

# Caring

Headlines

April 4, 2013

## Enhancing handover communication with SBAR

Situation  
Background  
Assessment  
Recommendation



*See Jeanette Ives Erickson's column on page 2*

During change-of-shift handover of patient, Steve Henderson, orthopaedic staff nurses, Bailey Fairbanks, RN (center) and Genevieve De Los Reyes, RN, review SBAR information.

# Enhancing handover communication with SBAR

Originally developed by the US Navy as a communication technique, SBAR has been adopted by many hospitals across the country as a simple, effective format for handover communication. SBAR stands for: Situation, Background, Assessment, Recommendation.

**W**hether talking about change of shift, transferring patients from one unit to another, or discharging patients to other facilities, at some point, every patient admitted to MGH is transferred from one care team to another. We call this transfer of care, a 'handover.' Throughout the years, handovers have taken many forms: from written documentation, to taped reports, to face-to-face communication, to countless other iterations.

Today, *warm* handovers are considered the standard. Warm handovers are the verbal sharing of information:

- from one care provider to another
- from one unit to another
- from one organization to another

The transfer of care from one team to another is one of the most pivotal junctures in health care. Studies show that effective communication during handovers has a favorable impact on patient safety and continuity, so *how* we communicate is of utmost importance. Some patient information is essential; some may be less relevant, so having a way to prioritize and standardize the information we share during handovers is key.

Originally developed by the US Navy as a communication technique, SBAR has been adopted by many hospitals across the country as a simple, effec-



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

tive format for handover communication. SBAR stands for: Situation, Background, Assessment, Recommendation. It's a mechanism for deciding what information should be shared and at just the right level of detail. SBAR provides standardized prompts to help staff formulate concise information, minimizing the need to repeat it over and over:

- Situation: identify yourself and your position, the patient's name and current situation. Describe what's going on with the patient
- Background: share the relevant history and physical, the physical assessment pertinent to the problem, treatment/clinical summary, and any pertinent changes
- Assessment: offer your conclusion about the present situation
- Recommendations: explain what you think needs to be done, what the patient needs, and when

*continued on next page*

Phase II of the Innovation Unit roll-out began April 1st, bringing the total number of Innovation Units to 39. As we continue to strive to improve care and reduce costs, warm handovers, SBAR, and inter-disciplinary rounds will be key to our success.

Warm handovers using the SBAR approach are one of the interventions being implemented on our Innovation Units with great results.

On the Ellison 16 Medical Unit, staff use SBAR for nurse-to-nurse report as well as inter-disciplinary rounds. And they've expanded on the concept by calling nursing homes, rehab hospitals, and other facilities an hour after patients have been admitted to make sure staff at the receiving facilities understand the plan and any other relevant information. In measuring re-admission rates, they've found that of the patients whose facilities were called, the re-admission rate was 16%. Those whose facilities weren't called had a re-admission rate of 27%.

Many patients on the Lunder 9 Oncology Unit are transferred to Spaulding Rehabilitation Hospital. Staff have built relationships with the staff there, visiting each other's sites and holding weekly meetings to review patients' progress. SBAR is used to facilitate communication from the acute-care to the long-term-care setting. Nursing director, Barbara Cashavelly, RN, tells me there's open communication between the units, and patients and families are comforted knowing their primary caregivers have a relationship with their rehab team.

On our Obstetrics Unit, a patient was spared a pre-term birth because a thorough SBAR exchange resulted in a Neurology consult that revealed a less critical diagnosis, allowing the patient to carry her baby to term.

The Psychiatric Unit has also expanded on the concept of warm handovers, bringing patients to the outpatient psychiatric clinic prior to discharge so they can meet staff and see where the clinic is located for future appointments. This has resulted in a decrease in missed outpatient appointments for Blake 11 patients.

Because warm handovers and the SBAR format are key elements of the important work being done on Innovation Units, a two-pronged educational program was developed to help familiarize staff with their use. The HealthStream course, *Innovation in Care Delivery: SBAR*, provides information about the principles, concept, and components of SBAR, while unit-based in-service training by Knight Nursing Center educators gives staff an opportunity to try it out, ask questions, and engage in meaningful discussion about all aspects of warm handovers.

Phase II of the Innovation Unit roll-out began April 1st, bringing the total number of Innovation Units to 39. As we continue to strive to improve care and reduce costs, warm handovers, SBAR, and inter-disciplinary rounds will be key to our success. And as we continue to learn from the work on Innovation Units, I look forward to hearing more stories of how you incorporate these interventions into your daily practice and tailor these tools to meet the individual needs of your patients and families.

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*As Paul Revere might have said if he'd only known:*  
**“eBridge is coming! eBridge is coming!”**

—by Sally Millar, RN; and Gino Chisari, RN

**A**s phase I of eBridge gets under way later this month, nurses on adult, medical-surgical inpatient units will begin electronically documenting initial nursing assessments (INAs). A pediatric INA is also being developed and will be available in phase II of the project, scheduled to go live in November. Also in the fall, clinicians will have the ability to electronically document progress notes and view them in the Document Repository (aka Notes Repository). The interim MGH-developed eBridge application is intended to:

Sample initial nursing assessment page in eBridge

- be a ‘bridge’ to Partners eCare, the integrated health information system that Partners will adopt in 2016
- be easy for clinicians to use by employing a familiar platform
- provide an application where notes would not have to be printed and manually signed
- introduce an abbreviated ‘gray book’ for forms, such as health care proxies, consents, etc.
- introduce more computers on units so clinicians don’t have to wait to enter their documentation
- be piloted on hand-held devices
- simultaneously roll out Windows 7 on clinical workstations to decrease log-on times

**Initial Nursing Assessment**

**Health Management**

Reason for hospitalization: Right foot cellulitis x 2 weeks 20h KMT

Past medical history:

Social history:

Current home services:

|  |   |  |                            |
|--|---|--|----------------------------|
| <input checked="" type="checkbox"/> Home health aide | <input type="checkbox"/> Homemaker        | <input type="checkbox"/> Hospice             | 23h JV<br>23h MF<br>1h DJL |
| <input type="checkbox"/> Occupational therapy        | <input type="checkbox"/> Nursing          | <input type="checkbox"/> Nutrition           |                            |
| <input type="checkbox"/> Social work                 | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Respiratory therapy |                            |
| <input type="checkbox"/> Other                       | <input type="checkbox"/> Speech therapy   | <input type="checkbox"/> None                |                            |
|  |   |  |                            |

Alternative/ Complementary practices **Do you currently use any of the following?**

|                                       |   |  |                   |
|---------------------------------------|---|--|-------------------|
| <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> Acupressure                  | <input checked="" type="checkbox"/> Aromatherapy | 20h KMT<br>1h DJL |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Herbal medicine              | <input type="checkbox"/> Homeopathic therapy     |                   |
| <input type="checkbox"/> Reiki        | <input checked="" type="checkbox"/> Therapeutic touch | <input type="checkbox"/> None                    |                   |
|                                       |   | <input type="checkbox"/> Other                   |                   |

**Admission Vitals**

Temperature:  F =  C

Height:  ft  in =  cm

Measured  Estimated  Reported

Weight:  lbs =  kg

Sally Millar, RN, director of PCS Informatics; Tony Weiss, MD, co-chair of the Clinical Policy & Records Committee; and Debbie Adair, director of Health Information Services, are leading the transition from Acute Care Documentation to eBridge. Joanne Empoliti, RN, clinical nurse specialist, has provided subject-matter expertise and solicited input from nurses and others as part of the vetting and approval process. The Norman Knight Nursing Center is coordinating education efforts. Project manager, Ann McDermott, RN, is coordinating the hardware roll-out with Information Systems.

Training began April 1st with the assignment of a mandatory HealthStream course for nurses on participating units; other training options will be offered, including a demonstration of eBridge and optional classroom sessions. Training will continue through April 29th, with the go-live date scheduled for April 30th.

For more information, contact Sally Millar at 6-3104, or Gino Chisari, RN, at 3-6530.

# What does a culture of safety look like?

—by Lela Holden, RN, patient safety officer, MGH Center for Quality & Safety

**B**est-case scenario: everything goes perfectly for every patient, every day. And most of the time, that's the case. But every once in a while, something unexpected happens. We've all been there: a patient fall; an error in a patient's alerts; a medication wrongly recommended. Events like this can happen even in areas with a strong culture of safety. On March 7, 2013, as part of Patient Safety Awareness Week, three leaders from just such areas shared stories illustrating how leaders can respond to these events in ways that engender learning and process-improvement.

Nursing director, Susan Morash, RN, told of a fall that occurred on her unit. Even though the patient wasn't injured, staff were immediately informed. Discussion about the incident led to a change in practice: when a patient voices a need to use the bathroom, a speedy response by staff should follow. They created a sign stating that whoever's closest to the patient's room should respond, and the primary nurse will be paged. Staff nurse, Lily Shaw, RN, recalled how her colleagues offered emotional support after a patient fall, which was not only comforting but reinforced their culture of safety and teamwork.

Michael Sullivan, PT, director of Physical and Occupational Therapy, spoke about the culture within his department of constantly improving processes. He shared that issues and concerns are routinely communicated across departments. Staff talk openly about the challenges they face with an eye toward systemic improvement.

Lisa Brugnoli-Semeta, RN, nurse manager of MGH Back Bay, shared an event related to a medication order. Again, the patient wasn't harmed, but she viewed the event as an opportunity to learn. Brugnoli-Semeta shared the ac-

tions she takes to build, nurture, and sustain a culture of safety:

- Be respectful: it's about the process, not the person
- Be inclusive: all staff who need to know are brought into the discussion and then more staff
- Keep the dialogue transparent, not behind closed doors
- Inform new hires that the team shares errors and successes, so those coming in will continue to build on the culture of safety

Though these leaders represent diverse clinical areas, they have similar approaches to safety. They all use adverse events as opportunities to learn, a practice from which we could all benefit.

For more information about creating a culture of safety within Patient Care Services, call Colleen Snyderman, RN, director, PCS Office of Quality & Safety at 643-0435.



(L-r): presenters, Michael Sullivan, PT, director, Physical & Occupational Therapy; Lily Shaw, RN, staff nurse, and Susan Morash, RN, nursing director; and Lisa Brugnoli-Semeta, RN, nurse manager, MGH Back Bay.

# Patient's well-being drives clinical decision-making

Unfortunately, Mr. C's code status was unclear. The advance directive that had accompanied him from his home state shed little light on the subtleties of what he considered 'appropriate or acceptable treatment.'

**M**y name is Ida Meister, and I'm a staff nurse on the Lunder 8 Neuroscience Unit. The Buddha is quoted as saying, "Don't look for applause." We do what feels ethical, well-chosen, and loving—that's reason enough for our actions. A recent example of this concerns a 68-year-old man with extensive co-morbidities who was transferred to MGH from out of state, and his 95-year-old mother/caregiver who had suffered a recent stroke.

Mr. C lived with his mother, who was also his healthcare proxy (or agent). He was diabetic, but paid no mind to diet or blood-sugar and had a cavalier attitude about his hypertension, morbid obesity, and other health issues, often refusing to take his medication. He was divorced, and had been estranged from his two adult children, a son and a daughter, whom he hadn't seen in months. His elderly mother had not seen him since he was hospitalized in his home state.

During that hospitalization for abdominal pain, it was discovered that Mr. C had had a GI bleed, a heart attack, and changes in his mental status. It was assumed he'd had a seizure, and he was transferred to MGH.

My colleagues worked for nearly two weeks to meet the needs of this complex patient. Mr. C had developed an immunological reaction to medication, was covered with lesions that leaked large amounts



Ida Meister, RN, staff nurse, Lunder 8

of albumin, sloughing off layers of epidermis and putting him at great risk for infection. This required constant and exacting care. Mr. C's PICC line was extremely close to open wounds. He was at risk for sepsis and renal failure. There had been no evidence of seizure activity, only multiple metabolic problems, but he'd been brought to the Neuroscience Unit, so he was my patient now.

Unfortunately, Mr. C's code status was unclear. The advance directive that had accompanied him from his home state shed little light on the subtleties of what he considered 'appropriate or acceptable treatment.'

In collaboration with his care team and case manager, I felt Mr. C's family should be notified. I thought they should come in and see him to get a realistic understanding of his situation and the degree of his suffering. No informed decisions regarding his care could be made without them.

I've never shied away from irate, hostile, defensive, or dysfunctional families. For me, the key is lis-

*continued on next page*

I felt a sense of relief come over Mr. C's family. I knew they'd be able to go back to their hotel comfortable that they'd resolved these thorny issues... Everyone involved in Mr. C's care performed to the top of their capabilities; not for 'applause,' but to ensure the well-being of our patient and his family. And that was reason enough.

tening and keeping an open mind. Sometimes, that's not as simple as it sounds. There were many phone calls to various family members. I tried to convey that constant telephoning wasn't the best way for them to appreciate Mr. C's extensive care needs. I tried to stress, without panicking them, that putting off a visit was not advisable. The daughter was hesitant to make the trip—it was highly inconvenient.

"Do you think he'll live until Saturday?" she asked.

I replied, "Your father is acutely ill and in a great deal of pain. We're working very hard to address his medical issues. But his situation is very complex."

I counseled the daughter and grandmother separately over the phone. The grandmother, despite a hearing impairment and advanced age, was more realistic and grounded. I think they ultimately agreed to come because they felt I understood their concerns and reservations and welcomed their input.

After many laborious calls, I was able to convince Mr. C's daughter to pick up her brother and grandmother (Mr. C's mother), and come to Boston the next afternoon.

I had laid much of the groundwork over the phone. The next day, I made a point of greeting Mr. C's family as soon as they arrived on the unit. I tried to put them at ease as I brought them to the bedside. The room was full of monitors and equipment given Mr. C's many debilitations, and I thought it might be overwhelming for them.

I encouraged them to observe as I went about caring for Mr. C, explaining the many treatments he'd received: transfusions, repletions, blood work, dressings, daily consultations with vigilant dermatology and medical teams, recommendations of the PICC team, etc. I showed them his lesions and explained what we were doing about them; I let them know I had extensive experience with dermatology and burn care. I wanted them to understand the full scope of his condition. I treated them with respect as welcome participants. I tried to allay their anxiety with the skill that comes with a lifetime of caring and a desire to alleviate suffering.

Any family, however fractured or dysfunctional, needs to know that the people caring for their loved ones truly care. There's no substitute for that.

The senior resident who met with the family was kind and professional, but he hadn't yet developed a relationship with the family. So I felt my role was to help ease everyone into a discussion while creating a

relaxed and comfortable atmosphere. The senior resident and I made a great team. I could see the family's tension dissipate.

During the family meeting we obtained a DNR/DNI (Do Not Resuscitate/Do Not Intubate) order, ascertained that if dialysis became warranted it would be acceptable to, 'try it for a while to see if it reversed the problem,' then re-assess whether to continue. A new healthcare proxy form was signed, in which the mother, son, and daughter were named as proxies (in descending order). All in attendance were satisfied with the result.

I felt a sense of relief come over Mr. C's family. I knew they'd be able to go back to their hotel comfortable that they'd resolved these thorny issues.

They repeatedly stressed how glad they were that they'd made the trip to Boston; they felt they were doing what Mr. C really wanted, and they appreciated the excellent care he was receiving.

Later that night, Mr. C was transferred to a medical unit. Staff on that unit felt well prepared to receive him based on the thorough report we provided. We explained Mr. C's condition in meticulous detail, informed the attending physician of the most recent lab values; albumin transfusions; the blood-sugar, steroid, and tube-feeding situation; kidney concerns; and his risk for infection.

Everyone involved in Mr. C's care performed to the top of their capabilities; not for 'applause,' but to ensure the well-being of our patient and his family. And that was reason enough.

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

Was it Shakespeare who said discretion is the better part of valor? As it turns out, it may be an important part of nursing, too, as Ida's narrative so beautifully demonstrates. What a subtle and skillful example of ethical comportment. Ida recognized the depth of Mr. C's suffering and knew his family wouldn't be able to appreciate it without physically seeing him. Driven by her clinical knowledge, her collaboration with the rest of the team, and her compassion for Mr. C, she took a risk and called his family. It took courage (and perseverance) but it ultimately brought peace and reconciliation to a family that had been estranged for many months.

Thank-you, Ida.

# Medical Nursing's Albert H. Brown Visiting Scholar Program

—by Jennifer Sargent, RN, nursing director

**O**n March 19, 2013, Medical Nursing's second Albert H. Brown Visiting Scholar Program hosted Eileen Stuart-Shor, RN, assistant professor in the College of Nursing and Health Sciences at the University of Massachusetts, Boston. In her opening remarks, associate chief nurse, Theresa Gallivan, RN, thanked MGH Board of Trustees member, Dorothy Terrell, for her generous support of the program that now bears her late husband's name.

Stuart-Shor's presentation, "Health Equity: Addressing Racial and Ethnic Disparities in Health and Health Care," spoke to the importance of providing culturally tailored care to close the gap created by health-care disparities. Said Stuart-Shor, "It's the responsibility of the provider, not the patient, to find a way to bridge those differences." As long as we possess curiosity, respect, and empathy, we're on our way to addressing the disparities that exist in health care. Staff nurses, Erin Marino, RN, and Suzanne Murphy, RN, shared narratives related to disparities in care, and Stuart-Shor facilitated a discussion about the value of a narrative culture in helping staff realize the importance of being present to patients and recognizing the contributions of our colleagues.

Deb Washington, RN, director of PCS Diversity, facilitated the lunchtime session, "New Frames for Delivering Care to a Diverse Society," where participants identified missed opportunities that occur in the course of our daily practice. Discussion centered on 'cultural humility' versus 'cultural competence' and the importance of individualizing patient care.

In one afternoon session, associate chief nurse, Kevin Whitney, RN, presented, "Professional Associations: the Voice of Nursing," in which he outlined reasons nurses should strive to become the voice of healthcare equity. He encouraged attendees to register to vote, seek certification, and join professional organizations.

The final session, "Achieving Health Equity: Exemplars from the Field," was a discussion with panelists

Chantal Kayitesi, LPN, and Maggie Sullivan, RN. Kayitesi shared her work as refugee women's health access coordinator at MGH Chelsea Heath Center and the challenges faced by refugee families. She stressed the importance of making sure non-English-speaking patients understand care plans, discharge instructions, and medications. Sullivan spoke about her role as a family nurse practitioner with Boston Health Care for the Homeless. She spoke about the challenges associated with 'connecting with' homeless patients and the transient nature of the majority of homeless individuals. Finally, Stuart-Shor shared her own work with Roxbury Heart and Sole and its sister organization in Kenya. All three panelists shared unique dimensions of their innovative programs and how they're striving to provide equitable care for the populations they serve.

For more information about Medical Nursing's Albert H. Brown Visiting Scholar Program, contact Jennifer Sargent, RN, 4-6020.



(L-r): Chantal Kayitesi, LPN, refugee women's health access coordinator; Maggie Sullivan, RN, family nurse practitioner; and Albert H. Brown visiting scholar, Eileen Stuart-Shor, RN, assistant professor in the College of Nursing & Health Sciences at UMass, Boston.



# Preventing catheter-associated urinary-tract infections

Throughout Partners, an internal performance framework has been established to address these conditions using hospital-based process-improvement initiatives... MGH will focus on catheter-associated urinary tract infections (CAUTIs) as our part of the internal performance framework.

*Question:* What are hospital-acquired conditions?

*Jeanette:* Hospital-acquired conditions are conditions that patients acquire during the course of their hospitalization. These conditions can impact patients' recovery and length of stay, so preventing them is a high priority. And in many instances hospital-acquired conditions *are* preventable and therefore may not be reimbursable.

*Question:* How is MGH responding to this?

*Jeanette:* Across the country, efforts are being made to reduce hospital-acquired conditions. Throughout Partners, an internal performance framework has been established to address these conditions using hospital-based process-improvement initiatives. For 2013, MGH will focus on catheter-associated urinary tract infections (CAUTIs) as our part of the internal performance framework.

*Question:* Why did MGH select CAUTIs?

*Jeanette:* MGH CAUTI rates show opportunities to improve. You can review your own unit's CAUTI rates on the nursing-sensitive indicator board. An inter-disciplinary CAUTI Tiger Team has been formed to look for ways to further reduce CAUTIs and share this important work throughout the hospital. In July of 2012, the Tiger Team instituted a

Provider Order Entry (POE) template highlighting indicators for urinary-catheter placement. POE also includes a 24-hour, electronic prompt for re-assessment. Last summer, in an effort to further reduce CAUTI rates, an educational program for nurses entitled, *Prevention of Urinary Catheter-Associated Infections*, was assigned through HealthStream.

*Question:* What can we do to help reduce CAUTI rates?

*Jeanette:* There are many evidence-based interventions that nurses and patient care associates can perform to help prevent CAUTIs. The number one contributing factor for CAUTIs is the duration of catheter placement, so we must continue to re-assess patients' need for catheters and remove them as soon as possible.

Other strategies include: accurate assessment and re-assessment of the need for urinary catheters; aseptic technique during insertion; and appropriate maintenance of urinary catheters. It's important to remember that provider orders are required for all insertions and removals of urinary catheters. We've made excellent progress in reducing the incidence of catheter-associated urinary tract infections, but much more can be done.

For more information about hospital-acquired conditions, catheter-associated urinary tract infections, or the work of the CAUTI Tiger Team, call Colleen Snyderman, RN, director, PCS Office of Quality & Safety, at 643-0435.

# Cherished colleague and nurse leader retires

*MGH bids farewell to nursing director, Susan Tully, RN*

**H**ow do you say good-bye to a nurse leader who's been a fixture in the MGH community for more than 40 years. No matter the role—staff nurse, supervisor, or the one she loved most, nursing director—Susan Tully, RN, was the epitome of Excellence Every Day with her passion for patient care, indomitable work ethic, and devotion to her staff and the MGH community.

As nursing director of the Surgical ICU, Tully was responsible for one of the most high-stakes environments in the hospital with its constantly shifting landscape of patient needs and critical decision-making. As if made for the role, she led the unit with skill, humanity, humility, and tremendous grace under pressure.

Some may recall Tully's leadership in bringing two surgical ICUs together—two units with very different patient populations and cultures into what is now the Ellison 4 SICU, a unit that boasts a highly integrated staff with a solid culture of teamwork and collaboration.

Like all great leaders, Tully cultivated leadership  
*continued on next page*



Susan Tully, RN,  
former nursing director, SICU

Saying good-bye in style—Tully style, that is. In homage to their beloved leader, staff of the SICU donned Tully's trademark scrub dress and TEDS (stockings) for a farewell photo on her last day as nursing director. Ever the good sport, Tully (center back) took the tribute in stride.



## Retirement (continued)

in her staff, encouraging autonomy in patient care, supporting participation in collaborative governance, and instilling in them the confidence to test boundaries and reach beyond their comfort zones. She encouraged staff to take sound clinical risks when it would benefit the patient, and she always, always, recognized their skill and abilities as clinicians.

An innovative thinker and risk-taker herself, Tully was involved in developing the New Graduate Critical Care Nursing Program, the highly successful, six-month, intensive learning experience for new graduate nurses interested in practicing in the ICU setting. She worked with the hospital to create the rare opportunity for a reporter from *The Boston Globe* to shadow a veteran nurse as she precepted a new-graduate nurse in the ICU.

This eight-month glimpse into a world the public rarely sees showcased nursing practice at its best. The result was an award-winning, four-part series that earned international acclaim.

Tully served on the board of the PCS Clinical Recognition Program. It is further testament to her leadership abilities that the first clinician ever recognized as a clinical scholar was a member of Tully's SICU staff.

It's well known that nursing directors are typically asked to leave the unit during Magnet site visits so staff will feel free to speak honestly and openly to appraisers. But that directive what tacitly ignored during our recent Magnet site visit as appraisers *sought Tully out* to give her the feedback her staff had so effusively shared about her transformational leadership and what it had meant to them.

Says Paula Restrepo, RN, SICU staff nurse, "Leadership has always been key to the success of our unit. I want to thank Susan her for her vision, dedication, and hard work in making this unit a great place for patients and nurses."

Staff nurse, Kelly Galavin, RN, adds, "Susan viewed her position as one of service not oversight, and she role-modeled that approach throughout her entire career. She always showed flexibility, adaptability, and fairness, which told us she understood that nurses have lives outside of work, and we appreciated that."

In 2006, Tully was nominated for *Nursing Spectrum's* Nurse of the Year Award in the category of Excellence in Nursing Management. She was nominated by her staff—and not just nurses—patient care associates, housekeepers, secretaries, residents, fellows, attending physicians, and allied health professionals. When asked what the key to being an effective leader is, Tully said, "If you take care of your staff, staff will be in a better position to take care of patients."

So how do you say good-bye to a nurse leader who's given so much of herself to her patients and staff over the course of her distinguished career? Perhaps the best way is to just say, Thank-you. Thank-you for your strength of character, your caring and compassionate manner, and your commitment to creating an environment of excellence. You will be missed. You will be remembered. And you will always be an important part of our MGH family.



Tully, as *Nursing Spectrum's* Nurse of the Year in 2006.

### Published by

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

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### Next Publication

April 18, 2013

# Announcements

## Blum Center Events

Shared Decision Making:  
"Uterine Fibroid Treatment"  
Wednesday, April 10, 2013  
12:00–1:00pm  
Speaker: Julie Jolin, MD

National Health Observances:  
"Understanding Advance-Care  
Directives"  
Tuesday, April 16th  
12:00–1:00pm  
Speaker: Carolyn LaMonica, RN

Benson-Henry Talk:  
"Stress Reduction  
for the Whole Family"  
Wednesday, April 24th  
12:00–1:00pm  
Speaker: Rana Chudnofsky

**Special Event**  
(registration required)  
Leana Wen, MD, will discuss  
her new book,  
*When Doctors Don't Listen*  
Friday, April 12th  
12:00–1:00pm  
Copies are available at the  
General Store.

E-mail [jsear1@partners.org](mailto:jsear1@partners.org) to  
register.

For more information,  
call 4-3823.

## Memorial celebration for James Silvia, RN

A memorial celebration  
to honor the life of  
James Silvia, RN, will be held:

April 4, 2013  
7:00am  
Shriners Hospital for Children  
51 Blossom Street

A breakfast reception will follow  
in the East Garden Dining Room  
at MGH.

## Save the Dates

### Financial Assistance Seminar

Thursday, April 25, 2013  
12:00–1:00pm  
Thier Conference Room  
Representatives from Harvard  
University Employees Credit  
Union and the MGH Institute of  
Health Professions will discuss  
options to help finance your  
education.

### Higher Education Fair

Thursday, May 23rd  
12:00–3:00pm  
Bulfinch Tent  
One-stop-shopping for  
certificate, undergraduate, and  
graduate clinical and non-clinical  
programs, including nursing,  
research administration, inpatient  
coding, healthcare policy, and  
administration. Featured schools  
include Boston University; Bunker  
Hill Community College; MGH  
Institute of Health Professions;  
Simmons College; and UMass,  
Boston.

For more information,  
call 4-3241.

## Senior HealthWISE events

All events are free for  
seniors 60 and older

### Lecture Series

"Common Skin Conditions  
of the Foot"  
Thursday, April 4, 2013  
11:00am–12:00pm  
Haber Conference Room  
Speaker: Quinn Charbonneau,  
resident, MGH Podiatry Service,  
will talk about maintaining  
healthy feet.

"Depression: When is it More  
than Just the Blues?"  
Thursday, April 25th  
11:00am–12:00pm  
Haber Conference Room  
Speaker: Anthony Weiner, MD,  
director of MGH Outpatient  
Geriatric Psychiatry,  
will talk about how to identify  
signs and symptoms of depression.

Hypertension Screenings:  
Monday, April 22nd  
1:30–2:30pm  
West End Library  
151 Cambridge St.  
Free blood pressure checks with  
wellness nurse, Diane Connor, RN.

### Special Event

Boston Conservatory Cabaret  
will perform songs from favorite  
Broadway musicals  
Monday, April 8th  
2:30–3:30pm  
Thier Conference Room  
(RSVP required call: 4-6756)  
For more information,  
call 4-6756.

## Connell Visiting Scholar

Angela Barron McBride, RN,  
international nurse leader and  
Connell visiting scholar will  
present,

"Orchestrating a Career for  
Nursing Leadership"

April 5, 2013  
9:30am

O'Keefe Auditorium

For more information,  
call 3-0431.

## ACLS Classes

Certification:

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

Day one:  
April 8, 2013  
8:00am–3:00pm  
O'Keefe Auditorium

Day two:  
April 22nd  
8:00am–1:00pm  
Thier Conference Room

Re-certification (one-day class):  
May 8th  
5:30–10:30pm  
Founders 130 Conference Room

For information, contact Jeff  
Chambers at [acls@partners.org](mailto:acls@partners.org)

Classes are subject to change;  
check website for current dates  
and locations.

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).



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