

# Caring

Headlines

January 5, 2012

## Cultural traditions, MGH traditions converge in spirit of the holidays



Clockwise from top left: Rabbi Ben Lanckton lights menorah in MGH Chapel; good Samaritans deliver gifts for MGH HAVEN Program recipients; members of MGH Chaplaincy lead visitors in annual holiday song fest; HAVEN representatives package donations for delivery to families.

# Facing the future with ingenuity and innovation

*focusing on consistency, continuity, and coordination of care*

**O**ur bicentennial celebration reminded us that our work over the past 200 years has been ground-breaking; we have led the evolution of health care as we know it. While our accomplishments are numerous and well documented, our work is by no means done. As we channel our efforts to ensure equitable care and access to all, we must continue to provide care that is safe, timely, efficient, effective, and centered around the needs of patients and families. In past issues of *Caring Headlines* and at Nursing Grand Rounds, I've talked about designing a new patient-care delivery model and about re-designing disease-specific care. While cost-containment and efficiency are *part* of this work, the real goal is improving patient care. If we do this right, I know we're going to discover something as revolutionary as any of our past accomplishments.

While cost-containment and efficiency are *part* of this work, the real goal is improving patient care. If we do this right, I know we're going to discover something as revolutionary as any of our past accomplishments.

This past year, I've spent time talking with many of you, interviewing patients and families, benchmarking other healthcare organizations, and researching the literature. I believe that re-designing care will require transformational change—change that cannot occur at the risk of our patients. Some of these changes will be 'designed, tested, validated, and replicated' on innovation units. Just as the name implies, innovation units are settings specifically created to test change and measure outcomes. If we don't like what we see, we recalculate, re-group, or abandon the idea altogether. Our work on innovation units is geared toward improving clinical outcomes, enhancing patient- and staff-satisfaction, and reducing costs and lengths of stay. The core principles behind innovation units are:



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

- Care is patient- and family-focused, evidence-based, accountable, autonomous, coordinated, and continuous
- Clinicians are highly present and know the patient
- Care is provided by designated nurses and physicians who assume accountability to ensure continuity
- Continuity of the team is a basic precept
- Every novice team member is mentored by an experienced clinician
- Every patient has the opportunity to participate in the planning of his/her care
- Technological advancements create opportunities for improved communication and efficiency

Based on my conversations with you, our goals for innovation units are:

- Knowing the patient
- Coordination of care (consistency and reliability)
- Consistency of teams
- Building a plan of care around the patient where patient care and teaching are aligned
- Clinical support aligned around patient
- Learn from experience

*continued on next page*

Success will depend on our ability to improve quality and safety, create healing environments, integrate research and evidence-based practice into care delivery, and ensure opportunities for professional growth and education... As we move forward with this work, the tenets of relationship-based care will inform our efforts.

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The graphic below illustrates the process of care before, during, and after hospitalization. Continuity will be enhanced by standardizing wherever possible, such as using rounding check sheets, hand-off guidelines; and standardized systems for the transfer of information upon admission and discharge.

We expect our work on innovation units to reduce lengths of stay and re-admissions. One intervention we're exploring is the use of follow-up phone calls to ensure patients adhere to discharge instructions and have the resources they need at home.

As we move forward with this work, the tenets of relationship-based care will inform our efforts. Engaging patients and families as key members of the care team will help us identify over-use, under-use, and mis-use of resources.

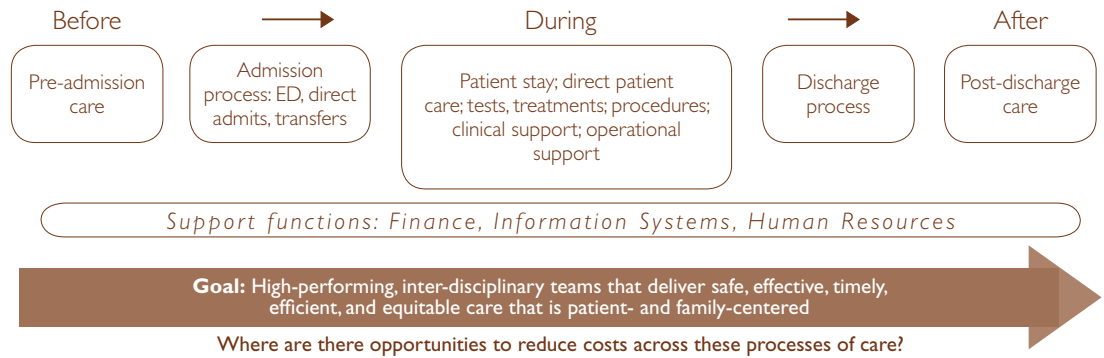
Nearly 150 clinicians and support staff within Patient Care Services are involved with this work. They have developed rounding check lists, a patient discharge check list, a discharge readiness form, and a post-discharge telephone follow-up program. In the spring, 12 innovation units will go live with these 'tests of change': (Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac; and Blake 12, Neuroscience ICU).

This is an exciting time in the evolution of care delivery. I will keep you informed as this work unfolds. For more information, or if you have questions, thoughts, or ideas, please e-mail me or call 6-3100. Thank-you.

**Update**

I am pleased to announce that Brenda Miller, RN, has accepted the position of nursing director for the Ellison 17 and 18 pediatric units.

**Patient Journey Framework**



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(Cover photos by Paul Batista, Joe Ferraro, and Michelle Rose)

# Tourette's syndrome: *the misunderstood disorder*

—by Zary Amirhosseini, disability program manager

Tourette's syndrome is a neurological disorder characterized by repetitive, stereotyped, involuntary movements and vocalizations called tics... To learn more about Tourette's syndrome, go to: [www.tsa-usa.org](http://www.tsa-usa.org).

**B**efore you read this article, do the following exercise: Set a timer for 90 seconds, then start writing the *Pledge of Allegiance*. While writing, blink your eyes and shrug your shoulders as many times as you can. Scratch out and re-write every third word.

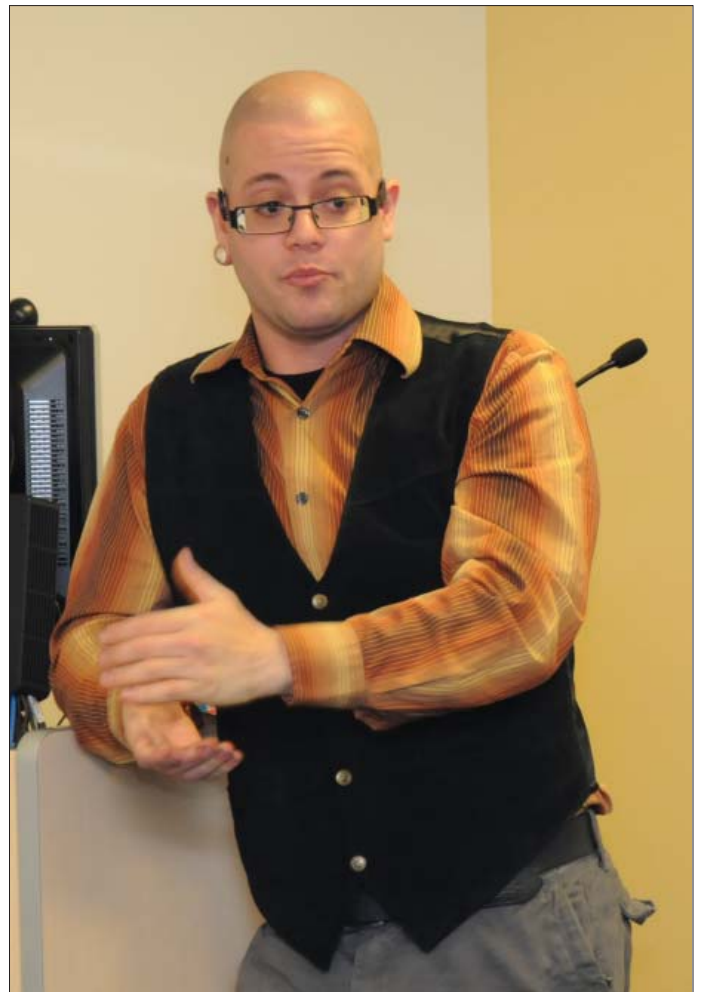
Ready? Go.

How'd you do? How far did you get? How did you feel as you were writing? Welcome to the life of someone with Tourette's syndrome.

On December 7, 2011, Ellen Meyers and her son, Eric Tashlin, an articulate young man with Tourette's syndrome, presented, "Helping Tourette's Syndrome Patients Thrive in the Healthcare Setting." Meyers talked about her experiences as the parent of a child with Tourette's syndrome. Tashlin was diagnosed when he was 13 years old (onset of Tourette's is usually between the ages of 7 and 10).

Said Meyers, "He was preparing for his bar mitzvah when our rabbi complained that he was being disruptive, continually sniffing during his lessons. He also exhibited vocal tics such as barking, chirping, 'popping,' clearing his

*continued on next page*



## Disability Awareness (continued)

throat, and motor tics such as clapping and flapping his arms. Eric started barking like our family dog—he sounded so much like the dog, people on the phone couldn't tell if it was him or the dog they were hearing in the background.”

Tashlin's neurologist said there was no way to know how Tourette's syndrome would affect him, but it would most likely disappear by young adulthood. One of the challenges Meyers faced as a parent was having to educate the educators at his school about his disability. This involved arranging for him to have extra time on exams and providing books on tape because of his rapid eye-blinking. He also had symptoms of obsessive-compulsive disorder.

Meyers was first confronted with Tourette's when Tashlin began to speak. A life-long resident of the United States, Tashlin spoke with a perfect British

accent. It's a symptom of his Tourette's that comes and goes. Says Tashlin, “My facial muscles behave differently when I speak with a British accent. I've tried to duplicate it when I'm not experiencing Tourette's, and I can't even come close.”

Meyers shared that Tashlin's back and abdominal muscles are in a constant state of ticking. Many individuals with Tourette's have actually fractured their cervical vertebrae from the constant pressure of neck tics. Chronic pain often accompanies Tourette's symptoms.

Tashlin's symptoms were much more severe when he was younger. “Growing up with Tourette's was hard at times; it was quite isolating. Like many with Tourette's syndrome, I have other issues such as attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD). I would frequently have intrusive thoughts such as worrying about dirt or germs, which would result in repetitive hand-washing. Once, I became so obsessed with the song *All I want to do is have some fun*, I sang it for seven months.”

As you can imagine, finding a regular job was difficult for Tashlin, so he started his own company designing specialized adaptive equipment. When asked how Tourette's affects his social life, he says he has a great social life; his friends consider his tics part of who he is. The only time it's an issue is when he encounters strangers and those unfamiliar with the syndrome. Even in the healthcare industry, many caregivers are unfamiliar with Tourette's. Tashlin believes clinicians can become more knowledgeable by spending time listening to their patients with Tourette's.

Tourette's syndrome is a neurological disorder characterized by repetitive, stereotyped, involuntary movements and vocalizations called tics. Tourette's syndrome occurs in people from all ethnic groups; males are affected three to four times more often than females. Often, individuals with Tourette's are not diagnosed (or are misdiagnosed) when symptoms are mild. It's not uncommon for the syndrome to go undiagnosed for years. Because of the way Tourette's is portrayed in the media, many people, including healthcare professionals, think all individuals with Tourette's exhibit coprolalia (the involuntary utterance of obscenities). But only 10% of Tourette's patients exhibit this symptom.

Though Tourette's syndrome can be a chronic condition with symptoms lasting a lifetime, most people with the condition experience their worst symptoms in their early teens with improvement occurring in the late teens and into adulthood.

For more information about Tourette's syndrome, go to: [www.tsa-usa.org](http://www.tsa-usa.org). For information about how to better accommodate patients with Tourette's syndrome, call Zary Amirhosseini at 3-7148.

Opposite page:  
Eric Tashlin shares  
his experience with  
Tourette's syndrome.

Below: his mom,  
Ellen Meyers, talks  
about parenting a  
child with Tourette's.



# Every contribution by every member of the care team makes a difference

Mr. H had been admitted to the Phillips House with a cystic fibrosis exacerbation... Placing PICCs in cystic fibrosis patients can be challenging because their veins have been accessed so many times, scar tissue develops at the insertion site.

**M**y name is Robert Ferdinand, and I am a nurse in the IV Therapy Department. In early August of 2010, as a member of the PICC Team, I took report from the previous shift and learned there were ten patients awaiting insertion of peripherally inserted central catheters (PICCs). Four were patients awaiting discharge, and six needed PICC placement for IV antibiotic administration. After further review, I saw that the discharge patients weren't going to be discharged for another couple of days, and no patients on the list were in dire need of a PICC. So I planned to focus on the patients needing PICC placement for IV antibiotic administration. After reviewing each patient's consult, one patient stood out as a priority.

Mr. H had been admitted to the Phillips House with a cystic fibrosis exacerbation; his medical orders were to receive intravenous vancomycin for several weeks. Mr. H stood out as a priority because patients with cystic fibrosis are often 'repeat customers' for the IV team. Placing PICCs in cystic fibrosis patients can be challenging because their veins have been accessed so many times, scar tissue develops at the insertion site. It can be challenging to puncture a vein and thread a catheter through scar tissue.



Robert Ferdinand, RN, IV nurse

Upon arriving on the unit, I went to Mr. H's room to make sure he was available. I introduced myself to him, and he greeted me with a handshake. I immediately noticed that he was very cachectic (a generally weakened state resulting from debilitating chronic illness). I told Mr. H that I was an IV therapy nurse and I was there to insert his PICC line. I told him I wanted to review his medical record and I would return shortly to discuss the risks, benefits, and alternatives to the procedure.

I left the room and reviewed Mr. H's medical history, laboratory values, radiology reports, allergies, and the ordered treatment regimen. I saw that Mr. H was to receive IV vancomycin every 12 hours for several weeks. I also saw that he had a seizure disorder with a long neurological history and was scheduled for a CT scan with IV contrast. I conferred with Mr. H's nurse and attending physician to discuss catheter options.

*continued on next page*

At first glance, a 4Fr single-lumen poly PerQ-Cath PICC appeared to be sufficient. However, I discussed the CT scan with the doctor who said he'd probably be ordering more than one. So I recommended a power-rated PICC, which can also be used for IV-contrast-administration, and Mr. H wouldn't have to be stuck a second time.

I expressed my concern that Mr. H appeared cachectic and inquired as to the probability of his being ordered to receive total parenteral nutrition, because that would affect which type of catheter I'd use. Before I completed my sentence, the physician said that he intended to order total parenteral nutrition that evening. With that being established, I told the nurse and physician that a dual-lumen PICC would be the minimum requirement for Mr. H.

The physician said he'd prefer a triple lumen so that one lumen could be used for blood draws. I explained that a triple lumen would depend on whether the vasculature in Mr. H's upper arm could support a triple. I explained that there are guidelines as to how big a catheter we can place. The general rule is that the catheter should be no more than 1/3 the size of the vein to maximize hemo-dilution around the catheter and minimize the risk of developing a thrombophlebitis. Lastly, I explained that in most cases it's possible to obtain blood specimens from one of the lumens in a dual-lumen PICC. The physician considered this information, and we agreed that a dual lumen would be sufficient for Mr. H's treatment if his veins were big enough.

I returned to Mr. H's room and began the informed-consent process. I explained the risks, benefits, and alternatives to Mr. H, and he agreed to have the PICC-line inserted. But he seemed apprehensive. He became anxious and grimaced in fear. I asked if he was okay and, after a short silence, he explained he was scared because the previous PICC-line insertion (at another hospital) had been extremely painful and traumatic.

I assured Mr. H that we use local anesthetic to numb the area, and that I would explain everything I did before I did it. I told Mr. H that if at any point he wanted me to stop, to just let me know, and I would stop immediately. I told Mr. H to let me know if he felt any pain at the insertion site and I'd apply more local anesthetic to the area.

As I continued with the procedure, I told Mr. H that I found a great vein in his upper right arm. He told me he was right-handed and would prefer the insertion in the left arm. I explained that research shows fewer complications with right-sided insertions, and I explained that it would be placed high enough in the arm that there would be no range-of-motion limitations.

Mr. H said, "You're the expert. I trust you'll do what's best for me."

I grinned from ear to ear. Here was a patient apprehensive about a procedure due to a previous experience, and I was able to earn his trust before I even started the procedure.

I continued with the PICC insertion, explaining in layman terms every aspect of what I was doing. Mr. H actually asked questions about the procedure as I worked. After it was over, I explained to Mr. H that he would have a chest x-ray to confirm that the tip of the line was in the correct location.

As I left, Mr. H said, "That was so easy! I didn't feel a thing." He looked me in the eye, shook my hand for an extended period of time, and said, "Thank-you," several more times.

As a nurse, I sometimes forget how much I affect patients' lives. When clinical situations like this arise, I'm confident in my knowledge, clinical experience, and individualized approach, certain that I'll give each patient the very best care based on his or her clinical situation and vascular-access requirements. I know I make a difference in their lives, and I look forward to the next time I get to make a patient's stay at MGH a little easier.

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

If you're one of those people who thinks all IV nurses do is insert IVs, Robert eloquently dispelled that notion. His advocacy, skill, and foresight in caring for Mr. H show the depth of his clinical expertise and spotlight the important role IV nurses play in the care of patients. Not only did Robert's clinical competence contribute to a positive stick for Mr. H, his confidence and compassion put Mr. H at ease before he even began. We're fortunate to have Robert and his IV nurse colleagues making life "a little easier" for our patients.

Thank-you, Robert.

As a nurse, I sometimes forget how much I affect patients' lives. When clinical situations like this arise, I'm confident in my knowledge, clinical experience, and individualized approach, certain that I'll give each patient the very best care based on his or her clinical situation and vascular-access requirements.

# Embracing technology as a learning tool

—by Gino Chisari, RN, director

The Norman Knight Nursing Center for Clinical & Professional Development

As we embark on a new year, we're excited about the possibilities that technology holds. It's our on-going mission to explore and employ the most up-to-date educational techniques to ensure we're the best clinicians we can be, providing the safest, highest quality care to our patients every day.

I recently found myself watching an old re-run of *Little House on the Prairie*, and I was struck by a scene I saw that took place in the old one-room schoolhouse. As the Ingalls children were sitting at their desks, they each pulled out a little individual-sized chalk board, a simple piece of slate framed with wood. It occurred to me that those chalk boards were an early form, if not the prototype, of hand-held educational devices. Chalk boards were the educational device of the day.

I began to think of other instances when advances in educational 'technology' played a part in nursing education. I remember being a member of the faculty at a nursing program when we made the (at the time unpopular) decision to allow students to use hand-held calculators for computing medication dosages. Believe me, it wasn't that long ago.

As we all know, technology has exploded with new products and gadgets, each one presenting new and exciting opportunities for educational and professional development.

With this in mind, staff of The Norman Knight Nursing Center for Clinical & Professional Development, led by e-Learning team leader, Tom Drake, have been working on ways to incorporate new technologies into our educational service lines and nursing competency development. I'm pleased to announce that you can now follow us on Twitter (our handle is MGHKNC), and you can also find us on Facebook.

We invite you to bring your own personal devices to the next course or class you attend sponsored by the Knight Nursing Center. Bring your laptop, iPad, or any

other portable device you're comfortable using to access information. Not only does this allow you to use the learning device best suited to your needs, it's one more way to support our going green initiatives.

Since launching our going green initiatives last year, (minimizing unnecessary hard-copy hand-outs) feedback has been very positive. Participants appreciate having the option to use whichever 'low-tech' or high-tech devices they prefer, and individuals learn more when they're able to use the learning strategies that work best for them.

As we embark on a new year, we're excited about the possibilities that technology holds. It's our on-going mission to explore and employ the most up-to-date educational techniques to ensure we're the best clinicians we can be, providing the safest, highest quality care to our patients every day.

I wish you all a Happy New Year. And be sure to check us out at:



For more information (or if you don't know what that means), call 3-6530.



# Veteran MGH nurse and MGH School of Nursing alumna remembered

—by Maureen Hemingway RN

Donovan will be missed by her friends and colleagues throughout Patient Care Services, but her legacy of kindness, compassion, and inclusion will long be remembered.

Veteran nurse, Frances ‘Fran’ Donovan, RN, passed away on September 18, 2011. She began nursing at a time when nurses still wore white dresses and shoes and sometimes a nursing school cap. Colleague, Maureen Hemingway, RN, remembers her this way: “I met Fran many years ago when I was a new graduate nurse on White 7. White 7 was one of two surgical wards at that time. The elevators in the Gray and White buildings still had a button for 3A. (3 and 3A were the surgical floors back then). Fran was proud to have graduated from the MGH School of Nursing. I found her to be a kind and generous resource on that busy surgical unit. I would see her coming with her bin of supplies and know I had an ally. I could quietly ask her questions and know I’d get an honest answer.

“I encountered Fran again when we worked in the operating room together. When MGH operating rooms began incorporating intra-operative auto-transfusion services, I became responsible for auto-transfusion. Fran had a single-minded devotion to blood recovery and was a great resource for physicians and nurses alike. It was through Fran’s expertise that many pa-

tients with diverse cultural and religious beliefs were able to achieve optimum health. Her commitment to caring for patients of diverse backgrounds in an inclusive, respectful, and knowledgeable manner is one of her greatest legacies. Fran’s devotion to our unit meant never having to think about coverage for auto-transfusion. Staff always worked out any scheduling issues. There always was, and still is, a shared commitment to put patients first.



Frances Donovan, RN  
veteran staff nurse

“Fran adored her grandchildren. Those of us with daughters and granddaughters can relate to the joy Fran derived from that world of fairy princesses and magic castles. Fran was quick to share pictures of her beloved grandchildren, stopping everyone at the corner of ‘OR 30’ and the ‘GOR’ desk. I’ll always remember her delight at telling us about those precious children.

“In times of loss, I’m comforted by that old story, imagining Fran on a sailboat leaving our shore. We’re sad to see her go, but know others on the far shore are waiting to welcome her with open arms.”

Fran Donovan will be missed by her friends and colleagues throughout the MGH community, but her legacy of kindness, compassion, and inclusion will long be remembered.

# Putting pain-assessment tools closer to the bedside

An important part of providing safe, high-quality, effective care is accurately assessing and re-assessing pain in a timely manner. Pain can interfere with healing, rehabilitation, sleep, and quality of life, so controlling it is a clinical priority.

**Question:** I've noticed new pain-assessment tools on some units. Can you tell us about that?

**Jeanette:** An important part of providing safe, high-quality, effective care is accurately assessing and re-assessing pain in a timely manner. Pain can interfere with healing, rehabilitation, sleep, and quality of life, so controlling it is a clinical priority. Recent studies show that 50% of patients who've had major trauma or surgery still have pain a year later. A high level of pain immediately following trauma or surgery is a good indicator of whose pain will linger.

**Question:** Why is it necessary to have these tools at the bedside?

**Jeanette:** A recent study showed that only 41% of patients at MGH were able to verbally express their pain. For those who could rate their pain, only 68% preferred a numeric pain scale over verbal description or functional pain scales. Showing patients a pain scale and explaining how it works helps improve the accuracy of pain ratings. Having these tools at the bedside gives nurses quick, easy access to whichever tool is best suited for the patient they're caring for.

**Question:** How do you use them?

**Jeanette:** For patients who are developmentally, physically, and mentally able to self-report, asking them to rate their pain is best. First ask about the location and nature of the pain, then show the assessment

tool, explain the different scales, and ask which one they prefer. For patients unable to self-report, observe for behaviors indicative of pain (listed on reverse of tool). Document both which tool was used and the score.

The Joint Commission requires that all patients be assessed for pain upon admission and informed about how we measure and treat pain. When pain is treated, we're required to assess the patient before and after the intervention to determine the safety and efficacy of treatment. At MGH we re-assess patients one hour after treating pain and every four hours after that for patients receiving on-going pain therapy.

**Question:** How are these pain-assessment tools being distributed?

**Jeanette:** The Pain Management Committee will be distributing the tools along with a brief training program over the next few weeks. Training will be tailored to the needs of each unit and patient population in collaboration with clinical nurse specialists and nursing directors.

**Question:** Where can I get more information about these pain-management tools?

**Jeanette:** Visit the Patient Care Services Excellence Every Day portal page at: [http://www.mghpcs.org/eed\\_portal/EED\\_pain.asp](http://www.mghpcs.org/eed_portal/EED_pain.asp), or call Paul Arnstein, RN, pain clinical nurse specialist, at 4-8517.

# Announcements

## The MGH Blood Donor Center

The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,  
7:30am – 5:30pm

Friday, 8:30am – 4:30pm  
(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,  
Thursday,  
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

## Senior HealthWISE events

All events are free for seniors 60 and older

Lecture Series

“Macular Degeneration”  
Thursday, January 5, 2012  
11:00am–12:00pm

Haber Conference Room  
Speaker: Chirag Shah, MD,  
Ophthalmic Consultants of Boston

“Boost Your Brain Power”  
Thursday, January 19th  
11:00am–12:00pm

Haber Conference Room  
Speaker: Marie Pasinski, MD,  
neurologist

Book Club

Thursday, January 19th  
3:00–4:00pm

West End Library  
151 Cambridge Street  
Community Room  
Book Club will discuss  
*Cleopatra: a Life* by Stacy Schiff.  
Light refreshments provided.

Hypertension Screenings  
Monday, January 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.

## 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).

## Attention clinical research nurses

The International Association of Clinical Research Nurses (IACRN) is looking for clinical research nurses interested in participating in a new local chapter.

The IACRN is an international organization dedicated to promoting the role of clinical research nurses and providing a forum for research nurses, research nurse practitioners, and others to discuss issues common to this specialized practice.

Membership in the Boston chapter is open to all interested research nurses in New England. Meetings are held three times per year. Next meeting:

March 8, 2012  
6:00pm  
location TBA

For more information, contact Mary Larkin, RN, at 4-8695, or e-mail [bostoniacrn@gmail.com](mailto:bostoniacrn@gmail.com).

## One-stop intranet site for strategic priorities

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

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

<http://priorities.massgeneral.org>.

## Make your practice visible: submit a clinical narrative

*Caring Headlines* is always interested in clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services.

Make your practice visible. Submit your narrative for publication in *Caring Headlines*.

Send submissions to:  
[ssabia@partners.org](mailto:ssabia@partners.org).  
For more information,  
call 4-1746.

## What you should know about human trafficking

January 11th is Human Trafficking Awareness Day

“Heightened awareness, enhanced response: a discussion on human trafficking and child sexual exploitation”

featuring speakers from the My Life, My Choice Project through The Family Justice Center, Boston Police Department, and the MGH Emergency Department.

January 11, 2012  
12:00–1:30pm  
Simches Conference Room 3-130

A light lunch will be served. Social Work CEUs available.

Please RSVP by January 3rd to 6-6976, or for more information, call Elizabeth Speakman, at 6-7674.

### Published by

*Caring Headlines* is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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For more information, call:  
617-724-1746

### Next Publication

January 19, 2012

# Blake 8 nurses go green and artsy-crafty at the same time

**Y**ou may have noticed some of your colleagues sporting colorful flower badge-holders. Those badge-holders are the handwork of a couple of industrious nurses on Blake 8 who salvage the brightly colored tops of medicine vials and turn

them into little works of art. Sold for a nominal fee, some of the proceeds help fund postage for bereavement cards sent to families of patients who die on their unit and other charitable efforts. For more information, call Christine Gryglik, RN, at 4-3886.



Blake 8 nurses, Christine Gryglik, RN, clinical nurse specialist (left), and Kim O'Leary, RN, resource nurse, turn recycling into an art form with their colorful flower badges made from salvaged medicine-vial covers.



(Photo on left and lower right by Paul Batista)

**Caring**  
Headlines  
January 5, 2012

Returns only to:  
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MGH, 55 Fruit Street  
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Boston, MA

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