

# Caring

Headlines

October 6, 2011

## Case Management

*A key component of patient-centered care*

October 9–15, 2011, is National Case Management Week, a time to celebrate the contributions and commitment of case managers and recognize the invaluable services they provide

Case Management marks its 16th year coordinating high-quality, patient-centered care at MGH.

*See  
story  
on  
page  
6*



Case manager, Eileen Gilligan, RN, discusses discharge planning with patient, Peter Homchuck

# Infection Control Survey: *Excellence Every Day in action*

In March of 2010, the Department of Public Health (DPH) initiated a survey process for acute-care hospitals in Massachusetts. The un-announced, multi-day Infection Control Survey will likely take place at MGH some time in the next few months.

**I**n March of 2010, as part of its statewide plan to prevent, reduce, and eliminate healthcare-associated infections, the Department of Public Health (DPH) initiated a survey process for acute-care hospitals in Massachusetts. The un-announced, multi-day Infection Control Survey will likely take place at MGH some time in the next few months. It will be coordinated by David Hooper, MD, and Paula Wright, RN, chief and director, respectively, of the MGH Infection Control Unit, and they will be assisted by staff of the MGH Office of Compliance and the PCS Office of Quality & Safety. Surveyor(s) will focus on infection prevention and control as they tour inpatient and outpatient settings, procedural areas, and ancillary locations as appropriate. Their assessment will be based on observations, interviews with staff, and a review of documents and patient records.

To help prepare for the survey, a multi-disciplinary tiger team was formed, led by Mallory Davis from the MGH Office of Compliance and George Reardon, director, PCS Clinical Support Services. The team was tasked with identifying any gaps we may have between policy and practice and closing those gaps through education and communication.

As you know, the PCS Office of Quality & Safety conducts quarterly visits, or tracers, on inpatient units. During these tracer visits, clinicians from all disciplines come together to review and discuss a patient's medical record, respond to questions, and review policies and practices just as they would in an actual regulatory survey. Tracers focus on a specific topic each quarter. To



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

help ensure readiness for the DPH Infection Control Survey, tracers in the quarter beginning October 1st will focus on infection control and prevention. In addition to the usual participants, an infection control practitioner and operations managers will take part. These tracers will focus on staff's knowledge of infection-control procedures and compliance with standards related to managing equipment, storing supplies, and providing patient- and family-education.

A number of resources are available (or will soon become available) to assist staff in preparing for the Infection Control Survey. The PCS Office of Quality & Safety has distributed the *Excellence Every Day Regulatory Readiness Resource Guide*, which includes a section on infection control and examples of the types of questions to expect from surveyor(s). Versions of the Guide have been distributed to patient care associates, operations associates, and unit service associates. And soon units will receive a poster highlighting Infection Control Do's and Don'ts.

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As clinical nurse specialist and Infection Control Tiger Team member, Christine, Gryglik, RN, reminds us, “Our goal is not just to prepare for the Infection Control Survey, but to take every opportunity to improve outcomes for patients in a sustainable way. Isn’t that what Excellence Every Day is all about?”

- Following are *some* of the areas we’ll be focusing on:
- Hand hygiene and compliance with fingernail policy
  - Compliance with Standard Precautions for all patients
  - Transmission-based precautions (Contact, Contact Plus, Airborne, Droplet, etc.)
  - Availability of personal protective equipment
  - Needle boxes present and not over-filled
  - Equipment cleaned and disinfected (with appropriate hospital-approved disinfectant) between patients
  - No food or drink in patient care areas, clean supply and soiled equipment areas, or areas where surfaces are potentially contaminated (for instance, where specimens are collected)
  - Clean equipment properly stored and identified
  - High-touch surfaces in patient rooms cleaned daily
  - Precaution gowns tied at both neck and waist
  - Gloves pulled up over cuffs of gowns
  - Gloves and gowns removed followed by hand hygiene before coming in contact with clean surfaces
  - Checklist completed during central venous and pulmonary catheter insertion
  - Ventilator-associated pneumonia and catheter-associated urinary-tract infection-prevention measures
  - Patient- and family-education documented
  - Refrigerator temperatures checked and documented
  - Clean supplies and linens on covered cart or in cabinet or container or clean utility room

- Sterilization and high-level disinfection practices including process monitoring
- IV compounding and use of multi-dose vials

In the coming weeks, information about the survey will be added to the PCS Excellence Every Day Web Portal (Regulatory Readiness page) that can be accessed through PCS Clinical Resources.

As always, we are committed to providing the best possible care to every patient and family in every moment of every day. As clinical nurse specialist and Infection Control Tiger Team member, Christine, Gryglik, RN, reminds us, “Our goal is not just to prepare for the Infection Control Survey, but to take every opportunity to improve outcomes for patients in a sustainable way. Isn’t that what Excellence Every Day is all about?”

**Honorable mention**

I’d like to take this opportunity to congratulate our Case Management Department, and specifically, Roseanne Karp, RN, who was recently recognized as a clinical scholar by the Clinical Recognition Review Board—the first of her department to do so. This is a wonderful milestone, one that has opened the door for others to follow. To Roseanne, the Case Management Department, and all who provided support and guidance along the way, I say, well done!

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# 'AMMP-ing' up for higher education

—by Waveney Small-Cole, staff assistant

Recipients of this year's AMMP scholarships (l-r): Christine Marmen; Chantal Kayitesi; Tirza Martinez; Farhiya Mahamoud; Evelyn Abayaah; and Christa Brutus; Not pictured: Nghi Huynh; Claudio Rodriguez; and Fabella Narcisse.

The Association of Multicultural Members of Partners (AMMP) is committed to assisting employees of minority backgrounds to gain higher education and advance in their careers toward leadership positions. This year, despite a challenging economic climate and considerable budgetary constraints, MGH supported the AMMP scholarship program, awarding more than \$13,000 to minority employees pursuing higher education.

On September 8, 2011, AMMP hosted a reception for families, friends, and co-workers to honor its 2011

scholarship recipients. In his remarks, Jeff Davis, senior vice president for Human Resources, reminded recipients of the importance of education, saying, "Today, a bachelor's degree is worth a hundred thousand dollars more in lifetime income than a high-school diploma, and a master's degree is worth *five hundred thousand dollars* more in lifetime income than a bachelor's degree."

This year's recipients are:

- Evelyn Abayaah, performance improvement coordinator, Center for Quality & Safety
- Christa Brutus, senior medical technologist, MGH Core Laboratory
- Nghi Huynh, administrative assistant, Nursing Administration
- Chantal Kayitesi, refugee women's access coordinator at MGH Chelsea, pursuing a nursing degree at Regis College
- Christine Marmen, education development project specialist, Knight Nursing Center
- Farhiya Mohamoud, histology specialist, Pathology
- Claudio Rodriguez, supervisor, Nutrition & Food Services
- Tirza Martinez, patient service coordinator in the Ambulatory Care Center, currently attending Bunker Hill Community College to earn an associate's degree in Nursing
- Fabella Narcisse, operation associate and third-year student at Roxbury Community College

Scholarship chair, Waveney Small-Cole, introduced a new concept called, "A Drop of Culture," where each recipient shared a cultural belief or tradition with the gathering. Quoting Ghandi, Small-Cole said, "No culture can live if it attempts to be exclusive."

For more information about the AMMP scholarship program, call 6-1345.



(Photo by Michelle Rose)

# Key to successful recognition process: Preparation. Preparation. Preparation.

—by Mary Ellin Smith, RN, professional development manager

**W**hen staff nurse, Natacha Nortelus, RN, received a letter informing her that she'd been denied recognition as an advanced clinician, she thought, "I know I'm practicing at the advanced-clinician level. Why was I denied?" She wasted no

time in trying to find the answer to that question.

In 2009, clinicians and leadership throughout Patient Care Services were asked to complete a survey describing their perceptions of the Clinical Recognition Program (CRP). While most respondents viewed the program as positive and beneficial, the survey found that when a colleague was denied recognition at a desired level, it had a negative impact on respondents' perceptions of the program, and in many cases affected their decision to apply for recognition themselves.

The responsibility of the Clinical Recognition Review Board is to determine whether clinicians are actually practicing at the level they're applying for. The board reviews portfolios against established criteria, develops questions based on that review, and interviews the applicant. Three board members (led by a member of the applicant's discipline) interview the clinician with the singular goal of looking for evidence that the applicant meets the criteria for the desired level of recognition. Following the interview, findings are shared with the full board. They re-evaluate the information and make a determination as to whether the applicant meets the criteria for the level being sought.



Natacha Nortelus, RN, staff nurse

A denial simply means that *evidence of the criteria* was not found in the portfolio or the interview. It doesn't necessarily mean that the applicant isn't practicing at that level. To minimize the possibility of being denied, the review board recommends that before submitting your portfolio, you:

- visit the CRP website <http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp> for tips on how to prepare
- review the criteria for the level of recognition you're seeking and make sure you have examples that demonstrate you consistently practice at that level
- have colleagues and area leadership review your portfolio and provide feedback
- submit your portfolio for an anonymous pre-review by e-mailing it to MGH PCS Clin Rec
- schedule a practice interview with someone who's been through the process

When Nortelus received her letter, she scheduled a meeting with the lead interviewer. It turns out, says Nortelus, "I hadn't talked enough about my decision-making process. I just assumed they knew what I was thinking. And I never fully articulated what I do to influence practice on my unit."

Several months later, Nortelus re-submitted her portfolio and arranged a practice interview with a colleague from another unit. "It was such a different experience this time," she said. "I *really* talked about my practice." Two weeks later, Nortelus was recognized as an advanced clinician.

"Being denied," she said "was hard because I had invested so much time preparing my portfolio. But in the long run, it actually helped me." Nortelus reports that since being recognized, several of her colleagues have begun to work on their portfolios.

For more information about the Clinical Recognition Program, call Mary Ellin Smith, RN, at 4-5801.

# MGH Case Management now in its 16th year

—submitted by Maria Sweeney, RN

**A**s MGH celebrates its historic bicentennial anniversary, Case Management marks its 16th year coordinating high-quality, patient-centered care. While MGH was founded in 1811 in response to a need for better care for the sick

and indigent people of Boston, Case Management was founded in 1995 in response to a need for improved navigational services for hospitalized patients from admission to discharge. Under the guidance of now MGH president, Peter Slavin, MD, and current director of Case Management, Nancy Sullivan, a group representing nurses, social workers, and physicians created the department that has come to be locally, nationally, and internationally recognized as a leader in case management.

The department has undergone significant change in the past year. Says Sullivan, “We have an incredibly hard-working team that really stepped up during this time of transition. Our clinical documentation reviewers continue to identify opportunities to improve revenue and increase accuracy. Our administrative and clinical support staff

keep the department running smoothly, and our leadership team makes sure we stay connected to our mission and vision and the important initiatives put forth by Partners and MGH.”

Sullivan is proud of the department’s participation in the CMS Demonstration Project and the program’s success in identifying opportunities to improve care while containing costs (see clinical narrative on page 8). The CMS Demonstration Project has been cited as a model of care and emulated in many venues across the country.

Staff of Case Management have been published in professional journals, sought case-management certification (the department is 49% certified), participated in collaborative governance, and presented at local and national conferences. Of note, this year, Roseanne Karp, RN, became the first case manager recognized as a clinical scholar in the PCS Clinical Recognition Program.

Case Management Week will be observed October 10–14, 2011. The department will have educational booths in the Main Corridor, October 11th and 13th. Health Care Proxy forms and the booklet, *Five Wishes*, designed to help families make critical healthcare decisions, will be available. Stop by to learn more about the important role of case managers.

For more information, call 4-9108.

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The Case Management Society of America defines case management as the collaborative process of assessing, planning, facilitating, and advocating for options and services to meet an individual's health needs through communication and resources to promote quality, cost-effective outcomes.



# Anticipation grows for acute care documentation

—by Michele Cullen, RN, senior project specialist

**O**n Wednesday, September 14, 2011, at the Acute Care Documentation (ACD) Fair under the Bulfinch tent, MGH clinicians got a sneak peek at e-chart, the future of inpatient electronic documentation

at MGH. Roll-out of this much-anticipated new tool is scheduled for the spring of 2012 on three pilot units: the Ellison 4 Surgical ICU, the Ellison 9 Cardiac ICU, and the White 9 General Medical Unit. E-chart automates the documentation of flow sheets, assessments, and notes, and more than 300 clinicians had an opportunity to test drive the system at the recent fair.

Scenes from the recent Acute Care Documentation Fair; where clinicians got a sneak peek at e-chart, the new inpatient, electronic documentation program.

Response to e-chart was overwhelmingly positive, with comments like:

“I love how easy it is to use.”

“I’m really happy that patient care associates will be able to use the new system.”

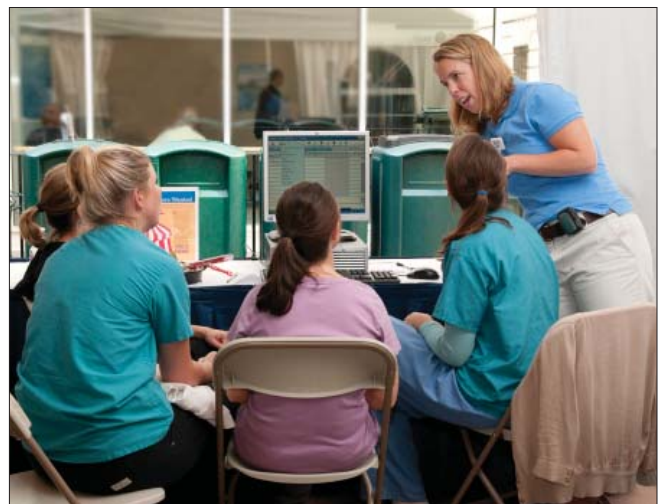
“I love the buttons that populate my notes [meds, allergies, history, etc.]”

“When do we start?”

Unit-based training will take place in the weeks prior to

each unit going live. The ACD team will offer similar fairs in the coming months to give staff an opportunity to check out the new e-chart. Watch *Caring Headlines* for announcements.

For more information about acute care documentation, contact Ann McDermott, RN, at 3-6983; Michele Cullen, RN, at 6-6874; or Brenda Delaney, RN, at 3-6621.



(Photos by Michelle Rose)

# Case manager provides comfort, continuity for patient in CMP Demonstration Project

Lee was a home-bound, 57-year-old woman with health issues related to chronic obstructive pulmonary disease (COPD), depression, anxiety, and drinking.

**M**y name is Susan Lozzi. I've been a nurse at MGH for 30 years; a case manager for 12. I've worked in the inpatient and outpatient settings, and I've provided care-management for high-risk patients as part of the MGH/Medicare CMP Demonstration Project for the past five years.

That's where I met 'Lee' in 2006. Lee was a home-bound, 57-year-old woman with health issues related to chronic obstructive pulmonary disease (COPD), depression, anxiety, and drinking. Her primary care physician had requested she receive skilled nursing care in the home that could also address her mental-health needs. She was in a wheelchair and oxygen-dependent. As I completed my therapeutic assessment, it became clear that establishing a trusting relationship with Lee was going to be a challenge. She was fiercely independent and adamant that she not depend on her family.

Lee had many issues. She had inadequate insurance with no secondary insurance and was ineligible for Medicaid. She had to pay 20% of her oxygen bill every month. She would frequently forget to apply for a benefit and enlist my help in the re-application process. Eventually, she needed a hospital bed, which added yet another monthly financial burden.



Susan Lozzi, RN, case manager

New government programs have been developed to assist patients with inadequate insurance. Finding programs, educating Lee, and helping her apply for them was a time-consuming intervention, but one that paid off. Lee was able to secure extra help for the cost of her medications and monthly Medicare D premiums. With my assistance Lee was able to maximize her financial benefits and negotiate a reasonable payment plan for many of her expenses.

Lee required continuous re-assessment of her home-care support. I was able to tap into a small CMP fund created for patients with situational needs to help bridge the financial gap, and with her permission, I referred her to our CMP social worker who established a therapeutic relationship with her.

Lee had not yet named a healthcare agent. I understood that the concept of a healthcare agent conflicted with her goal to remain independent. But gradually, her PCP and I discussed the ethical and moral issues with her, and she appointed one.

*continued on next page*



Housing was another issue. Lee lived in subsidized housing that used 50% of her income and came with several accessibility issues, which increased her sense of isolation. She preferred to be in East Boston near her sister, so I referred her to the CMP community resource specialist, and soon Lee moved into a smaller apartment in East Boston.

Staying current with Lee's medical appointments, emergency-room visits, and admissions required frequent medication reconciliation. Her PCP and I maintained an accurate list of medications identical to the one Lee used. She would frequently call me with questions about side-effects, and I would collaborate with her PCP, psychiatrist, MGH therapists, and other specialists, including her CMP social worker to answer her questions.

Three years into our relationship, Lee developed breast cancer that required a mastectomy. Pre-operatively, I asked her PCP to order skilled home care to maximize mental-health support and physical conditioning prior to surgery. I knew she wouldn't have full use of her arm after surgery, so I asked the CMP community resource specialist to arrange for a hospital bed to be delivered to her home.

Lee came through surgery fine, but the cancer had spread to other parts of her body. When her access to skilled home care ran out, Lee's sister began to call me at her request. This was a turning point. This was when her family, her PCP, the CMP team, and I became her support system.

Lee was hospitalized for pneumonia. She was treated and discharged home. In my follow-up call, I determined that Lee needed more skilled care than could be provided at home. I coordinated her return to the MGH Emergency Department for a medical evaluation then arranged for her to be transferred to a skilled nursing facility that could meet her care needs 24 hours a day.

Lee recognized her disease progression. The CMP social worker provided much-needed emotional support as I coordinated Lee's medical care.

I received many calls from Lee over the next few days asking if she was going to have medical bills for the care she was receiving. Her history of struggling with medical bills motivated Lee to reach out to her sister for help with her Medicaid application. I discovered that another hidden family issue had been a barrier to her Mass Health application, so I assisted the family in overcoming it.

Lee wanted to be in a facility closer to her elderly mother, so I arranged for her to be transferred, but the night before she was to be moved, she was rushed to the MGH Emergency Department again. I met her there, and we discussed her needs. She did not want more testing. She wanted to go to the facility near her mother as planned.

I contacted Lee's oncology team so they could hear her wishes. All invasive tests were cancelled, I coordinated her discharge with the hospital team, and Lee was taken to the facility of her choice.

Lee asked me to convey her wishes to her family; she hadn't told them the extent of her illness. I explained that Lee's time was limited and that she would be going to a skilled nursing facility for symptom-management and end-of-life care. I suggested they treat her like 'a princess' for her remaining days. This opened the door for her family to rally around her, and they became the center of her life.

I visited Lee in the skilled nursing facility and helped her clarify her new goals. She understood it was time to rest and let others care for her.

Lee passed away a few weeks later with her family at her side. When I visited her just days before her death, I got the sense that she knew she was valued by her family, by her healthcare team, and by me. It was rewarding to know that my care had made a difference in her life and in her death.

Empowering Lee to ask for help in one area of her life enabled her to delve into other more fragile areas. Lee taught me to meet patients where they are. She made a huge contribution to the development of my professional practice.

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

How fortunate for Lee that she had an advocate like Susan in the last weeks, months, and years of her life. And what an incredible testimonial for the CMP Demonstration Project that allowed this relationship to grow and flourish. Susan was a source of strength, guidance, and support for Lee in matters of everything from health insurance to her ability to remain independent. Susan's expertise allowed Lee to have options, make choices, and retain some control as her health began to decline. This narrative beautifully highlights her creativity, expertise, and compassion.

Thank-you, Susan

When I visited her just days before her death, I got the sense that she knew she was valued by her family, by her healthcare team, and by me. It was rewarding to know that my care had made a difference in her life and in her death.

# Mind-Body Resiliency

## *The Benson-Henry Institute for Mind-Body Medicine at MGH*

—by Margaret 'Peg' Baim, RN, and Leslee Kagan, RN

**P**eg Baim, RN, and Leslee Kagan, RN, have provided clinical programs in mind-body resiliency for more than 20 years at the Benson-Henry Institute for Mind Body Medicine at MGH. The Institute is led by Herbert Benson, MD, who has long recognized the essential contributions of nursing to the inter-disciplinary team. Benson is a pioneer in the study of mind-body medicine, specifically the relaxation response that buffers the harmful effects of stress.

Baim joined the Institute in 1990. Her specialties are cognitive applications of positive psychology and contemplative meditation. She directs the Lighten Up

Program for healthy weight-management and the Relaxation Response Resiliency Program, designed to help patients minimize medical symptoms and build resilience. Baim is the clinical director of the Center for Training in Mind-Body Medicine, a nurse practitioner, and a researcher at the Institute.

Says Baim, "Obesity, diabetes, depression, and atherosclerosis are among the most common causes of mortality and morbidity in the United States. Through the science of mind-body interactions, we now understand that these conditions are caused, or exacerbated, by imbalances in the stress-immune system. Many holistic nursing interventions serve to restore this balance making the mind-body approach a vital addition to nursing knowledge."

Kagan joined the Institute in 1999. As director of Women's Health, she facilitates the Mind Body Program for Women, the Mind Body Program for Health and Fertility, and Relaxation Response Resiliency. Her work in menopause has been recognized by the North American Menopause Society. She is a contributing author to *Our Bodies Ourselves: Menopause*.

Says Kagan, "Mind-body science related to women's health is a burgeoning field. It offers key roles for nurses to empower women with self-care practices that restore resilience, alleviate symptoms, and tap into inner resources for healing."

Kagan and Baim will be teaching two new mind-body-spirit nursing certificate programs offered through the MGH Institute of Health Professions starting this fall. For more information or to be added to the holistic nursing e-mail list, contact Kathleen Miller, RN, at 781-485-6176.

Leslee Kagan, RN (left) and Margaret Baim, RN, at the Benson-Henry Institute for Mind Body Medicine located at 151 Merrimack Street.



(Photo by John Shaw)

# The Norman Knight Nursing Center for Clinical & Professional Development

Recently, the Knight Nursing Center has begun to look for opportunities to support all our colleagues in Patient Care Service. Toward that end, we will be introducing Inter-Disciplinary Grand Rounds on October 13, 2011.

**Question:** Some of my newer staff have asked about services provided by The Knight Nursing Center. Can you help clarify?

**Jeanette:** The Norman Knight Nursing Center for Clinical & Professional Development supports the educational needs and professional development of staff within the department of Nursing. Recently, the Knight Nursing Center has begun to look for opportunities to support all our colleagues in Patient Care Service. Toward that end, we will be introducing Inter-Disciplinary Grand Rounds on October 13, 2011. You may recall an article in *Caring Headlines* (June 18, 2009), where Gino Chisari, RN, director of the Knight Nursing Center, reminded us that the mission of the center is to, “promote life-long learning and clinical excellence by establishing, supporting, and fostering learning opportunities for the attainment of knowledge and skills necessary to deliver safe, competent, and compassionate patient-centered care.”

**Question:** What’s on the horizon for the future?

**Jeanette:** As we head into the fall and winter, several factors influence the programs we will offer. As you know, we’re preparing for Magnet re-certification, a Joint Commission visit, and the launch of our new innovation units. Our colleagues in the Knight Nursing Center are developing programs that address the learning needs of staff and ensure we possess the knowledge and skills necessary to achieve Excellence Every Day.

**Question:** Can you give me an example of some of the programs we can expect to see?

**Jeanette:** Some educational offerings, such the annual regulatory education course assigned to staff every fall, are required by regulatory agencies such as the Joint Commission or the Center for Medicare and Medicaid (CMS). These mandatory courses ensure that as an organization we continually educate ourselves on current practices so that we deliver the best possible, safe, effective, care.

Other offerings, such as our new courses in conflict-management resolution, pain-management bundling, and advanced arrhythmias are designed to offer continuous professional development and include the latest evidence-based information. These courses are often developed as a result of requests from staff, and they’re taught by our own experts on the subjects.

Staff of the Knight Nursing Center work hard to develop programs that meet the needs (and requests) of staff and keep them informed of new advances and technology in their areas of practice.

**Question:** What’s the best way to contact the Knight Center?

**Jeanette:** I suggest you visit the Knight Nursing Center website at: [www.mghpcs.org/knightcenter](http://www.mghpcs.org/knightcenter). You’ll be able to check out the educational offerings and view videos of past Nursing Grand Rounds presentations. For all other inquiries, call 6-3111.

# Nursing journey about always striving to set the bar higher

—by Clare Swan, RN, staff nurse



Clare Swan, RN, staff nurse

Why have I stayed a nurse all these years? As every nurse knows, when you talk about your job, just about everyone's response is, "I could never do that."

Nothing compares to reading Ayn Rand beneath the New York skyline or studying Nietzsche atop a mountain summit. Nothing, that is, except being a player in the real-life game of nursing.

Imagine Florence Nightingale moving among soldiers' beds lined up like fallen dominoes, holding a dying boy's hand, mopping a feverish brow with a cool cloth, or touching water to parched lips. What's the connection between this scenario and nursing today? The connection is elemental, and difficult to analyze without seeming almost voyeuristic.

As a young, impressionable high-school graduate, I decided to become a nurse because I wanted a vocation that would allow me to move from place to place and always be able to find a job—to work whatever shift I wanted and get a decent wage for it. But other occupations afforded that luxury; so why nursing? Or more to the point, why have I stayed a nurse all these years?

Friends of mine had become nurses, and surely that influenced my initial decision. But as every nurse knows, when you talk about your job, just about everyone's response is, "I could never do that."

Why is that?

I'd like to be able to say that nurses are a special breed—sensitive, compassionate, empathetic. There's no doubt that those traits are necessary to be a good nurse. But I compare nurses to poets who try to strip away the trappings of culture and civilization and get to the very basics of existence—love, procreation, spirituality, death—to marvel at the universe revealed in a blade of grass and somehow bear witness to it. Nurses experience all this and more.

The average person would look away, uncomfortable, anxious, maybe even sickened, if she encountered what nurses encounter on a daily basis. And for good reason. In the past 45 years, I've inserted my gloved hand into a craterous opening in a man's back to pack his wound. I've watched a doctor slice a pregnant woman's belly open to save the life of an infant. I cared



for a man who had murdered his wife and her lover then shot himself in the head, but managed to survive. I've comforted the family of a young paraplegic who took his own life on my watch and cursed him for doing so. I cared for a paralyzed man my own age who couldn't speak and was believed brain-damaged for 20 years. He was 'warehoused' in a nursing home until a speech therapist taught him Morse code and rescued him from oblivion. I've pushed my breath into a dead man's lungs trying desperately and futilely to revive him and carried the memory of his putrid breath with me for weeks afterward. I've watched miraculous recoveries, slow painful deaths, families who deserted their loved ones, and families who stood vigil until the last breath expired. I've seen courage and despair in equal measure and wondered if I'd be capable of mustering one or surviving the other.

These are the things, good and bad, that test nurses on a daily basis. We understand what really matters in life because we see what matters, and only what matters, every day. In the wake of a near-death experience, people often re-evaluate their lives and re-order their priorities. But nurses see these transformational events all the time. They are the defining moments of existence and the focus of our professional lives. Nurses are like rubberneckers passing a wreck on the freeway, voyeurs with a job to do. We know that each experience is a kind of gift that teaches us and shapes our practices.

I'm middle-aged now, and the time for thinking I could do or be anything is behind me. I am what I am. I feel myself beginning to mentally sum up all that I've learned. Deep in my soul, I have my own fire, my own burning flame. And from my own life, I continue to draw lessons from the suffering, mercy, despair, and redemption I've seen.

There's a small measure of guilt in being a nurse. Over the years, I've *received* more from my patients than I was ever able to give them. All nurses understand this: in an intangible, human way, there's more coming in than going out. Maybe that's why we do it. To feed the flame.

So what is this thing called compassion? The first seven letters spell, 'compass.' Like a compass, compassionate care takes you in all directions while having a profound effect on your professional practice. It heightens the importance of every interaction with every patient, as each contact is potentially a key factor in the healing process. As patients are so much more than their individual

parts, caring and communication become components of healing. Nurses enter into therapeutic partnerships where each patient's autonomy is respected.

To feel genuine compassion, I believe you have to be with the patient. Their cries, their words, their facial expressions, their

body language motivate you to alleviate their pain. We do what we can to alleviate pain, and when we can do nothing else, we sit and watch and wait for a miracle.

Compassionate care is embodied in the knowledge and skill of its providers. Consider the case of a young woman diagnosed with breast cancer who has a needle-phobia and is about to begin chemotherapy. Watch as her fear and anxiety slip away at the hands of a nurse with expert knowledge and IV skills. Listening to and observing patients with all our nursing powers contributes to the diagnosis and treatment as much as all the high-tech tests and procedures.

Like Nightingale in the Army hospital, for whatever combination of compassion and art, we try to be faithful, we don't give up. As I reflect on my own nursing journey, I'm reminded of the importance of bringing compassion to our practice and always striving to set the bar higher.

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# Professional Achievements

## Dahlin and Lynch present

Constance Dahlin, RN, and Maureen Lynch, RN, presented, "Palliative Care Nursing: the Art and Science," at a meeting co-sponsored by Dana Farber Cancer Institute and MGH, June 2, 2011.

## Dahlin presents

Constance Dahlin, RN, presented, "Caring, Collaborative Communication: Nursing in Palliative Care," and, "AgeWISE: Improving Quality Geriatrics and Palliative Care at the Bedside," at the Palliative Care Conference in Portland, Maine, June 15, 2011.

## Perry presents

Donna Perry, RN, professional development coordinator, presented, "Making a Difference: Expanding Humanitarian Capacity for the Human Good," at the International Humanitarian Studies Association, at Tufts University, June 4, 2011.

## Devaney presents

Lynn Devaney, RN, research nurse coordinator, presented, "Development and Integration of ACS NSQIP into the Morbidity and Mortality Conference," at the National Conference of the American College of Surgeons, July 25, 2011.

## Trio publishes

Constance Dahlin, RN; Emily Gallagher, RN; and Jennifer Ternel, MD; authored the article, "Early-Intervention Palliative Care: Implications for Nursing," in *The Oncology Nurse*.

## Nurses present

Constance Dahlin, RN; Maureen Lynch, RN; and Marie Bakitas, RN, presented, "Managing Symptoms at End of Life," at a meeting of the Oncology Nursing Society, April 29, 2011.

## Inter-disciplinary team presents

Constance Dahlin, RN; Juliet Jacobsen, MD; Vicki Jackson, MD; and Margaret Seaver presented, "Outpatient Palliative Care," at the Annual Assembly of the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association, in Vancouver, February 16, 2011.

## Walsh certified

Laura Walsh, RN, staff nurse, Outpatient Infectious Diseases Clinic, became certified as an AIDS registered nurse by the HIV/AIDS Nursing Certification Board, in July, 2011.

## Scott presents

Katrina Scott, MDiv, staff chaplain, presented, "Religious Aspects at End of Life," at the Summer Bioethics Program, at the Yale Inter-Disciplinary Center for Bioethics, July 21, 2011.

## Walsh president-elect

Laura Walsh, RN, staff nurse, Outpatient Infectious Diseases Clinic, was appointed president-elect of the Boston Chapter of the Association of Nurses in AIDS Care, in July, 2011.

## Coakley and Lee publish

Susan Lee, RN, nurse scientist, and Edward Coakley, RN, authored the article, "Geropalliative Care: a Concept Synthesis," in the July-August, 2011, *Journal of Hospice and Palliative Nursing*.

## Davis appointed

Steven Davis, finance manager, PCS Management Systems, was appointed chair of the Committee on Government Revenue Cycle of the Massachusetts chapter of the Healthcare Financial Management Association, September 6, 2011.

## Inter-disciplinary team publishes

Joan Renaud Smith, RN; Angelika Zollfrank; and Joan Rosenbaum, MD; authored the article, "Neonatal End-of-Life Spiritual Support Care," in the *Journal of Perinatal and Neonatal Nursing*.

## Haiti team recognized

The team deployed to Hôpital Albert Schweitzer in Haiti received Outstanding Volunteer recognition by the US Army Boston Healthcare Team, in September, 2011. That team included: Marjorie Curran, MD; Grace Deveney, RN; Katherine Fillo, RN; April Kaufman, RN; Kerry Quealy, RN; Colleen Shea, RN; and Susan Taricani, RN.

## Peterson elected

June Peterson, RN, professional development specialist, was elected president of the Northeast Organization of Nurse Educators in September, 2011.

## Nurses publish

Maureen Lynch, RN; Constance Dahlin, RN; Todd Hultman, RN; and Edward Coakley, RN, authored the article, "Palliative Care Nursing—Defining the Discipline?" in the *Journal of Hospice and Palliative Nursing*.

## French recognized

Brian French, RN, manager of The Knight Simulation Program and The Maxwell & Eleanor Blum Patient & Family Learning Center, was named the 2011 Jonas Scholar by the National League for Nursing, in July, 2011.

## Hilsman and Zollfrank publish

Gordon Hilsman and Angelika Zollfrank authored the chapter, "In Search of Theory and Criteria for the Practice of Distance Supervision," in *Reflective Practice: Formation and Supervision in Ministry*.

## Sutcliffe, Trainor present

Shaun Sutcliffe, RN, and Linda Trainor, RN, presented, "Bariatric Data Collector: Best Practices," at the annual conference of the American College of Surgeons' National Surgical Quality Improvement Program, July 23–26, 2011.

## Tyrrell presents

Rosalie Tyrrell, RN, professional development manager, presented, "Understanding and Leading a Multi-Generational Workforce," at the annual leadership conference of the Massachusetts Organization of Nurse Executives, April 5, 2011.

## Nurses present

Amanda Norton, RN; Christina Kim, RN; Kathy Kates, RN; and Margaret Mahoney, RN, presented, "A Community-Based Participatory Research Approach to Diabetes Education with a Homeless and Low-Income Female Population," at the Sigma Theta Tau 22nd International Nursing Research Congress, in Cancun, July 13, 2011.

## Hayward-Baxter elected

Ann Hayward-Baxter, MDiv, became president-elect of the Advisory Council of the Pediatric Chaplains Network, 2011–2013.

## Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, was appointed a member of the Education Advisory Board for the American Pain Society, July 5, 2011.

## Whitney elected

Kevin Whitney, RN, associate chief nurse, was elected president of the Organization of Nurse Leaders of Massachusetts and Rhode Island in August, 2011.

## Clinical educators present poster

Clinical educators, Mary McAdams, RN, and Sheila Golden-Baker, RN, presented their poster, "Developing Subject Matter Experts to Design On-Line Learning Events," at the National Nursing Staff Development Organization, in Chicago, July 9, 2011.

## Sutcliffe and Trainor present

Shaun Sutcliffe, RN, and Linda Trainor, RN, presented, "The Bariatric Data Collector: Work Flow Solutions for Quality Improvement," at the National Conference of the American College of Surgeons, July 25, 2011.

## Burke and Briggs present poster

Sheila Burke, RN, and Susan Briggs, MD, presented their poster, "The Role of Nurses in International Disasters," at the 17th World Congress on Disaster and Emergency Medicine, in Beijing, May 31–June 4, 2011.

## Nurses present poster

Jan Stewart, RN; Diane Doherty, RN; Sheryl Gaudet, RN; Kathleen Myers, RN; and Joanne Hughes Emполiti, RN, presented their poster, "I Care Rounds: Implementing a Standardized Approach to Improve Patient Satisfaction and Nurse Presence," at the Academy of Medical-Surgical Nurses, September 8–9, 2011.

# Announcements

## October is Health Literacy Month

The Patient Education Committee invites you to:

"Health Literacy: Just the Facts Ma'am"

Speaker: Jen Searl, health educator,  
Tuesday, October 25, 2011  
12:00–1:00pm  
Haber Conference Room

For more information,  
call 4-3085.

## October is Domestic Violence Awareness Month

The Domestic Violence Working Group invites you to visit a booth in the Main Corridor for information and a chance to enter a raffle.

October 12th  
10:00am–2:00pm  
October 20th  
7:00–11:00pm

"How to Support Someone Experiencing Intimate Partner Violence,"

presented by staff from  
Chaplaincy, EAP, HAVEN, and  
Police & Security  
October 13th  
12:00–1:00pm  
Yawkey 2-210

"Children Who Witness Partner Abuse,"

presented by Maxine Weinreb,  
EdD, Child Witness to Violence  
Program at BMC  
October 27th  
12:00–1:00pm  
Yawkey 2-210

For more information,  
call 6-7674.

## American Assembly for Men in Nursing

### Seeking members for new chapter

The American Assembly for Men in Nursing (AAMN) is seeking members to launch a New England chapter. AAMN is a national organization that provides a framework for nurses to meet, discuss, and influence factors that affect men in nursing. The AAMN offers scholarships, continuing education programs, and advocates for research and education for the recruitment and retention of men in nursing.

Membership is open to all nurses, male and female. For more information on joining the New England chapter, e-mail Gerald Browne, RN, or visit [aamn.org](http://aamn.org).

## 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  
(in the Partners directory).

## pink tips book-signing

Author, Ann Murray Paige, will be on hand to sign copies of her new book, *pink tips: breast cancer advice from someone who's been there*.

Thursday, October 27, 2011  
11:00am–1:00pm  
at the MGH General Store

Paige is the sister of MGH nurse, Ellen Silvius, RN, and a former MGH patient whose battle with breast cancer was chronicled in the award-winning documentary, *The Breast Cancer Diaries*.

For more information,  
call 6-3732.

## AccessAbility Fair

Wednesday, October 19, 2011  
10:00am–4:00pm  
under the Bulfinch tent

In honor of National Disability Awareness Month, the Office of Patient Advocacy and the Council on Disability Awareness invite you to the first annual AccessAbility Fair. Learn about:

- Adaptive equipment and technology
- Community resources
- ALS (Blum Center; 12:00pm)
- services for children with developmental disabilities (Haber Conference Room; 1:30pm)

"In Our Own Voices"

Thursday, October 20th  
12:00–1:00pm  
Blum Center

presented by volunteers from the National Alliance on Mental Illness

"Autism"

Thursday, October 20th  
12:00–1:00pm  
Blum Center

presented by Sarabeth Broder Fingert, MD, and Susan Connors, MD.

For more information or to request disability accommodation, e-mail: [mghaccessibility@partners.org](mailto:mghaccessibility@partners.org).

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For more information, call:  
617-724-1746

Next Publication  
October 20, 2011

# It's that time again

## What you need to know about the flu

**Question:** Why is it necessary to get vaccinated for the flu?

**Jeanette:** According to the Centers for Disease Control and Prevention, the flu is a contagious disease. It is caused by the influenza virus, which can be spread by coughing, sneezing, and nasal secretions.

Anyone can get the flu, though the rate of infection is higher for children. Symptoms usually last a few days and may include: fever; chills; sore throat; muscle aches; fatigue; cough; headache; and runny or stuffy nose. But those at risk can get sicker. Each year, thousands of people are hospitalized or die as a result of contracting the flu. Getting the flu vaccine can protect you from getting the flu and may also help avoid spreading the disease to others.

**Question:** Do I need to get vaccinated every year?

**Jeanette:** Yes. Influenza viruses are constantly changing, so annual vaccination is recommended. Each year scientists try to match the vaccine to the viruses most likely to be a factor that year. It can take up to two weeks for the vaccine to take effect, and protection lasts approximately one year.

**Question:** Are there any risks associated with the vaccine?

**Jeanette:** Like any medication, flu vaccine can cause problems such as severe allergic reactions, but the risk is extremely small. And you cannot get the flu by being vaccinated.

**Question:** Where can I go to get vaccinated?

**Jeanette:** Occupational Health Services is offering its annual seasonal flu clinics. Remaining sessions will be held:

MGH Main Campus  
(Saturdays) October 15th and 22nd  
9:00am–3:00pm  
WACC Tea Leaves and Coffee Beans

Schrafft's Center  
Wednesday, October 26th  
8:30am–1:00pm  
Partners Conference Room, 5th floor

You'll need your MGH/PHS ID badge to receive the vaccine. For those unable to attend a clinic, you may walk in to Occupational Health Services or call 6-2217 to schedule an appointment.

**Question:** Where can I find more information about the flu vaccine?

**Jeanette:** Speak with your doctor, or visit the CDC website at [www.cdc.gov/flu](http://www.cdc.gov/flu).



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