

# Caring

Headlines

April 5, 2012

## Bystander Training



*Would you know what to do if you witnessed an episode of domestic violence?  
(See story on page 4)*

Community psychologist, story-teller, and artistic director of Life Story Theater, Alan O'Hare (left), moderates "Bystander Awareness and Action," a program sponsored by the MGH Men Against Abuse group. Actors, Peter Staley and Linda Mayer role-play an incident of domestic violence as a springboard for discussion.

# The IOM Report on the Future of Nursing

Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act. —the IOM Report on The Future of Nursing

**M**any of you are familiar with the Institute of Medicine's report, "The Future of Nursing: Leading Change, Advancing Health," issued in October of 2010. The report was the culmination of a two-year initiative undertaken in collaboration with The Robert Wood Johnson Foundation to assess and transform the nursing profession. The report states: "With more than three million members, the nursing profession is the largest segment of the nation's healthcare workforce. Working on the front lines of patient care, nurses can play a vital role in helping realize the objectives set forth in the 2010 Affordable Care Act... A number of barriers prevent nurses from being able to respond effectively to rapidly changing healthcare settings and an evolving healthcare system. These barriers need to be overcome to ensure that nurses are well positioned to lead change and advance health."

Four key recommendations to overcome those barriers were identified in the report:

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



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

The Robert Wood Johnson Foundation and the American Association of Retired Persons have joined forces to assist states in implementing these recommendations. This initiative, called The Campaign for Action, is a collaborative effort to implement solutions to the challenges facing nursing, and build on nurse-based approaches to improve quality and transform the way Americans receive care. The goals put forth by this alliance, in direct response to the IOM recommendations, include:

- doubling the number of nurses with doctorate degrees by the year 2020
- ensuring that nurses engage in life-long learning
- preparing and enabling nurses to lead change to advance health
- building an infrastructure for the collection and analysis of inter-professional healthcare workforce data

In September of 2011, Massachusetts was accepted as an action coalition state, and since then, the Massachusetts Action Coalition has established a

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The future is now. The call to action is upon us. If nurses are truly to play a part in shaping the future of health care, we must marshal our thoughts, actions, and resources to meet this challenge. I hope every MGH nurse will join me in committing to advance the recommendations of the IOM report on The Future of Nursing.

number of short-and long-term goals, including:

- working with nurses and colleagues in all practice settings to disseminate the recommendations of the IOM report
- building a statewide consensus for academic progression, including plans to increase diversity
- developing a plan for statewide adoption of the Nurse of the Future Nursing Core Competencies®
- implementing the plan for academic progression to increase the number of BSN-prepared nurses throughout the state
- removing scope-of-practice barriers for advanced practice nurses and strengthening inter-disciplinary collaboration
- utilizing data to understand healthcare workforce needs and demographics

To achieve these goals, several projects are underway, such as developing a survey to determine which institutions use the Nurse of the Future Nursing Core Competencies® and what barriers may exist to adopting them. Funds have been allotted to hire a part-time Action Coalition project director. And a number of fund-raising events are planned to support this investment in the future of nursing.

On March 19th and 20th, a special two-day event was held to kick off the Massachusetts campaign. MGH was fortunate to sponsor sessions where Susan Hassmiller, RN, senior advisor for Nursing at The Robert Wood Johnson Foundation and director of the Campaign for

Action, presented an overview of the national outreach and education activities. Dr. Hassmiller stressed the need for nurses to take an active role in transforming healthcare, saying, “The IOM recommendations are for the benefit of our patients and families. We need to ensure that quality care is accessible and efficient and results in improved patient-care outcomes.”

If you’re asking yourself what you can do to support this important work, here are a few thoughts:

- Know the scope of your own practice. Work with your nursing director to identify barriers in practice
- Look for opportunities to work across disciplines to develop new ways of providing care
- Share your practice. If you enjoy teaching and mentoring, help new nurses (at all levels) transition into practice
- Learn about educational opportunities that would help advance your practice
- Participate in collaborative governance
- Be sure to answer the questions on your nursing-license renewal form and respond to questionnaires and surveys you’re asked to complete

The future is now. The call to action is upon us. If nurses are truly to play a part in shaping the future of health care, we must marshal our thoughts, actions, and resources to meet this challenge. I hope every MGH nurse will join me in committing to advance the recommendations of the IOM report on The Future of Nursing.

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# Bystander Training

*What would you do if the situation arose?*

—submitted by the Men Against Abuse group

**Below left:** Alan O'Hare, community psychologist, playwright, and Celtic storyteller;  
**Below right:** Jeffrey Cooper, executive director, Center for Medical Simulation and member of the MGH Men Against Abuse group

A young couple gets on the subway and sits near you. You're within earshot, so you can hear their conversation. They're coming from an office party. The man becomes increasingly angry and starts harassing his wife, accusing her of flirting with her male colleagues. He calls her a slut. She cowers, shaken. He raises his voice. She moves away.

He moves in closer. You wonder if he's going to hit her. What do you do?

This was the scene that actors, Peter Staley and Linda Mayer, played out on March 22, 2012, in the Satter Conference Room before an audience of rapt viewers. The session, "Bystander Awareness and Action," was organized by the MGH Men Against Abuse group, an offshoot of the Domestic Violence Working Group, which was formed in 2005 by HAVEN; Police, Security & Outside Services; and the Employee Assistance Program. The event was intended to raise awareness about domestic violence and to provide guidance and a forum for discussion about how to respond in volatile situations. These situations can arise any time, anywhere, including in the workplace.

The program was moderated by Alan O'Hare, a 'seanchie' (Celtic storyteller), community psychologist, playwright, and director of Life Story Theatre. O'Hare shared that domestic violence is not unique to any one demographic—it affects people of all cultures, races, religions, and sexual orientation. He prepared attendees for what they were going to see before inviting the actors to begin their scene. After a few excruciating moments, O'Hare stopped the action and asked attendees to discuss their reactions. How do you feel? What do you think? The overriding response was a feeling of helplessness.

Action resumed. Tension in the scene escalated. The threat of physical harm seemed imminent. Attendees were visibly ill-at-ease watching the story unfold. O'Hare stopped the action again. This time he asked, "What should you do? Should you intervene?" Responses were varied and passionate. The main concern

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## Safety (continued)

Attendees were reminded of how pervasive and insidious domestic violence can be. In a particularly chilling observation, O'Hare noted, "If you don't do anything, you've done something."

was for the safety of the woman and whether intervening would put her at greater risk. The safety of the person intervening was also a consideration.

Liz Speakman, LICSW, director of the MGH HAVEN Program, was on hand, and O'Hare invited her to share her thoughts and expertise. Speakman agreed: there's no right answer. Anything you do, even with good intentions, could escalate the situation further. She suggested a subtle approach, perhaps covertly letting the woman know you're there; making eye contact to get a sense of whether she wants you to intercede; letting her know she has an ally. Speakman and O'Hare both supported the idea of alerting the police or authorities as the safest option.

Attendees were reminded of how pervasive and insidious domestic violence can be. In a particularly chilling observation, O'Hare noted, "If you don't do anything, you've done something."

Jeff Cooper, HMS professor of Anesthesia in the MGH department of Anesthesia, Critical Care, and Pain Medicine, and executive director of the Center

for Medical Simulation, shared information about the Men Against Abuse group and its interest in raising awareness about domestic violence. This was the group's first foray into intervention training.

Cooper espouses the same kind of 'speak-up' skills and practices in his work to help clinicians raise concerns about patient safety.

Says Cooper, "There are many situations where we have an opportunity to speak up and make a difference. I hope we can continue this kind of training so others at MGH will feel comfortable doing the right thing at work, at home, or anywhere the opportunity presents itself."

Thanks to the Men Against Abuse group, including Lenny DeBenedictis, Matt Thomas, and Jim Heffernan, for their contributions to this thought-provoking program. For more information about the group or future MAA events, call 617-768-8906.

For information about the HAVEN program, call 617-724-0054.



At left: in a spontaneous role-playing exercise, Jeff Cooper (center) intervenes during heated argument between a husband and wife (played by actors, Peter Staley and Linda Mayer). Moderator, Alan O'Hare, observes and offers feedback. The exercise was part of the "Bystander Awareness and Action," program sponsored by the MGH Men Against Abuse group.

# The Clinical Recognition interview

—by Ann Jampel, PT, and Christine McCarthy, RN

“I thought I would be grilled—like being in a court of law.”  
“I thought it would be worse than it was.”  
“I wasn’t sure what to expect.”  
“I felt the interviewers were genuinely interested in hearing about what I do.”

These comments are from some of the advanced clinicians and clinical scholars who responded to a follow-up survey on their experience participating in the Clinical Recognition Program. Respondents were asked what they had expected beforehand, what surprised them, and what advice they would give to those applying for recognition as advanced clinicians or clinical scholars.

A prior survey conducted in 2010 sought to shed light on staff and leadership’s familiarity with the Clinical Recognition Program, its strengths and challenges, and the impact the program has on clinicians. That survey revealed that the interview process was perceived as daunting by some—so much so that it prevented many staff from applying.

Reading the responses was insightful to Review Board members, giving them an opportunity to reflect on the interview process and reinforcing the importance of preparing clinicians for what to expect when they apply.

*Logistics of the interview process:*

- Interviews take place in the reflection room on Founders 3
- The room has three comfortable chairs and a sofa
- The interview takes between 45–55 minutes
- There is no dress code

*The interview team:*

- The interview is conducted by three members of the Review Board

- The lead interviewer is a member of the applicant’s own discipline
- At least one interviewer is from another discipline

*The interview:*

- The goal of the interview is to allow applicants to elaborate on various aspects of their portfolio and more fully demonstrate that they practice at the advanced-clinician or clinical-scholar level
- Part-way through the interview, there is a brief break to allow the interviewers and/or the applicant to address any information that might not be evident in the portfolio or expound on any other issues

*Advice from advanced clinicians and clinical scholars:*

- Do a mock interview. I did one with someone outside my discipline, and it gave me a perspective from someone who didn’t know my practice
- Select anecdotes from your practice that fit the criteria of the level you’re applying for
- I left open-ended questions in my narrative in the hope that I would be asked questions, and I was prepared with the answers
- Use the website. It has a video of an interview and a lot of helpful information (<http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp>)
- No one in the room knows your practice better than you do. Tell your story
- Reflect, reflect, reflect, and then relax
- Once we got going, it got easier to talk about my practice. After all, I had lived the clinical situation I described in my narrative, and I knew what was in my portfolio. After a while, it became more of a conversation

For more information about the Clinical Recognition Program, call Ann Jampel, PT, clinical education coordinator, at 4-0128.

# NERBNA Excellence in Nursing Practice Awards

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

At 40th anniversary NERBNA celebration, Excellence in Nursing award recipient, Tricia Gordon, RN (second from right) with colleagues, (l-r): Holly Milotte, RN; Kathy Myers, RN; and Jill Pedro, RN

**O**n February 10, 2012, the New England Regional Black Nurses Association (NERBNA) celebrated its 40th anniversary with the presentation of its 24th Excellence in Nursing Awards at the Boston Copley Marriott Hotel. The awards recognize nurses for outstanding performance in practice, leadership, research, and education or teaching.

Orthopaedics staff nurse, Tricia Gordon, RN, was one recipient of the Excellence in Nursing Practice Award along with seven other Massachusetts nurses. In

one letter of recommendation, Gordon was described as, “one of those staff members who gives the impression she loves the bedside and everything about caring for patients. Tricia is the ultimate preceptor. She stimulates her students to think, provides alternative ideas, and encourages students to find solutions for themselves rather than giving them the answers. Tricia’s aptitude for identifying and prioritizing critical aspects of patient care and her remarkable ability to grasp difficult concepts in medical physiology are commensurate with those of many surgical residents and young attending physicians. She has a genuine, enthusiastic passion for patients and a tremendous curiosity about the science behind patients’ problems.”

NERBNA is part of a national effort to unify, educate and increase the number of African American Nurses practicing in this country. It is dedicated to investigating, defining, and responding to the healthcare needs of African Americans throughout New England and implementing changes to ensure optimal care is available to all. NERBNA provides educational programs to enhance nurses’ competencies in leadership and ethical practice, and advocates for health services in communities to reduce the mortality and morbidity rates for diseases pervasive in minority populations.

The keynote speaker at the event was National Black Nurses Association president, Deidre Walton, RN. Walton acknowledged the countless accomplishments and milestones attributable to NERBNA nurses and urged attendees to ‘do more.’

For more information about NERBNA or their Excellence in Nursing awards, contact Gaurdia Banister at 4-1266.



(Photo provided by staff)

# It's the old, 'Never-judge-a-book-by-its cover,' story

*On February 7, 2012, inter-professional rounds at the MGH Institute of Health Professions focused on, "Unconscious Bias: How it Affects our Interactions and Decisions in Providing Care." The following narrative, written by Joyce Shapiro Gordon in 2006, was presented at this annual event geared toward first- and second-year students in Nursing, Physical Therapy, and Speech-Language Pathology because it speaks to an important and timeless issue in patient care.*



Joyce Shapiro Gordon, CCC-SLP

Mr. M was 55 years old and had suffered a stroke... As I read his history, I found myself thinking: This patient is not a good candidate for therapy. His psycho-social history is longer than his medical history.

**M**y name is Joyce Shapiro Gordon, and I am an outpatient speech-language pathologist. I treat mostly adult patients who present with various neurological etiologies. A patient's potential for benefiting from speech therapy is assessed prior to initiating treatment, and there are many factors that can affect the prognosis, including the psycho-social aspects of a patient's life.

I like to think of myself as non-judgmental, both personally and professionally. However, working with Mr. M showed me that I, too, am capable of hasty judgments and unfair assumptions when it comes to an individual's potential for change.

Mr. M had been evaluated by another clinician in our department and was referred to me for treatment. He was 55 years old and had suffered a stroke. His

speech-language profile revealed the kind of deficits I would have expected from the type of stroke he suffered—decreased word retrieval, auditory comprehension, reading comprehension, graphic, and mild cognitive skills. As I read his history, I found myself thinking: This patient is not a good candidate for therapy. His psycho-social history is longer than his medical history.

Mr. M had been homeless for a number of years. Prior to his stroke, he had been jailed for 12 years for various crimes. He had lost an eye in a fight and had a scar from being stabbed somewhere along the line. He also suffered from long-term alcoholism and gambling addiction. My heart sank. I felt compassion for the 'poor guy' who had led such a miserable life, but I felt apprehensive about my ability to offer him any treatment that would make a difference.

Fortunately, being a seasoned therapist (and having experienced some of my own life struggles) I had the

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But now when those patients first come through the door, I find myself reading their reports a little differently. I still make sound clinical decisions about a patient's potential prognosis. But I linger a bit longer as I read their reports and hope I don't pre-judge or assess their potential too hastily. I try to combine my professional expertise with a new awareness of the inexplicable and awesome resiliency that exists in many people.

good sense not divulge my misgivings about his prognosis.

Mr. M began coming in for weekly speech-language therapy sessions, and I worked with him for approximately six months. It didn't take long to realize that he was one of the most motivated patients I ever worked with. He was living in a shelter, regularly going to AA meetings, and he always completed his therapy assignments. He had been an avid reader prior to his incarceration and while in jail, and he yearned to be able to comprehend and enjoy the written words in books again. He was a polite, endearing gentleman, socially appropriate, and appreciative of my help.

In the course of his treatment, I learned that Mr. M had never had a bank account. So as part of our therapy, we focused on how to go about opening one. We worked on questions he would ask bank tellers; how to balance a checkbook, and how to budget the social security checks he received each month. Mr. M did not have much space in his room, but he learned how to manage his files in an accordion folder. He categorized medical reports, bills, bank statements, and other documents so he could easily access them when needed. For the first time in his life, Mr. M got a cell phone. He learned how to manage his bills, call the phone company when he had questions, and stay in touch with friends.

I once asked Mr. M, "To what do you attribute your motivation? What enables you to work so hard at therapy and make these monumental changes in your life?"

He replied: "I'm fifty-five years old. If I don't do it now, when will I do it? I wasted so much of my life, and now I've been given another chance. I don't want to blow it this time."

I've learned many things from my patients over the years. I remember as an undergraduate working with children whose mothers had had rubella during pregnancy. These children had facial anomalies, were blind, deaf, and intellectually delayed. Because they were prone to self-abuse, they wore gloves and helmets for their own protection. I remember sitting with a little girl who had all of the above challenges. She was holding one of those 'touchy-feely' books with all the different textures signifying different animals. I remember thinking, Oh, great. How can I possibly reach her

when she can't hear, see, or feel anything with her hands? As I watched, the little girl picked up the book, brought it to her face, and used her nose to feel the different textures.

It was then that I humbly accepted her as my teacher. That was my initiation, if you will, my first realization that no matter how much training I had, my best teachers would always be my patients.

When it was time to discharge Mr. M from therapy because he had made such significant progress and was functioning well in his everyday life, he told me how painful it was to have to discontinue his sessions.

He said, "The thought of not coming back feels like cutting off my arm."

It was difficult for me, as well. He was an inspiration to me and one of those patients I always looked forward to seeing. We had both come a long way since I first started treating him.

Not all patients who come to us with complicated histories are able to turn their lives around the way Mr. M did. But now when those patients first come through the door, I find myself reading their reports a little differently. I still make sound clinical decisions about a patient's potential prognosis. But I linger a bit longer as I read their reports and hope I don't pre-judge or assess their potential too hastily. I try to combine my professional expertise with a new awareness of the inexplicable and awesome resiliency that exists in many people. I continue to be grateful for the powerful lessons my patients share with me, and I find my life enriched both personally and professionally by their teachings.

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

We all heard those sayings growing up: "Never judge a book by its cover." "Never judge a person until you've walked a mile in his shoes." Who would have guessed those sayings held so much wisdom for caregivers? Joyce's narrative reminds us that an open mind may be the first, best thing we can bring to our practice. And like all expert clinicians, Joyce recognized the opportunity to learn from her patient. What a wonderful story.

Thank-you, Joyce.

# Fall risk in patients with acute psychosis

—submitted by the Research and Evidence-Based Practice Committee

**F**all-prevention programs have been implemented in many institutions throughout the Boston area, including one exclusively psychiatric facility, McLean Hospital. Many of the patients at McLean are young and middle-aged adults who may not seem like candidates for falling, and may not score high as fall risks, but were falling nonetheless.

On January 10, 2012, Margaret Knight, RN, and Catherine Coakley, RN, presented their original research, “Fall Risk in Patients with Acute Psychosis,” published in the *Journal of Nursing Care Quality*. Coakley is the nurse director of the Schizophrenia and Bipolar Disorders program at McLean, and Knight is a nurse researcher and consultant/clinical specialist at McLean and an assistant professor at UMass, Lowell.

Traditional fall-assessment and prevention tools aren’t necessarily accurate in identifying patients at risk for falling in psychiatric facilities. Despite implementing the Morse Fall Scale, the fall rate at McLean remained at 4.83 (per 1,000 patient days).

The project team sought to identify the factors that increase fall risk and interventions that would be most effective in reducing the fall risk in a non-elderly, psychiatric, patient population. After reviewing every fall over a three-month period, they learned that patients who were falling were acutely ill and had a high incidence of multiple medications (many were medication naïve), frequent medication adjustment, poor food and fluid intake, and sleep disturbances.

Individual and cross-case analysis revealed surprising findings. They learned that rapid titration of medications and certain drug combinations were a common factor. There was no change in blood pressure when nurses checked postural vital signs, but upon closer analysis, they found tachycardia and postural pulse changes.

The team looked at the number of anti-psychotic and poly-pharmacy medications and identified ‘critical indicators’ that increase the risk of falls in their patient population. They found that a heart rate equal to or greater than 100, more than two anti-psychotic drugs, more than ten medications overall, more than two mood stabilizers, loading-dose mood stabilizers, a first psychotic admission (the drug naïve patient), and/or non-compliance were all red flags for fall risk. With this information, they developed and implemented an inter-disciplinary Quality Improvement Plan. After three months using this new criteria for fall assessment, the fall rate decreased to 0.46, and cumulative fall rates remained at or below 1.3 per 1,000 hospital stays.

Said Coakley, “What we know from this research is that healthy, non-elderly individuals with acute psychiatric problems are at risk for falls. In this population, typical risk factors are not present, and complex medication regimes may play a role.”

For information on the next meeting of the REBPC Journal Club meeting, call Laurene Dynan, RN, at 4-9879.



(Photo by Paul Batista)

Presenters, Margaret Knight, RN (standing), and Catherine Coakley, RN (seated on left)

# The Allan Moore, MD, Memorial Medical Services Blood Drive

Nursing director and co-chair of the annual Allan Moore, MD, Memorial Medical Services Blood Drive, Susan Morash, RN, (standing), with White II staff nurse, Hollie O'Bryan, RN, and senior pheresis technician, Josué Castillo

**M**edical resident, Allan Moore, MD, was passionate about his commitment to patient care. His crusade to get healthcare providers to donate blood was the stuff of legends. Moore believed that healthcare workers have an obligation to donate blood as part of their clinical practice. Every

year throughout his residency, he coordinated an employee blood drive, using staff meetings, inter-disciplinary forums, and casual encounters with colleagues to garner support. Sadly, Moore was killed in a motor-vehicle accident in 2008, but the blood drive he established continues in his name.

This year, the Allan Moore, MD, Memorial Medical Services Blood Drive will be held May 1–31, and all MGH employees are encouraged to participate. Both whole blood and platelet donations are welcome. (Platelet donors should call in advance to set up a time to donate and earn double points.)

To take part in the challenge, visit the MGH Blood Donor Center in the Gray Lobby where you'll be asked which team you'd like to support (nursing, house staff, fellows, attending physicians, or practice-based teams). Weekly prizes will be presented for certain categories.

Much of the blood donated at MGH is used on medical units. Organizers hope that the 2012 Allan Moore, MD, Memorial Medical Services Blood Drive will break records for most blood donated in a single month. If you're not eligible to donate, feel free to recruit a friend or colleague to donate in your place. Or cover for a colleague so he or she can donate.

Giving blood is a simple, meaningful way to help patients and at the same time honor the memory of a cherished colleague. For more information, contact your blood drive captain or call the Blood Donor Center at 6-8165.



# Ministering to cancer patients is 'hairy' experience for oncology chaplain

**O**n March 16, 2012, oncology chaplain, Katrina Scott, once again kept her appointment at the Images Boutique on Yawkey 9 to cut her hair so her locks could be used to make wig(s) for cancer patients. Says Scott, "I try to support the spiritual needs of patients throughout their cancer experience. As oncology chaplain, I've come to appreciate the special circumstances of living with the limitations of illness while trying to keep a sense of self."

The Chaplaincy is committed to providing spiritual care to patients and families. Ministry is available to people of all faiths and to those of no religious affiliation. For more information, call 6-2220.



**Below left:** Oncology chaplain, Katrina Scott, says good-bye to her ponytail as Images Boutique stylist, Erin Evers, prepares to cut.

**Below:** Scott and Evers pose for camera before forging ahead with a new 'do.'

**At left:** A beautiful mane of hair is ready to be made into a wig for some unsuspecting oncology patient.



(Photos provided by staff)

# Acute Care Documentation

## *E-chart is on the horizon*

*Question:* What is Acute Care Documentation (ACD)?

*Jeanette:* ACD is the name of the project to develop a computer software to replace the green and gray books currently used for inpatient clinical documentation. It's a joint undertaking between BWH and MGH that will provide real-time information from physiological monitors and other applications on flow-sheets, notes, and assessments so it can be accessed by all healthcare professionals.

*Question:* I've heard the term, 'e-chart.' Is that the same as ACD?

*Jeanette:* E-chart is the name we're giving to the acute care documentation software application. Like other MGH applications, you will be able to access it through the Clinical Application Suite (CAS), and it will be available on-site and from remote computers.

*Question:* What information will be contained in e-chart?

*Jeanette:* E-chart will integrate several Partners/BWH/MGH clinical applications such as hemodynamic monitoring and ventilators, some electronic medication administration record (eMAR) information, allergies, laboratory data, and code status. Much of the documentation between the two institutions has been standardized so that document templates will be the same for all healthcare professionals, including the initial assessment for nurses, physicians, and health professionals.

*Question:* What has been done so far?

*Jeanette:* The two organizations have implemented a multi-site content governance infrastructure to standardize content across all disciplines at MGH/BWH. Over the past two years, hundreds of clinicians at both institutions have come together to help design the overall layout that will best fit our work flow (including adult content for all specialties, and pediatric content).

*Question:* Will we have more computers?

*Jeanette:* Additional computers will be placed in hallways and, if possible, nurses' stations on inpatient units. Some clinicians who see patients throughout the hospital will have portable devices such as laptop computers so they can look up or add information without having to wait for an available unit-based computer. The ACD team will work with unit leadership to make sure enough computers are available and placed in optimal locations.

*Question:* When will we actually start using e-chart?

*Jeanette:* We will test the software on three pilot units (the Ellison 4 SICU, the Ellison 9 CICU, and the White 9 General Medical Unit) beginning this fall. It will be rolled out hospital-wide after we've had a chance to rectify any issues that may arise during the pilot phase.

*Question:* Will there be support when we first go live?

*Answer:* Staff will be available to assist clinicians as they transition to this new software, and classes will be offered to give clinicians hands-on experience in the new capabilities of e-chart.

For more information, call Ann McDermott, ACD clinical project manager, at 617-643-6983.

# Certified Nurse Day

*honoring nurses who are board-certified in specialty areas*

Certified Nurses Day is observed each year on March 19th, on the birthday of Margretta 'Gretta' Madden Styles, a legendary champion of nursing certification. Styles led the first comprehensive study of credentialing in the 1970s and was a respected leader in a number of national and international nursing organizations. On March 19th, we honor those nurses who have become board-certified in their specialty areas. A nursing license (RN) allows nurses to practice. Certification attests that a nurse possesses advanced knowledge, skill, and practice in a particular specialty.

According to a 2011 survey of MGH nurses, 643 nurses in direct-care positions and 200 nurses in leadership positions are currently board-certified.

Through The Norman Knight Nursing Center for Clinical & Professional Development, review classes are available to assist nurses in preparing for certification exams in Oncology, Neuroscience, Advanced Trauma Care, Gerontology, Cardiovascular, Medical-Surgical, and Adult Critical Care Nursing. A review course/study group is currently underway preparing nurse leaders to take the Nurse Executive certification exam.

In addition to review courses, funding is available through the Demetri Souretis Fund and the Berke Gerontology Fund to reimburse nurses for certification and re-certification test fees. The reimbursement form can be obtained from the Nursing Support Office in Bigelow 1034 or by e-mailing: [pcsmsobig1034@partners.org](mailto:pcsmsobig1034@partners.org). For more information about nursing certification, call the Knight Nursing Center at 6-3111.

Staffing educational booth in the Main Lobby on March 19th, Certified Nurse Day, are professional development specialists, Patricia 'Tricia' Crispi, RN (left), and Carol Ghiloni, RN.



# Announcements

## Attention nurses Get pampered for Nurse Day

In honor of Nurse's 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.

## Blum Center Events

Shared Decision Making:  
"Low Back Pain"

Wednesday April 11, 2012  
12:00–1:00pm

Sponsored by the Stoeckle  
Center

Presented by Steve Atlas, MD

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](mailto: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.

## ACLS Classes

Certification:

(Two-day program  
Day one: lecture and review  
Day two: stations and testing)

Day one: April 9, 2012  
8:00am–3:00pm  
O'Keefe Auditorium

Day two: April 23rd  
8:00am–3:00pm  
Thier Conference Room

Re-certification (one-day class):

April 11th  
5:30–10:00pm  
Founders 130

May 9th  
5:30–10:00pm  
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](http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf)

## Advance Care Planning Information Booth

The PCS Ethics in Clinical Practice Committee is holding its 12th annual Advance Care Planning Information Booth

Monday, April 16, 2012  
National Healthcare Decisions  
Day  
8:00am–3:00pm  
in the Main Corridor

The goal is to encourage patients to articulate their wishes regarding their healthcare decisions, increase awareness among healthcare providers about respecting those wishes, and emphasize the importance of providing information related to advance care planning for patients, families, and staff.

Copies of the Massachusetts Health Care Proxy form, a list of helpful websites, and consultations will be available.

For more information,  
call 643-0481

## New time for Ostomy Support Group

The Ostomy Support Group will meet at 6:00pm on the third Thursday of each month. Meetings held in the Wang 455 Surgical Clinic Conference Room

For more information, call  
617-726-8853.

## 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 for your situation.

Tuesday, April 24, 2012  
Schiff Conference Center  
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

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### Submissions

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

### Next Publication

April 19, 2012

# Professional Achievements

## Banister publishes

Gaurdia Banister, RN, executive director, The Institute for Patient Care, and Marion Winfrey, RN, authored the article, "Enhancing Diversity in Nursing, a Partnership Approach," in the *Journal of Nursing Administration*.

## Chisari appointed

Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, was appointed co-chair of the Nurse of the Future Committee for the Organization of Nurse Leaders of Massachusetts and Rhode Island, and the Massachusetts Department of Higher Education, in February, 2012.

## Inter-disciplinary team publishes

Maria Winne, RN, nursing director; Christine Annese, RN, staff specialist; Barbara Cashavelly, RN, nursing director; Beth Nagle, RN, clinical nurse specialist; Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development; Shiga Takashi, MD; and Susan Lee, RN, nurse scientist, authored the article, "Implementation of Two Nurse Practitioner Inpatient Models," in *The Journal of Nursing Administration*, in February, 2012.

## Rubin appointed

Krista Rubin, RN, nurse practitioner, Cancer Center, was appointed chair of the Skin Cancer Committee for the Dermatology Nurses Association in February, 2012.

## Rubin presents

Krista Rubin, RN, nurse practitioner, Cancer Center, presented, "How To's of a Skin Cancer Screening," at the annual convention of the Dermatology Nurses' Association, in Denver, February 16, 2012.

## Tyrrell presents

Rosalie Tyrrell, RN, professional development manager, presented, "Understanding and Leading a Multi-Generational Workforce," at the Boston Oncology Nursing Society, January 10, 2012.

## Coakley and Barron publish

Amanda Bulette Coakley, RN, staff specialist, and Anne-Marie Barron, RN, clinical nurse specialist, authored the article, "Energy Therapies in Oncology Nursing," in *Seminars in Oncology Nursing*.

## Nurses present

Staff nurses, Denise Dreher, RN, Kristen Bodnaruk, RN, and Marcy McCormick-Gendzel, RN, presented, "Vesicant Infusions" via tele-conference to nurses at the King Edward VII Hospital in Bermuda, January 23, 2012.

## Gallivan, Carrol and Williams publish on-line

Theresa Gallivan, RN, associate chief nurse, John Carroll, and Michele Williams, authored the article, "The Ins and Outs of Change-of-Shift Hand-offs Between Nurses: a Communication Challenge," on-line at <http://qualitysafety.bmj.com> in February, 2012.

## Inter-disciplinary team publishes

Nancy Kelly, RN; Diane Mahoney, RN; Alice Bonner, RN; and Terrence O'Malley, MD, authored the article, "Use of a Transitional Minimum Data Set (TMDS) to Improve Communication Between Nursing Home and Emergency Department Providers," in the *Journal of the American Medical Directors Association (JAMDA)*.

## Clinical Recognition Program

Clinicians recognized  
November 1, 2011–March 1, 2012

### Advanced Clinicians:

- Joanna Hollywood, OTR/L Occupational Therapy
- Richard Soria, RN, Medical ICU
- Thomas Hunter III, RN, Medical ICU
- Ellen Fern, RN, Endoscopy Unit
- Amanda Laskey, RN, Emergency Department
- Jodi Klein, PT, Physical Therapy
- Janice Tully, RN, Case Management
- Angela Chyn, RN, Emergency Department
- Rebecca Santos, CCC-SLP, Speech, Language and Swallowing Disorders
- Karen Rosenblum, RN, Inpatient Psychiatry
- Megan Hughes, RN, Oncology
- Melissa Mullen, RN, Emergency Department

### Clinical Scholars:

- Robin Azevedo, RN, Labor & Delivery
- Diane DeTour, RN, Anti-Coagulation Management Service
- Susan Barisano, RN, Post-Anesthesia Care Unit
- Karon Konner, LICSW, Social Work



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