

Caring

Headlines

April 19, 2012

Occupational Therapy Month focuses on inter-disciplinary collaboration

Teaching • Problem-solving



Collaboration • Teamwork

Occupational therapist, Allison Pinsince, OTR/L, collaborates with staff nurse, Robert Droste, RN, to position splint for patient in the Burn Unit ICU.

Understanding scope of practice

ensuring patient safety by respecting the parameters set by regulatory and licensing bodies

Scope of practice refers to the specific procedures, actions, and processes a licensed individual is authorized to perform.

In my last column, “The IOM Report on the Future of Nursing,” I referred to the four recommendations put forth by the Institute of Medicine to empower nurses to lead change and advance health in the 21st century. One of those recommendations was for nurses to practice to the full extent of their education and training. In order to do that, clinicians need to understand the scope of their own practice.

Even among healthcare professionals, sometimes the distinction between licensure and scope of practice becomes murky. Both have to do with being qualified to practice in a particular field or discipline, but licensure (such as nursing or social work) signifies that a clinician possesses entry-level knowledge, the minimum level of knowledge required to practice in a health profession. Whereas scope of practice refers to the specific procedures, actions, and processes a licensed individual is authorized to perform. Scope of practice is limited to what is allowed by law, and every jurisdiction has different laws and licensing bodies regulating scope of practice. For example, in Massachusetts, the Board of Registration in Nursing oversees scope of practice for nurses practicing in this state.

At MGH, physicians, advanced practice nurses, and physician assistants are the only clinicians authorized to diagnose and treat patients. They are acting within their scope of practice when they do so. All other cli-



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

nicians are required to have a written (or, on occasion, verbal) order to initiate medical tests and treatments.

The following (partial) list contains examples of actions that should *not* be taken without an order from a physician, advanced practice nurse, or physician assistant:

- medication administration
- blood tests, point-of-care testing, EKGs
- urinary catheter placement and/or irrigations
- IV starts
- insertion of rectal tubes
- standardized order sets (templates)

Standardized order sets are different from standing orders, and this can be a source of confusion for some. Standing orders are hospital-wide orders that have been approved by the MGH General Executive Committee and do *not* require a separate order from a physician, advanced practice nurse, or physician assistant each time they're carried out. There are only two standing

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We all want to provide high-quality, efficient care to every patient who comes through our doors. We want to practice to the full extent of our education and training. We *don't* want to put patients at risk by practicing outside our scope of practice.

orders at MGH: they apply to the administration of (1) influenza and (2) pneumonia vaccine as appropriate.

A standardized order set refers to any of the test(s), treatment(s), or procedure(s) 'routinely' performed in a specific setting to facilitate and foster consistency of care among certain patient populations. The Endoscopy Unit is a good example of an area that uses standardized order sets. A large percentage of patients on the Endoscopy Unit are there for routine endoscopic procedures and will receive a similar set of pre-procedure interventions, such as: having a peripheral intravenous access port inserted, having an infusion started, or having their blood sugar levels checked. These are standardized orders, established and agreed upon by the appropriate physicians and departments in collaboration with nurses to ensure optimal care for every patient. *But even standardized order sets require an actual order from a physician, advanced practice nurse, or physician assistant before they can be acted upon.*

The only situation in which a licensed clinician is authorized to initiate an intervention outside of his/her scope of practice is in an emergent situation where the clinician makes an informed assessment that the patient would be at risk if treatment were delayed. If waiting for an order from a physician, advanced practice nurse, or physician assistant would *not* put the patient at risk, then an order should be secured before the intervention is carried out.

Any discussion about scope of practice should include some mention of competency. Just because a clinician is licensed and authorized to perform certain tasks, doesn't mean he/she is competent to perform them. This is where training and education come in. At MGH, basic competencies are addressed during New Employee Orientation (for nurses), and specialized competencies are covered during unit-specific orientation as clinicians transition to their new practice areas. Some examples of basic competencies include: skin and wound care; medication-administration; point-of-care testing, documentation; and patient- and family-centered care, to name only a few. An example of a unit-specific competency might be intra-cranial pressure monitoring in the Neuro ICU.

We all want to provide high-quality, efficient care to every patient who comes through our doors. We want to practice to the full extent of our education and training. We *don't* want to put patients at risk by practicing outside our scope of practice.

I hope this column has helped shed light on some of the nuances around scope of practice. When we've received the appropriate training and education, when we've demonstrated our competency to perform certain interventions, and when we have an order from a physician, advanced practice nurse, or physician assistant to carry out those interventions, we are practicing within our scope of practice.

For more information, call the PCS Office of Quality & Safety at 3-0140.

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Occupational Therapy

*meeting patients' needs with innovative,
collaborative solutions*

—submitted by the department of Occupational Therapy

Occupational Therapy addresses the functional needs of individuals limited in their ability to perform life activities due to injury, disease, or developmental challenges. During April, National Occupational Therapy Month, we celebrate the many contributions of occupational therapists as they help patients lead more meaningful and productive lives. The theme of this year's celebration is inter-disciplinary collaboration and the importance of creative, evidence-based problem-solving.

Integrating the Sensory Modulation Approach to Reduce Restraint Use in Delirious Patients

—an interview with Karen Turner, OTR/L

Occupational therapists, Lauren Cosgrove, OTR/L (left), and Karen Turner, OTR/L, demonstrate the use of weighted blankets, one of many sensory-based interventions used to calm agitated patients.

The MGH Restraint Reduction Committee was formed in May of 2011 to help decrease the use of restraints and isolation. This multi-disciplinary team, comprised of occupational therapists, nurses, and social workers, is working together to explore and evaluate alternatives to restraints for patients experiencing delirium. After

reviewing the literature on sensory-based interventions as an alternative to restraints, the team developed a proposal to trial sensory-based interventions with patients with delirium in the Surgical ICU.

Sensory modulation is a relatively new approach in the mental health setting. It encourages patients to use their sensory systems (touch, movement, etc.) to regulate mood and emotions. Though some sensory experiences (certain colors, for example) are considered universally soothing, many elements of what patients find soothing are unique to the individual.

The first patient trial was conducted in January, 2012, by Karen Turner, OTR/L, and Lauren Cosgrove, OTR/L. A patient in the Surgical ICU was restless and delirious, awaiting placement of a feeding tube because he refused to eat or bathe or groom himself. It can be challenging to converse with patients in delirium, but Turner and Cosgrove spoke to him about activities he enjoyed, like sports and coaching. They posed questions to learn about his sensory preferences, providing two options and letting him choose. Did he want music on or off? Did he want his bed raised or not? By the time they left, the patient was more settled and alert and able to engage in choices. He had agreed to brush his teeth and drink from a cup.

For Turner and Cosgrove, this interaction generated other ideas to calm delirious patients in the SICU. It's good progress for the inter-disciplinary Restraint Reduction Committee in terms of turning research into new practices for the safe, compassionate treatment of patients experiencing delirium.



(Photo provided by staff)

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Occupational Therapy (continued)

Improving the Way NICU Babies Learn to Eat by Mouth —an interview with Julie Park, OTR/L

In the Neonatal ICU, cluster feeding based on a baby's chronological age is the current practice for teaching premature infants and other medically involved babies to eat, a key first milestone toward greater independence. Recent studies show that cue-based feeding—an individual, developmental-based approach to introducing bottle feeding—better serves babies' nutritional and developmental needs and decreases length of hospital stays.

After attending a Developmental Interventions in Neonatal Care conference in 2010, a team of MGH nurses, physicians, occupational therapists, and speech-language pathologists returned to MGH and formed a team to implement cue-based practice here. Utilizing their expertise in oral feeding, occupational therapist, Julie Park, OTR/L, and SLP fellow, Jean Ashland, are developing materials to help teach NICU nurses how to assess a baby's readiness for bottle-feeding via the Infant-Driven Feeding Scale (IDFS).



Feeding readiness and nipping skills are some of the cues NICU nurses will be assessing in order to effectively implement a cue-based feeding program. Is the baby alert and awake before feeding? Is the baby suckling on his hands or fussing to eat? Does the baby have adequate muscle tone? Can the baby maintain vital signs during feeding? Park and Ashland are developing a teaching program, including a PowerPoint presentation, HealthStream module, and video library of infants at various stages of development. Nurses will be able to use the videos to practice assessing babies; pre-training will start this month.

The team is organizing a conference to be held in July that will bring experts in cue-based feeding to MGH. Park, Ashland, and a group of IHP student nurses are researching the implementation and outcomes of this program with the goal of publishing in the near future.

In the NICU, Julie Park, OTR/L, occupational therapist, prepares mom and infant for cue-based feeding session.

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The Saebo Splint: a New, Dynamic Splint Benefits Stroke Patients

—an interview with Julie MacLean, OTR/L

Julie MacLean, OTR/L, outpatient occupational therapist, specializes in neurological rehabilitation. In managing stroke patients over the years, MacLean has observed that many patients are able to make a fist but unable to open their hands afterward, significantly limiting their ability to function.

As she researched solutions, she came across an ad for a conference: Improving Upper Extremity Motor Recovery Following Stroke: Using the Saebo Arm Training Program and Saebo Functional Dynamic Orthoses. She'd heard of the system but had no direct experience with it. The clinical theory behind it seemed sound. It sparked her spirit of inquiry, so she decided to attend the conference.

MacLean found that the Saebo splint has a dynamic design that assists patients in opening paretic hands. Through repetitive functional training, the splint helps facilitate recovery by re-training the motor pathways in the brain that control grasp and release. After the conference, MacLean sought training in the use of the splint. She already had a patient in mind as an ideal first candidate.

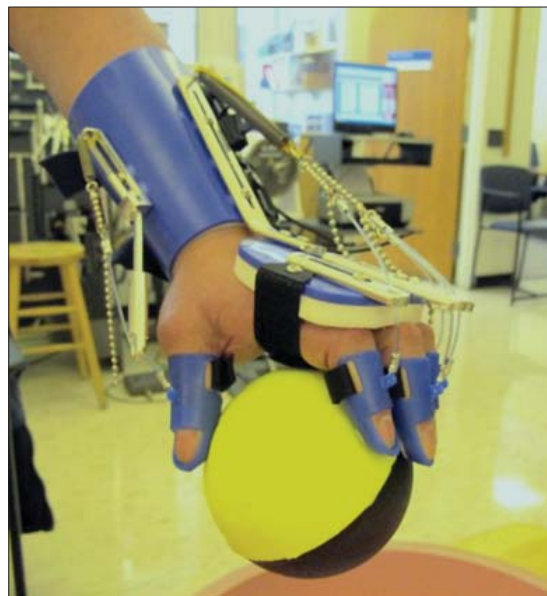
'Jane,' a recent young stroke patient, had limited hand function. She couldn't extend her fingers to pick up a ball. Using the new splint, Jane participated in

weeks of extensive occupational therapy, systematically using rote and repetitive activities until the motor action became automatic. MacLean learned how to adjust the dynamic components of the splint and grade the activity demands to constantly challenge Jane's evolving motor performance. By the end of her treatment, Jane had gained enough fine motor control to paint her own fingernails. Some of her motor return may have been the result of natural recovery, but the success Jane experienced motivated MacLean to try the splint with other patients.

Since then, MacLean has used the splint with five patients and seen significant functional gains in four of them. Though the device appears to have a greater effect on patients whose strokes are more recent (within the past 12 months), she has seen gains in longer-term stroke patients. One gentleman regained enough function to resume zipping his daughters jacket, which for him, was a very meaningful activity.

Motivated by MacLean's success, other clinicians have become interested in this new technology. Recently, Sharon Serinsky, OTR/L, pediatric occupational therapist, completed Saebo training and now uses the device with many of her patients. MacLean looks forward to using the splint as a tool to help other patients achieve their functional goals, and educating other clinicians on this dynamic treatment option.

For more information about the treatment and services offered by the department of Occupational Therapy, call 617-726-4997.



(Photos provided by staff)

Left: close-up of the dynamic Saebo splint
At right: occupational therapist, Julie MacLean, OTR/L, works with patient using the splint

Health Information Translations

—by Judy Gullage, RN; Shellie Legere, LICSW; Vita Norton, RN; and Maryellen Robertson, RN,
for the PCS Patient Education Committee

If you're looking for a resource for health information for patients that's written in plain language and offers numerous translation options, look no further. The Health Information Translations application is now available through Partners Handbook. Developed through a collaboration of health education specialists, the Health Information Translations website offers information on a variety of health topics from diet and nutrition, to diseases and conditions, to surgery and treatment options. Once you find the information you're looking for, you can print it in English and many other languages. Some information is avail-

The Health Information Translations application is now available through Partners Handbook.

able in audio and/or video format, which may be appropriate to meet the educational needs of some patients.

To find Health Information Translations:

- Go to Partners Handbook (Start—>Partners Applications—>Clinical References—> Partners Handbook)
- Select the Patient Education Info icon
- Select Health Information Translations from the list of options

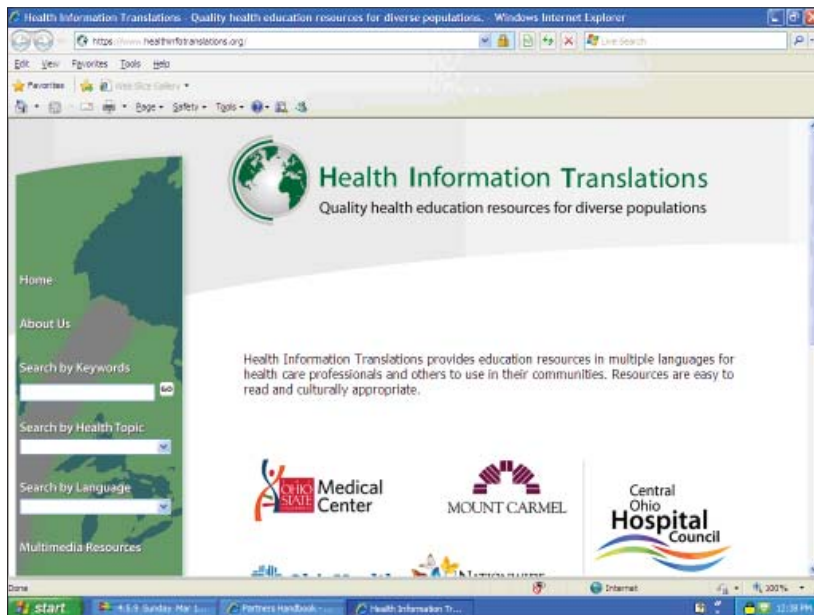
You can search by key word, health topic, or language by:

- clicking on the appropriate drop-down menu
- selecting the desired topic and language

For example, if you wanted to find an Arabic translation for “How to use a glucose meter,” you would:

- click on the drop-down menu under Search by Health Topic
- select Home Care
- scroll down to “How to use a glucose meter” and click on it
- select the desired language from the list of available languages (in this case: English, Russian, French, Spanish, Somali, Chinese, and Arabic)
- the documents will appear on the screen in both languages
- click on the Print icon in the lower right corner of the screen

Health Information Translations can be an invaluable resource when providing health information to non-English-speaking patients and families. For more information, call 617-643-2166.



April is National Occupational Therapy Month...

It was then that I learned about John, a 20-year-old student who had fallen four stories and sustained a C6-spinal-cord injury and bilateral wrist fractures.

My name is Kimberly Erler, and I've been an occupational therapist for two and a half years. The day I met 'John' started no differently than any other Monday morning. As I started to read about new patients who had been admitted over the weekend, a nurse came over to ask about the care plan for one of her patients. It was then that I learned about John, a 20-year-old student who had fallen four stories and sustained a C6-spinal-cord injury and bilateral wrist fractures.

After my initial heartbreak for this young man whom I hadn't even met yet, I started thinking about what my role would be and the best time to initiate occupational therapy. I wasn't intimidated by the severity and complexity of John's injuries; I was excited about this opportunity to work with him in the acute phase of his injury. I knew how important occupational therapy would be for his long-term success and functional recovery.

As a student, I had completed a three-month clinical rotation at a rehabilitation hospital working on the adolescent and young adult team. During that time, I developed a passion for working with individuals whose lives had been changed by spinal cord injuries. I love that the unique skills of occupational therapy can help patients who've had everything taken away from them, regain control of their lives. After doing a quick 'walk-by' of John's room, I realized that translating



Kimberly Erler, OTR/L, occupational therapist

what I had learned in the rehab setting to the acute-care experience would make for an interesting challenge given the fragility of his medical status at this stage.

Although John's medical status was tenuous, it was clear that occupational therapy should be initiated as soon as possible. John's spinal cord was damaged at the C6-7 level, meaning he could move his arms, shoulders, and elbows, but his wrists would be much weaker, and his digits might not have any active movement at all. Being able to move his wrists would be essential if he hoped to participate in functional tasks using what's called a 'tenodesis grasp.' Evaluating John's strength was going to be difficult because he was in heavy post-operative 'casts' that restricted his movement. I decided a conversation with the orthopedic service was warranted to discuss his orthopedic precautions in the setting of his neurological rehab.

After much discussion about what was best for John, the orthopedic doctor agreed that he should be placed in light-weight splints and permitted to do

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...and National Donate Life Month

46-year-old Michael was getting ready to work his night shift when he developed a really bad headache. By the time Alice got to him, he was on the ground, seizing. Fifty minutes later, Michael was in the operating room at MGH having a hemi-crani and intraventricular catheter placed.

My name is Kelli McLoughlin, and I am a recent graduate of the Nurse Residency Program. He didn't want to wait until Saturday to see Alice again. He asked her out the very next night. They've now been married 11 years. They decided not to have children of their own after agreeing to raise three of their grandchildren together. Michael worked weekends at one job and overnight shifts during the week at another so he could be home for his 'girls' during the day. In the fall, Michael could always be found at neighbors' homes, rake in hand; and in winter, a shovel. In the summertime, he'd put on his Elvis costume and serenade Alice at neighborhood block parties until she begged him to stop.

"Alice," I said, "When did Michael ever find time to sleep?"

"He didn't," she said. "Michael lived for people. And people lived for him."

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Over the next week and a half, Maryanne, my preceptor, and I cared for Michael. When I say we cared



Kelli McLoughlin, RN, staff nurse

for Michael, I mean I apologized every time I had to pinch his chest, extremities, and nail beds in order to assess his neurological state. When I say we cared for Michael, I mean, not only did we know every inch of his skin, but we measured output from every orifice of his body. When I say we cared for Michael, I mean we cared for him, and Alice, and his son, and their niece, and Michael's two brothers and sister, and Alice's father and sister, and all their friends.

When I say we cared for Michael, I mean I watched in awe as Maryanne reduced complicated medical jargon to simple language for Alice and reinforced that the situation was not good; things were not getting better. I specifically remember her telling Alice she couldn't have imagined a worse nightmare. It wasn't fair. It wasn't supposed to happen; she was sorry we had to meet under these circumstances. Somehow, as Maryanne and I delivered more and more bad news, we all began to bond with one another. I began to understand how the truth was better than sugar-coating already bad news. Bad news is bad news. I started to think something was wrong with me because unlike Maryanne, I had not yet shed one tear.

Michael herniated the next morning, and they tested him for brain death. When I say we cared for

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Sanders receives Molly Catherine Tramontana Award

— submitted by Kathya Gavazzi, RN, clinical nurse specialist

The Molly Catherine Tramontana Award for Outstanding Service and Patient Care was established in memory of Molly Catherine Tramontana in 2007 by her parents, family, and friends. The award recognizes nurses in the Labor & Delivery Unit for their dedicated service to the department and to their patients. Each year, the recipient is recognized at a special luncheon, and his/her name is added to the plaque displayed at the entrance to the Labor & Delivery Unit.

This year, six nurses were nominated: Julie Clark, RN; Shana Crow, RN; Tara Hutchings, RN; Paula Nelson, RN; Jenny Sweet, RN, and this year's recipient, Laura Sanders, RN. Sanders was nominated by several individuals from different disciplines.

In her letter of support, Andrea Hennigan, RN, wrote, "Laura embodies what I believe is the spirit of this award."

Beth West, RN wrote, "Laura consistently provides exacting, detail-oriented care to both high- and low-risk patients while at the same time taking pride in traditional nursing practice. She knows her 'special fluffing' goes a long way toward healing and making people feel good."

Patient care information associate, Paul Treen, nominated Laura, saying, "Laura is always the first one there to help, regardless of how busy she is. That really tells you the kind of nurse she is."

The Tramontana family and leadership of the Vincent Department of OB/GYN came together on March 16, 2012, to celebrate this great honor, followed by a luncheon in the Trustees Room.

For more information about the Molly Catherine Tramontana Award, go to: <http://www.massgeneral.org/obgyn/tramontana>.

Molly Catherine Tramontana Award recipient, Laura Sanders, RN (center with flowers), surrounded by family, friends, colleagues, and members of the Tramontana family.



(Photo by Joe Ferraro)

Understanding the role of social worker

Question: I'm new to MGH and was wondering about the role of inpatient social worker. It seems much broader than where I used to work.

Jeanette: You're not alone; many staff don't realize the full scope of social work practice at MGH. Most of what inpatient social workers do is clinical, helping patients and families cope with illness, disability, or related stresses. Social workers also help patients understand and connect to community resources, such as Meals-on-Wheels, and other services. MGH social workers are all master's-prepared, licensed, mental health professionals. A flier describing the work of inpatient social workers should be posted on your unit. If you don't see it, ask your social worker.

Question: One of my patients is struggling to cope with a serious diagnosis. She is also the primary caretaker for her mother. Is there a way to connect her with social-work services after she's discharged?

Jeanette: It's terrific that you're attuned to your patient's need for ongoing support. Social Service's outpatient mental health providers help patients with a variety of concerns including:

- adjusting to illness/disability
- anxiety and depression
- caregiver concerns
- work and school difficulties
- relationship problems
- trauma
- loss/bereavement

The best way to refer is to call 6-2643 and ask for, "Intake," or fax a referral to 6-7676, attention: intake coordinators.

One of the intake coordinators will contact the patient and conduct a brief telephone interview to determine what assistance is needed. The intake coordinator will get back to you with the outcome.

Question: I have a patient who's in an abusive relationship but not yet ready to speak with HAVEN staff. I want to give her information for when she is ready. Is there a number she can call?

Jeanette: Staff of HAVEN, our Intimate Partner Abuse intervention program, follow patients (inpatient and outpatient), from the time of crisis for however long they need to get their lives back in order. We're fortunate to have full-time HAVEN staff available on the main campus and in the Revere and Chelsea health centers. You can contact HAVEN directly and/or give the patient the following contact information: 617-724-0054 (Boston); 617-887-3513 (Chelsea); 781-485-6108 (Revere). E-mail: haven@partners.org. Or visit their website: <http://www.mghpcs.org/socialservice/Programs/Haven/>.

Question: It might be helpful to be able put patients in touch with others in similar circumstances. Is that something social workers could help with?

Jeanette: Patients tell us all the time how important it is to be able to talk with others in similar situations. Social Service has developed a robust support group program, including groups devoted to: bereavement, families caring for patients with Alzheimer's, transplant, AIDS/HIV, domestic violence (Spanish-speaking groups available), a variety of cancer-related groups, and much more. The complete list is available on-line at <http://www.mghpcs.org/socialservice/Groups.asp>. Some groups are offered in conjunction with other departments and/or are available at our health centers.

A special program for cancer patients and their families matches them with mentors who've already been through cancer treatment. The Network for Patients & Families also offers an annual survivorship conference. To refer patients to this network, contact Paula Gauthier, LICSW, program coordinator, at 617-643-1784, via e-mail, or go to the Blum Cancer Resource Room on Yawkey 8C.

gentle range-of-motion exercises. It was time to execute the plan and begin John's rehabilitation.

When I went in to meet John for the first time, he was still on a ventilator, which made communication very difficult. I explained that I was part of the rehab team, and that my role was to help him begin participating in his self-care again. He appeared disinterested, keeping his eyes closed, until I removed the heavy post-op casts, then he briskly raised both arms with an ear-to-ear grin.

During the next few sessions, we focused on moving and strengthening his arms. He was consistently demonstrating a return to C7, which meant he was able to straighten his arms and extend his wrists. Although that might not seem any more important than any other movement, I knew that the ability to extend his arms meant he might eventually be able to transfer himself. And being able to extend his wrists would give him the tenodesis grasp, which meant he would be able to perform his activities of daily living (ADLs) independently.

One day, John kept trying to tell me something, but I just couldn't read his lips. Finally, his mother said, "Are you trying to say you want to look outside?"

And with a nod of his head that couldn't be misinterpreted, John's message was clear. The ICU nurses, who never fail to go above and beyond for their patients, worked together to re-arrange his bed, ventilator, and other equipment so John could look outside. It was clear to me that the architectural design of the Lunder Building had a visible impact on this young man's rehab. He was able to exert control over his environment when control over everything else in his life had been taken away. To me, this was about much more than being able to look outside. It was about John taking the first step in advocating for his own needs. This was a pivotal moment in his rehab. It told me he was ready for more.

Because John was an amateur writer and constantly frustrated by not being able to speak (despite becoming proficient in adaptive strategies like the communication letter board), I chose writing as one of his treatment options. I thought it would be a meaningful and motivating activity for him, and he might be able to achieve some success at it. I also thought that being able to brush his own teeth would help motivate him to want to engage in his own ADLs again.

A universal cuff is a piece of equipment that wraps around a person's palm and has an insert into which tools can be placed. It allows people who don't have the ability to activate their digits to 'hold' items. When I entered John's room, I asked if he'd like to try these

activities, and he immediately spelled out the word, 'No' on his letter board. He went on to spell the word, 'Normal.' John didn't want to do anything if he couldn't do it the way he had before his injury.

Expecting him to be reluctant, I gave him the option of writing or brushing his teeth. He chose writing. I placed the universal cuff on his left hand because it was slightly stronger, and I inserted a pen. In very short order, John wrote his name. He smiled. I smiled. His mom smiled so hard she cried. John kept at it, eventually writing, "I'm right-handed. Can we put it on the other hand?"

John had real success writing. I wanted to push him to brush his teeth, but he was too tired. When I left, he agreed to try to brush his teeth with his nurse that night. The next day, his nurse found me to tell me he'd done a great job and that *he'd* been the one to remind *her* he was supposed to try it himself. The positive reinforcement of being successful at writing had given him the confidence to try another adaptive task. I rarely choose writing as the first task for a person with a new spinal cord injury, but for John it was 'just right' because it was motivating and important to him.

I became an occupational therapist because I wanted to make a difference in people's lives by facilitating participation in meaningful activities. John was just at the beginning of his journey. And it was clear he would have many more bumps along the road to recovery. But in that state-of-the-art ICU room with John's bed facing out the window, I know I made a difference helping him get some independence back.

A few weeks later, he was transferred to rehab at the same facility where I had done my clinical rotation as a student. I'll never forget my sessions with John because that experience made me a better clinician.

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

Kim's narrative gives us insight into the intricate planning that goes on before an occupational therapist even enters the patient's room—understanding the back story, the impact the injury will have on the patient's life, as well as the many complexities of the injury itself. When Kim entered John's room with that universal cuff, it could have gone either way. But Kim made the session meaningful for John, so he seized the opportunity to re-gain some control over his life.

Kim's passion for working with individuals whose lives are changed by spinal cord injuries was clearly evident in this narrative.

Thank-you, Kim.

John was just at the beginning of his journey. And it was clear he would have many more bumps along the road to recovery. But in that state-of-the-art ICU room with John's bed facing out the window, I know I made a difference helping him get some independence back.

In less than six hours, Michael's heart would be beating in another man's chest. Michael was still my patient. I reached for his hand one last time. "Go, Michael. You did it. You really did it." I was so grateful for all this man had taught me, and he had done it without ever opening his eyes or saying a word.

Michael, I mean I experienced grief in its purest form. I felt the heart-wrenching agony that accompanies shock, sadness, denial, anger, and finally, helplessness, as one watches her best friend, her soul mate, deteriorate before her eyes despite the best medical treatment.

During this time, I had been working closely with the New England Organ Bank (NEOB) to determine whether Michael would be eligible to donate his organs. Maryanne and the rest of the medical team felt sure Alice would not agree to organ donation. After the subject had been delicately broached, Michael's brother surprised everyone by revealing he had end-stage liver cirrhosis and was in need of a transplant. Alice re-visited her decision. She knew Michael would do anything to help his family but felt he'd been through enough. She finally arrived at the decision to let Michael's brother have the liver. But if it couldn't go to him, she didn't want anyone to have it.

Having had some personal experience with organ donation, Maryanne and I suspected that Michael's brother wasn't sick enough to be on the transplant list. The NEOB representative confirmed our suspicion. A heavy feeling set in with the team. We'd all worked so hard to keep Michael alive; it was anti-climactic to end things on this note. The NEOB representative packed up her things. Just Alice and her dad remained. The Neuro ICU physician, Maryanne, and I pulled chairs around Michael's bed and sat with Alice.

When I say we cared for Michael, I mean I felt an overwhelming duty to represent what he would have wanted. I looked at my patient in his bed. I knew him, but I was conflicted. I was the youngest and least experienced person in the room. This was probably a good time to stay quiet, listen, and learn. But somewhere deep inside, I felt a transfer of strength, and I knew it was now or never.

"Alice," I choked out, my voice almost a sob. "Michael has never opened his eyes. He's never spoken a word to me. But I feel as if I know him through you and your family. I can't help think he'd not only want to help his family, he'd give a stranger the shirt off his back. He lived for the joy of helping others. Somewhere, even right here in this hospital, there are families like yours, sitting at the bedside of a loved one, praying for a miracle. Michael could be that miracle for them."

A long silence followed. I felt Maryanne and the physician's eyes on me, probably in disbelief that I'd raised the issue again. But I was compelled. It was as if Michael was talking to Alice through me. I looked at Alice and realized I had been right. I could see the wheels turning. She had changed her mind. She took Michael's hand and said, "Everything."

Alice consented to everything—organs, corneas, skin grafts, bone grafts, tissue donation, even research. When Alice said her last good-bye to Michael, she turned to me and began to sob.

"Thank-you," she said. "I would always have regretted that decision. Of course Michael would want to help others. I just didn't want to put him through any more. And I would have regretted that. Thank-you."

As soon as Alice left, I caved. My mind went cloudy, my hands became clumsy.

"Kelli," said Maryanne. "We all have our turns. Trying to save a patient, then suddenly switching to organ perfusion is devastating. You wouldn't be the nurse you are if you didn't feel something." My eyes welled up with the tears that had escaped me all week.

As the hour of Michael's surgery approached, I felt a thud of panic in my chest. I hovered around Michael's bed. He was ready. But I wasn't. I clasped his hand in mine and said a prayer that the surgery would go well and he'd remain stable enough to donate. I prayed for his soul and for his family. "Come on Michael," I said, "You can do this."

I was reluctant to leave Michael's side when the OR team prepped him and surgical teams from other hospitals began to arrive. Everyone told me how lucky I was to see a full organ-recovery surgery, but I knew it wasn't luck. Maryanne and I had worked very hard to get Michael and his family to this point. The only tears in that operating room were accompanied by a smile. "Go, Michael," I thought. "You're really going to do this."

After the organs were taken away, I looked at my watch. In less than six hours, Michael's heart would be beating in another man's chest. Michael was still my patient. I reached for his hand one last time. "Go, Michael. You did it. You really did it." I was so grateful for all this man had taught me, and he had done it without ever opening his eyes or saying a word.

When I say we cared for Michael, I mean it was a privilege to care for Michael.

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

Nurse theorist, Virginia Henderson, RN, said nurses, "must get inside the skin of each of her patients in order to know what he needs." Kelli got inside Michael's skin. She became his voice, his protector, his advocate. She was as courageous and compassionate in her post-mortem care as she was in her end-of-life care. I think it's safe to say that Kelli's interventions had a profound effect on Michael, his family, and many others we may never know about.

Thank-you, Kelli.

Coming Events

Nurse Recognition Week 2012

Thursday, May 3

Chief Nurse Address
presented by Jeanette Ives Erickson, RN, chief nurse

2:00–3:00pm, O’Keeffe Auditorium
and Haber Conference Room

Friday, May 4

Presentations by former Yvonne L. Munn Nursing Research
award recipients

“An Evidence-Based Practice Project on the Use of Non-Invasive
Mechanical Modalities for Venous Thromboembolism (VTE)
Prophylaxis in the Surgical Intensive Care Unit,”
presented by: Paula Restrepo, RN; Deborah Jameson, RN;
and Diane Carroll, RN

“The Impact of Death and Dying in the Intensive Care Unit
on New Graduate Nurses,”
presented by: Tara Tehan, RN; Mary Guanci, RN;
and Donna Perry, RN

10:00–11:30am, O’Keeffe Auditorium

Sunday, May 6

Staff Nurse Breakfast
7:00–9:00am
Trustees Room

Monday, May 7

“Caring for the Caregiver: Recognizing Compassion Fatigue
and Developing Self-Care Skills,”
presented by Mary Susan Convery, LICSW, oncology social worker,
MGH Cancer Center

7:30–8:30am, O’Keeffe Auditorium
(repeated at 10:00am Tuesday)

“Shaping the Future of Health Care through Innovation,”
presented by Ellen-Marie Whelan, RN, senior advisor, Centers for
Medicare & Medicaid Services (CMS) Innovation Center

1:30–2:30pm, O’Keeffe Auditorium

Tuesday, May 8

“Caring for the Caregiver: Recognizing Compassion Fatigue
and Developing Self-Care Skills,”
presented by Mary Susan Convery, LICSW, oncology social worker,
MGH Cancer Center

10:00–11:00am, O’Keeffe Auditorium
(repeat of Monday’s 7:30am presentation)

“Taking the ‘T’ to Cultural Competence: is the Red, Orange, Blue or
Green Line Your Best Practice?”
presented by Deborah Washington, RN, director of PCS Diversity

1:30–2:30pm, O’Keeffe Auditorium

Wednesday, May 9

Research Day

Posters on display throughout Nurse Recognition Week
O’Keeffe Auditorium Foyer

Interactive Nursing Research Poster Session
10:00am–12:00pm, O’Keeffe Auditorium Foyer

18th annual Yvonne L. Munn Nursing Research Lecture
and presentation of the 2012 Yvonne L. Munn Nursing Research
Awards

“The Bucket List: Advancing an International Research
Agenda using Administrative Data in the Evaluation of Leadership
and Organizations,”
presented by: Jeffrey Adams, RN, nurse scientist, Yvonne L. Munn
Center for Nursing Research

1:30–3:00pm, O’Keeffe Auditorium

Staff Nurse Reception
3:00–4:30pm
Trustees Room

Announcements

Attention nurses Get pampered for Nurse Day

In honor of Nurse Day, Bloomingdale's invites MGH nurses to a night of pampering in the cosmetics department of their Chestnut Hill location.

Thursday, April 26, 2012
6:00–8:30pm

Bloomingdale's, Chestnut Hill

Enjoy Beauty 101, the latest beauty tips from the experts, as well as samples and one-on-one consultations. Mini massages, manicures, and light snacks will also be available.

This is Bloomingdale's way of showing appreciation for all that nurses do and contribute to the local community.

For more information,
call 617-630-6740.

ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review
Day two: stations and testing)

Day one: May 14, 2012
8:00am–3:00pm
O'Keefe Auditorium

Day two: May 21st
8:00am–3:00pm

Thier Conference Room

Re-certification (one-day class):

May 9th
5:30–10:00pm
Founders 130

June 11th
2:00–7:00pm
Founders 130

For information, call 6-3905
or go to: <http://www.mgh.harvard.edu/emergencymedicine/education/acls.aspx>

To register, go to:
http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf

OB-GYN nursing scholarship offered

The von Metzsch Endowed Scholarship Program to advance nursing education in the Vincent Obstetrics and Gynecology Department is currently accepting applications from staff within the Vincent Obstetrics and Gynecology Department.

Applications must be submitted by May 30, 2012. Recipients will be announced July 17, 2012.

For more information,
call 6-1392.

EAP Work-Life Seminars

"Understanding financial aid and college funding"

Seminar will explain college financial aid, student loans, and strategies for choosing the best financial-aid options.

Tuesday, April 24, 2012
Yawkey 4-910
12:30–1:30pm

presented by Tom Murphy,
director of Student Services,
Harvard University Employee
Credit Union

Feel free to bring a lunch.
For more information,
call 6-6976.

Cancer in the Family: Living with Uncertainty

An annual conference for patients,
families, and friends.

Saturday, April 28, 2012
9:00am–3:00pm
Simches Research Center
185 Cambridge Street
Charles River Plaza

No charge, but registration is
required, and space is limited.
Complementary lunch
For more information, or to
register, call: 617-724-1822

Organized by the
MGH Cancer Center and
Network for Patients & Families
Sponsored by the Conquer
Cancer Coalition of Massachusetts

Blum Center Events

Healthy Living Series:

"Laughter Yoga"

Friday, April 20, 2012
12:00–1:00pm

In honor of National Humor Month, Stress Awareness Month and International Moment of Laughter Day, we will be hosting this informational and interactive session on Laughter Yoga with Laura Malloy, LICSW, director of Yoga Programs for the Benson-Henry Institute for Mind-Body Medicine.

Registration required.

E-mail pfic@partners.org, or call
617-724-3823. Space Limited.

Programs are free and open to
MGH staff and patients.

All sessions held in the Blum
Patient & Family Learning Center.

For more information,
call 4-3823.

Senior HealthWISE events

All events are free for
seniors 60 and older

Boston Conservatory Cabaret
Friday, April 20, 2012
3:00–4:00pm

Thier Conference Room

Students from the Boston
Conservatory Cabaret return to
perform Broadway show tunes
and classic songs.
Light refreshments will be served.
RSVP to: 617-724-6756.

Book Club

Thursday, April 19th
3:00–4:00pm

West End Library

Paul Revere's Ride by David
Hackett Fischer. Discussion led by
Helen Bender, librarian.
Light refreshments provided.

Hypertension Screenings:

Monday, April 23rd
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.

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Submissions

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to: ssabia@partners.org
For more information, call:
617-724-1746

Next Publication

May 10, 2012

MGH celebrates National LGBT Health Week



MGH celebrated National Lesbian, Gay, Bisexual and Transgender (LGBT) Health Week with an information booth in the Main Corridor, March 27, 2012, one of several events held during that week. For more information about the LGBT Employee Resource Group, send e-mail to: LGBTmgh@partners.org.

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