rate on the intervention units. Patients older than 65 benefited most from the FPTK. While there were fewer fall-related injuries on intervention units, the difference between control units and intervention units was not statistically significant. A greater number of subjects is needed to adequately predict whether the tool kit can help prevent injuries. But regardless, this is a valuable piece of research geared toward preventing falls in the acute-care environment.

The next Research Evidence-Based Practice Committee Journal Club meeting is scheduled for July 13, 2011, 4:00–5:00pm in Founders 311. Nancy Allen will present her research on the, “Feasibility and acceptability of continuous glucose monitoring and accelerometer technology in exercising individuals with type 2 diabetes.”

For more information, call 4-9110.

At recent meeting of the REBPC Journal Club, nurse researcher, Diane Carroll, RN (back right), presented her research on a fall-prevention tool kit designed to help decrease patient falls in acute-care hospitals.



(Photo by Paul Batista)

# Celebration of community health improvement spotlights bicentennial scholars

—by Susan Leahy, communications manager, Center for Community Health Improvement

**At right:** MGH president, Peter Slavin, MD, congratulates bicentennial scholar, Ahmed Ahmed, following his remarks at the 200 Years of Commitment to the Community celebration. **Below:** poster display session in progress.

The MGH Bicentennial Scholars Program, a new college admission, scholarship, and completion initiative, is a gift from MGH to the community in honor of our 200th anniversary. On June 10, 2011, under the Bulfinch tent, the hospital celebrated 200 years of commitment to the community with a program highlighting past, present, and future efforts to support good health in the diverse communities we serve. Complete with a multimedia retrospective, poster display, and celebration of the MGH bicentennial scholars, the event featured remarks

by Boston Mayor Thomas Menino, Massachusetts Public Health Commissioner, John Auerbach, MGH president, Peter Slavin, MD, and executive director of the MGH Center for Community Health Improvement, Joan Quinlan.

Slavin noted that our commitment to the community is imbedded in our mission to, “improve the health and well-being of the diverse communities we serve. Not only do we do our best to care for patients in the hospital, we work with communities to improve the health of all populations within our reach.”

Bicentennial scholars, Ahmed Ahmed of Revere, and Maria Rodriguez of East Boston, shared their personal stories including their desire to go to college and pursue careers in health care.

The poster display revealed the depth and breadth of the impact MGH is having on local communities. Topics ranged from Medical Interpreters and Community Health to Community Medicine and the Curriculum for Internal Medicine Residents at MGH; from Boston Healthcare

for the Homeless to Engaging Youth in Health and Science, and much more.

The Bicentennial Scholars Program is more than a scholarship. The program supports 26 students in the class of 2012 to gain admission to, succeed in, and graduate from college. Scholars receive coaching, SAT preparation, and continued support after they begin their college education. Each student receives an annual scholarship of \$5,000. It is hoped that this program will help increase the number of Boston Public School students who actually graduate after entering college. A study by the Boston Private Industry Council showed that only 41% of Boston Public School students in the class of 2003 had graduated by 2009.

For more information about the Bicentennial Scholars Program or the Center for Community Health Improvement, call Susan Leahy at 3-5288.



(Photos provided by staff)

# Entry-level physical therapist learns thing or two about flexibility

My plan upon entering his room was to share my knowledge of the effects of bed-rest and immobility with Mr. B to help motivate him to participate in physical therapy.

**M**y name is Kelly McDermott. I started my career at MGH with a six-month internship and have been a licensed physical therapist for 11 months. On this particular day, Bigelow 11 was busy, as usual. It was late Friday afternoon, and I asked one of my colleagues if she could see a new patient for me while I finished up with my current patient. Without hesitation, she agreed to examine Mr. B.

When she finished, she came over to give me a summary. “Mr. B is going to need rehab,” she said. “He’s well below his previous functional baseline. He declined bed mobility and wasn’t enthusiastic about physical therapy.”

I left the hospital that evening thinking, “I might not be enthusiastic about working with a physical therapist, either, if I were 84 years old and lying in a hospital bed on a Friday night.”

Monday morning, I arrived on the unit, prepared to motivate and educate Mr. B. I reviewed his chart: 84-year-old male with a history of prostate cancer, post-radiation treatment with a chronic indwelling catheter. He presented with worsening sacral ulcer, difficulty am-



Kelly McDermott, PT, physical therapist

bulating, and repeated rupture of catheter balloon. His primary impairments included limited range of motion, muscle performance, posture, balance, and endurance in setting of deconditioning. Despite his refusal to stand, transfer, or ambulate with my colleague the previous Friday, I gathered from his history that Mr. B had been fully independent in regard to ambulation and stair-climbing with two single-point canes prior to admission. My plan upon entering his room was to share my knowledge of the effects of bed-rest and immobility with Mr. B to help motivate him to participate in physical therapy. I would gather more data on his quality of movement and aerobic capacity, and I was sure Mr. B would decide to mobilize.

Mr. B lay in his bed; his wife sat in the corner. I introduced myself to them.

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Sometimes it's difficult not to encourage patients to perform at their maximum potential, especially when they've been recently independent. But it's more important to provide what that patient truly needs. Mr. B needed to be heard. He needed verification that those who were present, were actually listening.

His wife gave me a warm smile and nudged her husband, "The physical therapist is here. It's time to get moving."

Mr. B, stoic in nature, and appearing defeated already, replied, "I'm sorry, I can't. I just can't do whatever you're going to ask of me."

He then listed his reasons: chronic back pain that had increased since lying in "these terrible beds"; heel pain from a pressure ulcer; multiple tests done earlier in the day; and fatigue.

Mr. B's demeanor was slightly defensive from the get-go, as if he were expecting me to push back. Instead of staying with my original plan, I grabbed a chair and sat down next to him. Time for Plan B.

Stoic, soft-spoken, Mr. B said, "What, you're not going to make me get up?"

I told him I wasn't there to make him do anything he didn't want to do. However, if his goal was to walk again and return home, then we'd better have a more detailed conversation about his perception of what was limiting him. I didn't say a word for the next 15 minutes—I listened. There were times I disagreed, times I felt he was wrong, but who was I to interject my own perceptions?

When Mr. B was done talking, I addressed each and every one of his concerns to let him know I had listened. By the end of the session, Mr. B's head was elevated under two pillows, he had a hot pack, and the foot of his bed was elevated to allow for more knee flexion and posterior pelvic tilt to relieve his back pain. I 'floated' his heels to remove pressure under his ulcers, I adjusted his ankles to reduce joint stiffness, and turned his lights off so he could finally get some sleep now that he wasn't in so much pain.

Although Mr. B no longer complained of pain when I left his room, he didn't give any indication that he was satisfied with our session. As I left, I thought, Gosh, this man came in with chronic catheter balloon ruptures, fully capable of walking prior to admission, and I just spent 20 minutes listening to him and re-positioning him. What had I really done for him? Was it even effective?

The next morning when I arrived on the unit, Mr. B's nurse tracked me down and said, "I don't know what you did, but Mr. B's been asking for you all morning: 'Where's Kelly, the physical therapist? I'm waiting to work with Kelly, the physical therapist.'"

From then on, I greeted Mr. B every morning (coordinated with nursing) at 8:30 while he sat in his bedside chair, drank his coffee, and read the newspaper. He liked checking in with me first thing, so we could plan our treatment time for the day. I warmed up to him. He warmed up to me. We had a mutual understanding and respect for each other's roles: patient and healthcare professional.

As time went on, Mr. B did more of the listening, often asking questions about his heart rate, blood pressure, position changes, exercise, etc. He enjoyed learning about the effects of exercise. Although still stoic, instead of me motivating him, Mr. B started showing signs of self-motivation and self-advocacy. Mr. B was in the hospital for two weeks, and by the time he was discharged to a rehab facility, he was ambulating short distances in the hallway.

Through this experience, I learned that my plan of care for the day cannot be rigid; nothing can be rigid in the acute-care setting. So often, plans need to change due to medical instability, interruptions for medical testing or imaging, patients' responses, etc.

The first time I walked into Mr. B's room, I quickly learned that my expectations were very different from his. Sometimes it's difficult not to encourage patients to perform to their maximum potential, especially when they've been recently independent. But it's more important to provide what that patient truly needs. Mr. B needed to be heard. He needed verification that those who were present, were actually listening. It turns out that Plan B was, in fact, more effective.

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

In this narrative, Kelly, an entry-level physical therapist shows us the power of being present and truly listening. Following her instincts and guided by the needs of her patient, Kelly had the willingness and presence of mind to abandon 'Plan A.' Because she was flexible and at the same time addressed all of Mr. B's concerns, she was able to build trust, engage Mr. B in his own therapy, and instill confidence in him that he was being heard. This narrative shows signs of a long and promising career.

Thank-you, Kelly.

# Nurses explore innovative model linking nursing care to obesity solutions

—by Cindy Harrington, RN; Jeanette Gentile, RN; Maribeth Smith, RN; and Kelley Blouin, RN

The obesity epidemic has become a major health issue of our time. The Centers for Disease Control and Prevention call our society, “obesogenic,” characterized by environments of increased food intake and decreased physical activity. Approximately 72.5 million adults in the United States are obese. Obese individuals are at an increased risk for cardiovascular disease, diabetes, depression, cancer, and many other debilitating illnesses, with an estimated annual expenditure of \$147 billion dollars to the healthcare industry.

Nurses are in a unique position to address this epidemic. Their knowledge, expertise, and relationships with patients’ families enable them to know patients as

individuals and learn their unique responses to illness. As direct-care providers, nurses learn what’s important to patients and help find meaning. Lasting solutions are only possible when providers abandon ‘one size fits all’ interventions in favor of individualized strategies to manage illness. As part of our graduate course work, we had an opportunity to address the issue of obesity and explore an innovative model linking nursing care to obesity solutions.

At MGH, nurses screen patients upon admission for tobacco use—the leading preventable cause of death and disease in the United States. Obesity is a close second, likely to surpass smoking in the coming years. So why don’t we screen for obesity, too?

Obesity is not an easy problem to solve. Healthy People 2020, a federally sponsored program whose ten-year goal is to improve the nation’s health by raising awareness, identifying priorities, and setting attainable goals, recognizes that nursing can play a key role. For example, nurses are in a position to use the admission process to help obese individuals lose weight through novel interventions.

The proposed strategy is to screen for obesity upon admission. If patients’ height and weight are entered in the computer and their body mass index (BMI) calculated, the system could alert the nurse when a patient’s BMI is 30 or above. A system could then be put in place to integrate a weight-loss program into the plan of care, directed by the clinical nurse specialist and maintained by the primary care provider, including a nurse practitioner, after discharge.

Re-design and innovation are the mainstays of healthcare solutions, and nurses have a real opportunity to lead and influence those solutions, particularly in combating the obesity epidemic.

(L-r): Jeanette Gentile, RN; Kelley Blouin, RN; Dorothy Jones, RN; Maribeth Smith, RN; and Cindy Harrington, RN



(Photo provided by staff)

# Nurse executives complete new DNP program at MGH Institute of Health Professions

—by John Shaw, MGH Institute of Health Professions

**A**t MGH, life-long learning is more than just a catchy slogan. Case in point: three MGH nurse executives recently graduated among the first class of the Doctor of Nursing Practice for Nurse Executives program at the MGH Institute of Health Professions. Receiving diplomas at the May commencement ceremony were Jeanette Ives Erickson, RN, senior vice president for Patient Care; Marianne Ditomassi, RN, executive director of PCS Operations, and Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development.

(L-r): Ives Erickson, Ditomassi, and Chisari receive doctoral degree in Nursing Practice for Nursing Executives at IHP graduation ceremony.



(Photo by Jeff Thiebauth)

The program—the first in New England and one of only a handful in the country—allows nursing executives to learn alongside colleagues, share real-life challenges, and strategize solutions in a supportive, interactive, academic setting.

Says Ives Erickson, “This is a wonderful program where nurse executives can come together and discuss the issues they face every day in their respective areas. It helped me explore new ways to evaluate and improve executive and clinical practice.”

Ditomassi agrees. “The course gave us a forum to network, learn from one another, raise expectations, and celebrate successes. The journey gave us an opportunity to test new ideas in a safe, collaborative way.”

According to program director, Linda Andrist, RN, the curriculum is based on the School of Nursing’s existing DNP degree with additional topics such as leadership theory, negotiation skills, informatics, and management-assessment tools designed exclusively for nurse leaders. Says Andrist, “Doctorate-prepared nurse executives will help change health care in the twenty-first century and impact care-delivery by emphasizing evidence-based practice.”

Chisari developed a better understanding of his role as a leader in a complex practice environment. Says Chisari, “The ability to conceptualize outcomes that bring about positive change is very relevant to our work in nursing. It’s critical to establish a strong relationship between nursing practice and positive patient outcomes.”

For more information about the Doctor of Nursing Practice for Nurse Executives program, contact Linda Andrist at [landrist@mghihp.edu](mailto:landrist@mghihp.edu), or go to [www.mghihp.edu/nursing](http://www.mghihp.edu/nursing).

# Professional Achievements

## McHugh honored

Michelle McHugh, RN, nurse practitioner; at the MGH Revere Health Care Center; received the Exceptional Preceptor Award for 2011 from the Massachusetts Coalition of Nurse Practitioners, in April, 2011.

## Zollfrank honored

Angelika Zollfrank, MDiv, supervisor, Clinical Pastoral Education, received the 2011 Emerging Leader Award from the National Association for Clinical Pastoral Education in Salt Lake City in April, 2011.

## Oertel appointed

Clinical nurse specialist, Lynn Oertel, RN, was appointed a member of the Medical and Scientific Advisory Board of the National Blood Clot Alliance in May, 2011.

## Hultman appointed

Todd Hultman, RN, nurse practitioner; was appointed a member of the Primary Palliative Care Performance Improvement Module Committee of the American Board of Internal Medicine, April 27, 2011.

## Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, presented, "Using the Gain-Control Theory of Pain as a Guide to Educate Nurses," at the Northeastern Organization of Nurse Educators conference in Woburn, April 1, 2011.

## King presents

Janet King, RN, staff nurse, presented, "Do You Have the Courage and Commitment to Make your Practice Evidence-Based? What is the Process Involved in Doing a Research Poster?" at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 9, 2011.

## Fern and King present

Staff nurses, Ellen Fern, RN, and Janet King, RN, presented, "Collaborating to Link the World of pH and Best Practice," and "Link your Commitment to Optimal Patient Care by Expanding your Nursing Practice," at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 6-11, 2011.

## Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Sensation and Sensibility," at Tufts University, March 14, 2011.

## Doyle and Viscosi present

Nurse practitioners, Diane Doyle, RN, and Elene Viscosi, RN, presented, "The Role of the Advanced Practice Nurse in a Radiation Oncology Setting," at the 36th Congress of the Oncology Nursing Society, April 30, 2011.

## Rinehart and Jackson present

Todd Rinehart, LICSW, and Vicki Jackson, MD, presented, "The Program in Palliative Care Education and Practice," at the Center for Palliative Care, Harvard Medical School, April 5-12, 2011.

## Jeffries presents

Marian Jeffries, RN, clinical nurse specialist, presented, "Predictors of Skin Breakdown and Pressure Injury in the Tracheostomized/Stoma Patient," at the Professional Development Symposium of the North Eastern Organization of Nurse Educators, in Woburn, April 1, 2011.

## Kelleher presents

Mary Lou Kelleher, RN, clinical nurse specialist, presented, "Effectiveness of the Use of the Moon Balloon on Hospitalized Children," at the National Society of Arts in Health Care conference in San Francisco, April 15, 2011.

## Klein presents

Aimee Klein, PT, physical therapist, presented, "What Do You Value?" at the White Coat Ceremony of the Northeastern University Physical Therapy Program, April 21, 2011.

## Nurses present poster

Elizabeth Johnson, RN; Jane D'Addario, RN; and Elizabeth M. Johnson, RN, presented their poster, "Paving the Way to Oncology Nursing Practice: a Summer Clinical Fellowship for Senior Nursing Students," at the annual congress of the Oncology Nursing Society, April 28-May 1, 2011.

## Lauture presents

Evelyn Lauture, LICSW, presented, "Earthquake's Impact on Mental Health and Family Life: the Role of Social Workers," at the Haitian Health Career Seminar at the BU School of Medicine, April 9, 2011.

## Scott presents

Katrina Scott, MDiv, staff chaplain, presented, "Humanism in Health Care," at the 70th anniversary conference of the American Humanist Association in Cambridge, April 9, 2011.

## Lozzi and Smith present

Susan Lozzi, RN, case manager; and Erin Smith, LICSW, social worker, presented, "Patient Navigation in a Complex Medical System," at the National Institute for Case Management and American Case Management Association conference, in Orlando, Florida, April 8, 2011.

## Norton presents

Beth-Ann Norton, RN, nurse practitioner, presented, "Medications for IBD: How to Help Your Health Care Provider Help You Minimize Side-Effects and Risks of Immunomodulators and Biologics," at the Boston Patient and Family IBD Symposium of the Crohn's and Colitis Foundation, in Wellesley, April 3, 2011.

## O'Toole presents

Jean O'Toole, PT, physical therapist, presented, "Breast-Cancer-Related Lymphedema: the Evidence," at the Vermont Lymphedema Network, in Burlington, Vermont, March 26, 2011.

O'Toole also presented, "The Natural History of Cording Following Treatment for Breast Cancer," at Research Day at the Dana Farber Cancer Center, March 25, 2011.

## Nurse practitioners present

Nurse practitioners, Jean Treacy, RN; Erin Barry, RN; Martha Brezina, RN; Eileen Comeau, RN; Elizabeth Delulis, RN; Kellyann Jeffries, RN; Jack Kane, RN; Tracey Lafferty, RN; Michelle Letourneau, RN; Jen Logan, RN; and Jeanne Vaughn, RN, presented, "Acute Care of Oncology Patients in an Inpatient Oncology Nurse Practitioner Unit," at the 36th congress of the Oncology Nursing Society, April 30, 2011.

## Tehan elected

Tara Tehan, RN, nursing director; was elected treasurer of the Massachusetts Association of Registered Nurses in April, 2011.

## Slater presents

Bonnie Slater, RN, staff nurse, presented, "Demystifying Pancreatitis," at the annual meeting of the New England Society of Gastroenterology Nurses and Associates, in Burlington, March 26, 2011.

## Serinsky presents

Sharon Serinsky, OTR/L, occupational therapist, presented, "Behavior Through a Sensory Lens," at the Boston Institute for the Development of Infants and Parents, at the Massachusetts School of Professional Psychology, March 19, 2011.

## Lee and Norton present poster

Vita Norton, RN, and Corrina Lee, RN, presented their poster, "Caring for the Morbidly Obese Patient with a Gynecologic Malignancy," at the annual congress of the Oncology Nursing Society, April 28-May 1, 2011.

## Cronin presents poster

Julie Cronin, RN, presented her poster, "Family Member's Perceptions of Most Helpful Nursing Interventions During End-of-Life Care of a Loved One," at the annual congress of the Oncology Nursing Society, April 28-May 1, 2011.

## Nurse researchers publish

Diane Carroll, RN, nurse researcher; Annette McDonough, RN, external nurse scientist; and Leanne Matura, RN, external nurse scientist, authored the article, "Symptom Experience of Pulmonary Artery Hypertension Patients," in *Clinical Nursing Research*, April, 2011.

## Carroll presents poster

Diane Carroll, RN, nurse researcher; presented her poster, "Needs of Older Patients and Their Spouses after a Cardiovascular Procedure," at the spring meeting of the Council of Cardiovascular Nursing and Allied Professionals, European Society of Cardiology in Brussels, April 2, 2011.



## Professional Achievements (continued)

### Collins certified

Jacqueline Collins, RN, clinical nurse specialist, became certified as a wound specialist by the American Academy of Wound Management, in May, 2011.

### Cooper inducted

Stephanie Cooper, senior operations manager, was inducted into the Salem State University chapter of Phi Kappa Phi, May 11, 2011.

### Norton and Hanauer publish

Beth-Ann Norton, RN, nurse practitioner, and Stephen Hanauer, MD, co-authored the article, "PCE Updates on Crohn's Disease: Strategies for Early Diagnosis," in *Practicing Clinicians Exchange*, April, 2011.

### Seliverstov publishes

Irina Seliverstov, RN, staff nurse, authored the article, "Practical Management Approaches to Anticoagulation Non-Compliance," in the *Journal of Thrombosis and Thrombolysis*, 2011.

### Peterson elected

Gayle Peterson, RN, staff nurse, became a member of the Board of Directors of the Massachusetts Association of Registered Nurses in May, 2011.

### Rodenhi publishes

Kyle Rodenhi, PT, physical therapist, authored the chapter, "The Shoulder Complex," in *Exercise Therapy in the Management of Musculoskeletal Disorders*, in May, 2011.

### Chisari honored

Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical & Professional Development, received the *Nursing Spectrum Award for Advancing and Leading the Profession*, May 11, 2011.

### Harker honored

Jane Harker, RN, was awarded the Gabriele Schindler Excellence in Clinical Practice Award by the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 8, 2011.

### Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Repetitive Stress Injuries," at Tufts University, May 25, 2011.

### Hultman named outstanding preceptor

Todd Hultman, RN, nurse practitioner, received the Outstanding Preceptor Award, from the Massachusetts Coalition of Nurse Practitioners on May 5, 2011.

### Capasso certified

Virginia Capasso, RN, clinical nurse specialist, became certified as a wound specialist by the American Academy of Wound Management, in May, 2011.

### Fahey certified

Jean Fahey, RN, clinical nurse specialist, became certified as a wound specialist by the American Academy of Wound Management, in May, 2011.

### Amatangelo presents

Mary Amatangelo, RN, nurse practitioner, presented, "The Acute Stroke Consult," at the Northeast Regional Nurse Practitioner Conference, in Newton, May 5, 2011.

### Brown presents

Carol Brown, RN, nurse practitioner, presented, "12 Lead ECG Interpretation: STEMI, NSTEMI and Miscellaneous ECG Changes," at the Northeast Regional Nurse Practitioners Conference in Newton, May 4, 2011.

### Chang presents

Lin-Ti Chang, RN, staff specialist, presented, "Lessons in Medical Disaster Response Learned from the Haiti Earthquake," at a meeting of the Nurses Driving Access, Quality and Health, International Council of Nurses, in Malta, May 2-8, 2011.

### Orencole presents

Mary Orencole, RN, nurse practitioner, presented, "Heart-Failure Management in an Evolving Environment," at a CRM Therapy and Patient Management meeting of the Heart Rhythm Society, in San Francisco, May 3, 2011.

### Robbins presents

Christopher Robbins, RN, staff nurse, presented, "Advanced ERCP Hands-On," at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 6-11, 2011.

### Guanci presents

Mary Guanci, RN, clinical nurse specialist, presented, "Brain Death: Myths and Methods," at the Neuroscience Conference, in Hershey, Pennsylvania, May 12, 2011.

### Capasso presents

Virginia Capasso, RN, clinical nurse specialist, presented, "Prevention and Treatment of Pressure Ulcers," at Eastern Maine Medical Center in Bangor, April 11, 2011.

### Lally presents poster

Patricia Lally, RN, staff nurse, presented her poster, "Development of a Pre-Screening Tool for Pediatric Patients in a Hospital-Based GI Endoscopy Unit: Collaboration is Key," at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 5-11, 2011.

### Miguel presents

Karen Miguel, RN, staff nurse, presented, "Enhancing Teamwork and Communication: the Art (and Challenge) of Changing Culture," at the annual congress of the National Patient Safety Foundation, in Washington, DC, May 25-27, 2011.

### Olson presents

Gayle Olson, wellness coordinator, presented, "Training and Conditioning to Prevent Injuries," at the Spring Sports Medicine Symposium of the Massachusetts Interscholastic Athletic Association, April 5, 2011.

### Nurses present

Erin Dalia, RN, staff nurse; Jennifer Orcutt, RN, nurse practitioner; Marylynn Fahey, RN, nurse practitioner; Julie Marden, RN, staff nurse; Karen Pickell, RN, nurse practitioner; and Janet Rico, RN, nurse practitioner, presented, "An Innovative Role for Nurse Practitioners to Facilitate Patient Throughput," at the Northeast Regional Nurse Practitioner Conference, in Newton, May 5-6, 2011.

### Seliverstov presents

Irina Seliverstov, RN, staff nurse, presented, "Practical Issues in Outpatient Management," at the National Conference on Anticoagulation Therapy, May 6, 2011.

### Hession presents poster

Sandra Hession, RN, staff nurse, presented her poster, "Scope Processing can be an Endoscopy Unit's Strongest or Weakest Link," at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 6-11, 2011.

### Oertel and O'Neil present poster

Lynn Oertel, RN, clinical nurse specialist, and Jennifer O'Neil, RN, staff nurse, presented their poster, "Impact of Patient Self-Testing on Time in Therapeutic Range," at the National Conference on Anticoagulation Therapy, May 6, 2011.

### Jeffries presents poster

Marian Jeffries, RN, clinical nurse specialist, presented her poster, "Predictors of Skin Breakdown and Pressure Injury in the Tracheostomized/Stoma Patient," at the Professional Development Symposium of the Northeast Organization of Nurse Educators in April, 2011.

### Freehan and Rossi present poster

Marion Freehan, RN, nursing director, and Jamie Rossi, child life specialist, presented their poster, "Creating an Environment of Care for the GI Endoscopy Patient—the Role of the Child Life Specialist," at a meeting of the Society of Gastroenterology Nurses and Associates, in Indianapolis, May 6-11, 2011.

### Nurses present

Amanda Bulette Coakley, RN; Joanne Hughes Empoliti, RN; and Christine Annese, RN, presented, "Exploring the Use of a Standardized Approach to a Documentation and Communication Model to Promote High Quality Continuity Care," at the European Conference of the Association for Common European Nursing Diagnoses, Interventions and Outcomes, in Madeira, Portugal, March 25, 2011.

# A closer look at fall-prevention and the LEAF program

*Question:* Can you update us on the work being done around fall-prevention?

*Jeanette:* Fall-prevention is a challenge faced by all healthcare organizations and a major focus of the Joint Commission. Patient falls are recognized as nursing sensitive indicators by the Joint Commission and the National Database of Nursing Quality Indicators.

In 2008, under the leadership of Theresa Gallivan, RN, associate chief nurse, an inter-disciplinary Tiger Team was created to assess our fall-prevention status and provide recommendations for improvement. The team reviewed fall-risk assessment tools, developed universal interventions, and revised the patient care flow sheet. One of the Tiger Team's recommendations was to develop a comprehensive fall-prevention program, which we call, LEAF, (Let's Eliminate All preventable Falls).

*Question:* What is LEAF and who participates?

*Jeanette:* LEAF is an evidence-based program that educates staff on fall risks, fall-prevention strategies, and post-fall care. Prior to LEAF's roll-out, fall-prevention education was included in our new-hire nurse and patient-care-associate orientation and in the *65plus* program.

Following a pilot of the program on an inpatient unit, the LEAF team, under the direction of Keith Perleberg, RN, director of the PCS Office of Quality & Safety, and Theresa Gallivan, developed an implementation plan that involves the collaboration of *65plus*, the LEAF team, the Knight Nursing Center, PCS Quality & Safety, and collaborative governance committees. LEAF uses a blended approach to provide education to unit staff and leadership. This is accomplished through HealthStream and a Train the Trainers Class that covers key elements of fall-prevention, intervention, implementation, and any special fall risks associated with individual units. The LEAF team consists of Deborah D'Avolio, RN, team leader; Joanne Empoliti, RN; Susan Gavaghan, RN; Sheila Golden-Baker, RN; and Yassaman Khalili, RN. The PCS Office of Quality & Safety, the MGH Center for Quality & Safety, and our physician colleagues played a crucial role in implementation.

*Question:* What is the status of this work to date?

*Jeanette:* A LEAF Tool Kit has been developed and distributed to all units. It is available by accessing the CNS folder and selecting Leaf Toolkit 2011; it's also available in the recently distributed Magnet booklet. The LEAF Tool Kit consists of important resources, including the new Post-Fall Care Guidelines, Fall Debriefing Guidelines, and bedside signage.

Roll-out of the LEAF program to inpatient units began in October and was completed in May. We will soon be partnering with our ambulatory colleagues to assist in their fall-prevention efforts. And fall-prevention has been integrated into our new collaborative governance structure.

*Question:* How has the program been received by staff?

*Jeanette:* Feedback has been very positive with nurses reporting they've learned a great deal about fall risks and post-fall debriefing. They're happy to have the skill and ability to analyze special risks and brainstorm about fall-prevention with unit leadership.

Falls are rarely the result of just one risk factor; prevention involves taking patient and environmental factors into account. Acute illness, surgery, immobility, treatments, medications, and an unfamiliar environment are common factors that can contribute to falls. Staff at the bedside are active participants working with interdisciplinary colleagues to modify risk factors and keep our patients safe.

For more information about fall-prevention or the LEAF program, contact Deborah D'Avolio, RN, at 3-4873.

# Announcements

## No Smoking!

As part of the MGH Non-Smoking Policy, electronic cigarettes, also known as e-cigarettes, are not permitted anywhere on MGH campuses. To access the policy, go to the MGH Trove Library and access, "No Smoking Policy."

## AMMP scholarships

Applications available on-line

Starting in the fall, the MGH Institute of Health Professions (IHP) will partner with the AMMP Scholarship Program to offer a three-credit scholarship. Awardees are required to volunteer a minimum of 20 hours at the IHP. Scholarship is available in Nursing, Physical Therapy, and Speech-Language Pathology.

For more information, call 4-4424.

## Senior HealthWISE events

All events are free for seniors 60 and older

Lecture Series:

"Common Thyroid Conditions"  
Thursday, July 7th  
11:00am–12:00pm  
Haber Conference Room  
presented by Guiseppe Barbesino, MD

"Medications and Your Safety"  
Thursday, July 21st  
11:00am–12:00pm  
Haber Conference Room  
presented by Joanne Doyle Petrongolo, and Laura S. Carr, RPh,

Hypertension Screenings:  
Monday, July 25th  
1:30–2:30pm  
West End Library  
151 Cambridge St.  
Free blood pressure checks with wellness nurse, Diane Connor, RN.

For more information, call 4-6756.

## One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site: <http://priorities.massgeneral.org>.

## McGovern Award Nominations

Dedication, clinical excellence, compassion, teamwork. If these words describe your colleague, consider nominating him/her for the 2011 Brian A. McGovern, MD, Award for Clinical Excellence. Anyone may submit a nomination. Nominations are due by Friday, July 15, 2011, and must be submitted on-line at <http://mgpo.partners.org/Applications/McGovernAwards/Nomination.aspx>.

For more information, contact Cary Shaw at 617-643-3985.

## Diversity exhibit at Treadwell Library

Celebrate diversity in health care at Treadwell Library's Opening Doors exhibit highlighting contemporary and historical pioneers, including African American surgeons, famous black nurses in history, and a slide show on Latino and African American 'firsts' in a variety of MGH departments.

Come learn about these inspiring individuals.

Runs through the month of July  
Monday–Thursday, 7:00am–8:00pm; Friday, 7:00am–7:00pm  
Treadwell Library  
Bartlett Hall Extension

## Lunchtime Fitness Sessions

Lunchtime fitness sessions offered by personal trainer, Mike Bento, from The Clubs at Charles River Park.

Next session:

July 13, 2011

Haber Conference Room  
12:00–12:30pm

For more information, call 6-2900

## Clinical Recognition Program

The Clinical Recognition Review Board and Steering Committee are happy to announce a new initiative by which clinicians applying for recognition at the advanced clinician and clinical scholar levels can submit their portfolio for a preview prior to formal submission. This voluntary, anonymous process gives clinicians an opportunity to receive feedback on their portfolios from former review board members.

Reviewers will provide feedback on specific areas identified by clinicians, leadership, and review board members based on past experience.

For more information, e-mail questions or portfolios to MGH PCS Clin Rec

## Scholarships available

Students living in Charlestown majoring in non-MD health careers are eligible to apply for a Charlestown Health Care Merit Scholarship.

Applicants must have two semesters of college or graduate school, proof of residency, and submit an essay demonstrating leadership through community service.

To apply, go to: [www.mghihp.edu/merit](http://www.mghihp.edu/merit).

Deadline is July 8, 2011.

## Mandatory training on PHI available on HealthStream

All members of the MGH workforce are required to complete training on policies related to the security and transport of protected health information (PHI) by July 20, 2011.

Employees are asked to familiarize themselves with three policies:

- Physical removal and transport of PHI and personal information (PI): safeguards must be taken to protect PHI and PI during transport. Employees need permission from a supervisor or principal investigator before removing PHI or PI
- Laptop encryption: encrypt laptops, notebooks, and tablets used for any business purposes, even personally owned devices
- Portable USB drive encryption: use only encrypted USB drives to store confidential data

For more information, contact the Privacy Office at 617-726-1098.

## Free Summer Help

The City of Boston's Summer Jobs program may be the solution to your department's summer vacation coverage. Students spend 25 hours per week at the work site, July 6th–August 19th. The program is available at no cost to your department; the only requirement is a commitment to provide a meaningful work experience in a supportive environment.

This resource is available through the MGH Center for Community Health Improvement (CCHI) and supported by an on-site program manager who works closely with students and departments.

Note: we are recruiting department participation only. Students are selected from CCHI youth programs and partner schools.

For more information, call Galia Wise at 4-8326.

# Requesting a chaplain

## *the new Chaplaincy paging system*

**Question:** I understand there have been changes in the Chaplaincy Department's paging system. What is the new system?

**Jeanette:** At the beginning of May, Chaplaincy began using pager #2-7302 to contact the chaplain on call. This system is designed to make efficient use of resources while continuing to deliver excellent spiritual care to patients, families, and staff.

**Question:** How do I use this system?

**Jeanette:** Referrals and requests for consults can be placed three ways. The Chaplaincy office (6-2220) is staffed from 8:00am-4:30pm, Monday through Friday; messages are picked up until 7:00pm weekdays and 7:00am-7:00pm on weekends. Requests for consults can be made through the POE system, which allows you to describe the patient or family's request. These methods are best for non-urgent matters. The Chaplaincy pager (2-7302) immediately alerts the chaplain on-call, who will respond to the page. This option is intended for emergent situations such as end-of-life, acute/trauma, codes, and pre-operative requests.

**Question:** My unit has had the same chaplain for years and we have a good working relationship. Will that be affected?

**Jeanette:** Staff chaplains are assigned to specific patient care units; that will not change. Since all chaplains participate in the on-call schedule, the chaplain responding to the on-call pager will only cover your unit if your regular chaplain is not available. This ensures that chaplaincy coverage is available to the entire hospital, 24 hours a day, seven days a week, 365 days a year.

**Question:** What happens when there's a specific request for a faith-specific chaplain or faith-specific need, like Communion or the Sacrament of the Sick?

**Jeanette:** Staff chaplains are skilled healthcare professionals who assess the spiritual needs of people of all traditions or no tradition. Every chaplain is trained to provide spiritual support and can access faith-specific resources as necessary. We're fortunate to have a dedicated team of volunteer Eucharistic ministers who bring Communion on a regular basis, leaving staff chaplains free to respond to more critical spiritual needs.

For more information, call 6-2220.



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